Hanover
FOR OUR HOMELESS
HOUSING · SUPPORT · RESEARCH

Hanover Welfare Services

SUBMISSION TO SENATE SELECT COMMITTEE ON MENTAL HEALTH

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INTRODUCTION

The Work of Hanover Welfare Services

Hanover's mission is to empower people who are homeless or at imminent risk of becoming so, to enable them to take greater control over their lives and to stimulate and encourage change in Australian society to benefit them. This is achieved by delivering services, conducting research and through advocacy. It is a non-profit independent company limited by guarantee and is a registered charity.

Founded in 1964, Hanover's range of services assist approximately 450 people daily, involving the provision of both crisis and transitional accommodation, financial and material aid, counselling, meals, budgeting, medical assistance, work skills training and recreational opportunities.

Hanover Welfare Services has a strong interest in issues relating to mental health as a result of our work and research with people who are homeless, people who are at risk of homelessness and people going forward in their lives following a housing crisis or homelessness.

The relevance of Hanover's work to mental health issues

There is high prevalence of mental illness amongst our clients and we are constantly struggling with an inadequate mental health service system to ensure that our clients receive the support and treatment that they need.

Hanover greatly welcomes the Inquiry and the opportunity to record its experience in terms of the mental health system. We are well-positioned to comment on 4 of the terms of reference of the Senate Select Committee on Mental Health. Our submission is structured as follows:

1. **The prevalence of mental health conditions amongst the homeless population.**

2. **Adequacy of services in the mental health system for people with complex needs and drug and alcohol dependency conditions.**

Responding to terms of reference b and f.

- ***the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.***

- ***the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.***

3. **The effect of inadequate services on homeless people in terms of mental health.**

   Responding to term of reference e:
   - ***the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes.***

4. **How the service system needs be improved.**

   Responding to term of reference c.
   - ***opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;***

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1. PREVALENCE OF MENTAL ILLNESS AMONGST THE HOMELESS POPULATION

A substantial body of research both here and overseas has shown that people with psychiatric disorders are significantly over-represented amongst the homeless population. Accurate prevalence rates are extremely difficult for health or welfare professionals working with homeless people due to the high co-morbidity of substance abuse, acquired brain injury, intellectual disability and poor physical health. In addition, robust prevalence data is also problematic due to difficulties in obtaining a representative sample of homeless people and in using a standardised categorisation of the range and extent of mental disorders

A substantial review of the literature was conducted in the late 1980's as part of a benchmark study which found that "...between one quarter and one half of adult homeless persons are suffering sever and perhaps chronic mental disorder." (Herrman 1991:4) However, Herrman's primary data collection based on a diagnosis of severe mental disorders in a sample of inner urban occupants of insecure accommodation (including shelters) found a 70% life time diagnosis and 50% current diagnosis (past month).

Typically, sampling frames for studies of mental illness amongst those experiencing homelessness have been limited to people using inner city night shelters, meals or day centres, rooming houses and boarding houses. However, the experience of homelessness takes many forms and the majority of this population do not use such services any more, especially the two main growth cohorts of young adults and families with children.

There is therefore a wide range in the prevalence of mental illness and psychiatric disorders across the various sub groups of the population. In 1996, Hanover's data on the 3,000 adult clients assisted annually found that the prevalence of metal health problems ranged from 15% for clients at outer suburban services to 50% at our inner city crisis facilities.

More recent data from research studies suggests that the prevalence of mental health issues within the population has increased although longitudinal/time series comparative data using consistent indicators is not available. The Victorian Office of Housing has estimated that between 30-50% of those experiencing homelessness have a mental illness (VHS 2000).

Two informative indicators of the extent of the issue from national data collections provide the following prevalence rates:

- 70% of homeless service users have experienced psychological problems such as depression (n=999; CATI; Colmar Brunton 2004)
- 29% of homeless service clients required intensive and/or ongoing support for metal health issues (n=; support worker opinion; Thomson Goodall 2003)

It is inevitably problematic to obtain an accurate prevalence of mental illness or disorders amongst young adults due to the variance in development from adolescent to adult and the emergence of a diagnosable disorder. However, in a longitudinal

study of 403 homeless young people (aged 12-20 years), 26% were found to have 'a level of psychological distress indicative of a psychiatric disorder.' (Rossiter et al 2003).

The association between homelessness and mental illness clearly works in both directions. Both short-term episodes of a mental illness and chronic psychiatric disorders lead to loss of housing and/or inability to obtain or maintain independent housing. This population group are clearly more vulnerable to housing stress (through low income and discrimination) and housing crisis.

Equally important, homelessness, often with other underlying factors, can lead to mental illness such as depression, the onset of schizophrenia, and suicidal ideation. The comorbidity of substance abuse plays a significant part in both mental illness and homelessness. In a one month snapshot of all residents at an inner city crisis accommodation facility (n=98), 36% were reported to have a psychiatric disorder or personality disorder and 58% had a substance abuse (Horn 1998). People with mental illness often turn to alcohol and drugs for relief (McDermott and Pyett 1993).

Deinstitutionalisation has resulted in about 80,000 Australians with serious psychiatric disorders. In the 70s or 80s they would have been in residential or institutional care but are now in the general community. The majority of this population would be single persons and have relatively weak support networks willing and able to provide ongoing care and support to enable them to live 'independent lives'.

Implications

The prevalence of mental illness amongst the homeless population has profound implications for services such as Hanover which has been a lead agency in Australia in developing innovative services and programs. The nature of some of these is discussed below.

The debate on mental health needs in Australia should be clearly linked to the public policy issues of homelessness and the growing incidence of social exclusion.

2. ADEQUACY OF SERVICES IN THE MENTAL HEALTH SYSTEM FOR PEOPLE WITH COMPLEX NEEDS AND DRUG AND ALCOHOL DEPENDENCY CONDITIONS.

Response to terms of reference b and f.

- **the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.**

- **the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.**

Complex needs: lessons from the Women, Housing and Multiple Needs project

In 2002-2003, Hanover undertook a major research project examining how the service responses for women experiencing homelessness with complex and multiple needs could be improved. The impetus for the project was the experience in many service agencies of women who were identified as long term repeat clients of SAAP and other health and welfare services who are unable to be adequately supported within the current service system (Parkinson, 2004).

While the focus of the project was women with complex needs, we believe that many of the findings in terms of what was needed in the area of mental health services are highly relevant across the population of people who are homeless and at risk of homelessness.

The project involved a range of service agencies reporting on a sample of their female clients in terms of service use and needs. Altogether 74 case histories were collected for the study and of these:

- 77% were reported to have a diagnosed or undiagnosed mental illness;

- 41% had a history of hospitialisation within a psychiatric institution (20.3% of cases were unknown.).

- 18% of women required support for a psychotic episode whilst accessing participating services.

- 69% had substance abuse problems often linked to mental illness.

In addition, the study involved 24 interviews with women using services in those agencies. A wide range of information was collected as to the service gaps and how the service system could be improved.

For many women, housing instability was associated with periods of low functioning or sudden deterioration in mental health marked by occurrences of family conflict, domestic violence and or relationship difficulties, and drug use. Fluctuating mental health status made it increasingly difficult to maintain accommodation. Some women

experiencing poor mental health were reported to experience difficulty living with others in a crisis and transitional housing setting, which was characterised by conflict with staff, residents or neighbours; however at the same time were unable to cope when isolated from others.

Mental health services were difficult to access for approximately a quarter of women, with psychiatric assessment rating the highest (28%). The reasons provided for not being able to access psychiatric assessment/support were spread amongst "unable to provide immediate response" and "unwillingness to engage" for 36 percent each followed by "service not matching needs" and "client not eligible for the service" at 29 percent each.

The study was able to identify what would have helped in terms of mental health services for this client group as detailed below.

- **Homelessness specific focus**

Mental health support was described as being particularly helpful when it had a homelessness specific focus provided on an outreach case management basis. One woman reported being linked into this type of mental health service, which provided consistent support to her over a five year period. This support also focused on her housing needs as reflected in the following excerpt.

> *Excerpt from client service experience interview...*
>
> *I have a caseworker in the homelessness team: they encourage me to take my medication so it doesn't affect my daily activities. They visit you so you don't have to go chasing them.... And they help you find accommodation if you're not well enough and can't look after yourself... they have stood by me the whole time. They've been like family to me [Age 37].*

- **Accessibility**

Having good access to mental health service expertise within housing services was considered important, rather than referrals to external services which was considered by some to be time consuming and complicated. Or, at least involving the support worker closely in the referral process was considered helpful, as someone in poor mental health may not be able to effectively relay sufficient information to inform diagnosis.

> *Excerpt from client service experience interview...*
>
> *They weren't able to help me much when I had psychosis because they can't access mental health services very easily – they can't do it themselves.... Services like this need to be able to access those services directly and liaise with each other... wasn't able to access the service unless I told them everything and making myself vulnerable and I couldn't do it with my worker. It would have been better to go with my worker; if the service was more open to seeing the both of us I would have been able to get a diagnosis [Age 25].*

- **Non-voluntary admission/medication**

As to be expected women did not like being admitted non-voluntarily to psychiatric hospitals. Most of the women who had a non-voluntary admission to a psychiatric

hospital or enforced psychotropic medication did not report such to be helpful for their healing. For some it was the isolation while in hospital, the side effects of the medication, or the inconsistency of service provision within mental health services that were considered to be the least helpful.

> *Excerpt from client service experience interview...*
>
> *Unhelpful....being locked up in isolation so you don't kill yourself and treated like a child. When I am there I have to be a good girl – there is nothing wrong – I get depressed like every body else and have highs and lows. But the drugs make it hard to stay awake and fluid retention makes my eyes sore and I can't read a book because I find it hard to concentrate [Age 49].*
>
> *I don't function well in hospital. All the mental health teams – putting me in hospital or trying to put me into hospital. Just the inconsistencies for most of them across the services [Age 19].*

On the other hand one women who was hospitalised for major depression reported that her experience within hospital was beneficial and assisted her to gain insight to her situation and learn to identify the warning signs that indicated when her mental health was deteriorating

> *Excerpt from client service experience interview...*
>
> *Being in psych hospital made me realise what was important – gave me some perspective – it was about three years ago. Spent about 2 weeks in the hospital. I started to have another break down but I put supports in place to help with the situation [Age 36].*

- **Case planning**

Central to what was perceived as helpful in case work approaches regarding the management of mental health, was the opportunity for input from the clients into the decision making about crisis plans and treatment. For one woman, her involvement with a mental health case management team had been a useful and positive experience on past occasions, and when her involvement was not sought in subsequent case planning she was feeling excluded and powerless in her own recovery process.

> *Excerpt from client service experience interview...*
>
> *All the case managers I have had included me on their crisis report, crisis planned hospital admissions, but this Centre hasn't and it has caused a lot of crap that was unnecessary if they would just let me be part of the process, which I asked to be and they said that they don't usually let clients be part of the process. I have always been part of my own crisis plan case management plan. And they wonder why it is going wrong, because they have no input from me. They just make you take anti depressants and feed you Valium and I hate that [Age 19].*

Mental illness combined with drug and alcohol dependency: lessons from the Homelesseness and Drug Dependency Trial. www.hddt.org.au

During the late 1990s, Melbourne's inner city Crisis Supported Accommodation Services were becoming increasingly aware of the changing profile of residents staying within their facilities. Many of the homeless men and women presenting had problematic and often entrenched drug use patterns and other complex health and welfare issues. Illicit drug use, particularly the injecting of heroin was becoming a common occurrence with often alarming outcomes. The traditional older homeless male with an alcohol addiction, so commonly a feature of crisis accommodation in the past, was now being replaced by the emergence of younger men and women with drug dependency issues requiring emergency shelter.

The following key findings of the 1999 study (Horn 1999), represent the changing profile of clients presenting to services for assistance.

- Heroin use among Hanover's clients had increased by 40% to the point that clients had a prevalence rate of heroin use 10 times greater than that in the local communit

- Thirty-seven% of Hanover clients with a reported drug dependence, regularly use two or more categories of drugs (excludes alcohol).

- Sixty-nine per cent of the 1999 client group with a drug problem were using heroin compared to 40% in 1996.

- While alcohol may have been the preferred drug of choice/use in the early 90s, heroin was now steadily emerging as the predominant drug of use among homeless clients.

- Forty-nine% of clients surveyed who also had an alcohol or drug problem also presented with a psychiatric disorder. The largest proportion was a diagnosis of depression.

- Access to specialist drug and alcohol services had increased from 24% reported in 1996 to 37% in 1999. However, the demand for specialist services had increased. Over half (53% = 77) of the clients in 1999 had attempted to get into a program in the previous 12 months. One-third were not accepted into a specialist program. "No vacancies" was reported as the reason for no access to service.

Based on the above findings, Hanover Welfare Services made a submission to the Victorian Drug Policy Expert committee (DPEC) in December 1999, highlighting the complexity of issues presenting in relation to drugs and homelessness.

In May 2000, Hanover Welfare Services, The Salvation Army and St Vincent de Paul jointly submitted a proposal to government to Trial new strategies that would target the following four critical elements:

1. Harm Minimisation within homeless services
2. Access to specialist treatment services
3. Pathways to long-term housing, support and employment services
4. Better understanding of the needs of street based drug users.

In November 2000, the Trial proposal was successful in securing $7.5 million of funding from drug treatment services to pilot a three year project aimed at trialing strategies to engage individuals experiencing homelessness and drug dependency problems. The Trial was further supported by the Supported Accommodation Assistance Program (SAAP), through the release of housing stock for the supported accommodation component of the Trial.

The Homeless and Drug Dependency Trial (now a fully funded program) has demonstrated its unique capacity to engage and sustain homeless clients with alcohol and drug and mental health problems in a purposeful relationship, as the basis for ongoing case management.

The strengths of this strategy have clearly been demonstrated with key indicators showing that drug dependent homeless persons ongoing involvement in the Trial leads to a reduction in the chaos of their lives; increased housing stability and significant reduction in evictions; reduction in drug use or a stabilisation of problematic use; improved health status and a significant reduction in their use of acute services such as residential withdrawal, crisis services, mental health services and hospitals.

The evaluation findings of the Homelessness and Drug Dependency Trial identified that Crisis Supported Accommodation Services need to improve their capacity to meet the needs of clients with alcohol and drug combined with mental health problems.

Key recommendations emerging from the Trial include:

- increasing the Crisis Supported Accommodation Service capacity in the long term case management of homeless clients with a dual diagnosis of mental illness and drug dependency.

- providing integrated and accessible, specialist mental health secondary consultation, support and mentoring to Crisis Supported Accommodation Service staff on a daily basis.

- co-ordinating cross sector integration and linkage efforts in partnership with existing clinical and community based mental health services, public health services and drug and alcohol services, resulting in improved client outcomes and continuity of care responses.

- providing integrated case management to the target group that is directly linked with community based drug treatment services, and the Trial's Community Reintegration Program (CRP) and not defined by geographical catchment areas.

- additional professional development resources for Crisis Supported Accommodation Services in order to provide ongoing training and education opportunities for all crisis accommodation staff in the area of mental health and dual diagnosis practice.

3. THE EFFECT OF INADEQUATE SERVICES ON HOMELESS PEOPLE IN TERMS OF MENTAL HEALTH.

Response to term of reference:

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

Hanover has considerable evidence that the lack of appropriate support services for people experiencing a housing crisis or homelessness, has detrimental mental health outcomes. Or, looking at it another way, we have evidence showing the importance of the provision of support services to positive outcomes for people in housing crisis and following a housing crisis.

We present here evidence from two sources:

- the Family Longitudinal Outcomes study (FLOS)
- the on-the-ground experience in our services.

The Family Longitudinal Outcomes Study: the needs for family and social support services for families in housing stress.

The detrimental impact of homelessness on family health and wellbeing has been widely acknowledged (McCaughey 1992; Bartholomew 1999; Efron et al 1996; Walsh et al 2003). Parents can experience multiple problems such as emotional and physical health issues, poor nutrition, isolation, and relationship difficulties. These issues can hinder parents in the way that they relate to their children and their capacity to fulfil their parenting responsibilities.

Homelessness is a marker of multiple disadvantages. In 2003, over 41,000 families with accompanying children were assisted by homeless services nationally. Children who experience homelessness are a particularly disadvantaged group. They are faced with issues that include emotional and behavioural problems, learning difficulties and disrupted schooling, medical problems, poor nutrition and social isolation.

In 1992, Hanover commissioned the Australian Institute of Family Studies to undertake a study into family homelessness. The study's report (McCaughey 1992) acknowledged the health difficulties suffered by many children in families who experienced homelessness. In 1996, a collaborative research project between Hanover and the Royal Children's Hospital, which focused on the impact of homelessness on children (Efron et al 1996), found that the children in the sample had suffered major adverse psychological and physical health. Furthermore, the study found that the children's mothers had high rates of mental health problems (Horn et al 1996).

Building on the foundations of the two earlier studies, Hanover launched the Family Longitudinal Outcomes Study (FLOS) in 2000. This was a unique study designed to follow a sample of families, who had experienced homelessness, over a two-year

period. The aim was to explore the longer-term impact of homelessness on family wellbeing and housing stability.

In general, the study's findings emphasised the importance of stable housing for family wellbeing, especially the development and wellbeing of children. A child simply cannot be expected to thrive if that child is homeless. It is imperative, therefore, that homelessness amongst children be eliminated.

In addition, there were two important implications from the study.

First, it is essential to develop crisis, early intervention and prevention service response models that specifically focus on the needs of children in poverty, particularly those who have experienced, or are at-risk of, homelessness.

Secondly, the study showed the importance of ongoing support for these families once housing had been stabilised. It was only when housing had been stabilised that families were able to deal with the various other difficulties and disadvantages they faced.

The complexity of issues faced by families is illustrated in the following case studies.

The following quote is an example of a particularly horrific experienced endured by a young child who suffered from depression and anxiety. It occurred at school and involved his teacher. The child, only 8 years old, had refused to go back to school and had threatened to kill himself. His mother explained:

> *'[My son] has depression and anxiety and he had to change schools because with his old teacher, she wasn't very good and she sent him out of the room one day, down to a grade 3 class and he was in grade 2. Because he had drawn on his face with texta, everyone had sort of laughed...and that teacher cracked it and sent him down to grade 3. She made him stand up in front of the whole class and made all the class laugh at him and said "does this boy look nice or does this boy look stupid", and they [grade 3 class] all said "stupid", and she said "should this little boy go to school or kindergarten", and they all [grade 3 class] said "kindergarten", and she said "all have a good laugh at how silly he looks". He just didn't want to go back to school, he just flatly refused to go back to school, so he had one and a half weeks off until I could get him into the other school...he got really depressed and wanted to kill himself...but since he has been at the new school he's a lot happier' (sole parent, focus child aged 8 years).*

With parents, emotional wellbeing had deteriorated among those parents who had struggled over the two-year period of the study with multiple and complex problems. The following quote and case study illustrate the complex nature of some of the issues that confronted families:

> *'My husband is on anti-depressants at the moment [attempted suicide four months ago]...he's had several [episodes] of depression (is that in the family – hereditary?) no, not really...[doctors] can't really link it to*

that...it's dealing with everyday life, the housing, it gets us all to breaking point at times; and the employment, my husband's in a job that he really isn't enjoying at all now but we're not in the financial position that we're able to move...there's been so much pressure on our relationship I wonder how much it can tolerate...' (two-parent family, two children).

Case Study – "Alison and Peter":

This family, with four young children, had experienced a number of difficulties. They included mental health issues, drug misuse, financial difficulties, and isolation from extended family support.

When Alison was first interviewed for the FLOS she was in her late twenties and Peter was in his early thirties. Alison had a five-year-old daughter from a previous relationship and Peter had a 12-year-old and 10-year-old son from a previous relationship. Together they had two daughters, one aged two years and one five months old. Alison's five-year-old daughter was the focus child in the FLOS.

Both Alison and Peter had drug problems. Peter had been in and out of jail over the past ten years. While in jail, Peter attempted to address his drug issues by applying to enter drug programs. The family had moved house three times in the previous two years and were homeless when they contacted crisis support services. Over a period of several weeks they were given accommodation assistance, financial and emotional counselling, and drug support. They were able to secure immediate access to public housing but it meant that the family had to move from the city to the country. This suited them because they were able to escape the 'drug scene'. The move, however, meant a separation from their family support, leaving a distance of some 200 kilometres between them.

The family settled into their new area and Alison's five-year-old daughter started school, which she enjoyed, and received a 'fantastic report card'. The couple continued to receive professional support. Alison and Peter both had drug problems. They were on a methadone program, had drug counselling and Alison also received psychiatric care. She suffered from depression, anxiety and agoraphobia. They had also needed food vouchers.

One year into the study, the separation from family had started to have an impact. As Peter explained:

'I wanted to get away from Melbourne but I can honestly say ... that I wish that I was a bit closer to my mum and my family...'

Neither had been able to work because of their health difficulties. Alison had lost a lot of weight and had to have her sugar levels monitored.

because of suspected diabetes. Through it, she had to continue to care for the children, mostly on her own, because Peter had been too unwell to help.

Meanwhile, Alison's daughter, whom she described as an easy child to care for, continued to progress well at school. Feedback from the child's teacher had generally been positive. However, the child was having some problems with her reading. Alison and Peter thought that perhaps there was a problem with her eyes and were due to take her for an eye test. Alison's daughter had regular contact with her biological father and has 'always had a good relationship with her dad', and socially, she made friends easily.

By the fourth wave interview, however, health difficulties had overwhelmed the family and they were in significant crisis. Peter had suffered a breakdown and had been admitted to a psychiatric hospital. Alison explained:

'He's better now, it was just '[he was] stressed out and because he had no family up there [the country], he just lost control... so we ended up coming back [to Melbourne] cause that's where all our family is. It made it a lot easier'.

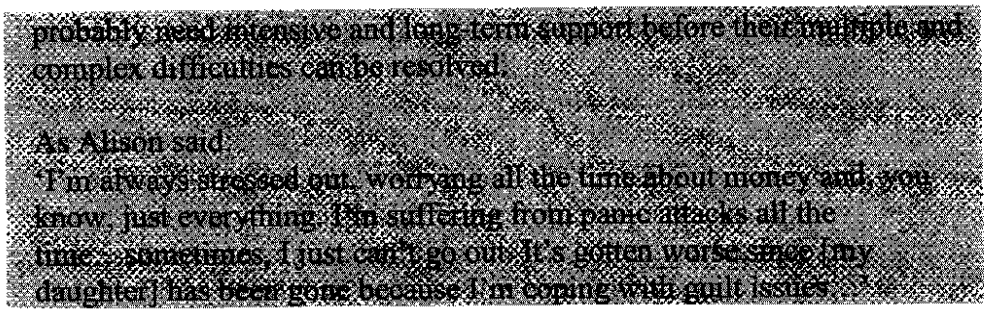
While Peter was in hospital, Alison had overdosed, stating that she was in 'a deep state of depression and took too much medication'. Alison was in a comatose state when her daughter found her. The now seven-year-old child was unable to wake her mother and thought she was dead. The episode prompted Alison to send her daughter to live with her father, hoping that things would be a lot more stable for her there. The relationship between mother and daughter had become strained. According to Alison, her daughter was not angry:

'Just withdrawn sometimes, she doesn't say anything about it [finding her mother unconscious]. If I try to bring it up, she doesn't really want to talk about it'.

Two days after Alison's overdose, the two younger children were taken into foster care for a couple of months. The two younger children were back with Alison and Peter, but Alison's seven-year-old daughter continued to live with her father.

On their return to Melbourne, the family were accommodated in a SAAP transitional house, where they had been for the past three months. With assistance from a crisis support service, they were put on a priority list for public housing. Transitional housing, by definition, is temporary and Alison did not feel stable. They were able to stay in the transitional accommodation until their public housing became available.

The family were closer now to their extended family support, but they still needed assistance from support agencies. On a few occasions, the family received food vouchers. Alison saw a drug and alcohol counsellor and Peter saw a psychiatrist. They have a long way to go, and will



On-the-ground experience at Hanover

Hanover believes that lack of appropriate support systems contribute significantly to poor mental health outcomes in our services. We also have anecdotal evidence of how better models of service provision can contribute to better mental health outcomes. The information in this section is drawn from informal discussions with staff rather than our formal research program.

In our services, it can be difficult to access a mental health Crisis Assessment Team (CAT) when we have a client in need. These teams in Victoria consist of psychiatric nurses who are able to make a diagnosis of mental illness and admit patients to hospital.

The client may be suicidal or psychotic but our experience is that the CAT may not have enough resources to come out and assess them. CAT gets many calls for assistance, but may not be able meet the demand especially out of hours or in certain locations. They may also be reluctant to come out for patients suspected of substance abuse.

Clients who have been hospitalised for serious mental health issues are often discharged from the psychiatric unit before they appear to have recovered. They are often discharged within a week and their symptoms are still present. If they are homeless, they have nowhere to go to once they are discharged. Sometimes people end up in inadequate rooming houses. It is not unusual for our client to leave the accommodation and end up on the streets again, unwell and homeless. We know of several clients who are picked up every couple of months, yet they are discharged in just a few days each time.

There are some good mental health outreach teams in inner Melbourne. But they mostly have full caseloads. While they do excellent work, they are often unable to take on new clients.

Sometimes when we call the CAT for an emergency assessment, the intake worker simply tells us to call the police. The CAT has decided they are not able to go out and meet our client, so they recommend the police deal with the matter. A mentally unwell homeless person may not be able to cope with a visit from the police. And sometimes the police are not able to deal appropriately with mentally ill people.

Homeless people often end up in crowded low cost hotels and crisis accommodation services. These places have many different types of people and are often stressful environments. Drug dealing, assaults and theft are commonplace. Clients who are trying to recover from depression or schizophrenia often find that their mental health suffers further because they are forced to live in inappropriate places.

We have a very positive experience with a new model of service delivery for homeless people with mental illness in the Homelessness Outreach Psychiatric Service (HOPS) for clients in Crisis Supported Accommodation Services.

HOPS teams primarily provide assessment and case management, which is delivered through an outreach capacity. They also provide support and education to the Crisis Supported Accommodation Services through consultation and case review forums. The eligible target group for this service are homeless persons aged 16-64, with a serious mental disorder and complex needs who:

- have a major psychiatric disorder
- receive no or sub optimal care from a mental health service
- likely to have drug or alcohol issues
- show evidence of a severe decline in social functioning and disconnection from natural support networks.

4. HOW THE SERVICE SYSTEM NEEDS TO BE IMPROVED

Response to term of reference c.

- **opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;**

Hanover believes that a collaborative approach is necessary to reconsider how we provide an integrated package of assistance that will enable those with serious psychiatric disorders to maximise their participation in the community and minimise reoccurrence of crisis and trauma through stable secure housing, ongoing preventative support and access to social and employment opportunities.

Such a model based on a restructure and rationalisation of current fragmented and silo based programs would lead to cost saving in the longer term through efficiency dividends in program management and reduced demand for the array of health, welfare and justice by this client group.

A collaborative approach is necessary to reconsider how we provide an integrated package of assistance that will enable those with serious psychiatric disorders to maximise their participation in the community and minimise reoccurrence of crisis and trauma through stable secure housing, ongoing preventative support and access to social and employment opportunities.

Such a model based on a restructure and rationalisation of current fragmented and silo based programs would lead to cost saving in the longer term through efficiency dividends in program management and reduced demand for the array of health, welfare and justice by this client group.

The need for affordable independent accommodation close to health services, public transport, suitable for this population rose significantly during the 1990s. Whilst some growth in supported housing through mental health services and other housing programs has targeted this group, countervailing pressures have been reducing the supply of affordable housing across both the private and social housing sectors. (for example VHS 2002; HJRT 2002).

There has been negligible increase in public housing stock over the longer term. In addition, there has been substantial loss of private housing options traditionally taken up by people on low incomes who have a serious psychiatric disorder, including:

- Decline in low cost hotels, rooming and boarding house beds (Kelly, 2004)
- Decline in Supported Residential Service (SRS) beds from 4,500 in 1993 to 2,300 in 2001 (Green, 2003)
- Declining investment in private rental units (Yates et al, 2000)

The Victorian Government, Office of Housing, introduced a priority waiting list process in the 1990s in response to the growing waiting list for public housing. The current Segmented Waiting List system gives highest priority to applicants with recurrent homelessness – invariably with complex issues.

About 1,000 allocations are made annually through Segment One, but waiting times have grown for this group and a significant proportion of households under Segment One vacate their tenancies prematurely or involuntarily. One of the reasons for this loss of housing tenure is the lack of support to prevent vulnerability turning into crisis for individuals with complex issues, including psychiatric disorders. The second priority is for those in unsuitable housing who have high support needs, including those with mental illness.

However, the piecemeal and reactive policy response to a structural issue has served to add layers of overlapping referral and support services to assist adults struggling in insecure, poor quality and unsupported accommodations settings.

Failure to address the structural factors has resulted in multiple demands across the range of health, justice, housing assistance and support services by individuals with mental health needs over time. Their dependence on services is exacerbated – increasing costs and reducing efficiency across those sectors. As inefficiency has increased, pressure points demand additional resources or program changes. Hence the plethora of small-scale pilots or projects reactive to these pressure points without deeper consideration of genuinely integrated models that are client focussed.

The current situation requires a restructure of assistance to people with high and complex needs in our community that is holistically constructed rather than fragmented within silos. This requires a high-level government commitment and vision to 'do it better'. It also requires legislative framework that includes performance targets based on a suite of agreed priority indicators.

The structural issues require both capital resources for affordable housing and recurrent monies for professional support as a preventative strategy for those who are assessed as vulnerable to crisis in the long term. Risk factors or vulnerabilities to loss of housing and social isolation should be used to determine eligibility for ongoing support.

The wealth of service experience can be used to inform effective support models for maintenance of housing, reduction in mental illness relapse and maximising social participation. In addition, an expansion of more intensive case management support is required to offer an integrated ongoing skilled resource to assist those with multiple complex issues. Such models need to accept the level of trauma inevitably attached to serious psychiatric disorders, homelessness and violence by building in therapeutic approaches within strengths based framework (Robinson 2003; Parkinson 2004; O'Brien at al 2002).

References

Bartholomew, T. (1999), A Long Way From Home: Family Homelessness in the Current Welfare Context, The Salvation Army, St. Kilda.

Colmar Brunton (2004) *National SAAP Client Satisfaction Survey*, prepared by Colmar Brunton Social Research, Commonwealth of Australia, Canberra.

Efron. D, Sewell, J. Horn, M. and Jewell, F. (1996), Can we stay here? A study of the impact of family homelessness on children's health and well being, Hanover Welfare Services, Melbourne.

Green (2003) 'The End of Institutions: Housing and Homelessness', *Parity* 16 (3): 5-7, Council to Homeless Persons, Victoria, Melbourne.

Herrman (1991) *Homelessness and severe metal disorders*, Monograph Series 2, prepared for the Health Care Committee, Commonwealth of Australia, Canberra.

HJRT (2002) *Housing for All*, Housing Justice Roundtable, Melbourne, September 2002.

Horn (1999), Horn, M. (1999), *Drugs and Homelessness, Prevalence of Alcohol and Drug Dependence among People Experiencing Homelessness,* August 1999, Hanover, Melbourne.

Horn (1998) *Suicidal Behaviour among Homeless people and its Association with Selected Risk Factor*s, MA Thesis, University of Melbourne, Parkville.

Kelly E (2004) *Crisis in Short-term Accommodation*, Project Report, Hanover Welfare Services, South Melbourne, August 2004.

McCaughey, J. (1992), Where Now? Homeless Families in the 1990s, Policy Background Paper No.8, Australian Institute of Family Studies, Melbourne.

McDermott F and Pyett P (1993) *Not welcome anywhere: people who have both a serious psychiatric disorder and problematic drug or alcohol use*, VicServe, Victorian Community Managed Metal Health Services, Melbourne.

Parkinson (2004) *'Getting my Life Back Together', Women, Housing and Multiple Needs*, Hanover Welfare Services, South Melbourne.

O'Brien A, Inglis S, Herbert T and Reynolds A (2002) Linkages *between housing and support – what is important from the perspective of people living with a mental illness*, AHURI, Melbourne.

Rayner K (2004), *Mental Health, Homelessness and Problematic Drug Use: Strengthening our Response,* Hanover Welfare Services, Salvation Army and St Vincent De Paul.

Robinson C (2003) *'Healing and stability: addressing the needs of homeless people with mental disorders'*, a paper presented at the third National Homelessness Conference, 6-8 April 2003, Brisbane.

Rossiter B et al (2003) 'Living Well? Homeless Young People in Melbourne', *Parity* 16 (2): 13-15, Council to Homeless Persons, Melbourne.

Thomson Goodall Associates (1999) *Understanding Demand for Crisis Accommodation*, A report prepared for the Inter Agency Working Party, Hanover Welfare Services, Melbourne.

VHS (2000) *Support Responses to Adults with a Mental Illness and Dual Diagnosis, Information Paper*, Department of Human Services, Melbourne, Victoria.

VHS (2002) *Victorian Homelessness Strategy: Action Plan & Strategic Framework – Directions for Change*, Department of Human Services, Melbourne, Victoria.

Walsh, P, Milford, C. and Cain, L. (2003), More than just a roof: a study of family homelessness in Queensland, Centre of Philanthropy and Nonprofit Studies in conjunction with Centre for Social Justice, Micah Projects Inc, Lifeline Community Care, Queensland Shelter, Social Action Office, Wesley Mission Brisbane and Brisbane City Council, Queensland University of Technology, Brisbane, http://cpns.bus.qut.edu.au (accessed December 2003).

Yates J and Wulff M (2000) Whither low cost private rental housing? in *Urban Policy and Research*, 18,1:45-64.