Submission to the Royal Commission into Victoria's Mental Health System

Severe Mental Illness and Homelessness

Homeless Outreach Psychiatric Services – Alfred Health and Melbourne Health

Homeless Outreach Mental Health & Housing Service

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Key Message

Homeless persons with Severe Mental Illness are a distinct group whose needs are poorly met in the current system. They have poor access to health care and housing and experience reduced quality of life and premature death.

Their needs would be better addressed through

- Access to long term supported tolerant housing
- Improved access to community outreach mental health services and acute and long term inpatient units
- Provision of individualised, comprehensive, co-ordinated, assertive, flexible long-term packages of care.
- Services that integrate mental health care, physical health care, and housing.

Executive summary

- The number of homeless persons is increasing in Victoria.
- The proportion of persons experiencing long term and chronic homelessness is increasing.
- People with severe and persistent mental illness (SPMI) are overrepresented in the long term and chronic homeless.
- Homelessness and severe and persistent mental illness can reduce life span by up to 20-30 years (Davies, 2018).
- The causes for the increasing prevalence of homeless persons with SPMI include:
    - The absence of affordable rental properties for people receiving Centrelink payments.
    - Inadequate availability of social and supported housing.
    - Limited provision of assertive outreach programs provided by mental health services.
    - The failings of the current episodic model of care for people with serious and persisting mental illness and chronic homelessness who require long-term support.
    - Short inpatient admissions driven by service demands.
    - People with severe and persistent mental illness being discharged from acute inpatient mental health units to homeless settings.
    - Inadequate forensic mental health inpatient services.
    - Poor integration of mental health services with other support systems including housing, physical health care, and alcohol and other drugs services.

- Proposed Principles to Guide System Change
    - Housing is a human right.
    - Housing homeless people saves lives.
    - Assisting people with complex problems requires integrated systems of support.
    - People should not be discharged from State facilities (hospitals, prisons, foster care etc.) to a homeless setting.

- Recommendations to address the needs of homeless people with SPMI :
    - Recognition of the presence and unique needs of homeless people with SPMI.
    - Enhancement of outreach engagement and continuity of care capacity in all community mental health services, including the development of assertive outreach services for homeless person in areas of need.

  - Development of peer support capacity within mental health outreach services
  - Provision of individualised, comprehensive, flexible long term packages of care.
  - Transitional housing for homeless persons following discharge from acute mental health units.
  - Increased availability and variety of tolerant housing.
  - Expansion of specialist primary care services in areas of high homelessness.
  - Improving access to acute detoxification services and longer-term alcohol and other drugs rehabilitation services for people with SPMI and homelessness
  - Expansion of access to Long Term Secure Extended care with improved capacity to manage substance abuse.
  - Developing novel programs for the residential care of people with serious and persisting mental illness, substance abuse and recurrent forensic activity.

- Service development should be guided by reliable cross sector data, up to date research, and robust service evaluation.

Background

The Burdekin Report (Burdekin, 1993) shed light on a group of homeless people with serious mental illness following de-institutionalisation. In response three Homeless Outreach Psychiatric Services (HOPS) were set up in inner Melbourne, working in collaboration with other homeless service providers. The experience of the HOPS teams over more than 20 years provides a valuable insight into the needs of this population, how they have progressed and how they may be best helped in the future.

The target population for the HOPS teams is people who suffer severe and persistent mental illness (SPMI) such as schizophrenia, who are homeless or at risk of homelessness, and are difficult to engage and/or avoid treatment. **They represent up to 20% of current clients in inner urban mental health services**. **By virtue of their complexity and disengagement, this population requires a different model of care to the majority of clients with serious mental illness.**

People with SPMI and homelessness commonly have a range of physical and substance use related comorbidities. Socio-economic disadvantage, childhood deprivation and trauma, family breakdown, forensic history, and head injury are all over-represented (Caton et al, 2005). These combine with homelessness to result in a significantly shorter life expectancy (Fazel et al, 2014).

The relationship between mental illness and homelessness is complex and bi-directional. Mental illness is a common pathway into homelessness, particularly following the development of psychotic illness and severe substance use. The experience of being homeless for any reason can lead to the development of a range of mental health problems, more commonly depression and anxiety (Appendix 2).

Once homeless, those with mental illness have an impeded pathway out of homelessness due to the effect their mental disorder has on planning, impulse control and social relationships. **The minimal availability of affordable private rental for single persons on the Disability Support Pension means that those with serious mental illness who commonly become disengaged from family and friends will remain homeless in the absence of transitional or social housing.**

There are high rates of substance use in this population. Substances decrease the efficacy of treatment for psychosis and other conditions. The lack of rapid access to detoxification and rehabilitation programs results in prolongation of homelessness and severe mental illness.

At the most severe end of the spectrum is a subgroup of homeless persons with '**community treatment resistance'** (Holmes et al, 2006). It has been estimated that at any point in time 10-20% of people being seen by HOPS teams fall into this category (Holmes et al, 2006). This group remain chronically unwell, persistently

estranged from family and other community supports and only receive intermittent mental health treatment at times of crisis, often cycling between homelessness and prison. Their disability continues over years despite concerted efforts at community management. These clients represent the failure of de-institutionalisation.

People who are homeless do not prioritise their physical health care. They have difficulties in keeping appointments, managing medication and engaging with treatment services. The nature of the mental illness, particularly with paranoid symptoms, can lead to active avoidance of treatment services. When healthcare is sought, it is usually for an immediate problem rather than for preventative care.

In response to these complexities and barriers to care, people with SPMI and homelessness require an assertive community treatment (ACT) model (Test et al, 1976). The principles the model of care for people with SPMI and homelessness have been well articulated and tested (Udechuku et al 2005, Coldwell et Al, 2007, Neumillar S et al, 2009). They include:

- Assertive outreach by clinical providers, whereby there is an emphasis on going out to see people in their own environment rather than relying on appointments in a clinic or hospital.
- A 'whole team' and multidisciplinary approach with an emphasis on communication and coordination within the team to promote continuity and integration of care.
- Shared and collaborative casework between clinical services and nonclinical providers such as housing providers.
- Continuity of care.
- Whole person care, including a focus of physical health and promoting independence, rehabilitation, community integration and recovery.
- Responsiveness and accessibility.
- Cultural sensitivity.

Assertive community treatment for homeless people and SPMI has been shown to be cost-effective with significantly lower days in psychiatric inpatient units and reduced presentations to emergency departments (Lehman, 1999).

Current problems

1. Increasing homelessness

The 2016 census (ABS, 2016) identified almost 25000 persons living in homelessness or in severely over-crowded settings in Victoria on census night. This includes individuals were:

- living on the streets (Primary homelessness)
- moving between various forms of temporary shelter and crisis accommodation (Secondary homelessness)
- living in crowded boarding houses without their own bathroom, kitchen or security of tenure. (Tertiary Homelessness)

While historically the population of homeless people with mental illness has been seen as older males, increasingly other cohorts are being seen. This includes single women and women with children escaping domestic violence, youth, Aboriginal people, and refugees without access to Commonwealth programs such as Medicare and Centrelink.

Traditionally homelessness in Victoria was thought of as a transient state, although the evidence to support this assumption was limited. It has become clear that this is not the case, with **people who experience episodes of homelessness spending long periods "trapped" in homeless settings**, albeit moving from one venue to another. For example, less than 10% of persons living in homelessness report being there for less than 3 months while almost 50% report homelessness of longer than I year (Bevitt, 2015).

Those with SPMI are even more likely to be chronically homeless. For example, the proportion of time homeless men with psychosis spent homeless the previous 12 months was 48% in 1999, 58% in 2004 and 74% in 2018 (Burton, 2019).

2. Limited housing options

2.1. Housing services

There is a severe lack in the range and quantity of supported housing for clients with SPMI. Stable supported housing leads to significant improvement in psychiatric and physical health. Once an individual is housed they begin to have the capacity to manage medication, keep appointments, improve their diet, and engage with rehabilitation and support workers. In the US, the National Health Care for the Homeless Council (National Health Care for the Homeless Council,

2019) uses the slogan “Housing Is Healthcare” to reflect the noticeable and definitive change in health that follows from the attainment of stable housing.

2.2. Housing First

The effectiveness of the Housing First approach for homeless people with SPMI has been well documented both internationally (Goering et al, 2014) and locally (Dunt et al, 2017). The literature indicates that rapidly housing a person who is homeless and suffers mental illness, and providing intensive outreach support, results in high levels of housing stability, improvement in mental and physical health, and a decreased cost to government. In a ‘housing first’ permanent supported accommodation in Melbourne there was increased housing stability and optimism, improved continuity of care and reduced psychiatric admissions for people with SPMI who had experienced long-term homelessness (Holmes et al, 2016). The Doorway program demonstrated that scattered-site housing with intensive support resulted in housing stability and improved physical and mental health care (Dunt et al, 2017). While this program also demonstrated an overall cost saving to Government of $3096 annually per participant, the goal was to **save lives not save money**. To date, there is very limited accommodation using a ‘housing first’ model in Victoria.

Local and international experience indicates that a proportion of clients have unplanned exits from housing first services. These clients commonly have persistent untreated psychosis and/or persistent high-level substance use. Absence of alternative venues for clients exited from Housing First services represents a significant system gap, with these clients showing a four-fold increasing in mental health admissions in the subsequent 12 months (Holmes et al, 2016). Intensive outreach support programs are beneficial to those who fail housing placements, but are not widely available.

The tolerance of housing first services to deal with the most challenging clients can wane over time. There can be a drift away from accommodating clients with SPMI in favour of less challenging clients, often without psychosis. It is essential that housing first services are properly resourced with supportive services and that there is oversight to ensure that they remain available to the most disabled and challenging clients.

2.3 Emergency accommodation

Given the severe shortage and difficulty accessing affordable long term accommodation, many people with SPMI use emergency accommodation services and access points to find short term emergency accommodation. This includes people discharged from psychiatric inpatient units (North Western

Mental Health Social Work 2016). A recent report highlighted the low number of funded crisis accommodation beds and the inadequate alternatives for the many people who need crisis accommodation (Northern and Western Homelessness Networks, 2019). The poor condition and lack of safety in many of the short term accommodation options has a detrimental effect on people's mental health. People's movement between different short-term emergency accommodations, across different Area Mental Health catchment areas, impacts continuity of clinical care and increases the likelihood that they do not receive adequate treatment for their mental illness.

3. Co-ordination of service delivery

People who are homeless and suffer severe and persistent mental illness often have multiple and complex needs. Their needs vary, but often include the need for housing, mental health and physical health care, assistance with family relationships, help navigating the legal and justice system, access to AOD treatments, financial support, and employment. All these services and programs are provided by different agencies funded at the federal, state and local government level. Navigating these different systems is complex for anyone, and more so for someone who is experiencing mental illness and does not have a stable home. Poor coordination between different service systems can contribute to persistent homelessness and illness.

Embedding mental health providers within non-clinical support agencies for homeless people can engage more into community mental health care, improve housing stability, and decrease mental health crises and hospital admissions (Lee et al, 2010). One example of this approach is the HOMHS program currently running in the Melbourne CBD (See Appendix 1). Integrated models of physical and psychiatric health care, with associated AOD services improve the likelihood of addressing all of an individual's health care needs. International and local research also indicates that an integrated model that is primarily directed towards housing and mental health treatment, leads to better engagement with physical health care services and decreased reliance on crisis health care through emergency departments (Goering, 2014).

4. Mental Health Services

4.1. Limited Assertive Community Treatment for difficult to engage clients

Many people with the most severe mental illness, homelessness and comorbidities do not receive assertive community treatment (ACT) despite

evidence as to its benefits (Coldwell, 2007). **Most community mental health services in Victoria do not have teams with expertise working with homeless people, nor the capacity or willingness to undertake ACT.** The current culture of many community mental health services is often "clinic bound". Active outreach of difficult to engage clients is often resisted due to cost pressures and other factors such as concerns about staff safety. Commonly "difficult to engage" clients are discharged as they "refuse to engage". They may also move out of area, which is an accepted outcome, despite evidence that housing instability is associated with a breakdown in the continuity of care and poor outcomes (Holmes et al, 2005b).

Strict adherence to the area mental health boundaries when providing care for people who are homeless, itinerant and mobile works poorly. The frequent need to transfer care between services despite the individual only moving a short distance, for example from the CBD to South Melbourne, reduces the capacity to build stable therapeutic relationships. **Block funding of area mental health services provides no incentive to engage and maintain continuity of care with people with SPMI who are homeless, and may inadvertently encourage poor care through the implicit and perverse incentive to move difficult clients to a different area mental health service**.

4.2. Admissions to acute settings and post-acute care

Despite a focus on community treatment, engagement and collaboration with clients with SPMI, admission to an acute psychiatric unit is often necessary. Chronic bed pressures work against the longer admissions often required, and contribute to a questioning the "value" of admitting homeless clients.

There is an increasing trend of metropolitan services discharging to homeless settings. One audit of five acute inpatient units revealed that 20% of discharges occur to homeless settings, including brief accommodation in cheap motels (North Western Mental Health Social Work 2017). When the discharge is to an emergency accommodation service in a different catchment area, there is an increased probability of discontinuity of care.

Following acute admission, there is a lack of rehabilitation programs either in hospital or a community setting. Prevention and Recovery Centres (PARC) and Continuing Care Units (CCU) are often very difficult to access for people with homelessness, comorbid drug and alcohol disorders, or forensic history. Admission criteria to PARC and CCU units often require people to have a discharge address and to be able to engage. Currently it is rare for people with SPMI and homelessness to access such services.

It is also very difficult to access Secure Extended Care Units (SECU), the regional inpatient rehabilitation units with much longer lengths of stay. In theory these units would be the next step for clients who have not been able to be managed effectively with community treatment and with short inpatient unit admissions, including those with 'community treatment resistance'. In practice this group can rarely access SECUs. This is due to a combination of poor availability and access assessments that determine that these clients are "not suitable" by virtue of substance use, poor engagement and past aggression. It is also the case that these clients are not seen as high a risk to others, in contrast to the chronic risk to themselves that occurs through being homeless, and therefore of a lesser immediate priority.

4.3. Forensic Clients

Many people seen by the HOPS teams have spent periods of time in prison and it is common for people to have their follow-up and treatment interrupted by going into custody. There are major challenges maintaining continuity of treatment in these circumstances. **Communication between prison health services and community mental health services is often haphazard**. It is not uncommon for people to be taken into custody without the knowledge of their treating community team. People who are on Compulsory Treatment Orders in the community are able to refuse treatment in prison, as the Order automatically ceases on incarceration, and there are often long waiting lists to be admitted to Thomas Embling Hospital for treatment under the Mental Health Act.

HOPS teams receive many referrals for people with SPMI who are released from prison into homelessness and who have not been receiving treatment. This group are particularly challenging to treat in the community and frequently require an inpatient psychiatric admission to hospital. They often have prominent psychotic symptoms, they are at high risk of illicit drug use and have an increased risk of overdose following incarceration, and there is often an increased risk of violence. At the point of release from prison, coordination of care between community mental health services and other service providers (accommodation, drug and alcohol, corrections and legal) is often poor.

5. Problems with Service delivery

5.1. Alcohol and Other Drugs (AOD)

5.1.1. Entry into both acute detoxification services and long term rehabilitation is difficult to access, especially without a discharge destination. There is often a delay in accessing AOD services, by which time an individual's motivation to stop substance use may have changed. Alcohol and drug

services often have admission criteria which exclude people with complex needs, including serious mental illness.

5.1.2. For many people with complex needs, having separate community mental health services and AOD services often does not work. The AOD service system is difficult to navigate and communication between services is often poor. Many of the issues faced are closely related, and having multiple clinicians who do not work together is less likely to be effective.

5.2. Multiple and complex needs initiative

The multiple and complex needs initiative (MACNI) has been a program for co-ordinating care to some of the most complex and challenging clients over the past 15 years. The program has success with individuals, including those with community treatment resistance, and has allowed for transition to less intensive forms of care. **The capacity of MACNI differs from that of the NDIS in its ability to work with the clients without their consent, to work within the framework of the Mental Health Act, to be delivered by experienced staff and lead by senior clinicians**.

5.3. NDIS

The NDIS is not well suited to clients with SPMI and homelessness. The NDIS application process requires a degree of engagement, organisation and persistence not commonly found in this population. If accepted, identifying services that can practically and effectively perform the outreach work required is difficult. Even if these services are found, they may not to have the experience or methods to deliver effective care. At the same time the client needs to be aggregable and co-operative, which is often not the case in this group.

The NDIS does not provide accommodation. This is understandable given that it provides services and aids. It is frustrating for workers to see clients signed up for NDIS packages for case management, social work, psychology, in addition to concurrent mental health, drug and alcohol and housing services, whilst still being unable to access stable accommodation. **It may be argued that, in the case of SPMI and homelessness, <u>the housing is the aid</u>.**

5.4. Physical health

While the Commission is focused on mental illness, it is important to note that homeless people also suffer very high rates of physical illness, causing significant disability and premature death. The reduction in life-span of homeless people who have mental illness is more a consequence of their physical illnesses and

substance use than their mental illness. It is therefore highly relevant for the Commission to consider issues relating to the co-morbid physical health care of homeless people with SPMI.

Despite the availability of Medicare to attend general practitioners, health care is more generally sought at times of crisis through emergency departments. Unfortunately, Emergency Departments (ED) are poor at recognising and responding to homelessness due to their focus on acute care (Lee S et al 2019). Homeless people are more likely to leave the ED while still unwell, more likely to represent to ED, and have decreased ability to manage their physical health problems once they leave hospital and return to the streets.

A detailed review of the health of homeless people in high-income countries published as part of a series on homelessness in The Lancet (Fazel S et al, 2014) describes rates of premature mortality higher than the rest of the population and an increased range of infectious disorders alongside mental illness and substance abuse. This has been described as “accelerated aging”. A study in Sydney (Chin C, et al 2011) showed homeless people used over four times the number of acute beds compared to the State average, with their being a high burden of mental illness, substance use and physical health comorbidities. There were generally low rates of linkage with general practitioner and ambulatory care services.

6. Outer urban and Rural Access

Homelessness with associated mental illness is not purely a problem of inner cities. There can be greater challenges when individuals move to areas where short-term and crisis housing may be of lower cost, however there is then a lack of support services for their full range of social needs. There may also be dislocation from natural supports including families and friends. Mental health services outside Melbourne have not been specifically funded to provide homeless outreach mental health care, further diminishing their ability to assist this population.

7. Youth Homeless

Homeless Youth is currently not well serviced by existing youth mental health services. Notwithstanding existing outreach capacity, the partnership and linkages between youth homeless services and youth mental health services have not been developed to the degree that they have in adult services. Opportunities to engage homeless youth with serious mental illness are being missed.

8. Research

Research has been conducted from the perspective of housing (Bevitt A, 2015, for example) and from the perspective of mental health (Holmes 2005, for example). There is a need for greater collaboration. A lack of uniformity in the definitions of mental illness and disparate methodologies for collecting accommodation history has delayed better understanding of the relationship between mental disorders and homelessness. The absence of useful data on the prevalence and distribution of homeless clients with SPMI, their accommodation use, and mental health service needs is also needed to identify where services need to be developed.

Recommendations

1. Housing
   - 1.1. Housing First
     1. Expansion of Housing First facilities to allow homeless people with mental illness to be rapidly housed and provided with intensive support until their mental state is improved and they are progressing in their personal recovery. A range of housing options are necessary, which might include both large congregate and scattered site locations. Some individuals will only require short-term intensive support and others with more severe illness in disabilities may require intensive support for many years.
     2. Co-ordination of Housing First facilities such that eviction from one can be co-ordinated with timed access to another.
     3. Develop incentives and service pathways for enhancing continuity of care in clients who have multiple disabilities and behaviours that are difficult to manage.

   - 1.2. Improved access to a range of other housing options for people with SPMI and homelessness including transitional and social housing

2. Co-ordinated service delivery
   - 2.1. Improved co-ordination between housing, mental health and AOD services to identify people who are homeless and suffer SPMI.
   - 2.2. Better integration of housing services, mental health services, and physical health services using an “all of government” approach
   - 2.3. Increased access of MACNI services for the most vulnerable and disengaged.
   - 2.4. Development of services to deliver specialised care packages to appropriate clients within the NDIS framework.

3. Service Linkages
   3.1. Area mental health services to develop formal linkages with homeless services to develop collaborative pathways of care. This may include liaison attachments of mental health staff in non-clinical agencies.

4. Mental Health Services
   4.1. Scoping of homelessness within each Area Mental Health Service.
   4.2. Development of responses to homelessness in people with SPMI in each service including the enhancement of assertive outreach capacity and/or the implementation of HOPS services in areas with high levels of homelessness, including outer urban and rural services.
   4.3. Enhancement of outreach engagement capacity in all community mental health services. This may be enhanced by financial incentives which link to KPIs measuring engagement success, collaborative case work, continuity of care and planned discharge (Holmes et al, 2014).
   4.4. Inpatient psychiatric units need to have capacity to support adequate inpatient length of stay, and not discharge people from hospital into homelessness. Activity based funding weighted to patients with high disability and homelessness could be one method of supporting this.
   4.5. Improved access to post-discharge and subacute care by increasing the number of beds available to clients with homelessness and developing admission criteria that do not preclude people with the complex problems.
   4.6. Improved access to SECUs by increasing the number of long-term inpatient rehabilitation beds and ensuring that there are beds available for the most complex clients who are not improving despite attempts to treat with ACT.

5. Forensic clients
   5.1. Improved coordination of care between forensic mental health services in prisons and community mental health services to improve continuity of treatment.
   5.2. Improved coordination of care to stop people being released from prison into homelessness.
   5.3. Increased forensic mental health beds.

6. AOD Service delivery
   6.1. Improved access to acute detoxification services and longer-term rehabilitation services for people with SPMI and homelessness
   6.2. Increased integration of community mental health services and AOD services
   6.3. Increased training for community mental health clinicians working in assertive community treatment teams. This includes training in diagnosis and management of drug and alcohol disorders for all staff and further growth in specialist AOD workers within the community mental health teams.

6.4. Resources to enable clinicians in HOPS teams to provide support and education for staff at crisis and supported accommodation regarding drug and alcohol issues

7. Physical health

   Public hospitals should establish specific programs to support the physical healthcare needs of homeless people, including those with SPMI. This may include having general medical staff attached to Homeless Outreach Psychiatric Services, having medical staff and credentialed nurses provide clinics in external agencies such as housing providers and day support programs, improved liaison with the small number of primary care providers that target homeless people, and develop inpatient teams that rapidly identify homeless people and establish care pathways for when they leave hospital (Gazey A et al 2018).

8. NDIS
   The role of the NDIS in the provision of services to homeless persons with SPMI needs to be evaluated. Gaps in the NDIS model of care for this group need to be identified and appropriate alternatives identified.

9. Youth Mental Illness and homelessness

   The relationship between youth early intervention services for psychosis and homeless services needs to be reviewed in order to determine the need for a specific youth homeless mental health service.

10. Research
    10.1. Development of Collaborative research projects bridging housing and mental health
    10.2. Research into accommodation and mental health service use in high vulnerability clients with psychosis.

Case study 1

Joe (a pseudonym) is a man in his early 50s who was diagnosed with schizophrenia in the 1980s and has a long history of street homelessness and itinerancy. He receives the Disability Support Pension that is managed by State Trustees. He currently receives depot antipsychotic medication by injection administered by HOPS every two weeks under a Community Treatment Order.

Joe has multiple recorded psychiatric admissions to various hospitals around Victoria, almost all of which have occurred since 2000. He has poor insight into his illness and does not believe he needs medication or follow-up. Joe continues to present delusional content in relation to his identity, and frequently expresses grandiose beliefs around owning various government organisations, such as State Trustees, who he believes owe him a large sum of money.

Joe engages with HOPS clinicians on a superficial basis and has a history of avoiding mental health services and poor compliance with medications. Joe regularly attends a local drop in service that services the homeless population. The service will contact HOPS when Joe presents there. This collaboration with non-clinical services has been essential in assisting HOPS clinicians to keep regular contact with him, as well as provide him with consistent psychiatric treatment. This assertive outreach approach to delivering psychiatric treatment has prevented Joe requiring a psychiatric admission in recent years.

Housing

Joe was a longstanding resident of private accommodation, before it became unavailable. After the closure, Joe was housed though DHHS in an Older Persons Office of Housing block. Shortly after commencing his tenancy, numerous complaints were made by neighbours that continued throughout the tenancy – largely noise complaints in relation to overnight guests. Attempts were made to engage tenancy and legal services to support Joe to maintain his tenancy, however DHHS took Joe to VCAT and he was evicted back to street homelessness. Joe is currently street homeless and begs around the local area. He occasionally couch surfs with friends for respite.

Joe currently has an active referral with a provider for supported crisis accommodation, however as he has no mobile phone to be contacted he frequently misses out on vacancies as he cannot be located in time to accept the vacancy. In addition, the lack of appropriate, affordable long-term housing options for Joe, such as mental health supported housing, make it difficult for Joe to break his cycle of homelessness.

Substance Use

Joe has a longstanding history of Polysubstance Use, including methamphetamines, and presents with increased aggressive behaviours when substance affected. This

includes threats towards staff, poor impulse control and verbal and physical aggression. Joe remains pre-contemplative around addressing his substance use and continues to decline support in this area.

Physical Health

Joe's physical health is significantly compromised by his social circumstances, substance use and mental illness. Joe is also overweight, and a heavy cigarette smoker. Joe will at times attend a GP for his immediate medical needs, however mainstream services have difficulties engaging him due to his delusional belief system and poor impulse control. Therefore, Joe will instead present to ED for emergency medical treatment, but will then frequently abscond prior to receiving the required treatment as he cannot tolerate the long wait times in this high stimulus environment.

NDIS

Although Joe would be eligible for NDIS supports, HOPS have so far been unable to engage Joe in an NDIS application due to the above circumstances.

Summary

Joe benefits from the assertive outreach and collaboration typical of HOPS. He would further benefit from the availability of 'housing first' accommodation and the integration of physical health services within the HOPS team.

Case Study 2

Alex (a pseudonym) is a street-homeless male in his 30s who has a diagnosis of schizophrenia and alcohol dependence.

Alex resides in a laneway in inner Melbourne, where he has now lived for some years. Alex is unemployed and is in receipt of a disability support pension administrated by State Trustees. He participates in a daily routine of attending City Libraries to access computers and read; however he remains significantly socially isolated outside regular contact with homeless outreach services and the care of a kind neighbour who provides him with occasional meals, clothing and support maintaining his living area.

Alex's family live interstate and he has had limited contact with them since leaving university. His father passed away a few years ago. His mother and older half-brother have attempted to provide support for Alex in the past by visiting him in Melbourne and having occasional phone contact facilitated by clinicians, but Alex has resisted offers to maintain contact with his family.

Prior to the development of his schizophrenia, Alex was reportedly a high functioning young man, excelling academically. On completion of Year 12, he attended university, but left unexpectedly before sitting his final exams. At this time, changes to his behaviour were reportedly such as neglect of his apartment and excessive alcohol consumption. The family lost contact with Alex soon after he left university and were unaware of his circumstances until contacted at the time of his first psychiatric admission 10 years later.

Alex has become well known to mental health services since first coming to the attention of HOPS. Throughout this time, Alex has had regular ongoing access to high-quality community mental health care. In the past Alex has had prolonged admissions to acute inpatient units, during which time he has ceased alcohol use. Following one of these admissions he was transitioned to a supported accommodation service where he remained for some months. During this time he was free from active psychotic symptoms and was abstinent from alcohol. He eventually returned to the streets, recommenced alcohol consumption, and his psychotic symptoms returned.

Compounding the current challenges is Alex's co-morbid alcohol dependence. This chronic addiction significantly impedes his treatment effectiveness, worsens his positive psychotic symptoms, and increases his social disability and general risk of harm.

Currently Alex is outreached a number of times a week by HOPS and support services. When his self-care and/or mental state decline to the degree that his is unable to perform basic activities of daily living he has brief admissions to address

his medical and psychiatric health. His current medication is an anti-psychotic injection every 3 weeks and oral multi-vitamins.

At his best, Alex presents as homeless Caucasian man in his [redacted]s who but who appears older than his stated years. He engages easily, is pleasant and polite. His affect is typically flattened with reduced reactivity. He is oriented to time and place. His speech is soft and monotone, and he is able to initiate and engage in discussions on a broad range of topics. He has limited insight into having a mental illness. When Alex is not at his best, he presents as dishevelled, malodourous wearing urine stained clothing. He quickly becomes irritable expressing frustration through verbal passive aggression that is often difficult to discern. Speech slurred, mumbling, expressing overt grandiose and persecutory delusional content most commonly related to religious themes or fictional characters. His judgement is grossly impaired.

Alex has not been able to engage with and NDIS assessment. Furthermore, from the perspective of clinical services, it is not clear if any services provided through the NDIS would be able to make a practical difference to his function.

Over-all, Alex baseline level of psychiatric and physical health falls below what, on face value, would be a minimum community standard, despite active outreach, brief admissions and longer inpatient stays. **Alex is Community Treatment Resistant** within the current service system. He cannot be treated effectively in the community without significant risk of mental and physical deterioration. Alex's current trajectory is towards an early death, probably within the next 5 years.

In order to provide the best opportunity for sustained reduction and/or cessation of his symptoms, and to provide the best opportunity to help restore his social functioning and optimal wellbeing, Alex needs access to a 'enabling environment' that can provide the psychiatric care and other opportunities for systematic rehabilitation that he needs. Placement in a Secure Extended Care Unit (SECU) would be appropriate for Alex, followed by access to 'housing first' accommodation.

Summary

Alex represents an example of a man with SPMI who in chronically street homeless in inner urban Melbourne. He remains street homeless due to the lack of access to AMHRU and housing first services)

Until recent years, people like Alex were relatively uncommon in inner urban Melbourne, in contrast to most other major cities in the developed world. Current trends show increasing long term homeless in persons with SPMI, including street homelessness.

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Appendix 1: Homeless Outreach Mental Health & Housing Service (HOMHS)

Based in Melbourne's CBD, HOMHS is a unique and innovative program which draws on Housing First principles[i] while addressing the complexity of needs experienced by long term rough sleepers with severe and enduring mental ill-health. Currently in its second iteration, HOMHS funded in 2017 under the Towards Home initiative[ii] by the Department of Health and Human Services, delivers exceptional outcomes for this client group. Cohealth is the lead agency and delivers services in a close working partnership with Inner West Area Mental Health Services, Launch Housing and McAuley Community Services for Women. The partnership actively works with other providers across multiple services sectors to achieve lasting change for people accessing care.

Using person centered approaches to care and treatment, the HOMHS model uses principles of connection, continuity and coordination that align with individually developed planning to proactively manage and prevent the likelihood of future tenancy breakdown. Most clients present with chronic homelessness, mental illness and drug dependence, along with past trauma and a range of physical health needs. The service response does not seek to priortise one need over the other rather, through this service, a client's needs are addressed collectively. Care is aligned to the principles of the Collaborative Recovery Model (developed by the University of Wollongong).[iii] The two fundamental approaches, Housing First and Collaborative Recovery are complementary and create an overarching person centered approach that enables actions that are tailored to the needs of people accessing care.

> Mary (a pseudonym) has often lived a very chaotic lifestyle, characterised by homelessness, substance misuse (ETOH) and poor follow-up with mental health services, leading to frequent hospital admissions and relapses. Since her referral to the HOMHS team Mary has been assertively followed up in the community. During this time Mary has been able to maintain stable accommodation as well as being linked into services to help her with her day to day functioning and social inclusion as well as a GP for her ongoing physical health needs.

A priority for HOMHS is to reach female rough sleepers. While access to service is not gender restrictive, engaging women in the service remains a key focus and informs the service response. Currently 40% of clients are female. HOMHS is available to people who have been rough sleeping for at least 12 months, or for extended periods over 3 years or more. In addition, to access the service people must have a severe and enduring mental illness. Typically, people present with a broad range of needs, and require multiple services. The service model recognises that people who present will invariably have a complex interplay of needs. People accessing the service identify a number of key changes in their lives following

engagement. In the most recent client survey, participants reflected on the impact of the service on their lives. Feedback included:

- “I now see my daughter and live a reasonably normal life”
- “Easily accessible and I like the outreach visits”
- “Help with family connectivity”
- “Have more motivation”
- “Good at keeping my routine when I have been a bit more aimless”
- “Constant contact and easily accessible”

Michael (a pseudonym) is supported by a number of services and has benefitted from HOMHS being able to manage the care that he receives from multiple partners. Michael is often overwhelmed by the myriad of appointments he has and often has difficulty managing his personal diary on a daily basis. HOMHS has facilitated holistic care for Michael through regular communication with the services involved in his care such as arranging care coordination meetings with his family and services.

Interestingly, housing was not highlighted by clients as a key factor in the survey comments, but without access to stable housing, much of the good work could not be achieved. Housing is critical to the success of HOMHS from initial engagement through to exiting the program. What drives the success of the program, is the recovery-oriented person-centred approach that recognises the unique needs of each person accessing care, and engaging key specialist staff to meet those needs. The central location is also critical to service success. In the recent Melbourne Streetcount, 65% of people stated they were accessing a service that day.[iv] The range of accessible services remains vital to addressing the needs of people who are rough sleeping.

Ten clinical staff are employed under the funding, including a psychiatric registrar and consultant psychiatrist. Other core clinical staff include mental health nurses, occupational therapist, care- coordinator, women’s support worker, care support worker, and a housing worker along with management and admin support. Every client has a key worker, however, a collective team approach ensures people benefit from multiple skills, experiences and perspectives. The reach of service provision is much wider than the core staffing, with links within partner agencies and across many key partners in Melbourne. Services can be scaled up and down to reflect individual need and to promote independence. Additionally, a flexible funding pool enables specialist assessment and intervention as indicated. The ability to effectively manage interactions with in-patient mental health settings to ensure a planned and coordinated approach to clinical care during acute episodes is vital to people’s wellbeing and ongoing trust in HOMHS.

The typical care pathway is strength based; future focused and is designed to address meaningful goals. Importantly, no time limit is placed on care. One client has been engaged with HOMHS from its original inception in 2013. Multiple pathways into care exist, each drawing on a strong partnership approach with local agencies. Low caseloads across the service, enable clients to be reviewed regularly to ensure the service remains responsive to need and evidence-based. In total 20 packages (6 hours of care weekly are available to provide care, currently HOMHS services 28 people. Since 2013, 58% of clients have been placed in permanent housing and remain housed.

Access to a range of services is essential, without the support of partners agency and staff, HOMHS would not be as successful. A key component of care for all, is access to clinical mental health care and psychosocial support. From 2013-2016 there was a 42% reduction in presentations to emergency departments by HOMHS clients. Inpatient admissions reduced by 4.9% in the same period. Any inpatient stay is now able to be more effectively planned and enables greater continuity of care. Typically, people also access AOD (alcohol and other drug) counselling or supports. The vast majority of clients also experience significant physical health needs. Access to quality primary health care, along with linkages to hospitals is critical. Providing GP and nursing care is key to successful client outcomes. Since July 2017, nine clients have been engaged with a GP, and all bar one client remain engaged with a primary care provider. Many clients present with blood borne viruses, a strong focus has been to provide the new hepatitis C treatment as indicated. The health needs of clients extend to podiatry, dietetics, diabetes education and exercise physiology. Clients are linked with legal services if required and several have accessed employment services to further enable their recovery journey.

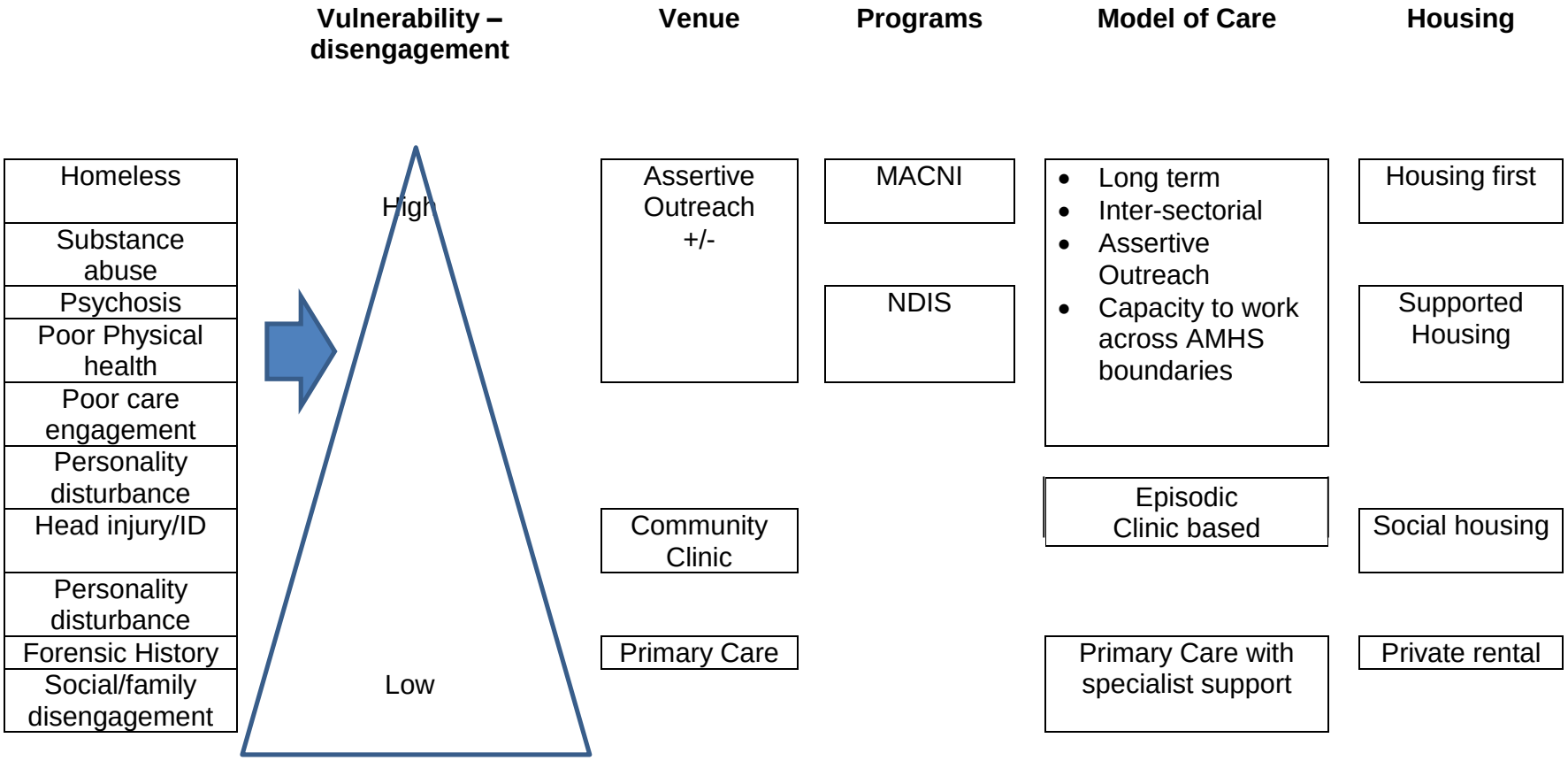
People accessing services have often experienced multiple inter-personal violence and abuse such as childhood/sexual abuse, family violence, sexual abuse during adulthood and other forms of violence during periods of homelessness/rough sleeping. Many are vulnerable to harm and exploitation from others, and often have lost connection with family. Often, they may be a risk to themselves through risky behaviour, drug/alcohol problems or addiction, self-harming or other forms of behaviour that may be detrimental to their health and mental health.

Connection to people and community is central to people’s recovery from mental ill-health. Beyond individual goals, HOMHS delivers a number of group programs to build skills, knowledge and capacity for change. Additionally, clients are linked to community groups to further support social connection. Consistent with the focus on female rough sleepers, a partnership has been developed with The Women’s Circus in Footscray. Through challenging physical activity in a welcoming and supportive environment, the activities build self-esteem and connection. Other group offerings include yoga, gym, walking and art. Groups are also specifically developed to address identified needs of clients.

Without a doubt, the single biggest challenge to the success of the HOMHS approach is access to permanent housing stock. This is likely to remain an ongoing challenge and reflects a point of divergence from the Housing First approach. In common with other programs, the funding cycle also presents challenges to continuity of care. In particular, the present funding commitment concludes in June 2019. Staff retention can be problematic in periods of uncertainty regarding future funding.

Individual elements of the HOMHS approach are perhaps not unique, however it is the combination of features and elements that informs the innovative approach. The assertive outreach approach is critical to engaging and maintaining contact with people in HOMHS. Meeting people on their own terms is a fundamental requirement to good service outcomes.

Appendix 2: Vulnerability – engagement model of mental health care for persons with SPMI



Appendix 3: Author List (Alphabetical order)

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Alex Holmes (Consultant Psychiatrist, Homeless Outreach Psychiatric Service, Melbourne Health)

Simon Jones (Consultant Psychiatrist, Homeless Outreach Psychiatric Service, Melbourne Health)

David Pruden (Team Leader, HOMS, the Drill Hall, Melbourne)

Debbie Sulman (Team Leader, Homeless Outreach Psychiatric Service, Alfred Health)

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