chp
council
to homeless
persons

Council to Homeless Persons – Submission to the Royal Commission into Mental Health

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Introduction

Council to Homeless Persons

Council to Homeless Persons (CHP) is the peak Victorian body representing organisations and individuals with a commitment to ending homelessness. CHP works to end homelessness through leadership in policy development, advocacy, capacity building and consumer participation.

What we mean by 'ending homelessness'

Homelessness occurs at the intersection of personal vulnerabilities, and structural forces such as poverty, housing affordability and security of tenure. People who become homeless are often financially disadvantaged and some will have spent a lifetime in insecure housing.

Ending homelessness doesn't mean that people will never find themselves without shelter. It means that homelessness will be rare, the experience brief, and it will not recur in a cycle of repeated homelessness.

To achieve this vision requires action to address both structural factors and personal vulnerabilities. Action is needed to reduce poverty, to improve the supply of housing that is affordable to people on low incomes, and to provide security for people's tenure within that housing. Simultaneously, Victoria requires services to help people manage the vulnerabilities that can make homelessness more likely. Vulnerabilities highly associated with homelessness include mental ill-health, eviction, job loss, family violence, relationship breakdown, or indeed a combination of these factors.

Reading this submission

In this submission, CHP has sought to provide information beyond that made available in the cover sheet. This submission does however respond to questions asked by the Royal Commission. We identify the need for our mental health system to recognise housing as a critical element of treatment. Drivers of poor mental health outcomes are addressed through the call for Housing First approaches, the examination of acute care exits into homelessness, and the call for housing (and health) focused justice diversion. We address prevention and early intervention where we highlight the importance of programs that reduce demand on hospital bed days. We have responded to these issues thematically.

In developing this response, CHP consulted with people with a lived experience of co-occurring homelessness and mental ill-health and treatment. Many of these consumers have also received mental health treatment while securely housed, and so are well placed to provide an informed perspective on the differences between these two experiences. Information from this consultation underpins our response, and illuminating excerpts are provided in support of evidence throughout this submission.

Executive Summary

Stand-alone mental and psychiatric hospitals provided residents with a place to live, but unnecessarily institutionalized many Victorians living with mental illness. The closure of these restrictive and isolated facilities assumed that social housing would be available to those with mental illness living on low incomes.

The assumption that those living with mental illness will have access to housing they can afford from which to receive their mental health care, underpins the successful provision of in-community mental healthcare. In 2019, we can now say that that assumption was false.

Today, a lack of appropriate housing means people are unable to receive effective in-community support, unable to adhere to their treatment plans or build relationships with their mental health professionals, and are subject to damaging instability and danger. Consequently, people with mental illnesses are now cycling through acute mental health care and exiting into homelessness, only to return repeatedly to hospital-based care, and/or incarceration. To improve Victorians' mental health, we must recognize housing as a core component of in-community mental health care.

Increasing the supply of social housing, and providing access to social housing and flexible support programs for those with complexity or exiting hospitals or prisons, aren't new ideas. Fine examples of these programs exist. We must finally begin to measure the housing and housing support needs of Victorians with a mental illness, and develop a plan to meet them.

This submission also discusses priorities for the built form of that housing. Most people living with mental health conditions can live well in scattered site housing that they can afford, with the availability of in-reach support that can flex up and down in response to changing needs. Congregate care facilities with high staffing levels and large numbers of people living at close quarters can present challenges, and are required for only a small number of people with very high levels of complexity. We also caution that the current heavy reliance on rooming houses in Victoria for low cost accommodation is also undermining mental health outcomes.

Victoria needs a range of housing options to reflect the breadth of needs of those living with mental illnesses. Some people will only require short-term support to sustain a tenancy after a period of ill-health. At the other end of the spectrum, those with complex mental illnesses and long histories of housing instability may require Housing First responses.

This submission explores the role of housing and support for particular cohorts among those experiencing mental ill-health (including young people with multiple vulnerabilities), and in reducing the drastic over-incarceration of people living with mental illnesses.

Once we fully recognise housing as a core component of mental health care we can take steps towards preventing the onset of mental illness, achieving positive treatment outcomes, and sustaining mental health gains into the future.

List of recommendations

- Increase the supply of social housing for people whose mental illness leaves them unable to afford market rents
- Implement and evaluate interdisciplinary rooming house outreach programs
- Recognise stable housing as a core component of mental healthcare
- Measure the housing and housing support needs of people living with mental illnesses and develop a plan to respond
- Recognise that scatter-site housing with flexible in-reach support is required by most people, while congregate housing with on-site support is needed by a small number of people living with considerable complexity
- Consider means to improve the security of tenure of people experiencing mental illness and living in private rental
- Expand programs that improve both access to, and retention of, housing like the Private Rental Access Program and TenancyPlus
- Increase the provision of integrated multi-disciplinary supports
- Resource organisations across a range of health and human services to work in a highly integrated way
- Fund a systematic rollout of Housing First programs for people with severe mental illnesses and histories of homelessness or housing insecurity
- Deliver social housing with access to step-down transitional in-reach care to those exiting acute mental health treatment who do not have an appropriate place to live
- Reduce the incarceration of people with mental illnesses
- Improve post-incarceration housing and support for people with mental illnesses to reduce recidivism
- Enhance and increase supply of health-focused emergency responses to those experiencing mental illnesses, and decrease police responses to this cohort
- Fund supports that house and intensively support young people with multiple co-occurring vulnerabilities.

Mental illness and housing.

Mental illness, poverty and housing affordability

'At the moment in the mental health system, there are two treatments; one for the poor, and one for the wealthy'

\- David Montgomery, Consumer / Advocate

Mental illness is a direct cause of poverty for many people. Poor mental health is strongly associated with reduced employment[1], and 34 per cent of those receiving the Disability Support Pension are doing so due to mental illness[2]. Many other people experiencing significant mental illness receive the lower Newstart Allowance. The Disability Support Pension is just 28 per cent of the average adult full time earnings, while Newstart is just 17 per cent[3] [4]. Such a low income leaves many people living in poverty[5].

For people with low prevalence, high severity illnesses, the risk of poverty and of homelessness is particularly high. Centrelink is the main source of income for 85 per cent of people with psychotic illnesses. A 2010 study found that the vast majority of people with psychotic illnesses had incomes of less than $400 per week[6]. Only 21.8 per cent of people with psychotic illnesses live in private rental, while 25.9 per cent live in rent-controlled social housing. Shockingly, 5.2 per cent of people with psychotic illnesses are homeless, while 12.8 per cent experience homelessness across the course of a year. The duration of that homelessness averages duration of 155 days,[7] whereas across the broader population 57 per cent of people experiencing homelessness do so for fewer than three months.[8]

The private rental market provides very few options for people living in poverty, including many people whose poverty results from mental ill-health. Across all of metropolitan Melbourne there were just 35 rental properties let in

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[1] Frijters, P., Johnston, D.W. and Shields, M.A., 2014, *The effect of mental health on employment: evidence from Australian panel data*, Health Economics, vol. 23, no. 9, pp. 1058–1071

[2] Productivity Commission, 2019, *The Social and Economic Benefits of Improving Mental Health; Productivity Commission Issues Paper*, p.19

[3] Both figures inclusive of the energy supplement, Disability Support Pension inclusive of the Pension Supplement. Both figures calculated at the maximum rate for a single person.

[4] Australian Bureau of Statistics, 2019, *6302.0 - Average Weekly Earnings, Australia, Nov 2018*

[5] Davidson, P., Saunders, P., Bradbury, B. and Wong, M., 2018, *Poverty in Australia, 2018*. ACOSS/UNSW Poverty, pp. 48-50.
and Inequality Partnership Report No. 2, Sydney: ACOSS

[6] Morgan, V., et al, 2010, *People living with psychotic illness 2010,* National Mental Health Commission, Canberra, p.53

[7] Ibid, pp. 60-61

[8] Australian Bureau of Statistics, 2015, *4159.0 - General Social Survey: Summary Results, Australia, 2014, Table 17. Homelessness*

the March 2019 quarter that would have been affordable to a single person on Newstart,[9] and just 148 affordable rentals available across the entire state. This continues a prolonged downward trend in the availability of housing affordable to those on our lowest incomes[10].

Even those few properties that are affordable to a person on a Centrelink income are likely to be leased to households on higher incomes[11]. Ensuring that housing is available and affordable to those who need it most will require Governments to invest directly in housing. Given that there are already 75,000 – 100,000 at-risk households who do not have access to affordable housing, an immediate investment in social housing is required, as well as strategies to provide a pipeline of affordable housing into the future[12]. The enhanced security of tenure in social housing also provides greater ontological security, which has a positive impact on mental health[13].

'Money, anxiety, it compounds depression. It isolates you from your community; you can't afford to do things that other people are doing, you can't afford to go out for a cup of coffee.'

\- [redacted] Consumer / Advocate

Recommendation: Increase the supply of social housing for people whose mental illness leaves them unable to afford market rents.

Homelessness leads to mental ill-health

'For prevention, get a bloody house!'

\- [redacted] Consumer / Advocate

The interconnection between access to housing and mental wellbeing has been extensively evidenced;[14] we know that housing supports mental health

[9] Victorian Government Department of Health and Human Services, 2019, *Rental Report March Quarter 2019,* p.19
[10] Victorian Government Department of Health and Human Services, 2019, *Rental Report March Quarter 2019; Affordable lettings by local government area – March quarter 2019* available at < https://dhhs.vic.gov.au/publications/rental-report>
[11] Hulse, K., Reynolds, M., Stone, W. and Yates, J., 2015, Supply shortages and affordability outcomes in the private rental sector: short and longer term trends, AHURI Final Report No.241. Melbourne: Australian Housing and Urban Research Institute, p.26
[12] Infrastructure Victoria, 2016, Victoria's 30-Year Infrastructure Strategy, p.104
[13] Rebecca J. Bentley, David Pevalin, Emma Baker, Kate Mason, Aaron Reeves & Andrew Beer (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, Housing Studies,
[14] Brackertz, N., Wilkinson, A., and Davison, J., 2018, Housing, homelessness and mental health: towards systems change, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne

treatment, while homelessness leads to mental ill-health. [15] In 2017-18, at least 30 per cent of those aged ten and over who sought help from a specialist homelessness service in Australia reported a diagnosed mental health issue.[16] This incidence is far higher than the 18.2 per cent of Australians who have a mental health condition.[17]

Research has demonstrated that housing insecurity both causes and prolongs mental ill-health, with a major Victorian study finding that just 15 per cent of people accessing specialist homelessness services had mental health issues *prior* to experiencing homelessness, while another 16 per cent only developed mental ill-health *after* their experience of homelessness commenced.[18]

'...Having complex needs, and not understanding my own condition - from the depression and anxiety that comes from being homeless, and your mind's just a mess.'

- [redacted] Consumer / Advocate

The failure to respond properly to homelessness is exacerbating the demand pressures faced by Australia's mental health system, leading to worse outcomes for consumers, and decreasing the efficiency of the resources used for mental healthcare.

Rooming houses and mental health

'I don't think people should be exited from either hospital or prison without a good tenure on a house. Not a rooming house. It's not good enough.'

- [redacted] Consumer / Advocate

Rooming houses are a common form of housing for people experiencing disadvantage. This includes those who are unemployed, have a disability, have a history of trauma, and are socially isolated, many of whom are not connected to services. [19] A prominent cohort within rooming houses are those with psychiatric illnesses.[20] Yet despite this vulnerability, most residents speak to only a few people each week – including fellow residents - and have no, or little

[15] Johnson, G., and Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 46, Issue 1, p.36.
[16] Australian Institute of Health and Welfare, 2018, *Specialist Homelessness Services Collection 2016-17*
[17] Australian Bureau of Statistics, 2015, *4159.0 – General Social Survey: Summary Results, Australia, 2014, Table 03. State and Territory*
[18] Johnson, G., and Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 46, Issue 1, p.36.
[19] Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p 36
[20] Ibid, pp.35 - 36

contact with support services.[21] Residents overwhelmingly report rooming houses to be dangerous and violent, dirty, and harmful to their mental health.[22]

People with mental illnesses report that independent housing is the best form of housing to support their wellbeing, with congregate facilities providing substantially less choice and control, but that far worse still are rooming houses.[23]

'I lived with someone with extreme schizophrenia, and he tried to set himself on fire, he was trying to kick my door down and kill me'

- [redacted] Consumer / Advocate

The provision of in-reach services to rooming houses is extremely poor. Despite the social isolation, service disconnection, and mental health needs of residents, very few existing services extend into the home of rooming house residents. There is some limited evidence that group-based rooming house outreach programs can achieve dramatic improvements in residents' wellbeing.[24] However these pilot programs have typically lacked ongoing funding, had low-quality evaluations and as a result have been short-lived.

In the absence of a strategy to ensure that *appropriate* affordable housing is made available to all people experiencing mental illness, the mental health needs of rooming house residents cannot continue to be ignored. There is a critical need to boost the capacity of programs that directly engage rooming house residents through funded in-reach programs.

'When I was getting released after six months in hospital, they just set me up in a rooming house. There was no support, and no connection to services.'

- [redacted] Consumer / Advocate

Recommendation: Implement and evaluate interdisciplinary rooming house outreach programs.

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[21] The Salvation Army Adult Services, 2011, 'No room to move? Report of the Outer West Rooming House Project', p.16

[22] Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p.25

[23] Nelson, G., Hall, G. B., & Walsh-Bowers, R., 1999, *Predictors of the adaptation of people with psychiatric disabilities residing in group homes, supportive apartments, and boardand-care homes,* cited in Nelson, G., Sylvestre, ., Aubry, T., George, L., Trainor, J., 2006, *Housing Choice and Control, Housing Quality, and Control over Professional Support as Contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness*, Administration and Policy in Mental Health and Mental Health Research, 2007, 34, p. 90.

[24] Council to Homeless Persons, 2019, *Council to Homeless Persons pre-budget submission 2019-2020*, p.6

Mental healthcare, treatment and housing.

Access to housing

'How can they provide follow-up care if they don't know where you are?'
- [redacted] Consumer / Advocate

Housing must be recognised as an essential component of mental healthcare. Deinstitutionalisation was predicated on the availability of appropriate places to live while accessing in-community mental healthcare. This has been a positive development for those with access to both housing and support in the community. However, governments have failed to fully recognise and fund the housing needed to complement the in-community mental healthcare system.[25]

The commonality between in-community care, Housing First approaches, and residential clinical care is that they all recognise housing as a precondition for mental healthcare, and indeed, as a necessary component of that healthcare. This understanding is missing from Victoria's mental healthcare system.

'I wasn't in housing long enough to be able to have a relationship with my doctor to get everything out that needed to be out to get a diagnosis, and it wasn't until I had housing that I've had a relationship with a doctor that has gotten me closer to understanding how I act and how to deal with it.'
- [redacted] Consumer / Advocate

Housing access is a significant challenge for those experiencing mental illness. A survey of respondents experiencing a range of high and low prevalence mental illnesses found that 90 per cent believed that they had been discriminated against in the private rental market.[26]

Social housing is also difficult to obtain with 41,677 households[27] on the Victorian waiting list for the 80,501 properties in the social housing pool[28] – a pool which is both fully occupied and declining in size.[29] Even priority applications for social housing are subject to an average waiting time of 10.5

[25] Green, D., 2003, *The End of Institutions: Housing and Homelessness*, in Parity Magazine April 2003, p.5
[26] SANE Australia, 2008, *SANE Research Bulletin 7: Housing and mental illness (June 2008)*, p.1
[27] Department of Health and Human Services Victoria, *Victorian Housing Register and transfer list by local area,* March 2019
[28] Productivity Commission, 2019, *Report on Government Services, Chapter 18 attachment tables; table 18A.3; Descriptive data – number of social housing dwellings, at June 30 (a), (b), (c)*
[29] Ibid

months.[30] The crisis in housing access is particularly dire for those with low prevalence mental illnesses. As mentioned previously, 12.8 per cent of people with psychotic illnesses experience homelessness within the course of a year, while a further 25 per cent are fearful that they will experience homelessness. A property being identified as affordable, does not guarantee that access to that housing will be targeted to those most in need[31]. Appropriate and affordable housing *access* must be both planned for, and delivered.

Most people who have severe mental illnesses and resultant difficulty gaining or sustaining housing, do not require their housing and mental health treatment to be co-located. Mental health consumers feel they have greater control in relation to their mental health supports when in scatter-site in-community housing[32]. There is also a substantial body of evidence demonstrating that in this circumstance they achieve better mental health outcomes[33]. Indeed, scatter-site distribution of permanent housing for people experiencing severe mental illnesses is at the core of the highly successful Housing First model.[34]

Permanent single-site housing with on-site services is only necessary for a relatively small number of people with severe mental illness with significant complexity. One study found that many residents of one such Victorian facility were happy with their current living situation "particularly in contrast to alternative housing options that would be available to them".[35] Another study found that 11 per cent of people living with psychotic illnesses were living in supported accommodation, while only 2.8 per cent rated this as their preferred accommodation type[36]. For those living with severe mental illness, scatter site, adequate, stable, well supported and affordable housing should be a priority for Governments.

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[30] Foa, N., 2018, *Standing committee on legal and social issues: Inquiry into public housing renewal program; Questions on notice: Deputy Secretary Housing, Infrastructure, Sport and recreation; Department of Health and Human Services*, p. 2
[31] Hulse, K.,Reynolds, M., Stone, W., and Yates, J., *Supply shortages and affordability outcomes in the private rental sector: short and longer term trends*, Australian Housing and Urban Research Institute, p.26
[32] Nelson, G., Sylvestre, ., Aubry, T., George, L., Trainor, J., 2006, *Housing Choice and Control, Housing Quality, and Control over Professional Support as Contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness*, Administration and Policy in Mental Health and Mental Health Research, 2007, 34, p. 98
[33] See for example the literature review Nelson, G., Sylvestre, ., Aubry, T., George, L., Trainor, J., 2006, *Housing Choice and Control, Housing Quality, and Control over Professional Support as Contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness*, Administration and Policy in Mental Health and Mental Health Research, 2007, 34, pp. 89-91.
[34] Pleace, N., 2016, *Housing First Guide Europe,* FEANTSA the European Federation of National Organisations working with the homeless, p.12
[35] Lee, S., Giling, J., Kulur, B., and Duff, C., 2013, *Exploring the impact of housing security on recovery in people with severe mental illness; Summary Report*, p.13
[36] Morgan, V., et al, 2010, *People living with psychotic illness 2010,* National Mental Health Commission, Canberra, p.59

Recommendation: Recognise stable housing as a core component of mental healthcare.

Recommendation: Measure the housing and housing support needs of people living with mental illnesses and develop a plan to respond.

Recommendation: Recognise that scatter-site housing with flexible in-reach support is required by most people, over congregate housing with on-site support for a small number of people with considerable complexity.

Keeping housing

'Having a home when you're receiving mental healthcare keeps you safe and secure.'
- [redacted] Consumer / Advocate

'And you've got an address where they can contact you.'
- [redacted] Consumer / Advocate

'And connection to community'
- [redacted] Consumer / Advocate

'You can actually start building up a good relationship with your GP and all of the services in your area, so that you finally get a good overall history going, and build a relationship with your professional'
- [redacted] Consumer / Advocate

Approximately half of all Victorians with mental illnesses have mild needs. Many in this cohort will not require public, community, or supported housing, yet may occasionally require support to resolve a crisis and maintain their tenancies. The Royal Commission should consider ways to improve the security of tenure of Victorians experiencing mental ill-health – particularly in the low-security private rental market.

Programs coordinating mental healthcare and housing support have proven effective across both private rental and social housing tenure.[37] [38] Time limited support during times of crisis may be all that is needed to sustain many people

[37] Brackertz, N., Wilkinson, A., and Davison, J., 2018, ***Housing, homelessness and mental health: towards systems change***, pp.34-35
[38] Victorian Government, 2018, *Family Violence Housing Blitz Package evaluation; executive summary*

experiencing mental illness to live well in the community. There should be an expansion of programs that offer support during a person's mental ill-health or associated crisis that can flex up and down over time, with access to brokerage funds that can support tenancy sustainment. Programs like Victoria's *Private Rental Access Program* and *Tenancy Plus* are both cost-effective and functional at achieving tenancy sustainment outcomes.[39]

In contrast to those whose mental ill-health results in episodic, time-limited crises, those who are likely to experience recurring or ongoing difficulty affording and /or sustaining a rental may require an ongoing subsidy, such as that provided by social housing.

Alongside an ongoing subsidy, many people will require far more flexible support periods than are currently available in order to sustain their recovery and housing. Many people experiencing mental ill-health, including those experiencing homelessness alongside complex mental illnesses, will require intermittent multidisciplinary support,[40] with very flexible case periods.

"Once 'Street to Home' got me housed post-hospital, it didn't change how often they checked in on me. They didn't cut back until I was ready"'

\- [redacted] Consumer / Advocate

A greater focus is required on integrated and long-term programs that are able to flex up and down in intensity for those with ongoing complexity. These programs include professionals from a range of disciplines as part of a service delivery team, where housing workers can complement the work of other support providers. Wrap around team-based mental health recovery supports might include: peer support, clinical mental health and health treatment, disability support, primary care, housing, community legal services, and addiction support.

Wrap around support can be provided either by existing agencies taking on new functions, or by multiple agencies providing services in an integrated way. Inter-agency collaboration is common across human services, including mental health, drug and alcohol, and housing and homelessness, but to date could not be considered an embedded feature of the system.

Consumers regularly report "falling through the cracks". This demonstrates that while efforts are being made by agencies to provide wrap around support, greater guidance and resources may be required to achieve this meaningfully .

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[39] Council to Homeless Persons, 2019, *Council to Homeless Persons pre-budget submission 2019-2020,* p.5. Available at: chp.org.au/wp-content/uploads/2019/03/CHP-Pre-Budget-Submission-2019.pdf

[40] Phillips, R. and Parsell, C., 2012, The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No. 179, Australian Housing and Urban Research Institute Limited, Melbourne, p.1

"All the service domains need to come together. And they need basic skills of listening.""

- [redacted] Consumer / Advocate

Recommendation: Consider means to improve the security of tenure of people experiencing mental illness and living in private rental.

Recommendation: Expand programs that improve both access to, and retention, of housing like the *Private Rental Access Program* and *TenancyPlus.*

Recommendation: Increase the provision of integrated multi-disciplinary supports.

Recommendation: Resource organisations across a range of health and human services to work in a highly integrated way.

Sustaining treatment outcomes

'My life was a mess until I got housing. Just moving from room to room to room. Dealing with people with their own mental health issues, and drug and alcohol addiction and stuff like that is really, really hard. Getting housing helped me keep appointments, workers have helped me keep appointments. Sometimes that drops off, and a good worker keeps you on track and connected to your appointments and your networks and stuff like that.'

- [redacted] Consumer / Advocate

A considerable body of research/ evaluation has demonstrated the effectiveness of Housing First as a response to people experiencing homelessness and who also have complex needs, including mental illness.

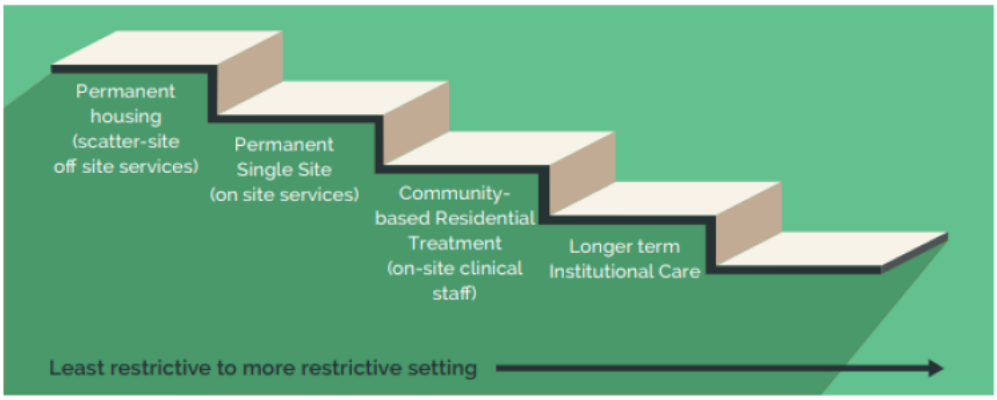
A growing consensus exists that Housing First programs are effective at supporting the recovery and long-term sustainment of treatment outcomes for people with severe mental illnesses and co-occurring homelessness or housing instability.[41] Housing First programs are denoted by eight principles: Housing as a human right; Choice and control for service users; Separation of housing and treatment; Recovery orientation; Harm reduction; Active engagement without coercion; Person-centred planning; and Flexible support for as long as required.[42]

[41] Pleace, N., 2016, *Housing First Guide Europe*, FEANTSA the European Federation of National Organisations working with the homeless, pp. 20-22.
[42] Ibid, pp. 27-37.

Housing First is not intended as a response to all forms of homelessness or all forms of mental ill-health. Housing First is a model of housing and support for people with severe mental illnesses who are experiencing or at risk of long-term homelessness. Housing First can successfully sustain housing for 80 per cent of this cohort, [43] while recognising that there are those for whom residential clinical care is required on a short or long term basis.

In Figure 1 (below) the least restrictive option 'Permanent housing (scatter-site off site services)' is a Housing First approach that meets the needs of most people experiencing co-occurring homelessness and severe mental illness. Far fewer people require the 'Permanent Single Site (on site services)' setting, which may also be delivered using Housing First principles. The remaining two settings are residential clinical care. Common to all mental health service settings highlighted in Figure 1 is that they recognise housing as a pre-condition for mental healthcare, and a necessary component of that healthcare.

Figure 1. [44]



While Housing First is often considered a "gold standard" approach to addressing a person's co-occurring homelessness and mental illness, Tsemberis makes clear that it is not an approach that can successfully meet the needs of those who require long term residential clinical care. [45] What all four stages approaches in Figure 1 do demonstrate is the need to consider housing as an important mental health support.

Pleace argues that while it is to be expected that programs should be contextually different when implemented in different jurisdictions, some incarnations of Housing First have failed due to low fidelity to the model's core

[43] Ibid, p.12
[44] Tsemberis, S., 2013, Presentation at the Final Conference of Housing First Europe in Amsterdam, as cited in Pleace, N., 2016, *Housing First Guide Europe*, FEANTSA the European Federation of National Organisations working with the homeless, p.76
[45] Ibid, p.76

principles.[46] Similarly, Johnson has argued that Australian Housing First programs should not aim for total fidelity with the *Pathways to Housing* program from which Housing First derives, but that "having the capacity to access and manage permanent housing… are fundamental to the Pathways to Housing program achieving significant housing retention success".[47]

Housing First programs have shown that residents with severe mental illnesses require far fewer days each year admitted to inpatient care compared to the period before they were housed. A rigorous study of a major Victorian Housing First program identified a decrease in hospital and psychiatric unit bed days of 80 per cent.[48] [49]

'You need support to get your feet on the ground again. Instead of them taking you from hospital into a place and leaving you – then the problems will start again'

\- [redacted] Consumer / Advocate

Remarkably, these improved outcomes for housed consumers were achieved without an increase in residents' use of community mental health care services. Improved outcomes instead reflected greater stability, improved consumer/clinician relationships, and resultant greater adherence to treatment plans.[50]

Recommendation: Fund a systematic rollout of Housing First programs for people with severe mental illnesses and histories of homelessness or housing insecurity.

[46] Pleace, N., and Bretherton, J., 2013, *The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness,* European Journal of Homelessness, Volume 7. No. 2, December 2013
[47] Johnson, G. et al., 2012, *Policy shift or program drift? Implementing Housing First in Australia*, AHURI Final Report No.184. Melbourne: Australian Housing and Urban Research Institute, p.14
[48] Johnson, G., Kuehnle, D., Parkinson, S., Sesa, S., & Tseng, Y., 2014, *Sustaining exits from long-term homelessness: A randomised controlled trial examining the 48 month social outcomes from the Journey to Social Inclusion pilot program*, Sacred Heart Mission, St Kilda, p.17
[49] Holmes, A., Carlisle, T., Vale, Z., Hatvani, G., Heagney, C., & Jones, S., 2017, *Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness*, in Australian Psychiatry, Volume 25 Issue 1, pp. 56-59.
[50] Ibid, pp. 56-59.

Stemming the flow into acute care, stopping the flow into prison

Acute mental healthcare and housing

'There's a study that shows that for every time you house a person you save money on mental health and prison. I think that's an important point to make. If you want to address mental health and drugs, and improve outcomes for people living with a mental health system, then Housing First is the best'

- [redacted] Consumer / Advocate

The lack of suitable housing exacerbates pressure on acute mental health services. The NSW Ombudsman found that a lack of appropriate accommodation options was a key factor preventing the discharge of mental health patients. This led to both reduced availability of acute beds for those who needed them, and to mental health staff referring inpatients to inappropriate housing options to promote earlier exits.[51]

Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.[52]

Exiting acute care into homelessness is self-defeating. Homelessness is destructive to a person's mental health,[53] and also restricts the provision of subacute and outpatient support to hospital-leavers.[54]

'You get better after-sale care on a laptop.'

- [redacted] Consumer / Advocate

This problem is only growing. The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13.[55] The number of people accessing Victorian homelessness services who report having a mental health issue has increased by 84 per cent in this same

[51] NSW Ombudsman, 2012, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability,* p.55
[52] Discussion in meetings between clinical mental health and homelessness services, 2018
[53] Johnson, G., Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 26, Issue 1, p.36.
[54] Stokes, B., 2012, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Government of Western Australia Department of Health and Government of Western Australia Mental Health Commission, p. 158.
[55] Australian Institute of Health and Welfare, 2019, *Specialist Homelessness Services Collection.*

period. As discussed earlier, without appropriate housing it is difficult to maintain a treatment regimen.

The period of transition from a psychiatric hospital into the community is marked by instability and stress. Compounding this stress, a lack of housing and poorly coordinated supports mean that many people exiting such facilities do not have their needs adequately met during this time.[56] Mental health hospital dischargees who received social housing and in-reach support required 22 fewer psychiatric in-patient bed days per participant, with the related financial savings eclipsing the cost of providing this support. Consumers' living conditions also improved.[57]

'Housing means that people wouldn't be in and out of hospital'

\- [redacted] Consumer / Advocate

With the cost of providing an acute bed in Victoria at $917 per patient per day[58], supporting people to transition successfully out of psychiatric hospitals is both cost-effective, and achieves better outcomes for consumers.

Recommendation: Deliver social housing with access to step-down transitional in-reach care to those exiting acute mental health treatment, who do not have an appropriate place to live.

The over-representation of people experiencing mental illness in prisons

'Instead of putting people back on the street like they've been doing, they need housing set up so that they can put them in housing. Because that is where the main problem starts; on the streets.'

\- [redacted] Consumer / Advocate

People who do not have access to adequate mental health supports can find themselves cycling through homelessness and prison.

The latest survey of prisoner health revealed that 54 per cent of Victorian prison entrants report being diagnosed with a mental health disorder prior to imprisonment.[59] Those experiencing comorbid homelessness and mental ill-

[56] Brackertz, N., Wilkinson, A., and Davison, J., 2018, Housing, homelessness and mental health: towards systems change, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, p.43

[57] Siskind, D., et al, 2014, *A retrospective quasi-experimental study of transitional housing programs for patients with severe and persistent mental illness,* Community Mental Health Journal, vol. 50, no. 5, pp.538–547.

[58] Productivity Commission, 2019, *Report on Government Services; Chapter 13 Attachment Tables, Table 13A.36*

[59] Australian Institute of Health and Welfare, 2019, *The health of Australia's prisoners 2018, Data tables: 03 – Mental Health – States & territories*

health are 40 times more likely to be arrested, and 20 times more likely to be imprisoned than those in stable accommodation.[60] In the absence of appropriate housing, prisons have to some extent, replaced the institutions that Victoria so fulsomely rejected in the past.

'If I was at my own house and I flip out, I'd get a different response than if I was standing on the corner, homeless. It's laughable that people think you get the same response if you're homeless – not even (expletive) close.'

\- [redacted] Consumer / Advocate

Incarcerating people is expensive. Each Victorian prisoner costs $324 per day[61]. A more cost effective and just option is to fund the housing and support that people require to live well in the community, which reduces both over-incarceration[62] and recidivism[63]. That 59 per cent of Victorian prison entrants have been in prison before[64] tells us that something is not working in our justice and rehabilitation system. Housing and support benefit the consumer, increase community amenity, and reduce costs overall.[65]

We can also do more to divert people from prisons. Currently, if a person experiencing housing insecurity and mental ill-health is arrested, it is common for them to be placed in prison or police custody as a method of safe management and containment.[66] This makes tenancy sustainment and treatment adherence extremely difficult. A law enforcement response to an episode of mental ill-health is a misplaced intervention for a person requiring healthcare. Appropriate health-focused emergency responses complemented by safe, stable and affordable housing, must be made available at a sufficient scale.

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[60] NSW Department of Corrective Services, 2004, *Submission to Experiences of Injustice and Despair in Mental Health Care in Australia consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission,* cited in Mental Health Council of Australia, 2014, *Not for Service,* p.220

[61] Productivity Commission 2019, *Report on Government Services: Chapter 8: Attachment Tables*

[62] Povey, C., Adams, L., and Roberts, S., 2013, *Homelessness and Policing; Submission to the Consultation on the Victoria Police Field Contact Policy and Cross Cultural Training*

[63] Willis, M., 2018, *Supported Housing for Prisoners Returning to the Community: a review of the literature,* Australian Institute of Criminology for State of Victoria, Corrections Victoria, pp. 10-11

[64] Australian Institute of Health and Welfare, 2019, *The Health of Australia's prisoners 2018; Data tables: 02 – Socioeconomic factors – States & territories*

[65] Willis, M., 2018, *Supported Housing for Prisoners Returning to the Community: a review of the literature,* Australian Institute of Criminology for State of Victoria, Corrections Victoria, p.38

[66] Baldry, E., 2014, *Complex needs and the justice system,* in *Homelessness in Australia*, Council to Homeless Persons, Sydney, p.201

'CAT (Crisis Assessment and Treatment) Teams need to be expanded. Now they don't turn up, and when they turn up they come with too many coppers. I understand that they need two, but they don't need ten. You feel threatened and it makes you more aggressive.'

- [redacted] Consumer / Advocate

Recommendation: Reduce the incarceration of people with mental illnesses.

Recommendation: Improve post-incarceration housing and support for people with mental illnesses to reduce recidivism.

Recommendation: Enhance and increase supply of health-focused emergency responses to those experiencing mental illnesses, and decrease police responses to this cohort.

Housing, mental health and young people

'Early and well-timed community and human service interventions to establish and maintain secure supported housing are likely to reduce if not eliminate years of high levels of police contacts, court appearances, associated legal processes, frequent custody and community corrections interventions and ambulance use.'

- Baldry, E., 2012[67]

Young people experience mental ill-health differently from adults, requiring different responses. Of particular concern is that Housing First models support a consumer's independence, whereas young people may not be fully independent and often require adult support and guidance.[68]

'A Housing First approach for youth must not merely replicate an established approach that works for adults and simply create Housing First 'Junior' by changing the age mandate. If Housing First is to work for youth, it must be built upon our understanding of the developmental, social and legal needs of young persons'

- Gaetz, S., 2014[69]

Gaetz provides a detailed consideration of the application of the Housing First model to young people in his literature review.[70] Many young people are more comfortable and achieve better outcomes in congregate care.[71] [72] Housing First *can* work for young people experiencing homelessness and mental illness, but in a context where the support delivered is commensurate with their needs, which are likely to be both greater and different from that of the adult population.

Those young people in particular whose needs are among the highest in the country have no appropriate support service. The lifetime institutional cost of agency contacts with these individuals runs to millions of dollars per person. These young people are identifiable before they become entrenched users of bed based health and human services.[73] Drastically improving the provision of housing and support for young people with multiple mental health, justice, and

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[67] Baldry, E., Dowse, L., McCausland, R., and Clarence, M., 2012, Lifetime institutional costs of homelessness for vulnerable groups, School of Social Sciences University of New South Wales, Sydney, for Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, p.107
[68] Gaetz, S., 2014, *Can Housing First Work for Youth,* European Journal of Homelessness, Volume 8. No. 2, December 2014, p.164
[69] Ibid, p.164
[70] Ibid
[71] Ibid, p.167
[72] Gaetz, S, 2017, THIS is Housing First for Youth: A Program Model Guide. Toronto: Canadian Observatory on Homelessness Press, p.7
[73] Baldry, E., Dowse, L., McCausland, R., and Clarence, M., 2012, Lifetime institutional costs of homelessness for vulnerable groups, School of Social Sciences University of New South Wales, Sydney, for Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

child protection interactions would be a sensible investment when considered against a lifetime of high-cost service use. [74] [75]

Recommendation: Fund supports that house and intensively support young people with multiple co-occurring vulnerabilities.

[74] Ibid
[75] Victoria State Government Sentencing Advisory Council. 2019, *'Crossover Kids': Vulnerable Children in the Youth Justice System; Report 1: Children who are known to child protection among sentenced and diverted children in the Victorian Children's Court*, p.94