



The Royal
Australian &
New Zealand
College of
Psychiatrists

Submission No. 13
(homelessness legislation)
A.O.C. Date: 18/08/09

**Submission to the House Standing Committee on Family,
Community, Housing and Youth**

Inquiry into homelessness legislation

August 2009

working
with the
community

Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to have the opportunity to make a submission to the Inquiry into homelessness legislation aimed at reducing the number of people who are homeless, decreasing the risk of people becoming homeless, and improving the outcomes of people who may be or who are at risk of homelessness. Following the release of the government White Paper *The Road Home: A National Approach to Homelessness* (Department of Families, 2008), RANZCP commends the Government for conducting this inquiry and for recognising that addressing the incidence of homelessness in Australia requires strategies to:

- (i) reduce the immediate shortfall in services available to, and that are readily accessible to, homeless people and;
- (ii) critically address the factors that contribute to and perpetuate homelessness.

There is consistent evidence to support the finding that people who are homeless have a much higher prevalence of mental illness than the general population (St Vincent's Mental Health Service and Craze Lateral Solutions, 2006). This submission particularly focuses on the **interaction of homelessness and mental illness** and the strong correlation between these two issues.

With regard to legislation, RANZCP advocates for a mixed approach that increases the system's crisis response capability whilst addressing the mediating factors that increase demands on the current Supported Accommodation Assistance Program (SAAP) and other crisis services. If the design and integration of services and legislation reflects a better understanding of the factors that contribute to homelessness, it is likely to reduce the extent to which more complicated and costly interventions are required later on, when problems have often become more severe.

RANZCP believes the issue of homelessness is more than just providing a home, and that the proposed legislation should focus on addressing the causes of homelessness not just the effects. Specifically, within the context of those with a mental illness who may be at risk of becoming homeless or who are already homeless, the most important principles that require immediate and long-term interventions include the focus on prevention and social inclusion. This is especially critical during significant transition and interface points in peoples' life where the risk of homelessness is exacerbated.

The key priorities for attention in the development of homelessness legislation are the focus of this submission, particularly as they relate to mental illness and homelessness. RANZCP looks forward to contributing further as this process develops.

Table of Contents

Executive Summary.....	2
About RANZCP	4
About Homelessness and Mental Health	5
The principles and service standards that could be incorporated into homelessness legislation.....	7
The principles and service standards that could be incorporated into homelessness legislation.....	7
1. The principles that should underpin the provision of services to Australians who are homeless or at risk of homelessness	7
2. The scope of any legislation with respect to related government initiatives in the areas of social inclusion and rights.....	11
3. The role of legislation in improving the quality of services for people who are homeless or at risk of homelessness.....	12
4. The effectiveness of existing legislation and regulations governing homelessness services in Australia and overseas.....	12
Conclusion	12
Summary of Recommendations	14
References	15

About RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 3000 RANZCP Fellows who account for approximately eighty-five per cent of all practising psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds, who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals.

About Homelessness and Mental Health

Approximately 1 in 5 Australian adults will experience a mental illness in any given year and about 1 in 7 children and adolescents will experience behavioural or emotional problems over a 6 month period (Department of Health and Ageing, 2007). Mental disorders are responsible for an estimated 11% of disease burden worldwide (thought to increase to 15% by 2020) (Department of Health and Ageing, 2007). The Australian Institute of Health and Welfare reported mental disorders to be the third leading cause of overall disease burden accounting for 27% of total years lost due to disability (Department of Health and Ageing, 2007). Projections suggest that the mental health related disease burden will grow markedly as a proportion of overall disease burden (Begg, Vos, Barker, Stanley, & Lopez, 2008). It has also been found that 24% of Australians with a moderate or severe disability also have a mental disorder (Department of Health and Ageing, 2007). With regards to services, only 38% of adults and approximately 25% of children and adolescents experiencing a mental disorder seek assistance from a health service (Department of Health and Ageing, 2007).

The census in 2006 determined that approximately 106,000 Australians were homeless (Chamberlain & MacKenzie, 2008), a situation associated with poorer health, employment, relationships, criminal outcomes, and increased risk of alcohol or other drug disorders (De Castella et al., 2009). It is not possible to say exactly how many of these homeless people suffer a mental illness although estimates are as high as 75% (Martens, 2001; Mental Health Council of Australia, 2009). Mental illness is a significant factor in causing or maintaining homelessness with symptoms of mental illness often resulting in conflict with family, co-tenants or landlords, or preventing people from engaging fully in employment resulting in a loss of accommodation (Mojtabi, 2005). Mental illness can also be caused or exacerbated by living homeless, with the constant social instability and potential for victimisation that often accompanies living homeless being highly traumatising. This can potentially trigger the onset or relapse of mood or psychotic disorders, particularly when coupled with substance abuse (De Castella et al., 2009). Evidence has also shown that for people living homeless and experiencing alcohol or other drug disorders, over 60% develop their problem only after becoming homeless (Chamberlain, Johnson, & Theobald, 2007).

Homelessness and mental illness are not the same and are generally treated as distinct issues. Yet there are strong correlations between the two issues and for those who experience both the risks to safety and recovery are greatly heightened. People experiencing combined difficulties are far less likely to participate in occupational and social pursuits (Herrman et al., 2004) or be in relationships (Folsom et al., 2005) than housed people living with psychosis. Combined mental illness and homelessness is also associated with poorer engagement with mental health services or support (Holmes, Hodge, Bradley, Bluhm, & Hodges, 2005). Accessing health services often only occurs in the event of a health crisis (e.g. illness, assault or intended or unintended self harm) that require emergency, highly intensive and costly intervention through emergency departments and admissions into medical, psychiatric, or alcohol and drug units (Kushel, Vittinghoff, & Haas, 2001). As a result, the cost of care for people living homeless is significant and in many cases difficult to provide due to the severity of the presenting medical and/or psychiatric illness, often complicated by psychosocial and alcohol and other drug issues (Salit, Kuhn, Hartz, Vu, & Mosso, 1998).

There are no simple remedies to homelessness. However, it is fundamental that any homelessness legislation includes provision for those people affected by mental disorder. Increasing the availability of crisis and/or more permanent forms of accommodation, with appropriate levels of support, will relieve some of the more obvious symptoms of homelessness, however these must be accompanied by

strategies that reduce the likelihood of people becoming or remaining homeless. Increasing funding at the crisis intervention end of the service spectrum will ultimately be less effective and more costly (in human, social and economic terms) than an approach that addresses causal factors, focussing on prevention and early intervention strategies that are integrated between Commonwealth, State/Territory, Local Government and community-based service providers.

Homelessness is a marker of severe illness and, therefore, of complex needs. For many, especially the longer-term homeless, it is far more than an accommodation or even a housing affordability issue. Increasing the amount of low cost housing will be of benefit to those who are already homeless but will not reduce the number of new people with severe illness from becoming homeless. Complex needs require complex interventions with integrated long-term services across sectors. For instance:

- Severe mental illness impairs the person's ability to access and use support programs;
- Homelessness, regardless of cause, leads to mental health and substance use problems;
- Models of housing for homeless people need to include programs to decrease rather than promote the risk of mental health and substance use problems; and
- The link between homelessness and mental illness needs to be approached at all levels including prevention, early intervention, treatment, relapse prevention, rehabilitation and recovery.

The Mental Health Council of Australia issued the report *Home Truths: Mental Health, Housing and Homelessness in Australia* in March 2009. This report is mindful that the target to reduce homelessness in Australia by 50% by 2020 can only be met if mental health services are reformed. RANZCP contributed to and strongly supports the 'Ten Home Truths' outlined in that report and believes that implementation of strategies to improve housing outcomes for people with a mental illness are essential to addressing the national housing crisis.

The principles and service standards that could be incorporated into homelessness legislation

RANZCP has noted the terms of reference of the Inquiry into homelessness legislation as follows:

“The House of Representatives Standing Committee on Family, Community, Housing and Youth shall inquire into and report on the content of homelessness legislation.

The Committee will make inquiries into the principles and service standards that could be incorporated in such legislation, building on the strengths of existing legislation, particularly the *Supported Accommodation Assistance Act 1994*.”

The terms of reference highlight five areas that the committee shall give particular consideration to.

RANZCP notes that the Government White Paper *The Road Home: A National Approach to Homelessness* (Department of Families, 2008) indicates that the Supported Accommodation Assistance Program (SAAP) Act will be repealed and replaced with a broader new Homelessness Act that will seek to set standards and guarantee quality services and adequate support to clients. RANZCP strongly submits that this new Act should ensure that the needs of people with mental illness are recognised and met. This includes the setting of targets in respect of those who are homeless or at risk of homelessness and suffering mental illness. Legislation should further provide for a range of accommodation types and support based on individual need. RANZCP recognises and strongly supports the added value that specialist homelessness services provide through their experience, skills and proven effectiveness in supporting people who are homeless to achieve sustainable positive outcomes.

Whilst RANZCP does not have the necessary expertise to advise on the drafting of such legislation, a number of recommendations are made for consideration of inclusion in homelessness legislation.

1. The principles that should underpin the provision of services to Australians who are homeless or at risk of homelessness

Recommendation 1: Prevention and early intervention of homelessness should be a priority

Homelessness will only be reduced by providing permanent housing with ongoing access to appropriate support services that aim to reduce demand for and reliance on short term interventions such as crisis accommodation. These services must target improvements in the delivery of relevant and appropriate supports during the transition and interface points within and between the primary health, mental health and community and welfare sectors. Although meaningful interventions will always be required, an increased focus on the prevention of homelessness needs to occur if the flow on to chronic illness is to be reduced and should not be the sole responsibility of any one service provider. Collaborative interventions involving all service providers are required.

A major factor in the increasing numbers of homeless people with mental illness is the failure of the mental health system to provide adequate treatment and support to people suffering chronic and severe illness. More effective servicing in mental health will reduce the incidence of homelessness and pressure on related services, and vice-versa. People with mental health problems require a range of

supported accommodation services, preferably permanent housing, with a focus on recovery. In addition, the severity of mental illness in many homeless individuals requires psychiatric hospital admission and treatment. There is a need to not only improve services for the mentally ill, especially those who are vulnerable to becoming homeless, but also to substantially increase the provision of infrastructure at a suitable level, for both supported accommodation and hospitals.

The lack of these services results in people being prematurely discharged from acute hospital settings into short term crisis accommodation and/or to no address at all. This illustrates a systemic issue rather than a criticism of any particular service or mechanism. Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors, perpetuates service gaps, cost shifting pressures and ineffective commitment of resources. There is a need for greater collaboration between all levels of Government, between services at each level of government and with the community sector.

Recommendation 2: Services should be available equitably to all homeless people

People who are homeless have multiple characteristics. Many people have multiple risk factors and an overly simplified targeting mechanism will mean that people with multiple or complex needs miss out entirely while others who are able to access the system receive only partial responses to their overall care needs.

Appropriate, effective and tailored services should be available to all people who are homeless, or at risk of being homeless regardless of age, health status, and ethnicity.

Recommendation 3: Special consideration should be given to rural and disadvantaged populations

It is important that legislation is developed to include and prioritise disadvantaged populations such as those with a mental illness or substance abuse problem, Indigenous populations, the elderly, young people, and those in rural and remote areas. RANZCP submits that it is necessary for these groups to receive dedicated interventions to meet their specific needs.

In particular, RANZCP draws the Government's attention to the needs of homeless people living in rural settings as these people have even fewer resources than homeless people in cities. Further, the lack of services in some communities can mean that people move to locations where homeless and related supports exist, but are at considerable distance from the communities where they are known and family or other informal care might best be provided. This can add to social dislocation and increase the likelihood of people losing access to income support, coming into contact with the police and justice system and a decline in their health as they lose contact with known health care providers. In addition to this, appropriate services should also be developed for Aboriginal and Torres Strait Islander Australians who have particular support needs and for whom more tailored services will be needed in order to be effective. Similar arguments would apply for those from Culturally and Linguistically Diverse (CALD) backgrounds.

The impact of homelessness on the vulnerable young people in our society can have a devastating impact on their mental health. Homelessness in children and adolescents can arise from many sources and is increasing due to the increased rates of family dysfunction and disintegration, especially amongst

marginal households. These children and young people subsequently lose the support and security of family and home at a critical stage in their lives when they are challenged with the stress of seeking an identity and role in society. Developmental interference with educational opportunity and peer support become additional burdens. The trauma of homelessness can exacerbate risk-taking behaviour, further endangering emotional wellbeing and lead to the development of co-morbid disorders that may carry over into their adult life.

Recommendation 4: Easy to understand and readily available assistance and support is necessary for homeless people seeking to access accommodation

Having a mental illness can affect basic abilities to think clearly, engage with others and work through bureaucratic processes. This adds to the difficulty in accessing accommodation services and sustaining tenancy. It can interfere with the ability to work through administrative requirements, such as completing application forms or attending appointments, and the capacity for independent living may fluctuate and be unpredictable. When a person is unwell, they may be heavily reliant on others to ensure the availability and coordination of support to gain housing. Without that support it may leave returning to the streets as the only option.

Recommendation 5: There is an increased need for intensive rehabilitation programs

The major service gap in mental health community settings that leads to homelessness is the lack of intensive rehabilitation programs, both residential and day programs. The phenomenon is described as “from the back wards to the back streets”. The unintended but frequent pathway for people with mental illness is discharge from often marginal and inadequately provisioned acute service settings straight to the broader community, where the service structures and systems to support people with mental illness to live safely or rehabilitate do not exist. Acute inpatient units increasingly discharge people with severe illness into crisis accommodation or “no fixed address”.

Recommendation 6: Tailored or local services with support networks (including family or other informal care networks), should be readily available

The lack of tailored or local services leads to further displacement from potential support networks (including family or other informal care networks), increased transience and reduced service access, consistency and effectiveness. Treatment for people with mental illness who are homeless, or at risk of becoming homeless, must be available in their local community and at home.

Recommendation 7: Service models should integrate both clinical and non-clinical supports based on overarching principles of social justice and prevention

A priority for service models should be rapid placement into permanent housing with ongoing access to support services as a way of increasing housing retention and decreasing psychosocial problems. In order to address these issues it is recommended that service models be funded that integrate both clinical and non-clinical supports, examples include NSW HASI Program and the US “Housing First” project. Such models allow for flexibility across catchment areas, are able to respond quickly (if not immediately) to crisis and changing needs, and address the person in an individualised, informal and

non-stigmatising manner. There are a range of approaches that might be taken to achieve better integration and outcomes for individuals. One approach might be to pool funds (Commonwealth and State) provided for clinical and non-clinical services which might be held by a single coordinating agency (fund-holder) responsible for integrating all components of care. Alternative approaches could include;

- (i) services maintaining separate, independent funding control but reporting to a broadly based steering group with an overarching monitoring and outcome-focussed performance reporting role or
- (ii) service providers that maintain independent operational autonomy and funding, but share a common set of high-level, outcome-focussed performance indicators that increase service accountability for the outcomes of the system as much as the specific service.

Addressing the needs of homeless people, especially those with mental illness, requires a shift from a simple "health" or "housing" model of care to a more integrated model that addresses the broad range of psychosocial problems alongside the health problems. The service system is currently chaotic involving numerous Federal government agencies, State government agencies and non-government organisations, including the charitable sector and volunteer organisations. Targeted mental health services to homeless people must be integrated with housing services, but also need to be linked with primary care, physical health services, rehabilitation services, employment services, financial support services, substance abuse services and the justice system. The entire service system needs to understand the impact a mental illness can have on achieving housing stability and recognise the importance of addressing permanent housing needs in stabilising mental illness.

Service systems need to be developed that are assertive in following homeless people across the geographic and structural divides of standard services, able to facilitate engagement and able to provide integrated outreach supports rather than expect homeless people to attend an office. There needs to be adequate resourcing to allow provision of time to build relationships and to make appropriate responses to unpredictable fluctuations in needs and capacities. This should be done in a manner that is consistent and respectful of the individual.

The provision of mental health and health services also needs to extend beyond the illness to include providing a broad array of services, linkages and connections to appropriate support systems, for example:

- Earlier, more considered and detailed discharge planning (especially from acute settings).
- The development of coordinated crisis plans and interventions.
- Collaborative case management to assist individuals with a mental illness integrate into their communities and decrease the potential for homelessness.
- The establishment of primary health care clinics and services for homeless people.
- Crisis outreach psychiatric and drug and alcohol services to engage with homeless people and support the range of non-government agencies involved in providing accommodation.

RANZCP believes that all strategies should aim to significantly reduce the rates of homelessness, and should be based on overarching principles of social justice and prevention. The following proposed targets are both measurable and attainable in the short term, with ongoing improvement expected over the long term:

1. A decrease in the number of people with a mental illness who enter and then subsequently re-enter the homeless service system.

2. A decrease in the number of people with a mental illness (and those in general) that are discharged from the hospital system into primary, secondary and tertiary homelessness.
3. An increase in the provision of treatment supports for and monitoring of people with a mental illness that cycle through the mental health system and end up being homeless.
4. A decrease in the number of homeless people with a mental illness appearing in other systems such as the justice system.
5. A decrease in the number of people with a mental illness who receive a disability or related pension being “breached” for non-compliance by Centrelink and losing their income for a defined period.
6. An increase in housing retention, increased uptake of mental health services and reduced drug and alcohol use of people with a mental illness.

These targets relate to interventions and transitions that are known, practical and quantifiable and, if measured, ought to build the evidence base required to link outcomes to some of the key factors that contribute to them.

2. The scope of any legislation with respect to related government initiatives in the areas of social inclusion and rights.

The Australian Government’s investment over the last few years has provided a significant boost to the mental health system, however RANZCP believes that the overall investment in the mental health service system remains inadequate and does not reflect the burden of disease in the community. A significant increase in funding to the mental health sector is required so that available resources are proportionate to the increasing number of people with mental illness.

Recommendation 8: To allow those people who are homeless, or at risk of homelessness, to be reimbursed at a 100% level under the Medicare Benefits Schedule, rather than the usual 85% level for consultations with all health providers.

Whilst the Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule (MBS) program has made mental health services more widely available, there is still a gap in services for people with more severe forms of mental illness.

People who are homeless are at increased risk from mental illness and, as set out in the earlier part of this submission, there is a significant correlation between people who suffer mental illness and homelessness. Accordingly, RANZCP believes it is imperative that people who are homeless are able to access specialist mental health services quickly and when needed. One barrier to provision of healthcare to people who are homeless is the cost of healthcare provision. A significant improvement in relation to Medicare legislation, would be to allow those people who are homeless, or at risk of homelessness, to be reimbursed at a 100% level for consultations with all health providers under the Medicare Benefits Schedule, rather than the usual 85% level. This would be an extension of the current arrangements that holders of health care cards are reimbursed 100% when attending general practitioners.

There is also a need for greater flexibility in the funding of Medicare subsidised services to encompass the particular characteristics of this transient and disadvantaged population, for example; loss of identifying papers; intermittent contact with service providers; and clinical needs arising from chronic conditions such as diabetes, chronic lung disease and especially mental illness and substance use.

3. The role of legislation in improving the quality of services for people who are homeless or at risk of homelessness.

Recommendation 9: Robust outcome measurement to ensure that people with mental illness are getting full access to homelessness services and benefiting from legislation

RANZCP believes that within government legislation and initiatives for people who are homeless or at risk of homelessness there should be robust outcome measurement to ensure that people with mental illness are getting full access to the service and benefiting from such legislation. Independent accountability and monitoring is essential to ensure that legislation is implemented successfully across Australia, and assessment and evaluation in terms of viability and effectiveness should be continuous.

4. The effectiveness of existing legislation and regulations governing homelessness services in Australia and overseas.

RANZCP Fellows have had a range of experiences in relation to the current SAAP Act. Whilst some provisions within the Act are viewed as positive, it is also perceived a missed opportunity. Episodes of care in the Area Health Services are a key opportunity for successful intervention with homeless people. To that end all efforts should be made to prioritise accommodation and after hospital support when a homeless person is admitted to a psychiatric unit. Frequently there is a waiting list for suitable accommodation, and a real lack of high support and extended care options. It is the perception that the numbers who transitioned to accommodation through SAAP are small, and that SAAP options are often not utilised when people who are homeless present to emergency departments. The need to strengthen accountabilities and reporting in relation to the Act remain.

Conclusion

Mental illness and homelessness are closely intertwined and must be addressed concurrently to ensure a holistic approach to improve the outcomes for people who are living with both problems. All legislation in respect to homelessness should ensure that the needs of people with mental illness are recognised and met. Legislation should further provide for a range of accommodation types and support based on individual need and, critically, should focus on addressing the causes of homelessness and not just the effects. Homelessness legislation should allow for flexibility across catchment areas, be able to respond

quickly to crisis and changing needs, and address the specific needs of people who are homeless, or at risk of becoming homeless, in an individualised and non-stigmatising manner.

The Royal Australian and New Zealand College of Psychiatrists thank the House Standing Committee on Family, Community, Housing and Youth for the opportunity to make a submission to this important matter and looks forward to working with the Australian Government in the development and implementation of robust legislation which supports the needs of the homeless.

Summary of Recommendations

1. Prevention and early intervention of homelessness should be a priority
2. Services should be available equitably to all homeless people
3. Special consideration should be given to rural and disadvantaged populations
4. Easy to understand and readily available assistance and support is necessary for homeless people seeking to access accommodation
5. There is an increased need for intensive rehabilitation programs
6. Tailored or local services with support networks (including family or other informal care networks), should be readily available
7. Service models should integrate both clinical and non-clinical supports based on overarching principles of social justice and prevention
8. To allow those people who are homeless, or at risk of homelessness, to be reimbursed at a 100% level under the Medicare Benefits Schedule, rather than the usual 85% level for consultations with all health providers.
9. A robust outcome measurement to ensure that people with mental illness are getting full access to homelessness services and benefiting from legislation

References

- Begg, S. J., Vos, T., Barker, B., Stanley, L., & Lopez, A. D. (2008). Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors. *The Medical Journal of Australia*, 188(1), 36-40.
- Chamberlain, C., Johnson, G., & Theobald, J. (2007). *Homelessness in Melbourne: Confronting the challenge*. Melbourne: RMIT Publishing.
- Chamberlain, C., & MacKenzie, D. (2008). *Australian Census Analytical Program: Counting the Homeless - Australia*. Canberra: Australian Bureau of Statistics: Commonwealth of Australia.
- De Castella, A., Lee, S., Freidin, J., Kennedy, A., Kroschel, J., Humphrey, C., et al. (2009). *Taking Mental Health Care to the Streets*. Melbourne: The Alfred Psychiatry Research Centre.
- Department of Families, H., Community and Indigenous Affairs. (2008). *The Road Home: A National Approach to Reducing Homelessness*. Canberra: Commonwealth of Australia.
- Department of Health and Ageing. (2007). *National Mental Health Report: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005*: Commonwealth of Australia, Canberra.
- Folsom, D. P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., & Golshan, S. (2005). Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System. *American Journal of Psychiatry*, 162(2), 370-376.
- Herrman, H., Evert, H., Harvey, C., Gureje, O., Pinzone, T., & Gordon, I. (2004). Disability and service use among homeless people living with psychotic disorders. *Australian and New Zealand Journal of Psychiatry*, 38(11-12), 965-974.
- Holmes, A. C., Hodge, M. A., Bradley, G., Bluhm, A., & Hodges, J. (2005). Development of an inner urban homeless mental health service. *Australasian Psychiatry*, 13(1), 64-67.
- Kushel, M. B., Vittinghoff, E., & Haas, J. (2001). Factors Associated with the Health Care Utilization of Homeless Persons. *Journal of the American Medical Association*, 285(2), 200-206.
- Martens, W. H. (2001). A review of physical and mental health in homeless persons. *Public Health Reviews*, 29(1), 13-33.
- Mental Health Council of Australia. (2009). *Home Truths: Mental Health, Housing and Homelessness in Australia*.
- Mojtabi, R. (2005). Perceived Reasons for Loss of Housing and Continued Homelessness Among Homeless Persons with Mental Illness. *Psychiatry Services*, 56(2), 172-178.
- Salit, S. A., Kuhn, E. M., Hartz, A. J., Vu, J. M., & Mosso, A. L. (1998). Hospitalization Costs Associated with Homelessness in New York City. *New England Journal of Medicine*, 338(24), 1734-1740.
- St Vincent's Mental Health Service and Craze Lateral Solutions. (2006). *Homelessness and Mental Health Linkages: review of national and international literature*. Canberra Australian Department of Health and Ageing.