SUBMISSION BY THE COUNCIL TO HOMELESS PERSONS TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

SUBMISSION INCLUDES:

PART 1: HOMELESSNESS AND MENTAL HEALTH

PART 2: YOUNG PEOPLE, HOMELESSNESS AND MENTAL HEALTH

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PART 1: HOMELESSNESS AND MENTAL HEALTH

Introduction

The Council to Homeless Persons (CHP) was established in 1972 and represents both individuals and organisations with a stake or interest in homelessness in Victoria.

The work of the Council to Homeless Persons incorporates:

- Representing the views and concerns of agencies, organisations and services that work to assist people experiencing homelessness.
- Advocating on behalf of people who are homeless to government and the wider community.
- Providing opportunities for people experiencing homelessness to have a voice and make a contribution towards policy related to homelessness.
- Working in partnership with other stakeholders to improve service provision for people experiencing homelessness.

There is a clear correlation between homelessness and mental health with people suffering from at least one mental disorder being over represented in the homeless population.

People who are homeless, in general, experience multiple layers of disadvantage and most have few or no social or family support networks. For those who are homeless with a mental illness, the disadvantage is further compounded through gaps in service delivery and a lack of access to the specialist treatment and support they need.

Young people who are homeless are a specific policy focus for the Council to Homeless Persons. About 46 percent of the recorded homeless population are under the age of 24. Studies also reveal that young people who are homeless are twice as likely to have a psychiatric disorder during their lifetime. Part 2 of this submission, contains a dedicated section on young people who are homeless experiencing mental illness with specific recommendations related to this group.

Evidence of Relationship between Mental Health and Homelessness

Research into mental health in the Australian community indicates that one in five people suffer a significant mental disorder. Most of these people live their lives without substantial difficulty. The limited research into mental health and homelessness in Australia has pointed towards much higher proportions of people with a significant mental disorder in the homeless population. Studies, concentrating on the inner city areas of major cities, have revealed that up to 75 percent of people who are homeless have a mental health issue (Hodder, Teesson & Buhrich, 1998:9, Herrman, et al, 1989: 1179).

It is important to state that mental health issues are both a trigger for and a consequence of people becoming homeless. Equally as important is the point that people who are homeless or at risk of becoming homeless are usually experiencing a combination of issues and circumstances, which affect both their material situation, their social and personal relationships and their physical, emotional and psychological

health. By definition, people who are homeless are disadvantaged and socially excluded. The circumstances of many people who are homeless, including those with mental health issues, is compounded by layers of disadvantage that leads to, over time, trauma, isolation and disempowerment. In understanding and developing responses to people who are homeless with mental health issues it is vital that the impact of other issues such as access to sustainable and affordable housing, insufficient income for basic needs, finding employment, the breakdown of family and personal relationships is acknowledged.

In the twentieth century, Western societies have become more aware and developed greater knowledge and understanding about people with mental illness and responses to them. Australia and other countries moved away from accommodating people with mental illness in large scale institutions that often provided poor accommodation and care toward assisting and supporting people in the community. This de-institutionalisation process delivered many positive outcomes and is generally viewed as the most appropriate way of supporting people with mental illness in the long term. However, the resources for community support services and infrastructure has not matched the need or demand. Many people who have left institutions or who would have been previously eligible for an institution, do not have the appropriate accommodation and support. . A resultant effect of this is homelessness.

There is sufficient evidence that substantial numbers of people who are homeless have mental health issues. The Council to Homeless Persons believes that greater understanding is needed of the circumstances of these people and additional and improved resources are required to ensure that people with mental illness do not become homeless and that people who are homeless with a mental illness receive the treatment, care and support they need. The failure to provide adequate assistance will only result in greater individual costs to these people and increased financial and social costs to governments and communities.

An important study, which interviewed people who visited or resided in the major hostels providing emergency accommodation in Sydney, found that 75 percent of respondents had a least one mental disorder. This compares with the prevalence rate of at least one mental disorder of 18 percent in the Australian general population (Hodder, Teesson & Buhrich, 1998: 9).

The study found that there were high proportions of people with:

- Schizophrenia (23 percent male, 46 percent female)
- An alcohol use disorder (49 percent men, 15 percent female)
- A drug use disorder (36 percent)
- A mood disorder (33 percent)
- An anxiety disorder (26 percent)
- A cognitive impairment (10 percent).

In addition:

- 93 percent reported at least one experience of extreme trauma in their life.
- One in two women and one in ten men reported that they have been raped.
- One in two people have at least one chronic physical illness.

- 9 percent of people reported that they are seropositve for Hepatitis B or C. This compares with a prevalence rate in the general population of about 1 percent.
- 11 percent of people interviewed in the study period had accessed a hospital emergency service and 71 percent consulted a health professional. (Hodder, Teesson &Buhrich, 1998: 9-10)

Research that interviewed 'disaffiliated' men living in hostels and cheap single room accommodation in Melbourne found that over 70 percent had a lifetime diagnoses of a mental disorder (Herrman et al, 1989: 1179). A number of studies have confirmed that compared with males from Australian community surveys, male adults who are homeless across every age group usually have at least twice the rate of any psychiatric disorder, mood disorders, substance use disorders and comorbid disorders (Herrman et al, 1990, Hodder et al, 1998, Kamieniecki, 2001).

At least four research studies have examined the question of whether homelessness precedes the development of psychiatric disorders or vice versa. Research that was undertaken in Melbourne, focusing primarily on adults, found that the onset of one or more lifetime mood, psychotic or substance use disorders preceded the onset of homelessness in 85 percent of subjects (Herrman et al, 1992, Kamienieki, 2001). However, there is also evidence that individuals with no psychiatric impairment when they first became homeless are at risk of developing psychiatric diagnosis the longer they are homeless (Winkleby et al, 1992, Kamienieki, 2001). Increasing duration of homelessness also appears to be a risk factor for substance use and possibly self-injurious behaviour (Pears et al, 1995, Kipke et al, 1993, Unger et al, 1997, Kamienieki 2001).

Executive Summary

There is a substantial and significant evidence indicating that mental health issues are prominent amongst people who are homeless.

Greater acknowledgment and action is required to address mental health and homelessness in both the National Mental Health Strategy, the National Homelessness Strategy and other related policy responses at both Commonwealth and State government levels.

Expenditure on mental health in Australia is inadequate and needs to be increased, as the general population and particularly people who are homeless are missing out on essential mental health support and treatment.

A clearer commitment and increased resources are required to enshrine, expand and develop a sophisticated and responsive community based mental health service system. This will allow long-term assistance to be provided and reduce the level of hospitalisation.

The Council to Homeless Persons supports the view that most people experiencing mental illness, including those who are homeless, should receive and have regular access to mental health treatment, support and counselling in community settings rather than in hospitals and large institutions. While there is a need for some provision of hospital-based responses, mental health services should largely be aimed at ensuring that clients can participate as fully as possible in the community. People who are homeless and experiencing a mental illness need specific on-going support to enable them to be part of community life.

The lack of resources and inadequate mental health service system response particularly affects people who are homeless experiencing a mental illness and who face multiple barriers and often lack social and family networks.

At the time of writing, there is the potential that funding for the Supported Accommodation Assistance Program (SAAP) in Victoria may be reduced significantly. SAAP is the major response to homelessness in both Victoria and Australia and already turns away large number of people each year due to a lack of accommodation and support places. Many SAAP clients and potential clients are experiencing a mental illness. A loss in funding to SAAP will only result in more people who are homeless with a mental illness not receiving any support at all.

Unfortunately, while mental health issue have been acknowledged in many government policy documents regarding homelessness, limited resources have been allocated to address the issue. The resources that have been allocated by government tend to be in the guise of pilot projects rather than recurrent service or program resources. Also, the articulation of mental health issues in relationship to homelessness tends to be ‘mixed in’ under the heading of high and complex needs. This does not assist in making the mental health issues faced by people who are homeless clear.

The lack of clarity in the service response to people who are homeless experiencing a mental illness combined with insufficient resources and a lack of funding and service coordination contributes to many people who are homeless with a mental illness not receiving essential treatment and counselling as well as playing a part in some people becoming homeless because the services they need are not available to them.

The narrow and clinical definition of mental health applied by many mental health services combined with high demand lead to a strict prioritisation of cases and contributes further to people who are homeless experiencing mental illness not receiving treatment and support.

Many homelessness assistance services in Victoria have encountered substantial difficulties in attempting to relate to the mental health sector. Attempts at establishing joint partnerships by homelessness assistance services have been frustrated by what appears to be a lack of willingness by mental health services to participate.

While governments have acknowledged the relationship between mental health and homelessness and the need for 'whole of government' approaches, no formal, structural or high level mechanism appears to be have been developed at either state or national level to improve coordination of service response.

The experience of being homeless and having a mental illness increases or exacerbates the need for hospital treatment. The time spent in hospital for people who are homeless with mental health issues could be greatly limited if appropriate community based services were available.

The Council to Homeless Persons believes that SAAP and homelessness assistance services should be the primary broker or service provider for people who are homeless. Difficulties for people who are homeless are compounded when they are required to navigate other public and non-government service systems. It is for this reason that we recommend that homelessness assistance services should be funded to provide a specialist mental health response to people who are homeless enabling an immediate professional assessment and diagnosis and to assist people who are homeless with a mental illness to access and maintain supported accommodation.

While there may a greater expectation for increased resources for mental health services and improved and more sustained treatments in the general population, it does not necessarily equate, should it come to pass, that more services will be available for marginal groups such as people who homeless. People, who are homeless including those experiencing mental illness, encounter many layers of disadvantage and exclusion, which require specific and flexible service delivery responses. As a result of the range of other issues impinging on their lives, people who are homeless are not able to and do not have the time to express their mental health issues to the same extent as other people.

Specific service delivery and policy strategies are required to meet the needs of specific groups of people who are homeless experiencing mental illness. In particular, the needs of young people, people in rural and regional areas and indigenous people.

The Council to Homeless Persons supports the recommendations and actions that enshrine the right of all people to the highest attainable standard of health, to adequate housing, to participate in policy, service design and delivery, to non-discrimination and the right to adequate income through the social security system.

The lack of sufficient mental health service delivery responses combined with an anxiety in many parts of the community about people who are homeless with mental illness and a portrayal of these people by many in the media as unsafe and unpredictable, all contribute to both an increase reluctance of people who are homeless experiencing mental illness in attempting to access services and continued poor material and emotional and social wellbeing outcomes for this already marginalised group.

While some data and information has been collected about people who are homeless experiencing mental illness, more quantitative and qualitative research is required to further improved and develop appropriate service delivery and policy responses.

List of All Recommendations

Part 1 Recommendations

1.1 That specific reference is made within the National Mental Health Strategy on the relationship between homelessness and mental health and the barriers or difficulties faced by people who are homeless in accessing mental health services.

1.2 That strategies and actions are devised within the National Mental Health Strategy to link homelessness programs such as the Supported Accommodation Assistance Program (SAAP) with the Strategy.

1.3 That funding for mental health within the Commonwealth Health Budget is increased substantially.

1.4 That through the National Mental Health Strategy, consensus between all levels of government on the importance of moving towards community based mental health responses is reached and that all governments fund this accordingly.

1.5 Building on greater cross-portfolio and inter-government collaboration, that specialist mental health services are funded within homelessness assistance agencies to provide specialist mental health assessment and support to both new clients and client living in supported accommodation. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.7)*

1.6 That the Commonwealth Department of Family and Community Services provide a substantial policy report regarding the actions and strategies related to mental health outlined in the National Homelessness Strategy.

1.7 That the Commonwealth Department of Family and Community Services homelessness policy response place greater emphasis on mental health and resource initiatives aimed at improving mental health responses for people who are homeless.

1.8 That through the National Homelessness Strategy or National Mental Health Strategy a broader definition of mental health is established which incorporates the exacerbating and compounding living experiences of people who are homeless.

1.9 That a national review of the discharge practices of psychiatric hospitals be undertaken to assess whether sufficient planning of the on-going support and accommodation of patients is occurring to prevent or limit relapse and hospital re-entry.

1.10 That within the homelessness assistance sector, long-term, supported accommodation with specialist mental health expertise is provided to people who are chronically homeless with lifetime mental health disorders. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.8 & 2.12)*

1.11 That, additional or new homelessness assistance workers, should be specifically resourced to receive extensive and accredited mental health training in order to provide outreach support and advocacy for people who are homeless experiencing a mental illness. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.16)*

1.12 That data collection mechanisms in both homelessness assistance and mental health services should have provision for recording the number of people who are homeless experiencing mental illness who do not receive either accommodation and support and mental health treatment and/or counselling.

1.13 That funding for the Supported Accommodation Assistance Program (SAAP) should be increased by more than 15 percent to enable the development of mental health specialist services and workers working specifically with people who are homeless and to meet general, unmet need. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.17)*

1.14 That a regional and rural mental health strategy and funding model be resourced and implemented to ensure that people from these areas are able to access the necessary mix of general and specialist mental health services. This strategy would place particular emphasis on disadvantaged people, including people who are homeless, living in rural and regional areas. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.10)*

1.15 That a National Indigenous Homelessness Strategy be resourced and initiated to, in partnership with indigenous people, gather information and respond to the issues facing indigenous people who are homeless. A significant section of the strategy should focus on the relationship between mental health and homelessness for indigenous people.

1.16 That both Commonwealth and State and Territory governments adopt a human rights institutional and legislative framework which supports people who are homeless with mental illness to access the highest attainable standard of health care, to access and maintain adequate housing, to participate in policy and service delivery processes that affect them, to prevent discrimination and vilification and to ensure that receive an adequate income.

1.17 That current processes, such as the SANE Stigma Survey, that record the views and stories of mental health consumers incorporate the experience of people who are homeless.

1.18 That policy processes, strategies and actions to address mental health and homelessness at a State or Commonwealth level be informed by case studies and stories of people who are homeless experiencing mental illness.

1.19 That a targeted education campaign directed at people who are homeless experiencing mental illness be implemented to assist in destigmatising mental illness and to provide improved access delivery of service information to this group. This campaign should be informed by case studies and stories of people who are homeless experiencing mental illness. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.15)*

1.20 That the Commonwealth Government ensures that adequate resources are provided to ensure that people who are homeless with a mental illness are able to access and maintain affordable housing and sufficient income to meet both basic and self care needs.

1.21 That the Commonwealth Department of Family and Community Services and the Commonwealth Department of Health and Ageing, Mental Health Branch resource and develop a research program which examines on a consistent and regular basis the mental health needs of people who are homeless in Australia.

1.22 That Victoria and other State and Territory governments resource and develop specific mental health and homelessness research projects which complement the Commonwealth research program.

Part 2: Young People, Homelessness and Mental Health Recommendations

2.1 That mental health practice responses be targeted to the changing life stages of young people through adoption of the key age brackets of 15-18, 19-21 and 22-25 in recognition of the changing legal, economic and social status of young people across these age ranges.

2.2 That a National Youth Mental Health Strategy be developed based on the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.3 That State and Territory Youth Mental Health Strategies be developed that complement and extend the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.4 That the inter-relatedness of youth homelessness and mental health issues be addressed in both the National and State/Territory Youth Mental Health Strategies.

2.5 That the National and State/Territory Youth Mental Health Strategies address the breadth of mental health responses required for young people experiencing homelessness, in particular:

- **improved access to services that treat young people for non-psychotic disorders (such as mood, anxiety and personality disorders), and**
- **improved coordination of homelessness assistance and mental health services.**

2.6 That the National and State/Territory Youth Mental Health Strategies are developed in consultation with a range of relevant stakeholders including young people experiencing homelessness and mental health issues.

2.7 That youth mental health workers be based within youth homelessness services such as youth refuges or youth transitional support services in both metropolitan and rural areas of Victoria. *(Please refer to Part 1 Recommendation 1.5)*

2.8 That youth specific mental health services be made available to young people experiencing homelessness in all parts of Victoria, with a particular emphasis required on rural and regional areas. *(Please refer to Part 1 Recommendation 1.10)*

2.9 That the Senate Select Committee recommend to the relevant Federal Ministers that funding to youth homelessness services remains a priority, and increases by 15%, in recognition that young people experiencing homelessness use homelessness assistance services as a gateway to mental health services.

2.10 That a coordinated rural and regional mental health strategy be developed through a National Youth Mental Health Strategy, with the detail developed through the State and Territory Mental Health Strategies. ***(Please refer to Part 1 Recommendation 1.14)***

2.11 That protocols be developed through the National Youth Mental Health Strategy between youth homelessness, drug and alcohol, and mental health services for working with young people with comorbid disorders.

2.12 That mental health and comorbidity specialist workers are established within youth homelessness services. ***(Please refer to Part 1 Recommendation 1.10)***

2.13 That a key component of the National Youth Mental Health Strategy is the development of an Indigenous Youth Mental Health Strategy, in consultation with Indigenous young people and their communities.

2.14 That culturally appropriate youth mental health services are available and accessible for young people from CALD communities, that information on mental health services is readily available in a range of community languages, and that community development strategies are employed that target key cultural groups to ensure that information is accessible and that issues of stigma may be addressed.

2.15 That a targeted education campaign be developed specifically for young people experiencing homelessness that aims to destigmatise mental illness, provide information on the mental health services available, and provide information on what mental health services do. ***(Please refer to Part 1 Recommendation 1.19)***

2.16 That specialist youth mental health training be developed targeting homelessness assistance agencies working with young people. ***(Please refer to Part 1 Recommendation 1.11)***

2.17 That the Senate Committee make a recommendation to the relevant Federal Minister that staffing levels to homelessness assistance services be more flexible to allow workers to respond intensively to young people with mental health issues. ***(Please refer to Part 1 recommendation 1.13)***

2.18 That the Senate Committee make a recommendation to the relevant Federal Minister that more flexible accommodation models be developed across Victoria, to enable homelessness assistance services greater capacity to accommodate young people with mental health issues.

The National Mental Health Strategy

Despite considerable evidence of the link between mental health and homelessness, the National Mental Health Strategy and the National Mental Health Plan makes little or no reference to homelessness.

There is also no reference to a link between the National Mental Health Strategy and the major programmatic response to homelessness in Australia, the Supported Accommodation Assistance Program.

The National Mental Health Plan refers to removing barriers and developing linkages and yet does not appear to make provision for improving access to mental health treatment and counselling for a group that is amongst our most disadvantaged.

The Council to Homeless Persons concurs with many other advocates that expenditure on mental health in Australia is inadequate. While Australia spends approximately 7 percent of its health budget on mental health, other OECD countries spend between 10 and 14 percent of total health expenditure on mental health (World Health Organisation, 2001). In Australia, mental health accounts for 13 percent of total disease burden (death and disability) and nearly 30 percent of the non-fatal disease burden (AIHW, 1999). The evaluation of the Second National Mental Health Plan appears to agree with this view when it concluded "in terms of a commitment to mental health expenditure, while there has been growth in real terms, this has simply mirrored overall health expenditure trends and is not sufficient to meet the level of unmet need for mental health services".

The funding shortfall does not meet the high demand and need for mental health services and this in turn exacerbates, in particular, the disadvantage of people experiencing mental illness with no support and family networks, which includes many people who are homeless.

While the Commonwealth government has funded many good general mental health initiatives in recent times such as ensuring a greater number of GP surgeries have mental health specialists, developing a suicide prevention strategy, establishing school based education on mental health and promoting responsible reporting of mental health in the media, only a small proportion of funding is allocated to enhancing and improving the capacity of the mental health service delivery response. Based on available figures, the Commonwealth government provides only 8.2 percent of its mental health budget towards the National Mental Health Strategy. The area of psychiatric drugs through the Pharmaceutical Benefits Scheme (PBS) comprises 43 percent of the funding, Consultant Psychiatric Services 17 percent, General practitioners 15 percent and the Department of Veterans Affairs 12 percent. Less than 1 percent is directed to research (Department of Health and Ageing, National Mental Health Plan 2004).

In addition, there appears little targeted resource allocation by the Commonwealth government to people experiencing mental health issues who are faced with multiple layers of disadvantage either within the National Mental Health Strategy or otherwise.

While the Council to Homeless Persons is primarily interested in increased mental health resources to assist people who are homeless experiencing mental health issues and does not have a view necessarily on the level of government that provides these resources, it is interesting to note that state and territory governments, on the available figures, spend $30 per capita more than the Commonwealth government on mental health. In 2001-02, the Commonwealth government spent $58.66 per capita in constant prices. This compares with Western Australia who spent $116.53, Victoria who spent $105.6 and South Australia who spent $104.03 (Department of Health and Ageing, National Mental Health Report, 2004).

However, between 1996-97 and 2001-02, the Commonwealth government has increased expenditure for the National Mental Health Strategy by 81 percent from $52 million to $94 million (Department of Health and Ageing, National Mental Health Report, 2004).

The evaluation of the Second National Mental Health Plan concluded, "While community treatment and support services have been strengthened, community treatment options are still seen as unavailable or inadequate. In particular, growth in resources to the non-government and residential sectors has not kept pace with their increased role.

The Council to Homeless Persons supports the view that most people experiencing mental illness, including those who are homeless, should receive and have regular access to mental health treatment, support and counselling in community settings rather than in hospitals and large institutions. While there is a need for some provision of hospital-based responses, mental health services should largely be aimed at ensuring that clients can participate as fully as possible in the community. People who are homeless and experiencing a mental illness need specific on-going support to enable them to be part of community life.

Of all the states and territories, Victoria appears to be leading the way in community treatment and support services. Although funding is generally inadequate to meet demand, specialist services such as EPPIC addressing early psychosis, SUMMIT addressing dual diagnosis, Spectrum addressing borderline personality disorder and Forensicare addressing forensic treatment are highly regarded at a national and international level. In 2001-02, Victoria provided 45.6 percent of total State and Territory funding to mental health services managed by Non-Government Organisations and 63.5 percent of total State and Territory funding to community residential mental health services. Victoria allocates only 34.5 percent of its funding to hospital inpatient services compared to 60.9 percent in South Australia and 54.1 percent in Queensland. Since 1992-93, Victoria and Tasmania, through their budgets, have made the commitment to move mental health services away from hospitals, particularly stand alone psychiatric hospitals (National Mental Health Report, 2004).

While Victoria may be a model for the appropriate mix of community based and hospital services, a lack of resources, high demand, prioritisation in service response and narrow definitions of mental health disorders, all contribute to many people who are homeless, even those with support workers advocating on their behalf, not accessing treatment and counselling.

Recommendations

1.1 That specific reference is made within the National Mental Health Strategy on the relationship between homelessness and mental health and the barrier or difficulties faced by people who are homeless in accessing mental health services.

1.2 That strategies and actions are devised within the National Mental Health Strategy to link homelessness programs such as the Supported Accommodation Assistance Program (SAAP) with the Strategy

1.3 That funding for mental health within the Commonwealth Health Budget is increased substantially.

1.4 That through the National Mental Health Strategy, consensus between all levels of government on the importance of moving towards community based mental health responses is reached and that all governments fund this accordingly.

Coordination of Funding and Services for People Who Are Homeless with Mental Health Issues

There is clear evidence that many people who are homeless experience mental health issues, which require immediate and on going support, counselling and treatment.

Unfortunately, while mental health issue have been acknowledged in many government policy documents regarding homelessness, limited resources have been allocated to address the issue. The resources that have been allocated by government tend to be in the guise of pilot projects rather than recurrent service or program resources. Also, the articulation of mental health issues in relationship to homelessness tends to be 'mixed in' under the heading of high and complex needs. This does not assist in making the mental health issues faced by people who are homeless clear.

The National Homelessness Strategy has two goals in relation to mental health. They are:

> To reduce the incidence of homelessness among people with mental health problems by:
>
> - Developing agreed Commonwealth-State plans by asking joint bodies such as the SAAP and HACC committees, the National Mental Health Working Group, and the Public Health Partnership to address homelessness among people with mental health issues;
> - Integrating mental health, drug and alcohol and other health services with stable long term accommodation options;
> - Supporting families and communities to provide care for people with mental health problems;
> - Using early intervention strategies to stabilise mental health problems and accommodation arrangements; and
> - Providing transitional support for people with mental health problems exiting health, statutory protection and correctional services.
>
> To help homelessness services provide effective services for people with mental health problems by:
>
> - Providing adequate resources to those government and community agencies which work in the areas of mental health and homelessness;
> - Integrating specialist mental health services and homelessness services; and
> - Ensuring that SAAP clients have effective and timely access to mental health services.
>
> (Department of Family and Community Services, Working Towards a National Homelessness Strategy, 2003)

The Commonwealth government provided $8.7 million over four years to the National Homelessness Strategy (NHS). The bulk of these funds were devoted to the

Family Homelessness Prevention Pilot Project and demonstration projects related to access and linkages to Centrelink.

One small NHS demonstration project, undertaken in the Northern Territory, was related to mental health and was to support people pre and post admission to a psychiatric hospital to secure housing and prevent homelessness (FACS, National Homelessness Strategy, Website).

The Victorian government through the Victorian Homelessness Strategy acknowledged the relationship between homelessness and mental health particularly in relation to reducing the risk of homelessness for people with mental illness leaving hospital. Small regional pilot projects have been funded that aim to reduce the risk of homelessness for people with a mental illness when leaving hospital, by improving discharge planning and access to appropriate housing and support options. Three regional pilot projects were allocated $418,500 for a period of 18 months (Victorian Department of Human Services, VHS Action Plan and Strategic Framework). Currently these projects are being evaluated and it is unclear whether any further resources will be devoted to the learnings and findings.

Funding and Service Coordination: The Service Delivery Experience

The evaluation of the Second National Mental Health Plan concluded that "appropriate responses to high and low prevalence disorders and the place of personality disorders in the mental health agenda, have not been clarified. Furthermore, there is now a somewhat confusing array of initiatives and strategies that are related to the mental health agenda (for example, the suicide and drug strategies) and ways for these to work in synergy need to be developed.

This lack of clarity combined with insufficient resources and a lack of funding and service coordination contributes to many people who are homeless with a mental illness not receiving essential treatment and counselling as well as playing a part in some people becoming homeless because the services they need are not available to them.

Homelessness assistance services regularly inform CHP that they find it very difficult to access mental health services in Victoria for their clients.

Factors or issues include:

- A strict intake criteria used by mental health services characterised by a tight mental health definition, severe prioritisation of cases, limited outreach responses and the appearance of an inflexible clinical approach to people with mental health issues which does not appreciate assessments made by homelessness assistance services.
- Poor communication and understanding between mental health and homelessness assistance services of work practices despite attempts by homelessness assistance services to improve this.
- The lack of acute care beds has led to shorter stays in hospital. Sometimes the time spent in hospital is not long enough to really stabilise a person's condition or to ensure the necessary support services are available to them once they return to community life.

- Poor discharge planning and communication and a lack of follow up and counselling once a person leaves hospital leads to a repetitive cycle of mental illness and homelessness
- Admission to hospital can jeopardise the housing arrangements for people with a mental illness unless adequate planning and communication can occur between relevant services.

Definition of Mental Health contributing to service barriers to people who are homeless

Defining and measuring mental health is complex and is about much more than the absence of illness. Mental health is more than a medical issue and while medical treatment is important in alleviating mental disorders, greater recognition and implementation of support and caring social structures is required (Robinson, Colin, 2001: 6).

The experience of homelessness is marked by insecurity and tenuousness. The development of mental illness adds another layer of complexity for people who are homeless. Just as there are a range of views and emphases in defining homelessness, there is also diversity of opinion in determining and defining mental illness. The lack of consensus regarding this has impeded the planning of services for people who are homeless with mental illness (Bachrach, 1996: 233).

The Australian Institute of Health and Welfare (AIHW) defines mental health as follows:

> Mental health is the capacity of individuals and groups to interact with one another and the environment, in ways that promote subjective wellbeing, optimal development and the use of cognitive, affective and relational abilities. It refers to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity.

The Victorian Mental Health Act 1986 (incorporating amendments made as at 6 December 2004) states that:

> A person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory (Section 8.1A, p23).

The Act states that it does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that a person is mentally ill (Section 8.3, p24)

In general, mental disorders are categorised into four groupings. These are:

1. Psychotic disorders – including hallucinations, delusions, thought disorders, behaviour disturbances, disturbances in feelings/emotions eg schizophrenia;
2. Affective (mood) disorders – including depressive disorders, minor depression, major depression, psychotic depression (with delusion/hallucination), manic depression eg post-natal depression, bipolar affective disorder;

3. Non-Psychotic disorders – including anxiety disorders, phobic disorders, post-traumatic stress disorder, personality disorder eg borderline personality disorder; and
4. Drug and alcohol disorders – including alcoholism, drug-induced psychosis (AIHW, Department of Health and Ageing)

There is some evidence that affective and non-psychotic disorders are more prevalent amongst the homeless population (Parker, Limbers and McKeon, 2002:6) and that some of these disorders such as personality disorders are not viewed by the mental health sector as mental disorders. Also, demand and limited capacity people in the mental health sector may result in people with these conditions being considered as having 'lesser' mental disorders and thus prioritising only the acute cases.

The result of this is that people with erratic or violent behaviour such as recurrent suicidal and self mutilating behaviours associated with personality disorder and those who are dually diagnosed, do not receive adequate mental health support or treatment. Some of these people become clients of supported accommodation services where they are supported by over-worked staff without mental health specialisation (Herrman & Neil, 1996).

In addition, this group of people, may also be refused supported accommodation and/or permanent secure housing due to disruptive behaviours that can result in eviction, house bans, potentially dangerous and violent situations, arrest, incarceration in jail or admission to psychiatric facilities. Stability in housing is rare amongst this group of people especially for those with untreated substance abuse disorders.

People with a mental disorder that is unrelated to short-term and effective treatment and those non-compliant and erratic people are more likely to be at risk of primary homelessness as it is difficult for them to access both mental health and supported accommodation services.

Communication

A key component of the work undertaken by homelessness assistance services is to network and develop service relationships with other public and community managed services in order to assist and support their clients fully.

Many homelessness assistance services in Victoria have encountered substantial difficulties in attempting to relate to the mental health sector. Attempts at establishing joint partnerships by homelessness assistance services have been frustrated by what appears to be a lack of willingness by mental health services to participate.

In some regions where partnerships have been formed, better outcomes have been achieved for people who are homeless with mental illness.

The evaluation of Second National Mental Health Plan acknowledges this point by concluding " Intersectoral collaboration has been evident in some pilot areas, but not developed in a systematic or coordinated way."

While governments have acknowledged the relationship between mental health and homelessness and the need for 'whole of government' approaches, no formal, structural or high level mechanism appears to be have been developed at either state or national level to improve coordination of service response.

The result is that both community based homelessness assistance and mental health organisations 'on the ground', experiencing high client demand, are attempting to develop partnerships with their own resources and are not supported by broader policy and service delivery structures.

Hospital Entry and Discharge Planning and Communication

The lack of community based mental health responses contributes to greater demand for a decreasing supply of beds in psychiatric hospitals. While some people experiencing mental illness will always need a level of hospital care, the demand for these beds could be reduced with more adequate community based or residential mental health responses.

The experience of being homeless and having a mental illness increases or exacerbates the need for hospital treatment. The time spent in hospital for people who are homeless with mental health issues could be greatly limited if appropriate community based services were available.

Between 1993 and 2002, the total number of beds in psychiatric hospitals has decreased by 25 percent from 7,991 beds to 5,934 beds.

The prioritisation of psychiatric hospitals is evident in the increase in the proportion of acute beds. In 1993, acute beds were 45 percent of total psychiatric beds in Australia. By 2002, this figure had risen to 65 percent.

In the Australian Capital Territory and the Northern Territory, all psychiatric hospital beds are acute.

In Victoria, the number of acute beds is 84 percent of total beds, in Western Australia acute beds are 79 percent of total beds. This compares to Queensland and South Australia where only 54 percent of beds are acute and New South Wales where 58 percent of beds are acute (Department of Health and Ageing, National Mental Health Report, 2004.

The strict prioritisation of beds within psychiatric hospitals results in many people experiencing mental illness, including those who are homeless, not accessing hospital care when they need it.

Workers from homelessness assistance services have provided case studies to CHP, which demonstrate this point. Workers recount that outreach mental health service were not available or able to provide assessments to assist in diagnosing people who are homeless with a mental illness. In some instances, particularly in rural areas, homelessness assistance workers at great risk to their personal safety, transported people who are homeless experiencing mental illness to psychiatric hospitals because

they were unable to make a referral in any other manner (CHP Consultation Report, 2003).

However, for people who are able to access psychiatric hospitals, the length of stay is often not adequate to stabilise their illness or for alternative accommodation or housing to be accessed once they are discharged.

Workers from homelessness assistance services again recount that people have been discharged from psychiatric hospital and either referred into a private boarding house, an inappropriate accommodation response to people with a mental illness or discharged, sometimes on a weekend when other services are not available, with nowhere to go.

A 2003 research study undertaken by the Australian Housing and Urban Research Institute (AHURI) which interviewed a sample of people who were homeless experiencing mental illness found that two in five had been admitted to hospital more than once because of their mental health, with over 50 percent stating that towards the end of their last stay in hospital staff did not talk to them about where they were going to be staying. After their last (mental health related) stay in hospital, 13 percent of participants went straight into the street at discharge. Only 16 percent received medical help from health staff visiting support and accommodation services. Support and Accommodation service staff were seen to offer the most support for mental health issues (Robinson, Catherine, Understanding iterative homelessness; The case of people with mental disorders, AHURI, 2003).

A further issue is that some people who are hospitalised risk losing their housing and personal property during their stay in hospital because of their inability to pay rent. The current support structures and planning do not appear to be in place to ensure that this does not occur.

The evaluation of the Second National Mental Health Plan acknowledges these issues in a broad sense by concluding that: “Continuity of care remains an elusive goal for the complex systems that deliver mental health care. In particular, follow up care into the community after hospitalisation for an acute episode is often lacking and puts consumers at risk”.

The Victorian Homelessness Strategy did acknowledge these issues and initiated some small pilot projects and encouraged greater cross sector collaboration.

While these pilot projects will provide some useful outcomes, the lack of resources, lack of community based mental health responses, lack of accommodation and housing and insufficient structural change mean that many people experiencing mental illness enter and are discharged from hospital without adequate support and accommodation planning.

The Council to Homeless Persons believes that SAAP and homelessness assistance services should be the primary broker or service provider for people who are homeless. Difficulties for people who are homeless are compounded when they are required to navigate other public and non-government service systems. It is for this reason that we recommend that homelessness assistance services should be funded to

provide a specialist mental health response to people who are homeless enabling an immediate professional assessment and diagnosis and to assist people who are homeless with a mental illness to access and maintain supported accommodation.

Recommendations

1.5 Building on greater cross-portfolio and inter-government collaboration, that specialist mental health services are funded within homelessness assistance agencies to provide specialist mental health assessment and support to both new clients and client living in supported accommodation. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.7)*

1.6 That the Commonwealth Department of Family and Community Services provide a substantial policy report regarding the actions and strategies related to mental health outlined in the National Homelessness Strategy.

1.7 That the Commonwealth Department of Family and Community Services homelessness policy response place greater emphasis on mental health and resource initiatives aimed at improving mental health responses for people who are homeless.

1.8 That through the National Homelessness Strategy or National Mental Health Strategy a broader definition of mental health is established which incorporates the exacerbating and compounding living experiences of people who are homeless

1.9 That a national review of the discharge practices of psychiatric hospitals be undertaken to assess whether sufficient planning of the on-going support and accommodation of patients is occurring to prevent or limit relapse and hospital re-entry.

Unmet Need, Mental Health and Homelessness

While more research could be undertaken, there is sufficient evidence to suggest that people who are homeless experiencing mental illness are not receiving the services they require to manage their illness and to participate in the community.

Over half the sample of homeless people experiencing mental illness who were interviewed as part of the AHURI study, did not access medical services or community based mental health services for treatment and assistance related to their mental illness (Robinson, Catherine, AHURI, 2003).

A report by the National Mental Health Council of Australia concluded that currently 62 percent of persons with mental disorders do not utilise mental health services. Some of the reasons for people not using services include stigma associated with mental disorders, fearfulness of medical treatments, poor distribution and costs associated with specialist services, and, inappropriate mix of medical and psychosocial services provided by government-financed systems.

People who are homeless will not have accessed mental health services for all the above reasons but also because they face multiple issues on a daily basis, which can entrench their disadvantage and exclusion. These issues include the search for accommodation and housing, relating to Centrelink to access and maintain income, experiencing the trauma and loss of the breakdown of relationships and attempting to establish new relationships, feeling isolated, lonely and unsafe, attempting to access employment and experiencing general health issues.

Both mental health services and homelessness assistance services in Victoria and Australia experience high demand and are generally operating at full capacity.

In Victoria, in the period 1997-2001, the number of consumers registered with mental health services has increased by 20 percent (SANE, Mental Health Report 2004). While there have been some additional resources provided to Victorian mental health services, the demand continues to grow and remain at a constant level.

Increased societal awareness of mental health and the economic costs associated with untreated mental disorders will create higher demand and greater expectations for more mental health services. This is reflected in the 2001 National Health Survey which found that 10 percent of adults reported that they had a long term mental health or behavioural problem, 9.5 percent of people had taken a pharmaceutical medication in the last two weeks and rates of severe psychological distress among adults in the community had increased from 8.2 percent in 1997 to 12.6 percent in 2001.

While there may a greater expectation for increased resources for mental health services and improved and more sustained treatments in the general population, it does not necessarily equate, should it come to pass, that more services will be available for marginal groups such as people who homeless. As mentioned before, people who are homeless including those experiencing mental illness experience many layers of disadvantage and exclusion, which require specific and flexible service delivery responses. As a result of the range of other issues impinging on their

lives, people who are homeless are not able to and do not have the time to express their mental health issues to the same extent as other people.

At the time of writing, there is the potential that funding for the Supported Accommodation Assistance Program (SAAP) in Victoria may be reduced significantly. SAAP is the major response to homelessness in both Victoria and Australia and already turns away large number of people each year due to a lack of accommodation and support places. Many SAAP clients and potential clients are experiencing a mental illness. A loss in funding to SAAP will only result in more people who are homeless with a mental illness not receiving any support at all. An evaluation of SAAP commissioned by the Commonwealth government and completed in mid-2004, concluded that in order to sustain service viability an increase of 15 percent of current funds was required. It also concluded that if service capacity was to be expanded and new ways of working initiated then a substantial increase of 35-40 percent was required.

Homelessness assistance services in Victoria and Australia are full to capacity and must continually turn away people who are seeking support and accommodation. In 2002-03, Supported Accommodation Assistance Program (SAAP) services in Australia are unable to provide accommodation to 225 people, on average, per day. On an average daily basis, less than 3 percent of SAAP accommodation can be provided to new clients. In Victoria, only 1 percent of SAAP accommodation can be provided to new clients. This is despite funding for SAAP in Australia over the past 5 years increasing by 34 percent and SAAP funding in Victoria increasing by 55 percent (AIHW, SAAP National Data Collection Demand and Annual Reports).

People who are homeless experiencing mental illness may also find that their mental health could be barrier to accessing support and accommodation services. Due to the high demand, support and accommodation services must make difficult decisions about which clients they allocate accommodation to. Some support and accommodation services may assess someone with mental health issues as requiring specialist support and treatment which their service cannot provide, other services may have to make allocation decisions based on client sharing accommodation and therefore the placement of the client with mental health issues is considered not appropriate and some decisions of some services may be shaped by perceived occupational health and safety risks.

The experience of many homelessness assistance services is that people who are homeless who do not receive adequate treatment and support can become aggressive and violent and threaten staff and property. Some of these services continue to accommodate and support these people despite being inadequately equipped to do so while others make the decision to accommodate and support other clients.

Recommendations

1.10 That within the homelessness assistance sector, long-term, supported accommodation, with specialist mental health expertise is provided to people who are chronically homeless with lifetime mental health disorders. ***(Please refer to Young People, Homelessness and Mental Health Recommendation 2.8 & 2.12)***

1.11 That, additional or new homelessness assistance workers, should be specifically resourced to receive extensive and accredited mental health training in order to provide outreach support and advocacy for people who are homeless experiencing a mental illness. ***(Please refer to Young People, Homelessness and Mental Health Recommendation 2.16)***

1.12 That data collection mechanisms in both homelessness assistance and mental health services should have provision for recording the number of people who are homeless experiencing mental illness who do not receive either accommodation and support and mental health treatment and/or counselling.

1.13 That funding for the Supported Accommodation Assistance Program (SAAP) should be increased by more than 15 percent to enable the development of mental health specialist services and workers working specifically with people who are homeless and to meet general unmet need. ***(Please refer to Young People, Homelessness and Mental Health Recommendation 2.17)***

Special Needs Groups

There are specific groups within the homeless population that require discrete strategies and responses in relation to mental health. Young people are a large proportion of the recorded homeless population and require particular attention. Substantive detail on young people, homelessness and mental health is contained in Part 2 of this submission. Two other groups requiring specific strategies and responses are people in rural areas and indigenous people.

Mental Health, Homelessness and people in rural and regional areas

Homelessness is just as substantial an issue in rural Victoria and Australia than in the cities. Some of the highest rates or concentrations of people who are homeless recorded in the ABS 2001 Counting the Homeless Census were located in rural areas.

People who are homeless experiencing mental illness face all the barriers and disadvantage of their city counterparts but in addition have to tend with geographical isolation and limited provision of both homelessness assistance and mental health services. In addition, there is less variety in mental health service responses and service delivery in many areas is restricted to a psychiatric hospital or clinic, which is often located several kilometres away. Mental health responses in rural areas are often almost exclusively located in a regional centre, considerable distances away from other smaller but significantly populated towns.

An analysis of the distribution of the Victorian 2004/05 Mental Health budget reveals that whilst the proportion of funding to Adult, Aged and general Psychiatric and Disability services reflects the population split between metropolitan and non-metropolitan areas, the funding for Child and Adolescent, Specialist and other service system capacity initiatives is lower in regional Victoria (Victorian Department of Human Services, Mental Health, Website).

Currently, about 29 percent of Victoria's children and young people, aged 0-19, are living in regional or non-metropolitan areas. However, only 23 percent of Victorian funding for Child and Adolescent mental health services in 2004/05 is distributed to regional Victoria (DHS, Victoria).

Regional and non-metropolitan Victoria also appears to miss out on specialist mental health services, which are almost exclusively located in Melbourne. Only 2.6 percent of Victorian funding for specialist mental health services in 2004/05 was directed to non-metropolitan areas (DHS, Victoria).

The proportion of mental health funding for service system capacity and development in Victoria in 2004/05 was also lower compared to the general population in many non-metropolitan regions particularly Hume, Gippsland and Grampians regions (DHS, Victoria).

Mental Health, Homelessness and Indigenous People

According to a number of reports, the extent of mental illness is recognised as a major issue in indigenous communities. However, the quality of information regarding this is generally poor and varies considerably between jurisdictions.

The need to respond to mental health in indigenous communities is stressed by the Human Rights and Equal Opportunity Commission's Aboriginal and Torres Strait Islander Social Justice Commissioner. In the Commissioner's 2004 Social Justice Report, he states:

> My experience in communities is that there is very little infrastructure or expertise in addressing mental health issues facing Indigenous peoples. It is a forgotten issue. Mental health issues are often masked through passive welfare or dealt with, inappropriately, through the criminal justice system. I have no doubt that mental health issues contribute to the crisis of family violence, anti-social behaviour, substance misuse and confrontation with the legal system, in Indigenous society. Similarly, while there are not very accurate figures on suicide, it is anecdotally known that Indigenous youth suicide is disproportionately high.

It has been well documented in data reports and both state-based and Commonwealth government homelessness strategies, that the number of indigenous people is over represented in the homeless population. The statistics for the Supported Accommodation Assistance Program (SAAP) show that, in Australia, 15,900 clients were indigenous people comprising 16.5 percent of total clients. This compares to only 2 percent of people who are indigenous in the general Australian population. In, Victoria, 4.5 percent of SAAP clients are indigenous compared to 0.5 percent in the general population (AIHW, SAAP NDCA, 2003-04).

Strategies and responses to indigenous homelessness at both State and Commonwealth level, whilst acknowledging poor health and 'emotional and social wellbeing outcomes' for indigenous people who are homeless, have tended to focus on addressing homelessness through improved access to housing.

The National Homelessness Strategy did state as one of its goals in relation to indigenous people that it would aims "to increase awareness and understanding of how the legacy of history continues to affect the emotional and social wellbeing of Indigenous people" (FACS, Working Towards a National Homelessness Strategy, 2003).

The Victorian Homelessness Strategy acknowledged the high rates of homelessness amongst indigenous people. It focused on the need for culturally appropriate services for indigenous people and initiated a pilot project, which placed housing support workers in indigenous agencies. The approach in Victoria regarding indigenous homelessness has emphasised improving access to housing as a means to improving other health outcomes.

There is currently no national data about the incidence or prevalence of mental health disorders among indigenous people in Australia. The 2004-05 National Aboriginal and Torres Strait Islander Health Survey may provide the first steps to obtaining this data (AIHW).

The national data that is available shows that indigenous people in Australia were hospitalised for conditions classified as 'mental and behavioural disorders' at a higher rate than the general population. The rate of hospitalisation for Indigenous people diagnosed with mental disorders due to psychoactive substance use was four to five times the rate of non-Indigenous population especially for indigenous males. Death rates from suicide for Indigenous people are about twice the rate for non-Indigenous people (AIHW).

Recent research undertaken in Western Australia by the Telethon Institute for Child Health Research into the Social and Emotional Wellbeing of Aboriginal Children and Young People extensively details the mental health issues for children and young people in Western Australia and points to further national work required in this area.

Generally, the report concludes that compared with the general population, Aboriginal people experience a much higher burden associated with the emotional or behavioural difficulties of their children. The report found that 24 percent of Aboriginal children were at high risk of clinically significant emotional or behavioural difficulties and that 5,500 Aboriginal children could benefit from treatment or support services for these difficulties (Telethon Institute for Child Health Research, The Social and Emotional Wellbeing of Aboriginal Children and Young People, Perth, 2004).

Clearly there is enough information available to suggest that both homelessness and mental health are major issues for indigenous people. However, more data and information is required especially the relationship between homelessness and mental health for indigenous people. While, indigenous people and communities are diverse, there is clearly a need to consult with and listen to indigenous people as part of a national strategy.

Recommendations

1.14 That a regional and rural mental health strategy and funding model be resourced and implemented to ensure that people from these areas are able to access the necessary mix of general and specialist mental health services. This strategy would place particular emphasis on disadvantaged people, including people who are homeless, living in rural and regional areas. ***(Please refer to Young People, Homelessness and Mental Health Recommendation 2.10)***

1.15 That a National Indigenous Homelessness Strategy be resourced and initiated to, in partnership with indigenous people, gather information and respond to the issues facing indigenous people who are homeless. A significant section of the strategy should focus on the relationship between mental health and homelessness for indigenous people.

Human Rights, Mental Health and Homelessness

The Council to Homeless Persons supports the recommendations made by the submission of the Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic to the Senate Select Committee on Mental Health.

Respect for human rights and the development of a human rights framework that establishes a range of institutional and legislative measures is of substantial benefit to people who are homeless including those who are experiencing mental illness.

The Council to Homeless Persons supports the recommendations and actions that enshrine the right of all people to the highest attainable standard of health, to adequate housing, to participate in policy, service design and delivery, to non-discrimination and the right to adequate income through the social security system.

Recommendations

1.16 That both Commonwealth and State and Territory governments adopt a human rights institutional and legislative framework which supports people who are homeless with mental illness to access the highest attainable standard of health care, to access and maintain adequate housing, to participate in policy and service delivery processes that affect them, to prevent discrimination and vilification and to ensure that receive an adequate income.

Stigma and Discrimination

People who are homeless face a multitude of barriers and excluding and generally do not have the resources and social and family networks available to others in the community.

In addition to this, some people who are homeless experience considerable grief at the breakdown of the relationship with family and/or partner. For some, the nature of the breakdown has involved violence and abuse. These circumstances, combined with no or temporary and poor accommodation and insufficient income contribute to and exacerbate mental illness, low self-esteem, feelings of loneliness, isolation and powerlessness and a reluctance to engage with support services.

The 2003 AHURI study which interviewed people who were homeless with a mental illness stated that "Overall, participants seemed deeply traumatised and grief stricken and struggled with desperation in a context of self loathing, shame and fear. Participants felt strongly stigmatised as 'failures' as 'welfare dependents' as 'no-hopers' and discussed difficult personal journeys of trying to re-learn a sense of self-worth" (Robinson, Catherine, AHURI, 2003)

The lack of sufficient mental health service delivery responses combined with an anxiety in many parts of the community about people who are homeless with mental illness and a portrayal of these people by many in the media as unsafe and unpredictable, all contribute to both an increase reluctance of people who are homeless experiencing mental illness in attempting to access services and continued

poor material and emotional and social wellbeing outcomes for this already marginalised group.

Recommendation

1.17 That current processes, such as the SANE Stigma Survey, that record the views and stories of mental health consumers incorporate the experience of people who are homeless.

1.18 That policy processes, strategies and actions to address mental health and homelessness at a State or Commonwealth level be informed by case studies and stories of people who are homeless experiencing mental illness.

1.19 That a targeted education campaign directed at people who are homeless experiencing mental illness be implemented to assist in destigmatising mental illness and to provide improved access delivery of service information to this group. This campaign should be informed by case studies and stories of people who are homeless experiencing mental illness. *(Please refer to Young People, Homelessness and Mental Health Recommendation 2.15)*

Proficiency and Accountability of General Services

The inadequacies of major structural support services for low-income people in Australia contribute to people becoming homeless and have a major impact on the emotional and psychological well-being and mental health of these people. The resultant effect is increased demand on both homelessness assistance and community mental health services along with a growing number of people who are receiving no assistance at all.

The homelessness assistance service sector has, by any comparative measure, broad and flexible criteria in assessing and responding to people who are homeless. SAAP provides support and accommodation to about 100,000 people in Australia each year. It also experiences high demand from people who are homeless requiring support and accommodation. This high demand and unmet need is contributed to by the inadequacies and tight criteria of other service systems. In other words, homelessness assistance and SAAP services, 'take on' clients who have not been supported by other systems and because they have a general entry criteria which is homelessness.

Many clients of homelessness assistance services have high and complex needs and a range of mental health issues. Despite having to deal with challenging behaviour and management of difficult living circumstances, homelessness assistance services continue to support people who otherwise would have nowhere else to go. Homelessness assistance services attempt to link people into other service systems but are often thwarted by tight entry criteria, long waiting lists and rationing and prioritisation processes.

There are major structural inadequacies that contribute to people becoming homeless. The lack of long-term affordable housing is a major one. Changes in the Australian housing market and provision of social and public housing have resulted in many low-

income people in Australia finding it increasingly difficult to access and maintain their housing. Reduced investment in public and social housing, increased rents and a diminishing supply of low-cost private rental housing and rapid growth in house prices have all contributed to the lack of housing affordability. People become homeless because they are living in 'housing stress' and can no longer afford the rent. Also once people are homeless it is increasingly difficult for them to access long-term housing again. The experience of losing housing and the challenges in attempting to find housing impacts on the emotional and social well being of people who are homeless and increases the demand on homelessness support and accommodation providers.

The lack of access to employment contributes to homeless people not having sufficient and sustained income to meet basic needs. There is strong evidence that unemployment increases the risk of poverty, contributes to inequality and leads to a range of debilitating social effects on unemployed people, their families and the community.

Apart from having clear material disadvantages, unemployment, particularly long-term unemployment can have a significant psychological impact on individuals, families and communities. Employment is the major source of social participation and interaction in Australian society and provides opportunities for meaningful and purposeful activity. The material and psychological impact of unemployment, combined with other factors can result in people becoming homeless. Jobs are often not located where housing is affordable reinforcing patterns of marginalisation and social exclusion.

Over 90 percent of clients in the Supported Accommodation and Assistance Program (SAAP), the largest national program for people who are homeless in Australia are unemployed or not in the labour force.

Most homeless people are receiving very low incomes or no income at all. Social security income is often insufficient for people to meet their costs for housing, food and other basic necessities and services. Australian social security benefits and pensions (income support) are low by OECD standards. Some people receiving government payments become homeless because their income is reduced or cut off because they have 'breached' or been unable to meet the mutual obligation requirements established by social security legislation.

Recommendation

1.20 That the Commonwealth Government ensures that adequate resources are provided to ensure that people who are homeless with a mental illness are able to access and maintain affordable housing and sufficient income to meet both basic and self care needs.

Research and Data Collection

This submission has already referred to some information that is available about mental health and homelessness. This evidence establishes that for many people who

are homeless, mental health and accessing the mental health service system are major issues. However, the existing information also poses more questions and indicates the need for more data and information.

Any research and data collection regarding mental health and homelessness would need to be based on a broad definition of mental health and not a narrow, clinical one. There is some anecdotal evidence, that needs to be confirmed, that those people with 'lesser' mental health disorders and those with erratic or violent behaviours (such as recurrent suicidal and self harm behaviours associated with borderline personality disorders) and those who are dually diagnosed, do not receive adequate mental health support or treatment. There is a strong argument that affective or non-psychotic disorder such as anxiety disorders, phobic disorders, post-traumatic stress disorder and personality disorders are more prevalent amongst people who are homeless (Parker, Limbers and McKeon, 2002). More data and information is required on these propositions and used to support strategies to improve mental health support for people who are homeless.

Likewise, further research is required into mental health and homelessness for specific target groups, especially young people, children, people in rural and regional areas and indigenous people.

Recommendation

1.21 That the Commonwealth Department of Family and Community Services and the Commonwealth Department of Health and Ageing, Mental Health Branch resource and develop a research program which examines on a consistent and regular basis the mental health needs of people who are homeless in Australia

1.22 That Victoria and other State and Territory governments resource and develop specific mental health and homelessness research projects which complement the Commonwealth research program.

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Part 2: Young People, Homelessness and Mental Health

Introduction

This section of the Council to Homeless Persons (CHP) submission relates specifically to the relationship between young people experiencing homelessness and mental health issues. Council to Homeless Persons welcomes the opportunity to respond to the Commonwealth Parliament's *Senate Select Committee on Mental Health*, and to provide comment on the discussion paper released in February 2004 as part of the National Mental Health Strategy, *Responding to the Mental Health Needs of Young People in Australia, Discussion Paper: Principles and Strategies*.

About Council to Homeless Persons

As stated elsewhere in this submission, the Council to Homeless Persons (CHP) is the leading peak body organisation representing all those in Victoria with a stake in homelessness including people who are homeless or have experienced homelessness.

CHP has a specific commitment to young people, and are currently funded for a Youth Policy Officer position. The key focus of this position is to seek improved outcomes for young people experiencing homelessness through:

- Seeking to influence government policy development and reform
- Working with the homelessness services, and related sectors with a view to improving outcomes for young people experiencing homelessness
- Raising awareness of youth homelessness issues amongst the Victorian community
- Consulting with and listening to, young people who are experiencing, or have experienced homelessness.

There are a number of key values that inform the work of CHP in relation to young people experiencing homelessness, and which underpin a number of the recommendations contained within this section of the submission.

- Young people should not be defined on the basis of their experience of homelessness.
- A structural analysis should accompany any discussion on young people and homelessness, including an awareness of the changing pathways for young people generally, and the implications for young people experiencing homelessness.
- Young people should be empowered and supported to participate in broader social processes, homelessness service delivery and homelessness policy development.
- Young people should be able to access youth specific services when seeking assistance with homelessness and other issues.
- Young people should be valued in an ageing society.

Executive Summary

Homeless young people in Australia have much higher rates of psychological distress and psychiatric disorders than young people in more stable living situations. Mental illness is a major factor both of the likelihood of people becoming homeless and in the lived experience of homelessness.

The most common disorders are mood disorders and anxiety disorders, such as post-traumatic stress disorder, and substance use disorders. A significant number of homeless young people experience psychotic disorders and many others have a personality disorder. Suicide and self-harm are also common amongst young people experiencing homelessness.

The purpose of this submission is to highlight the interrelatedness of youth homelessness and poor mental health. CHP believes that two key responses are required. Youth specific mental health services must be made widely available to young people. Young people have specific needs related to their age and developmental stages that make them unique and different to children and adults.

Secondly, enhanced linkages must be created between homelessness assistance services and mental health services to ensure that young people experiencing homelessness with a mental health issue can be adequately and appropriately supported, with a view to achieving long-term sustainable outcomes.

An overarching framework needs to be developed in order to ensure a comprehensive and coordinated response to young people. This can be achieved through the development of a National Youth Mental Health Strategy, with supporting State/Territory Youth Mental Health Strategies. The strategies must address the breadth of mental health responses required for young people including a greater commitment of resources to young people with non-psychotic disorders.

Additionally priority must be given to placing youth specific mental health workers within homelessness assistance services, which will ensure that young people receive a mental health response at the point of immediate need, within the context of the reality of their homeless experience.

The particular needs of young people in rural and regional areas, those experiencing comorbid disorders, Indigenous young people and young people from culturally and linguistically diverse backgrounds must be recognized and responded to.

Stigma is a key barrier to young people accessing mental health services, with significant effects on the mental wellbeing of homeless young people. Sound consultation with young people experiencing homelessness must inform the development of a targeted education and information campaign.

Finally the key role of youth homelessness services in supporting and linking young people with mental health issues must be acknowledged and supported through an increase in base funding, flexibility of staffing levels to allow intensive support, and the development of more flexible accommodation models.

List of Youth Specific Recommendations

2.1 That mental health practice responses be targeted to the changing life stages of young people through adoption of the key age brackets of 15-18, 19-21 and 22-25 in recognition of the changing legal, economic and social status of young people across these age ranges.

2.2 That a National Youth Mental Health Strategy be developed based on the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.3 That State and Territory Youth Mental Health Strategies be developed that complement and extend the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.4 That the inter-relatedness of youth homelessness and mental health issues be addressed in both the National and State/Territory Youth Mental Health Strategies.

2.5 That the National and State/Territory Youth Mental Health Strategies address the breadth of mental health responses required for young people experiencing homelessness, in particular:

- **improved access to services that treat young people for non-psychotic disorders (such as mood, anxiety and personality disorders), and**
- **improved coordination of homelessness assistance and mental health services.**

2.6 That the National and State/Territory Youth Mental Health Strategies are developed in consultation with a range of relevant stakeholders including young people experiencing homelessness and mental health issues.

2.7 That youth mental health workers be based within youth homelessness services such as youth refuges or youth transitional support services in both metropolitan and rural areas of Victoria.

2.8 That youth specific mental health services be made available to young people experiencing homelessness in all parts of Victoria, with a particular emphasis required on rural and regional areas.

2.9 That the Senate Select Committee recommend to the relevant Federal Ministers that funding to youth homelessness services remains a priority, and increases by 15%, in recognition that young people experiencing homelessness use homelessness assistance services as a gateway to mental health services.

2.10 That a coordinated rural and regional mental health strategy be developed through a National Youth Mental Health Strategy, with the

detail developed through the State and Territory Mental Health Strategies.

2.11 That protocols be developed through the National Youth Mental Health Strategy between youth homelessness, drug and alcohol, and mental health services for working with young people with comorbid disorders.

2.12 That mental health and comorbidity specialist workers be established within youth homelessness services.

2.13 That a key component of the National Youth Mental Health Strategy is the development of an Indigenous Youth Mental Health Strategy, in consultation with Indigenous young people and their communities.

2.14 That culturally appropriate youth mental health services are available and accessible for young people from CALD communities, that information on mental health services is readily available in a range of community languages, and that community development strategies are employed that target key cultural groups to ensure that information is accessible and that issues of stigma may be addressed.

2.15 That a targeted education campaign be developed specifically for young people experiencing homelessness that aims to destigmatise mental illness, provide information on the mental health services available, and provide information on what mental health services do.

2.16 That specialist youth mental health training be developed targeting homelessness assistance agencies working with young people.

2.17 That the Senate Committee make a recommendation to the relevant Federal Minister that staffing levels to homelessness assistance services be more flexible to allow workers to respond intensively to young people with mental health issues.

2.18 That the Senate Committee make a recommendation to the relevant Federal Minister that more flexible accommodation models be developed across Victoria, to enable homelessness assistance services greater capacity to accommodate young people with mental health issues.

Defining Young People, Homelessness and Mental Health

Defining Young People

CHP, in line with many homelessness assistance services and the *Supported Accommodation Assistance Act* 1994, defines young people as 15-25 years of age. However the practice of working with young people should entail a sound understanding of the needs of young people at different life stages. Young people between the ages of 15-25 undergo significant developmental change, changes in their legal rights and responsibilities and changing social expectations related to independence and responsibility.

This has particular implications for the practice of working with young people. By better understanding the changing life stages of young people, we are better placed to develop a practice response that is targeted to the needs of young people, and that recognizes the vastly different legal, social and economic implications, therefore increasing the potential for improved outcomes for young people.

For this reason we argue that grouping young people within age brackets of 15-18, 19-21 and 22-25 offers the opportunity to better target practice responses to young people, although the individual needs of young people will vary even within these age categories, in particular levels of maturity and individual capacity.

Recommendation

2.1 That mental health practice responses be targeted to the changing life stages of young people through adoption of the key age brackets of 15-18, 19-21 and 22-25 in recognition of the changing legal, economic and social status of young people across these age ranges.

Defining Homelessness

At the 2001 Census 23,713 people were recorded as homeless in Victoria. Young people are over represented within the homeless population, with 7,064 young people aged 12-25 counted as homeless in Victoria (Chamberlain and MacKenzie 2004:25). Young people in this age bracket represent 35% of the homeless population.

CHP supports the cultural definition of homelessness as used by the Australian Bureau of Statistics (ABS). The definition identifies three categories of homelessness, primary, secondary and tertiary.

Primary homelessness includes those people living on the streets, cars, squats, tents and other improvised dwellings. *Secondary homelessness* refers to those people who move frequently from one form of temporary shelter to another. This includes people living in homelessness assistance accommodation, and those living temporarily with other households often in overcrowded circumstances (often referred to as ‘couch surfing’), as they have no accommodation of their own. *Tertiary homelessness* refers to people living in rooming houses or boarding houses. They are considered homeless because the accommodation does not meet ‘minimum community standards’.

CHP argues that marginal residents of caravan parks should also be included in the tertiary homelessness category, as caravan park accommodation fails to meet the same 'minimum community standard' of housing as rooming houses.

Mental Health, Homelessness and Young People

Homeless young people in Australia have much higher rates of psychological distress and psychiatric disorders than young people in more stable living situations (Kamieniecki 2001).

Mental illness is a major factor both of the likelihood of people becoming homeless and in the lived experience of homelessness (Robinson 2003:20). While some young people become homeless due to mental illness, some young people experience the onset of mental health issues once becoming homeless, possibly in response to the stress and trauma of the experience of homelessness. With appropriate support and stabilization it is possible that some young people will see a diminishing of their mental health issue, for others long-term support and case management is required. Further research is urgently required in this area to enable a more detailed and specific understanding of the inter-relationship between homelessness and mental health issues.

Studies to date have found between young 48% and 82% of homeless young people have a diagnosable mental illness (Kamieniecki 2001:355). The most common disorders are mood disorders and anxiety disorders, such as post-traumatic stress disorder, and substance use disorders (Mildred 2002:5, Kamieniecki 2001:355). A significant number of homeless young people experience psychotic disorders and many others have a personality disorder (Parker, Limbers and McKeon 2002:6).

Project i[1], a longitudinal study of homeless young people in Melbourne, interviewed 403 young people who were experiencing homelessness between October 2000 and December 2001. The study found that:

- 26% of homeless young people surveyed reported a level of psychological distress indicative of a psychiatric disorder,
- 14% reported clinical levels of depression
- 12% reported clinical levels of anxiety
- 12% had clinical levels of psychosis
- 75% smoked everyday (5 times the national average for this age group)
- 40% of young women and 29% of young men's alcohol consumption is at high-risk elevated levels
- Marijuana use was high, with 49% of young people using it on more than 60 days in the previous 3-month period (Rossiter et al 2003:17).

Mental disorder may pre-date homelessness, or occur subsequently. Project i found that of the young people surveyed, approximately 50% of long term homeless young people, and 40% of newly homeless young people identified feelings of anxiety/depression as a reason for leaving home (Myers et al 2001).

[1] Project i is a three-year longitudinal study of homeless young people in Melbourne and Los Angeles. It is currently located at the Key Centre for Women's Health at Melbourne University.

Suicide and self-harm are also common amongst young people experiencing homelessness. For example, over 1 in 10 young people surveyed as part of Project i reported attempting suicide in the last 3 months, and over 1 in 3 deliberately hurt themselves or did something that they knew would hurt them. A startling 28% of young people who had attempted suicide had not told anyone about their attempt (Rossiter et al 2003:34).

The National Mental Health Strategy

a. *The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.*

The development of the National Mental Health Strategy offers the opportunity to develop a strategic vision for mental health responses in Australia, including developing a demographic profile of those deemed to be at greater risk of mental health issues, a comprehensive log of current research findings and current gaps in research, identification of joined up, cross-portfolio responses, and ultimately the development of targeted and practical responses to people experiencing mental health issues.

Comment has been provided elsewhere in this submission on the resources and division of responsibility for policy and funding of the National Mental Health Strategy. This section of the submission will focus on youth specific issues.

CHP supports the principles and strategies identified within *Responding to the Mental Health Needs of Young People in Australia Discussion Paper: Principles and Strategies*, released in April 2004.

CHP is keen to see this work continued and developed in greater depth through two mechanisms. Firstly, that the Principles and Strategies contained in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper* form the framework for a National Youth Mental Health Strategy, that complements the National Mental Health Strategy, and that recognizes the distinct experiences, needs and specialized service delivery that young people require.

Secondly, that the proposal contained within the discussion paper that each state and territory government "engage young people and services in a separate process to determine the most appropriate ways of implementing the suggested principles and strategies" (DoHA 2004:x) be undertaken as a priority, to ensure that adequate state based responses to the mental health needs of young people are developed, that are consistent with the national strategic framework.

In *Working Towards a National Homelessness Strategy: Response to Consultations*, the Commonwealth Advisory Committee on Homelessness (2003) recognizes the need for a coordinated whole of government response to homelessness. They state,

> *We must better integrate all the policies, programs and agencies that influence the income, employment, health, family relationships and housing of those who are vulnerable* (2003:10).

Working Towards a National Homelessness Strategy: Response to Consultations (2003) identifies the need for more effective links between homelessness assistance and mental health services. The development of National and State/Territory Youth Mental Health Strategies offers the opportunity to provide a practical response and better identify and coordinate service responses to young people experiencing homelessness with mental health issues.

CHP was pleased to see some discussion on the inter-relationship between homelessness and mental health issues already contained in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.* While the onset of mental health issues may result in homelessness for a young person, some young people who become homeless may experience the onset of mental health issues that are environmental, due to the stresses and strains of the experience of homelessness. For some young people, these mental health issues may be gradually resolved as their lives stabilise, for others their mental health issue is individual rather than environmental, and ongoing specialized case management and support is required.

Therefore both the National and State/Territory Youth Mental Health Strategies must consider the breadth of mental health responses required for young people experiencing homelessness, in particular improved access to services that treat young people for non-psychotic disorders (such as mood, anxiety and personality disorders), and improved coordination of homelessness assistance and mental health services.

Finally the development of both National and State/Territory Youth Mental Health Strategies must occur in consultation with young people experiencing homelessness and mental health issues, and key peak body and homelessness assistance services, and backed by current research.

Recommendations

2.2 That a National Youth Mental Health Strategy be developed based on the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.3 That State and Territory Youth Mental Health Strategies be developed that complement and extend the principles and strategies identified in *Responding to the Mental Health Needs of Young People in Australia Discussion Paper.*

2.4 That the inter-relatedness of youth homelessness and mental health issues be addressed in both the National and State/Territory Youth Mental Health Strategies.

2.5 That the National and State/Territory Youth Mental Health Strategies address the breadth of mental health responses required for young people experiencing homelessness, in particular:

- **improved access to services that treat young people for non-psychotic disorders (such as mood, anxiety and personality disorders), and**
- **improved coordination of homelessness assistance and mental health services.**

2.6 That the National and State/Territory Youth Mental Health Strategies are developed in consultation with a range of relevant stakeholders including young people experiencing homelessness and mental health issues.

Coordination of Funding and Services

c. Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care

Young people experiencing homelessness are less likely to have access to the resources required to seek treatment for mental illness (VicHealth 2003). Homeless young people are often focused on seeking stable accommodation and support, and may not access another service for treatment until their mental illness becomes critical (Lloyd et al 2004, Johnson & Bulic 2002, Sarikoudis 2002).

Even when young people are keen to access a mental health service, they may receive an inadequate response, often because their complex needs may span multiple program areas (Welch and Mooney 2001, Fail and O'Shaughnessy 2002). For example, young people with both mental health and substance abuse issues, common amongst homeless young people, often don't fit into conventional mental health, or drug and alcohol services. Indeed, young people experiencing homelessness with non-psychotic mood, anxiety and personality disorders, or a dual diagnosis of mental illness and substance abuse, are particularly poorly served by the current system and are falling through the gaps in service delivery (Kamieniecki 2001, Szirom et al 2004).

Many homelessness assistance workers report difficulties accessing mental health services on behalf of homeless young people, due largely to a lack of specialist youth mental health support programs, and a lack of specialist mental health accommodation. Homelessness assistance workers commonly report that mental health services are working to capacity, and that gaining access to the service for a young person is exceedingly difficult as they are either not viewed as a priority, or are perceived as difficult to work with.

While homelessness services will work to accommodate young people with mental health issues, accommodation and support will often break down without treatment and support from specialist mental health workers (CHP 2003, CACH 2003). This inadequate addressing of health care needs, results in many young people with a mental illness treading water in marginal accommodation interspersed with bouts of transience.

Better linkages need to be developed between homelessness assistance services and mental health services. Fostering collaboration between services will enable innovation in responses to homeless young people and improved understanding of the roles and capacity of both the mental health and homelessness assistance service systems.

Specialist youth mental health workers need to be placed within youth homelessness services such as youth refuges, or youth transitional support services. This type of innovative approach ensures that services are available to young people at the point at which they require them, fosters and develops linkages between homelessness assistance and mental health, and ensures a place based response to young people. This type of initiative could be trialed within a metropolitan and regional area, with a sound evaluation of the effectiveness of this type of response.

Of the mental health services available, many are generalist rather than youth specific services. This is particularly so in rural areas, where there are a limited number of generalist mental health services, let alone services specifically for young people. This is problematic, as young people are not getting services that are targeted to their particular needs as young people. Adult mental health services can be intimidating, and many young people will not access these services. Youth specific mental health services need to be available to young people across the state.

Recommendations

2.7 That youth mental health workers are based within youth homelessness services such as youth refuges or youth transitional support services in both metropolitan and rural areas.

2.8 That youth specific mental health services are made available to young people experiencing homelessness in all parts of Victoria, with a particular emphasis required on rural and regional areas.

Unmet Need, Young People, Mental Health and Homelessness

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

The discussion contained in this section of the submission will be confined largely to issues related to unmet need in supported accommodation and homelessness assistance, and the relationship to mental health outcomes, as this is the area of expertise for CHP.

Homelessness assistance workers play a crucial role in linking in people experiencing homelessness with a range of additional services and supports. Case coordination and management is a central focus of the role of a homelessness assistance worker, although this does vary depending on the type of service they are employed in and whether their role is to provide crisis, short, medium or long-term support. Commonly these workers play a generalist support role, and will refer people experiencing

homelessness to specialist services for support with issues such as mental health. It is unusual for a young person experiencing homelessness to self refer directly to a specialist service.

This is particularly the case where a young person may be experiencing primary or secondary homelessness. Unless a young person becomes critically mentally unwell, and requires hospitalization, they are likely to be focused on securing accommodation before giving consideration to other issues, whether they are mental health issues, substance abuse issues or other related issues.

As such homelessness assistance services often become the gateway for young people experiencing homelessness to access mental health and other specialist services. However as has been regularly documented, homelessness assistance services are generally working to full capacity (Erebus Consulting Partners 2004), with young people turned away on a daily basis without receiving assistance.

Homelessness assistance services in Victoria are currently facing an uncertain future however, as the State and Federal Governments argue over their respective responsibilities for funding through the fifth Supported Accommodation Assistance Program Agreement. CHP is deeply concerned that some of the most marginal young people in the state will be denied services if the funding crisis cannot be resolved. Politically, the argument over responsibility for funding currently being played out has shifted focus away from the need for a funding boost to homelessness assistance, and left homelessness services fighting to retain what they have, rather than seeking the increase in funding recommended by the SAAP IV evaluation (Erebus Consulting Partners 2004**)**.

There is a clear link between young people being able to access homelessness assistance services to address their primary need for accommodation, and their ability or willingness to access mental health services. Without youth specific homelessness assistance services, many young people would not access, or remain linked in with, mental health services. It is imperative that funding through the SAAP Agreement be increased by 15% as recommended in the SAAP IV evaluation, to ensure that young people experiencing homelessness are able to continue to access mental health services through the homelessness assistance system.

Recommendation

2.9 That the Senate Select Committee recommend to the relevant Federal Ministers that funding to youth homelessness services remains a priority, and increases by 15%, in recognition that young people experiencing homelessness use homelessness assistance services as a gateway to mental health services.

Special Needs Groups

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

Young People in Rural and Regional Victoria

Geographic isolation, and the difficulties in providing services to people who are thinly dispersed over large areas, means that many young people experiencing homelessness in regional and rural areas of Victoria often face difficulties in accessing suitable and timely mental health responses. Compounding this is the disproportionate distribution of mental health funding relative to population demographics. While approximately 29% of Victoria's children and young people aged 0-19 are living in regional or non-metropolitan areas of Victoria, only 23% of Victorian funding for Child and Adolescent mental health services in 2004/05 is distributed to regional Victoria.

Young people experience homelessness in all parts of Victoria. However young people living in rural and remote areas may be at greater risk of homelessness due to lower average incomes, higher living costs, limited employment opportunities, and poorer quality, and limited access to, affordable housing (CACH 2003).

Homelessness assistance services in rural and regional Victoria often have few alternative accommodation options outside of the accommodation provided by their service. Unlike the metropolitan areas where there may be a number of services located within a particular geographic area, rural and regional areas of Victoria often have one or two homelessness assistance services that cover a large geographic area. If a young person is not accommodated by that service, there may be no other accommodation option. There is greater pressure therefore on rural and regional services to accommodate a young person experiencing homelessness with a mental health issue, whether they are linked in with a mental health service or not.

This places additional pressure on the homelessness assistance services, their staff and other clients of the service. Without access to appropriate mental health support, the accommodation provided by the homelessness assistance service is likely to break down. Anecdotally homelessness assistance workers in rural and regional Victoria have consistently reported to CHP significant trouble accessing adequate mental health responses for homeless young people.

A coordinated rural and regional mental health strategy is required to ensure that an appropriate level of mental health services is available in the region for homeless young people. This strategy must form a key part of the National Youth Mental Health Strategy, with the detail, and locational expertise developed through the State and Territory Mental Health Strategies.

Recommendation

2.10 That a coordinated rural and regional mental health strategy be developed through a National Youth Mental Health Strategy, with the

detail developed through the State and Territory Mental Health Strategies.

Young People with Comorbid Conditions

Homeless young people are more likely than their home based peers to experience comorbidity. As one research report found, "homelessness is not incidental to comorbidity in young people but is frequently an integral part of the disorder" (Szirom et al 2004:21).

It is commonly suggested that the existence of comorbidity can lead to homelessness, or that the experience of homelessness can lead to the development of mental health disorders and subsequent substance abuse as a means of coping. Further research needs to be undertaken in this area with a view to establishing the environmental impact of homelessness on the mental health of a young person, and whether this reduces over time with the stabilization of accommodation, and the establishment or reestablishment of relationships and supports.

Regardless, homeless young people with both mental health issues and substance abuse issues often fall through the gaps in service delivery (Szirom et al 2004: 21). Young people with comorbidity issues often don't fit into conventional mental health or substance abuse services and will sometimes be handballed from one service system to another and back again.

Behavioural issues which can result from comorbidity, such as aggressive and socially unacceptable behaviour, can often limit a young person's access to services and support, from not only mental health or substance abuse services, but homelessness assistance services also (Szirom et al 2004:20, Keys et al 2005). This is particularly the case where a homelessness service requires a young person to share accommodation with another young person. Trapped in a vicious cycle, these young people become further marginalized with increasingly limited options.

The development of protocols between mental health services, drug and alcohol services, and youth homelessness assistance services could go some way to creating common understandings of the issues facing young people with comorbid conditions. Protocols can also assist in establishing sound working relationships on a regional basis, ensuring that these young people are not falling through the gaps, and fostering a collaborative approach to service delivery.

Protocols are most effective where a broader strategic framework exists that can drive the protocol development process across regions, and ensure some consistency of service delivery, particularly where young people may be transient and moving across regions.

However protocols cannot address the issue of service capacity to accommodate and work with extremely high needs young people. Many youth homelessness services are predicated on the assumption that young people can share accommodation and communal space. Young people experiencing comorbidity may find this extremely challenging, and the service must as a consequence make some difficult decisions around duty of care to the young person, other clients, and staff. Additionally the key

intention of homelessness assistance services is to move young people onto independent living. Young people experiencing comorbidity can find independent living extremely challenging, particularly without specialist support.

The establishment of youth specific mental health and comorbidity specialists within youth homelessness services is an additional strategy that would further complement the development of protocols, and considerably enhance the capacity of homelessness assistance services to accommodate young people with comorbidity disorders successfully.

Recommendations

2.11 That protocols be developed through the National Youth Mental Health Strategy between youth homelessness, drug and alcohol, and mental health services for working with young people with comorbid disorders.

2.12 That mental health and comorbidity specialist workers be established within youth homelessness services.

Indigenous Young People

26% of the Indigenous population are young people aged 12-24 (AIHW 2003a:322). Indigenous young people are more likely to live in areas classified as very remote, than non-Indigenous young people.

Education participation and educational attainment, rates of participation in the labour force and health outcomes all tend to be poorer for Indigenous young people than for non-Indigenous young people. Indigenous young people also have alarmingly high rates of morbidity and incarceration relative to non-Indigenous young people.

Historical dispossession is consistently and strongly identified by Indigenous people as "a continuing source of unresolved issues about the needs of Indigenous people, as well as their place in contemporary society" (Berry et al 2001:35). Berry et al (2001) argue that unless this is the starting point for recognizing the needs of Indigenous people, inappropriate responses will continue to be developed.

The AIHW (2003a) identify a number of broad factors that impact generally on poor health and wellbeing outcomes, and that they believe are relevant to Indigenous young people. These include,

- low socioeconomic status;
- degrees of social connectedness;
- degree of inclusion or exclusion from society, including racism and discrimination;
- the sense of control that people feel over their lives.

Indigenous young people are also consistently over-represented in homelessness assistance services relative to their population size in every state and territory in Australia (AIHW 2003:12). In Victoria 5% of all young clients aged 12-24 identified as Indigenous (AIHW 2003:15). Indigenous young women represent 71% of all Indigenous clients. While Indigenous young people have the highest mean number of

support periods at 1.94, they also have some of the shortest support periods, on average 1-3 days (AIHW 2003). Three key categories of homelessness have been developed that specifically relate to Indigenous people,

- Public place dwellers both voluntary and involuntary;
- Those at risk of homelessness including those living in overcrowded situations; and
- Spiritually homeless people (Memmott et al 2003).

The National Mental Health Strategy discussion paper, *Responding to the Mental Health Needs of Young People in Australia*, identifies Indigenous young people as being at high risk of mental health issues, although there is need for agreement on how to measure the social, cultural and emotional wellbeing of Indigenous communities. Despite this, data confirms that there are high rates of hospitalization for mental health disorders and behavioural issues, excessively high rates of death from mental disorders and high levels of suicide, self-mutilation and substance abuse (DoHA 2004).

The development of an Indigenous Youth Mental Health Strategy as a key component of the National Youth Mental Health Strategy offers the opportunity, in partnership with Indigenous young people and their communities, to address some of the issues that are particular to Indigenous young people, in a manner that is culturally, geographically and spiritually appropriate.

Recommendation

2.13 That a key component of the National Youth Mental Health Strategy is the development of an Indigenous Youth Mental Health Strategy, in consultation with homeless Indigenous young people and their communities.

Young People from Culturally and Linguistically Diverse Communities

The National Mental Health Strategy Discussion Paper, *Responding to the Mental Health Needs of Young People in Australia*, acknowledges that young people from culturally and linguistically diverse communities face an increased risk of mental illness. Currently, 14% of young people in Australia are born overseas, with the majority born in Asia (6%), followed by New Zealand and Europe (including the United Kingdom and Ireland) (AIHW 2003a: 19).

In 2000-01 there were 3,853 young people aged 12-25 who arrived in Australia as refugees through the Humanitarian program. 38% of these young people are on Temporary Protection Visas (Pitman 2003:20). At April 2002 just over 1 in 10 people in immigration centres were under 18 years of age, and the majority of them were male. Of the young people in detention, the largest group are from Iran (38%), with 28% from Afghanistan and 16% from Iraq (Pitman 2003:22).

Young people from CALD communities, particularly those that are recently arrived refugees, may struggle with a number of issues additional to those associated with developmental growth for young people, including competing cultural tensions, social isolation, financial difficulties and emotional stress (Kelly 2004, DoHA 2004).

Competing cultural tensions can cause anxiety, family conflict and identity issues, which can lead to the development of mental health issues, particularly anxiety and depression. This can affect young people who have arrived in Australia with family, and those who have arrived as independents.

Substantially reduced support and family networks, and low levels of English proficiency can lead to social isolation for some young people from CALD communities. Kelly (2004) notes that social isolation may be self-imposed for some refugees and asylum seekers due to feelings of shame due to poverty, traumatic experiences prior to their arrival (such as rape or the inability to support family members) and low income. These are all factors that contribute to not only an increased risk of mental illness, but homelessness also.

Financial stress, due to visa requirements that prevent a young person working, but also restrict their access to government financial assistance such as Youth Allowance, are also an increased risk factor in both the onset or exacerbation of mental illness and homelessness.

Victoria has the highest proportion of SAAP clients aged 12-24 years who were born overseas (13%), with 11% from non-English speaking countries. Nationally the total proportion of young people from non-English speaking countries who are SAAP clients is 9% (AIHW 2003:13). In Victoria slightly more young women than young men born overseas are SAAP clients (AIHW 2003:15). Young people who are SAAP clients and from non-English speaking countries were more likely to have support periods longer than four weeks (42%) which is a higher proportion than all other cultural groups.

The National Mental Health Strategy discussion paper, *Responding to the Mental Health Needs of Young People in Australia* states that young people from CALD Communities are less likely to voluntarily access mental health services due to language and cultural barriers, a lack of information on services and stigma.

Mental health services must be made available to homeless young people that are culturally appropriate and accessible. A targeted community education strategy also needs to be developed that ensures that information on services is available in community languages, and that an additional focus of the strategy is attempting to reduce the stigma associated with mental health services.

Recommendation

2.14 That culturally appropriate youth mental health services are available and accessible for homeless young people from CALD communities, that information on mental health services is readily available in a range of community languages, and that community development strategies are employed that target key cultural groups to ensure that information is accessible and that issues of stigma may be addressed.

Stigma and Discrimination

l. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

As stated earlier, young people experiencing homelessness are more likely to experience mental health issues, either in response to the trauma and stress of being homeless, or as a trigger to homelessness. However young people experiencing homelessness are concerned about the stigma of accessing mental health services.

Research conducted by Project i found that 40% of the young people surveyed felt they needed assistance with depression and/or anxiety, yet only 55% actually sought assistance. The three main reasons given by young people for not seeking assistance was that they were "to nervous or embarrassed to talk about the problem", they didn't know "where to go or what service to use" and they "thought the service couldn't help" (Rossiter et al 2003: 35). Alarmingly of the 11% of young people who had attempted suicide in the last three months, 28% had not told anyone about this (Ibid: 34).

Clearly a targeted education campaign needs to be developed specifically for young people experiencing homelessness. The campaign must have three key messages:

- Destigmatising mental illness
- Providing information on which services are available including location details
- Providing information on what mental health services actually do

Sound consultation with young people experiencing homelessness must inform the development of the campaign to ensure that the messages are delivered in an appropriate manner and medium, including an awareness of the need to develop resources in a range of community languages.

Recommendation

2.15 That a targeted education campaign be developed specifically for young people experiencing homelessness that aims to destigmatise mental illness, provide information on the mental health services available, and provide information on what mental health services do.

Proficiency and Accountability of General Services

m. The proficiency and accountability of agencies such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness

This section of the submission will be confined to a discussion of the proficiency and accountability of homelessness assistance services in dealing appropriately with people affected by mental illness.

As stated elsewhere in this submission, homelessness assistance services can and do accommodate a significant proportion of young people experiencing mental health issues. It is commonly recognized that young people accessing homelessness assistance services are often presenting with high and complex needs. While there is no agreed to definition, high and complex needs usually refers to young people experiencing one or more of the following issues, which has compounded or caused their homelessness:

- Mental health issues,
- Disability
- Substance abuse issues
- Poor physical health
- Violent or aggressive behaviour

Many of the homelessness assistance services in Victoria have developed innovative and creative practice responses to young homeless people with mental health issues, with a view to ensuring that young people experiencing homelessness receive a level of service that meets their need.

A recent qualitative study undertaken in Victoria by Keys et al (2005), investigated issues of access and exclusion to homelessness assistance services for young people. It focused particularly on young people with substance abuse issues, mental health issues and violent behaviour. The research found that homelessness assistance services, particularly those in regional and rural areas, had developed a wide range of innovative responses to young people with mental health issues. Many of these responses were individualized to enable them to respond to the particular needs of young people.

This is not to say that all practice responses to young people with mental health issues are appropriate however. Ongoing specialized training is required for homelessness assistance workers and mangers, to ensure that practice responses to young people with mental health issues are appropriate, dynamic and individualized.

Services participating in the study also reported a number of systemic barriers that limit their capacity to respond to young people with mental health or comorbid issues. These include:

- Staffing numbers and case load levels
- Lack of flexibility and range of accommodation models
- Limited access to and collaboration with specialist services such as mental health (Keys et al 2005)

Staffing levels and caseload levels significantly affect the capacity of services to provide more intensive support to a young person. Services stated that they often faced difficult decisions around prioritizing young people's needs, compared to other clients needs, and staff occupational health and safety.

For example, a young person in a youth refuge may be suicidal and require intensive support over a period of a week, but staffing levels do not allow for more than one worker to be present in the refuge at any time. This means that the other residents may not be receiving the daily support they require, and may also experience trauma and distress, should a suicide attempt be made. A young person exhibiting violent behaviour may pose a risk to staff or other clients, unless they can be accommodated in single person accommodation.

Accommodation models significantly affect the capacity of services to accommodate young people with mental health issues. Much of the youth specific homelessness assistance accommodation requires young people to share with other young people experiencing homelessness. This may be in a congregate accommodation facility such as a youth refuge, where common areas or bedrooms are shared, or a transitional housing property where young people live more independently and share a two bedroom flat or house.

Young people with mental health issues can find shared arrangements extremely difficult, as can their co-residents. Unless there is intensive support from specialized mental health workers in addition to the general homelessness assistance support, the accommodation arrangements can break down fairly quickly. More creative and flexible accommodation is required within homelessness assistance services, in addition to specialized mental health support.

Recommendations

2.16 That specialist youth mental health training be developed targeting homelessness assistance agencies working with young people.

2.17 That the Senate Committee make a recommendation to the relevant Federal Minister that staffing levels to homelessness assistance services be more flexible to allow workers to respond intensively to young people with mental health issues.

2.18 That the Senate Committee make a recommendation to the relevant Federal Minister that more flexible accommodation models be developed across Victoria, to enable homelessness assistance services greater capacity to accommodate young people with mental health issues.

Conclusion

Young people are over-represented not only in relation to the numbers of people affected by mental illness, but homelessness also. However the resource and practice responses to young people experiencing mental health issues and homelessness tend to lack coordination. As a generalist service response to young people, homelessness assistance services are often struggling to accommodate homeless young people experiencing mental health issues. Additionally there is a lack of youth specific and culturally appropriate mental health responses, particularly in rural and regional areas.

CHP is keen to see the principles and strategies identified in Responding to the Mental Health Needs of Young People in Australia Discussion Paper incorporated into a National Youth Mental Health Strategy, with complementary and locally relevant State/Territory Youth Mental Health Strategies supporting the national focus. We look forward to the opportunity to have further input into this process, with a view to improving the outcomes for young people experiencing mental health issues and homelessness.

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