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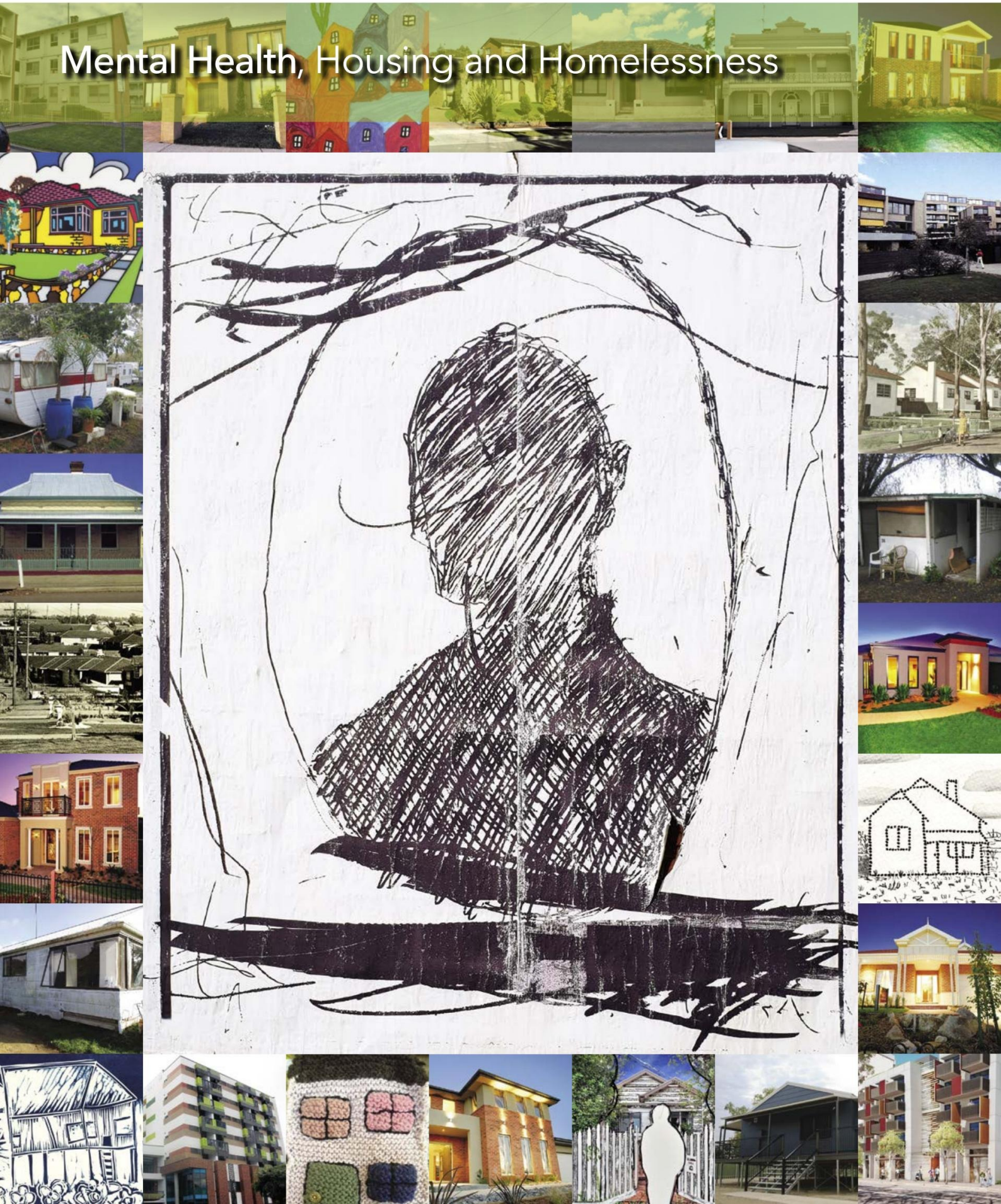
## Mental Health, Housing and Homelessness



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## *Parity*
### Australia's national homelessness publication

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**The 2020 *Parity* Publications Schedule**

| | |
|---|---|
| *June:* | Reforming Private Rental |
| *July:* | Meeting the Needs of Homeless Veterans |
| *August:* | Supporting and Sustaining Tenancies in Community Housing |
| *September:* | Implementing the Royal Commission into Domestic and Family Violence |
| *October:* | Homelessness Among Older Women |
| *November:* | Responding to Homelessness in WA (TBC) |

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# Editorial

Jenny Smith, Chief Executive Officer, Council to Homeless Persons

## Homelessness and mental ill health: without housing there is no way out

This edition of *Parity* is an exploration of the latest practice models and outcomes in preventing and ending homelessness for those with mental health conditions. However, this is only a partially accurate description. It breaks my heart to underline that so much of this edition speaks to the daily challenge of trying to support people without homes who have insufficient access to the mental health services and supports they need. The edition demonstrates the herculean effort required by all participants in this process, to just keep treading water rather than drowning in despair.

At least 30 per cent of those aged ten and over, who seek help from a specialist homelessness service in Australia have a diagnosed mental health issue.[1] This incidence is obviously far higher than the national rate of 18.2 per cent of Australians with a mental health condition.[2] Research demonstrates the obvious, that housing insecurity both causes and prolongs mental ill health. A major Victorian study found that just 15 per cent of people accessing specialist homelessness services had mental health issues prior to experiencing homelessness, while another 16 per cent only developed mental ill-health after their experience of homelessness commenced.[3]

The main reason mental ill-health results in homelessness, is that it forces people into poverty. When people are too unwell to work, experience discrimination in employment and rely on Centrelink incomes, they simply cannot afford housing in Australia's private rental market. For many people experiencing mental ill health, cheaper forms of housing, like share housing, are not workable options. This forces them into marginal forms of housing, like rooming houses, or transient accommodation, such as couch surfing, and ultimately to sleeping rough. Homelessness denies people the safety, space, and security they need to recover their mental health. In all forms of homelessness homelessness, all too often people encounter new and additional traumas that further erode their health.

This cycle of harm highlights the importance of prevention and early intervention. By preventing the entry into homelessness by someone struggling with mental health issues, the less likely they are to spiral further down and become seriously unwell. The faster we re-house people in the earliest stages of homelessness, the quicker their path to recovery and to sustaining the improvements achieved through mental health care.

We are currently in an unparalleled moment in history, when around the country thousands of people experiencing homelessness have been provided with temporary accommodation in hotels. This demonstrates that with the right investment, there is no need for people to sleep rough. However, if we look closely at the initiative, it is also clear that while it is an important step forward, it is not the whole solution. There has not been enough staff available to support all those provided accommodation. Where many people have been accommodated in the same hotel, pressures created by having many highly vulnerable people in one place without support have emerged, and in that context, some hotel occupants have felt unsafe.

This reinforces what we have long advocated. While temporary accommodation is important, a temporary room can never be a home. In order to deliver the environment of home that is so foundational to people's health and well-being, people need a proper home that meets basic community standards. Many people also need some support to transition to this new arrangement and support to sustain a tenancy.

This edition highlights how the failure to provide housing to people who are experiencing or at risk of homelessness and who are also experiencing mental ill health, exacerbates demands on acute mental health services. Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.[4] The number of Australians who have been discharged

from psychiatric hospitals into homelessness has grown by 49 per cent over the past five years.[5] Overall, the number of people referred to homelessness services from mental health services has grown by 46 per cent over the past five years.[6]

The obvious nexus between mental ill-health or mental illness and homelessness is not contested anywhere and you don't have to be student of Maslow's hierarchy of needs to appreciate that having secure housing is foundational to well-being. This is not in any way to suggest that all mental health issues are housing issues or that mental ill-health can be resolved by housing alone. Mental health service systems around the country are under unbearable pressure. However, the reform of mental health systems and services alone, will not necessarily assist those experiencing homelessness with complex mental health conditions. For these people, mental health reform needs to start with access to secure and sustainable housing.

While the cycle of harm created by the intersection of mental illness and homelessness can make pathways to wellness seem impossible, this edition of *Parity* highlights how recovery is possible with the right combinations of safe, secure and affordable housing and support. For many whose cycle of homelessness has become entrenched, assertive outreach is also critical to connect people to the services they need. Clinical mental health outreach, provided by health professionals, is also a vital ingredient in minimising the damage wreaked on people's health while they are homeless.

Given the inaccessibility of the private rental market, the only realistic option for people who are on our lowest incomes is social housing subsidised by government. While this is obvious, the sooner that this is acknowledged and made central to mental health care, the sooner we can get on with developing and delivering the best and most effective models of social housing.

It is also obvious, that for those experiencing long-term homelessness, including those with complex mental health issues, that Housing First is the evidence based response. The need for a secure and stable home with appropriate supports to allow the home-maker to flourish and to keep that home, is obvious. Not only does all the evidence show that Housing First is effective, these programs are efficient and save resources and imposts on the public purse, and most importantly they save lives.


## Acknowledgements

This edition was produced with the support and assistance of our wonderful edition sponsors: Neami National, Wellways, Orygen, Uniting Vic Tas, Micah Projects, cohealth and Mind Australia. Without their continuing support, this edition of *Parity* would not have been possible.


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# Housing Must Be Recognised as an Essential Component of Mental Health Care

Damien Patterson, Policy and Advocacy Officer, Council to Homeless Persons

The rate of homelessness among people with mental illness is shockingly high. This is particularly true for people with severe mental illness. An Australian study of people with psychosis found that at any point in time one in 20 had no home. Across the course of a year, one in eight would spend time homeless.[1]

The sad reality is, that this result is an inevitable consequence of our policy settings; of workplaces with too few rights for workers with mental illness, of social security payments set deeply below the poverty line, of cuts to social housing so that each day it's harder to get a home than the day before, and of distorting tax settings that mean the private rental market no longer offers affordable options. In this environment, mental illness causes poverty, and poverty causes homelessness.

## Mental Illness Causes People to Live in Poverty

Poor mental health is associated with reduced employment,[2] and 34 per cent of those receiving the Disability Support Pension (DSP) are doing so due to mental illness.[3]

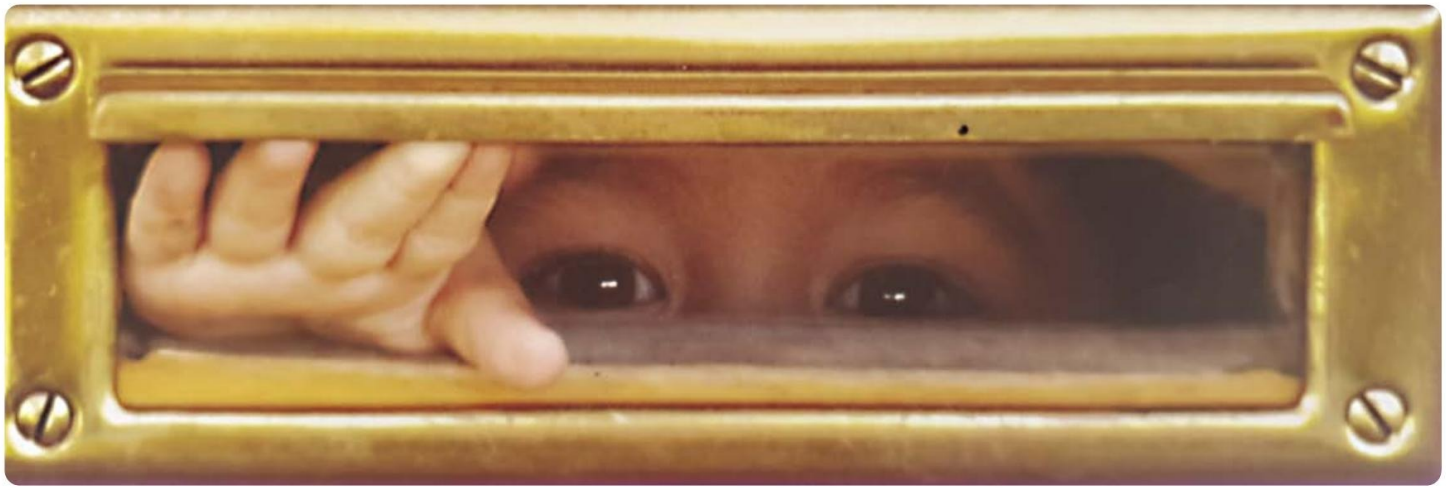
Many other people experiencing significant mental illness receive the JobSeeker (Newstart) Allowance, which is ordinarily lower than the DSP.[4] Ordinarily, the Disability Support Pension is just 28 per cent of the average adult full time earnings, while JobSeeker is just 17 per cent.[5,6] Such a low income leaves many people living in poverty.[7]

For people with low prevalence, high severity illnesses, the risk of poverty and of homelessness is particularly high. Centrelink is the main source of income for 85 per cent of people with psychotic illnesses. A 2010 study found that the vast majority of people with psychotic illnesses had incomes of less than $400 per week.[8]

## The Private Rental Market Does Not Adequately Provide For People Living in Poverty

The private rental market provides very few options for people living in poverty, including many people whose poverty results from mental ill-health. Across all of metropolitan Melbourne there were just 30 rental properties let in the December 2019 quarter that would have been affordable to a single person on Newstart,[9] and just 164 affordable rentals available across the entire state. Analysis of the approximately 70,000 rental properties advertised across Australia on the weekend of 21 March 2020 found that just nine were affordable to a person on the JobSeeker payment.[10] Crucially, this number increased to 1,040 when the temporary 'coronavirus supplement' is applied, demonstrating the importance of increased welfare payments to people's ability to access housing. These findings continue a prolonged downward trend in the availability of housing affordable to those on our lowest incomes.[11]

Even those few properties that are affordable to a person on a Centrelink income are likely to be leased to households on higher incomes.[12] Ensuring that housing is available and affordable to those who need it most will require governments to invest directly in social housing. Given that there are already 385,000 at-risk households who do not have access to affordable housing, an immediate and significant investment in social housing is required, as well as strategies to provide a pipeline of affordable housing into the future.[13]



The enhanced security of tenure in social housing also provides greater security, which has a positive impact on mental health.[14]

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

The lack of social housing means that when mental illness leads to poverty, this often results in homelessness. In 2018–19, 32 per cent of those aged ten and over who sought help from a specialist homelessness service in Australia reported a diagnosed mental health issue.[15] This incidence is far higher than the 18.2 per cent of Australians who have a mental health condition.[16]

## Homelessness as a Cause of Mental Illness

While mental illness causes homelessness in the ways described thus far, it is also true that homelessness often has serious impacts on people's mental wellbeing. The material realities of homelessness cause significant stress, and commonly mean prolonged periods where people have little chance to eat well or sleep soundly. People without a home are often vulnerable to traumatic experiences, such as experiencing or witnessing violence. Perhaps most notably, the experience of homelessness is denoted by feelings of disconnection, powerlessness, and low self-worth. Under such circumstances, it is perhaps surprising that the rate of mental illness among people experiencing homelessness is as low as 32 per cent. It is clear that a safe, adequate, and stable home is an essential precondition for mental health, and must be considered as a component of mental healthcare.

## Findings from Victoria's Royal Commission into Mental Health

Victoria is currently undertaking a Royal Commission into Mental Health. The Commission's interim report released in November 2019, published important and previously unseen data on specialist homelessness service system use by users of Victoria's acute mental health service system. The data shows that 17.3 per cent of people who exited a public acute mental healthcare service in the 2017–18 financial year also accessed a specialist homelessness service in that year.[17]

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

We know that homelessness increases people's use of acute mental healthcare, and the revolving door of people exiting mental health care into homelessness and then returning to care, adds to this demand. In order to reduce demand on mental health services, and make the most effective use of acute mental health services, people with chronic homelessness and severe mental illness should be provided with access to housing that they can afford.

## Conclusion

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

The rate of homelessness among people with mental illness is extremely high and must be addressed. For many people, mental illness requires them to live on Centrelink incomes far below the poverty line, making it very difficult for them to gain and sustain housing. This can be addressed in a number of ways, including improving the employment protections and support for people with mental illnesses, increasing Centrelink incomes, and improving the affordability of the private rental market for those on low incomes. However, the most impactful way to break the connection between mental illness and homelessness is to provide more social housing directly targeted at people experiencing mental illness and risk of homelessness. Alongside necessary supports, access to social housing not only ends a person's homelessness, but improves their mental health, and decreases their use of acute mental healthcare.

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# *'You feel worthless and you feel like you don't belong anywhere'*: The Impact of Housing on the Lives of People with Serious Mental Ill-health

Elise Davis, Sarah Pollock, Nadine Cocks, Mind Australia

## Background

Although access to safe housing is a basic human right,[1] housing needs are often unmet for the two-to-three per cent of the population who experience severe mental ill-health.[2] The cost of housing is a major factor in determining the type of housing people can access. With over 200,000 people on the waitlist for public housing,[3] securing long-term accommodation can be challenging. Private rental is largely unaffordable for people receiving Newstart and difficult for those receiving the Disability Support Pension. Not having stability in housing, combined with periods of being unwell and a lack of supports, means that periods of homelessness may occur. This is supported by the evidence demonstrating that the prevalence of severe mental ill-health is higher among homeless people than the general population.[4]

There is research on the housing and mental health interface, particularly on the system and policy level factors and the evaluation of specific housing and mental health programs. Much less is known about the lived experience and the impact of different housing types on mental health, with the exception of supported accommodation. A meta-analysis of qualitative studies demonstrated that supported housing was important for privacy, sense of control and enabling people to rebuild their lives although loneliness was an issue.[5]

What remains unknown however is the impact of housing on the lives of people with mental ill-health from the perspective of people with lived experience. The aim of this paper is to draw on qualitative research with people with lived experience of mental ill-health and housing difficulties to explore the impact of housing on their lives.

This paper is based on qualitative data collected as part of a larger study examining the intersection between housing and mental health. Trajectories is a national study conducted in partnership with Mind Australia and the Australian Housing and Urban Research Institute (AHURI). Ethics approval was obtained from the University of Wollongong for this study (2018/402). Interviews and focus groups were conducted with consumers (people who self-selected on the basis of having mental health and housing issues) and carers (people who care for someone who has mental health and housing issues). Interviews focused on people's personal accounts of their mental health and housing journeys. A grounded textual analysis, which allows categories to emerge from the data, was applied to the interviews and focus groups. Key themes reflecting the impacts on housing were identified.

The paper is based on the perspective of 86 participants recruited from the following areas Melbourne, Wangaratta, Sydney, Bathurst, Brisbane, Mackay, Adelaide, Berri, Hobart and Perth, Demographic data were collected for 83 people, including 63 consumers and 20 carers. Forty-five percent of the sample identified as female and the average age was 42 years. Participants in this study experienced many forced moves, housing insecurity and short-term housing experiences. Further information about the demographic characteristics of the sample can be found at *https://www.ahuri.edu.au/research/trajectories*

## Housing Experiences and Impact of Housing

Housing and the living environment affected several major areas of participants' lives, including their financial situation, feelings of safety, feelings of security, self-worth, relationships, perceived control, their environment and their ability to obtain employment (as demonstrated in Figure 1).

**Figure 1: Impact of housing**


Source: The authors.

## Housing and Financial Situation

The cost of housing not only impacted on the type of housing participants could afford, but also the extent to which participants were able to engage in other activities needed for a well-rounded life, including basic mental health support.
The decision to get mental health support needed to be weighed up against other essential living costs. There was also a financial impact of housing for carers who were paying rent or a mortgage for their family member. Where they were paying the mortgage costs for a dwelling they owned, but their family member lived in, their pensions were negatively affected because the property was seen as an investment property.

## Feelings of Safety

Most participants had housing experiences where they felt unsafe. This could be due to insecure housing (for example, broken locks) or to the negative behaviour of neighbours or other people in the neighbourhood (for example, substance misuse, violence or yelling). Carers also reported feeling unsafe at times when the person for whom they were caring was experiencing periods of acute illness and distress.

> *'And so, this particular person* [in a boarding house] *just absolutely lost it, which was just — and I was just shaking for the rest of the day. And so today when I heard that she was up and about, I didn't even come out to rest.'*
>
> — Consumer, Adelaide

## Feelings of Security

Short-term housing and transitional housing, while providing the person with a safe place to live, also created a lot of stress and anxiety about needing to find somewhere else to live in the long-term.

> *'… you've had this place at the time, over three months, and they've got other people to come in there, so then you're going to be homeless. So just extra stress: oh God, I've got something else to worry about.'*
>
> — Consumer, Sydney

## Self-worth

Feelings of worthlessness can come from, or be exacerbated by, a lack of secure housing and the process of getting assistance for housing. Participants spoke very negatively about their experiences with public housing staff.

> *'You feel worthless and you feel like you don't belong anywhere.'*
>
> — Consumer, Bathurst

## Relationships

Some housing experiences had negative effects on participants' relationships. Living with family placed significant pressure on both the familial relationship and the carer, and in some cases contributed to a permanent relationship breakdown. Housing played an important role for participants who were parents who may have lost access to their children.

> *'I've got a four-year-old son. I'd like at least a two-bedroom place so when I do have him unsupervised if he stays overnight, he's got a room. I get laughed at.'*
>
> — Consumer, Bathurst

## Perceived Control

Housing experiences were marred by an underlying lack of control over the process, in terms of both applying for housing and then maintaining the house. In public housing and private rental, participants felt significant pressure to maintain the house to someone else's standard.

## Environment

For several participants, the physical environment was part of what distinguished some of their best housing experiences. Participants also talked about the importance of being close to services and supports.

> *'It was bliss. It was so peaceful there. I didn't have any mental health dramas at all… It's in a quiet and cosy place and it's surrounded all by nature.'*
>
> — Consumer, Brisbane

## Employment

Some participants were too unwell to work, but even if they were able to work, the interdependency between housing and employment made securing either difficult.

> *'I've rung countless places [for housing] and they will not even give you their address if you're not working… For a job they want to know, where do you live? I don't want to lie yet I want to protect my chances of getting a job as well.'*
>
> — Consumer, Sydney

## Discussion and Implications

The results from this study demonstrated the far-reaching and cumulative impacts of housing on the lives of people with serious mental ill-health and their families and/or carers. The impacts of housing tended to be negative and have a negative impact on mental health. Employment, mental health support, social support, perceived control, feeling safe and security — all fundamental to mental health — were compromised for the participants because of their housing situation. The impact of this for someone who already has mental ill-health is significant and can contribute to major declines in mental health.

Access to safe secure housing is fundamental to, and the foundation of mental health recovery. The impact of not knowing when public housing would become available (if ever) has a negative impact on mental health. Even in transitional housing, participants felt like their life was on hold until they knew what would happen to them in the long-term. They held off taking next steps in their recovery such as employment, study, volunteering or trying to find or reconnect with family, friends or a partner until they had some stability and some sense of what their future would hold.

Several recommendations have emerged from the Trajectories project and reports can be accessed from https://www.ahuri.edu.au/research/trajectories. One of the recommendations that is clearly relevant to these analyses is that there is a clear need for medium-term responses that provide housing and support (up to three years). Short-term housing arrangements do not provide enough stability to enable people to focus on their mental health and start to work on their recovery. Medium-term housing arrangements would provide that stability. Support is needed in addition to housing to ensure that any changes in mental health/challenges are recognised early and supports are put in place to protect tenancy.


## Acknowledgements

We would like to acknowledge the participants in this study, our partners in the study and the AHURI team. We would like to acknowledge our peer researchers, who created a safe space for the participants and very generously shared their insights and experiences with the participants and team. These include Rebecca Egan, Greta Baumgartel, Philippa Hemus and Anthony Stratford.


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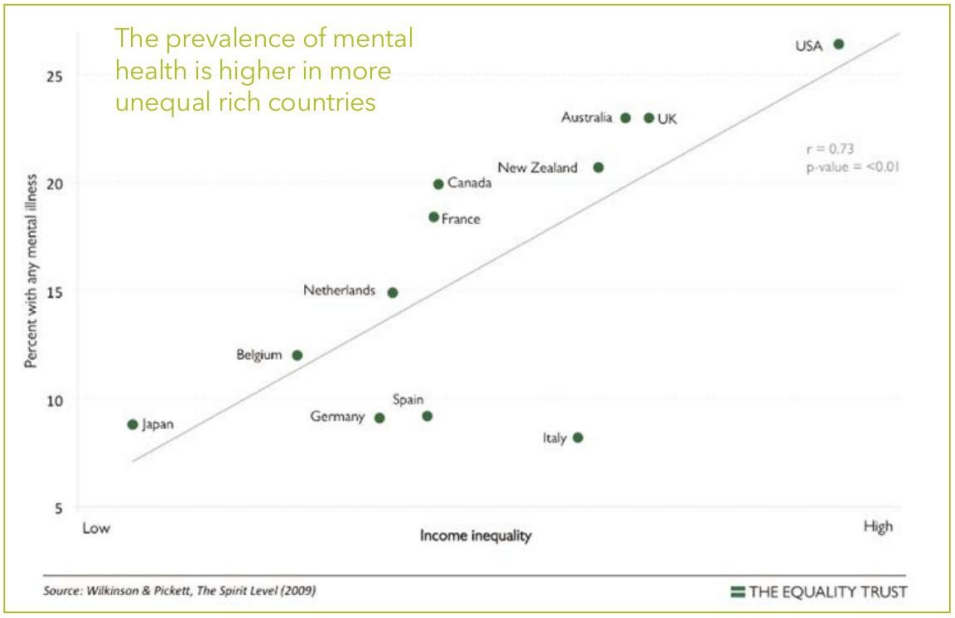
# Homelessness and Mental Illness: An Unhealthy Co-dependency

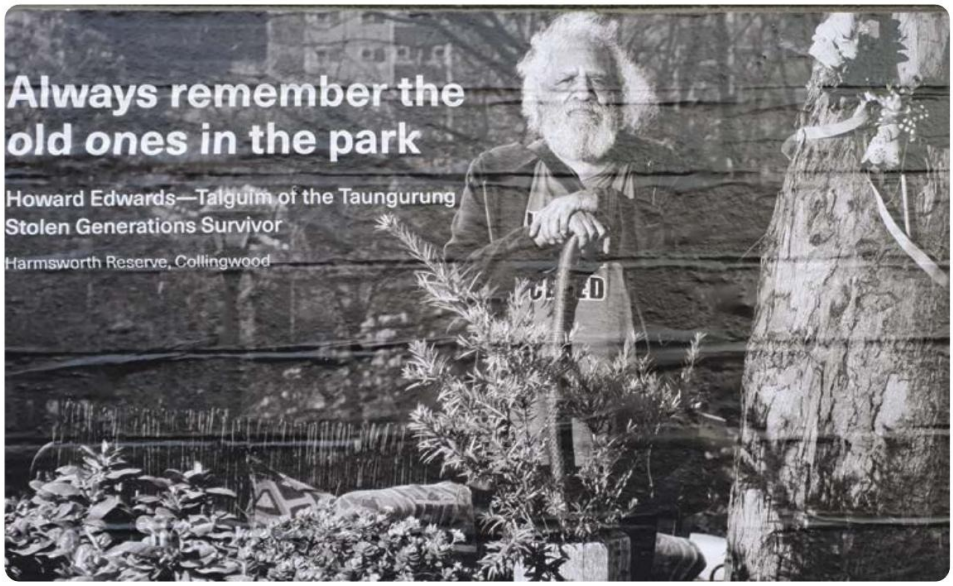
Peter Jones, Senior Policy Officer, Aboriginal Housing Victoria

## Introduction

During a time of global pandemic, new comparisons are being made between the health response of nations and our relative success in protecting citizens from harm. On Covid-19 infections Australia has performed well so far.[1] When it comes to mental health the jury was in some time ago: citizens living in more unequal wealthy nations are burdened with a higher level of mental illness than citizens living in more equal developed nations. In their ground-breaking work, *The Spirit Level*, the star United Kingdom (UK) epidemiologists of the time (2006) Wilkinson and Picket found that more unequal nations and states fared worse on social outcomes on almost every measure. When it came to mental health they had this to say:

> *'We first showed a relationship between mental illness and income inequality in eight developed countries with World Health Organisation data — the United States, France, Netherlands, Belgium, Spain, Germany, Italy, and Japan. Since then we've been able to add data for New Zealand and for some other countries whose surveys of mental illness, although not strictly comparable, use very similar methods — Australia, the UK and Canada. As the graph above shows, mental illness is much more common in more unequal countries. Among these countries, mental illness is also more common in the richer ones.'*[2]




These findings resonate with the experience of the Victorian Aboriginal community, where being granted fewer opportunities in a rich nation impairs mental wellbeing. This has its clearest expression in housing poverty, where if we had league tables on the burden of disadvantage, Victorian Aboriginal people would reluctantly appear near the top of all national charts. This goes hand in hand with a well-documented legacy of intergenerational trauma arising from systemic discrimination and a wealth and housing deficit — the hangover from two centuries of exclusion from economic participation.

## Scale of the Homeless Challenge for Aboriginal Victorians

For each of the past two years 17 per cent of Aboriginal people in the state of Victoria (compared with 1.7 per cent of Victorians as a whole) sought assistance from specialist homeless services.[3] Increasingly these people are not newly homeless, they have been to the well of specialist homeless services a number of times before but have been unable

| Service assistance type needed by ATSI Victorians 2015–2020 | Need identified in ATSI clients | Need identified as % of ATSI clients | Provided only | Provided and referred | Provided as % of need identified | Referred only | Not provided or referred |
|---|---|---|---|---|---|---|---|
| Long-term housing | 10,605 | 48.3% | 400 | 316 | 6.8% | 3,168 | 6,721 |
| Medium-term/transitional housing | 8,017 | 36.5% | 1,554 | 932 | 31.0% | 1,081 | 4,450 |
| Short-term or emergency accommodation | 10,077 | 45.9% | 4,673 | 2,412 | 70.3% | 643 | 2,349 |
| **Total** | **14,194** | **64.7%** | **4,760** | **3,980** | **61.6%** | **1,728** | **3,726** |

Table 1: Housing assistance received as a proportion of needed by Aboriginal Victorians 2015–2020[4]

to secure the long-term affordable housing which would stabilise their situation. Three quarters (76 per cent) of Aboriginal people accessing Victoria's specialist homeless support services from July 2019 to February 2020 had been in the system before.

From one perspective we may suppose it a strength that the system has not given up on these people. But we also know that fewer than seven per cent of Aboriginal people entering this system and assessed as having a long-term housing need received long term housing between 2015 and 2020 as the table above shows. These people are often in an entropic cycle of crisis. We know that they often shed confidence, family support and hope as this cycle continues without them attaining the stable housing which would allow them to reset their lives. The quotes from the recently published Trajectories report (Trajectories: the interplay between housing and mental health pathways) by MIND and AHURI researchers eloquently make the point.

> *'People who are cycling enter and drop out of housing, homelessness and mental health systems repeatedly. Cycling is characterised by a strong downward trajectory. This means that each time a person enters and drops out of the system their resources (for example, housing, social relationships, financial resources) are further eroded, with detrimental effects for their housing stability and mental health. In the most severe cases, prison becomes the final destination.'*[5]

> *'You can't get back what you lost on the way down.'*
>
> — Consumer, Brisbane

## An Unhealthy Co-dependency

In our submission to the Royal Commission into Victoria's Mental Health System, Aboriginal Housing Victoria argued that there was at times a symbiotic relationship between homelessness and mental illness in our state, characterised by both:

- the trauma and disorientation homelessness has in triggering first episodes of mental illness and in compounding existing acute mental health conditions, and
- the effect that mental illness has on destabilising housing security.

The important research report published by AHURI and MIND in February 2020 (*Trajectories: the interplay between housing and mental health pathways*) puts beyond doubt the existence of a profound reciprocal reinforcement of homelessness and mental illness in Australia. The first two major findings of the trajectories report (based on extensive literature review, analysis of longitudinal data including the Household, Income and Labour Dynamics in Australia Survey,[6] interviews and focus groups with carers and people with lived experience of mental ill-health and focus groups with housing and mental health services) were that:

1. 'Housing is the foundation for mental health recovery.'
2. 'Mental health, housing and homelessness are interrelated'.

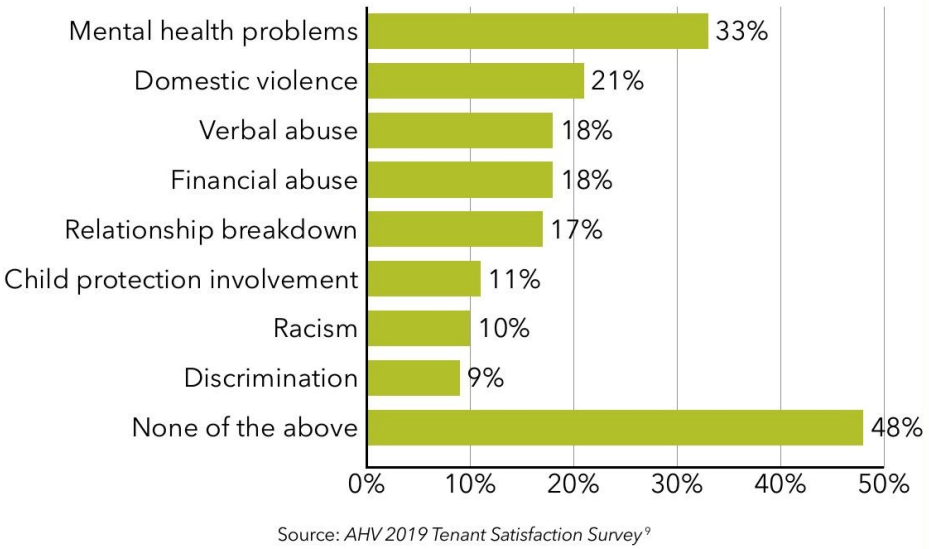
In the Aboriginal Housing Victoria (AHV) submission to Victoria's Mental Health Royal Commission we argued that:

> *'Many aspects of treatment for mental health conditions may be contested, have side effects or be inconsistent in their efficacy. However, providing mentally ill people with secure housing is not contested, makes long-term treatment viable and is consistent in its efficacy in reducing symptoms, removing trauma and providing a platform for recovery. Without twinning treatment with safe, secure housing the mental health service system is being set up for failure. In juxtaposition, a commitment to invest in secure housing for disadvantaged people is the surest, most effective investment the Government can make in improving mental health outcomes.'*

The *Trajectories* report reinforces this assertion. We know that the relationship between mental health issues and homelessness cuts in both directions. Mental health problems are implicated in one in four Aboriginal presentations to specialist homeless support services (11.4 per cent of Aboriginal Australians who present to homeless services do so primarily because of a mental health issue; a further 8.6 per cent with issues of mental health and family violence and a further 4.6 per cent with issues of family violence and mental health and drugs/alcohol).[7]

Meanwhile 96 per cent of people experiencing serious psychological distress are more likely to experience financial hardship within two years,[8] which in many cases undermines housing security.

The blindingly obvious point to be made about this is that the massive deficit we have in affordable housing in Australia must be tackled if we are to successfully address our high rates of mental illness. Machiavelli's




Source: *AHV 2019 Tenant Satisfaction Survey*[9]

Figure 1: Aboriginal Housing Victoria Tenants Satisfaction Survey 2019

view that governments should 'never waste the opportunity provided by a good crisis' comes to mind as community housing providers advocate that economic stimulus be injected into the housing market to build the affordable housing which will be demanded during a period of extended economic recession. Secure housing is critically important but we need to couple it with care and support for vulnerable people, especially those recovering from mental health challenges.

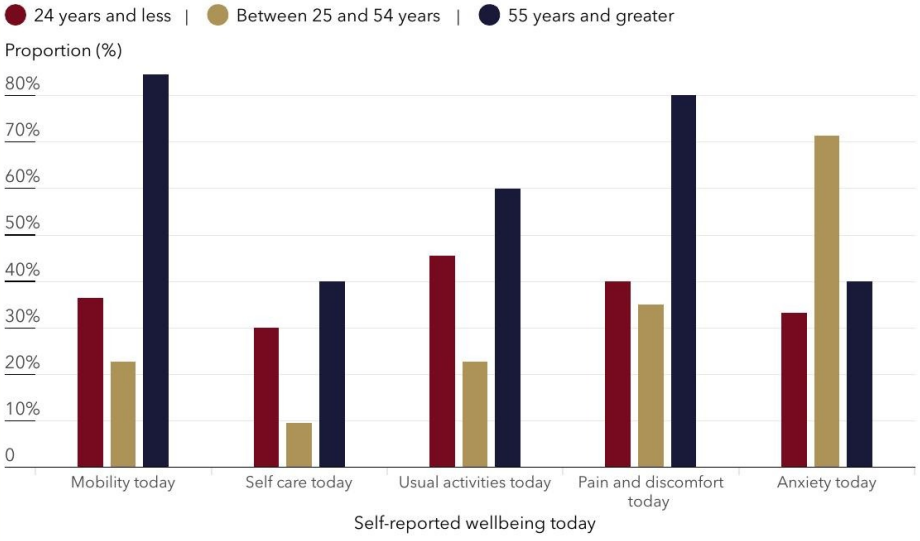
## Common Antecedents to Homelessness and Mental Illness

Significant life course events can have a major effect on housing stability and security. Aboriginal people experience many of the events that impel people simultaneously towards housing distress and mental health crisis more frequently and more acutely. This helps explain why Aboriginal people are at least ten times more likely to be homeless and at least twice as likely to experience a significant mental health issue. While people who have stable, secure and high quality housing are less likely to experience life event crises and are better placed to weather them when they arise, Aboriginal people are the group in the Australian community least likely to enjoy this inbuilt protection.

One third of the tenants of AHV's properties identify having experienced mental health problems. More than 70 per cent of our working age tenants were experiencing anxiety on the day of our 2018 survey of tenants. Mental health problems are more common than domestic violence, relationship breakdown or any other challenge that may place a tenancy at risk. More than two thirds of our tenants tell us that their life has improved significantly as a result of being securely housed. However, without intensive support of their psychological wellbeing, we estimate that at least one third of our tenants may be at risk of re-entering homelessness. Providing psycho-social support to these people once securely housed is critically important to help them rebuild their lives. One model for doing this is described later in the article.

While the experience of homelessness can compromise mental health and mental illness can destabilise housing, both experiences share some common antecedents and common protective factors. In particular, some of the precarious life course transitions that place people at risk of mental health crisis also place them at risk of homelessness. Dislocating transitional experiences of this kind include:

- young people leaving care and protection
- elders unable to secure culturally sensitive aged care support (many of whom will be stolen generations)
- young people relocating for education, training or work
- families experiencing child removal, family breakdown or family violence
- people seeking transition from justice facilities
- people who acquire a physical, psychiatric or intellectual disability.
- people who become drug dependent and/or experience co-morbid psychosis.




Source: *More Than a Landlord Household Pilot Study Report* (June 2018)

Figure 2: Aboriginal Housing Victoria Tenants Satisfaction Survey 2018: Individual Health and Wellbeing by Age

## Compound Disadvantage

Much more support is required for all people making these difficult transitions. But all of these experiences are vastly more commonplace in Aboriginal communities and much more likely to occur in clusters. A study undertaken in Western Australia (WA) in the mid-2000s underlines the quantum of deeper distress with which Aboriginal communities are unfairly freighted.

Professor Fiona Stanley's Telethon Institute conducted the Western Australian Aboriginal Child Health Survey in the mid-2000s which found that more than one in five Aboriginal children aged 0 to 17 (22 per cent) lived in families which had experienced 7 to 14 major life stress events in a single year. This pattern was true regardless of whether these Aboriginal families were living in metropolitan or regional and remote areas of WA. The results in the mainstream population were in the order of 0.02 per cent of the population experiencing similar levels of stress (a 1,000-fold difference).

These levels of toxic stress were found to be precipitated by extreme poverty (such as homelessness), severe maternal depression, substance abuse, family violence and abuse and neglect. Living in a family under this level of stress was found to magnify the risk of clinically significant emotional or behavioural difficulties by seven times.[10] Other data suggests that similar patterns of toxic stress continue to be experienced by Aboriginal children and families in Victoria. At the root of this psychological morbidity is acute housing and income poverty, housing instability, homelessness and intergenerational trauma.

> *'Life stress events. Over 20 per cent of Aboriginal children were living in families where seven or more major life stress events had occurred over the preceding 12 months. These children were over seven times as likely (Odds Ratio 7.34; CI: 4.30–12.7) to be at high risk of clinically significant emotional or behavioural difficulties than children in families where two or less life stress events had occurred. This variable is the strongest predictor of emotional and behavioural difficulties in Aboriginal children.'*
>
> — Western Australian Aboriginal Child Health Survey 2005, p.138

To take one example of the outworkings of this entrenched disadvantage, almost one in ten Aboriginal young people in Victoria (88 per 1,000) live in out of home care.[11] A 2009 CREATE foundation survey of young people leaving state care found that within a year of leaving care: 35 per cent were homeless; 46 per cent of boys were involved in the juvenile justice system; and 29 per cent were unemployed.[12] Other Australian research suggests more than 40 per cent of this cohort are pregnant in adolescence (Care Leavers Network), extending the cycle of vulnerability to a new generation.

The over-representation of Aboriginal young people in out of home care and the over-representation of this cohort in the homeless population within a year of leaving helps explain why more than half of the Aboriginal people in contact with homeless services in Australia are aged under 25.

Australian authorities face a major challenge to reduce the psychological vulnerability of young people leaving care. Extending care to the age of 21 would be an important first step. We know that doing so has been shown in other jurisdictions to significantly reduce homelessness (50 per cent), hospitalisation (35 per cent), arrest (45 per cent) and substance misuse (532 per cent) and to dramatically increase opportunities to pursue further education (150 per cent).[13]

More broadly, much greater support is required for vulnerable people making significant transitions. Memoranda of Understanding are required to transform human services into service systems, which place people at the centre of the 'system' and recognise that the most vulnerable are least likely to be able to navigate services (including housing and mental health services) which fail to interconnect. Cultural safety in mainstream services is vital if Aboriginal people are to avoid breakdown of their care.

## Aboriginal Housing Victoria is More Than a Landlord

While the AHURI/MIND Transitions team has demonstrated that 'housing is the foundation for mental health recovery', they also argued that the housing platform requires additional supports for full recovery. Fundamental policy ingredients for success (in addition to safe, secure and affordable housing) according to their analysis include:

- connection to a key worker
- support, co-ordination, assistance and advocacy to navigate the system
- access to psycho-social support
- financial security
- holistic support that meets the level of need
- timely access to support
- trauma counselling
- culturally appropriate services.[14]

For the past two years, AHV has been delivering an innovative wellbeing program to vulnerable tenants within northern metropolitan Melbourne. Had the *Transitions* template of policy recommendations (summarised above) been available at the time of the design of the program it could not have more closely resembled its essential features. This is qualified by our limited capacity to deliver financial security, except by providing very low cost housing.

AHV's support for Aboriginal tenants through our *More Than a Landlord* program (MTAL) uses the platform of stable accommodation to build pathways out of disadvantage for people whose lives have previously been characterised by crisis and trauma. This significantly reduces demand for acute and tertiary government services.

By delivering a targeted, coordinated and household/family based approach that facilitates access to support services, MTAL aims to maximise opportunities for Aboriginal households to enjoy the broader health and socioeconomic benefits that long-term, secure and


affordable housing can provide. This insulates residents against mental health crisis and suicide risk.

MTAL features include:

- a focus on strengths and aspirations rather than needs/deficit
- Aboriginal community led health promotion initiatives
- increased opportunities for social engagement and participation
- recruitment of an Aboriginal workforce, including opportunities for AHV tenants
- integration of activities and services from a household or family perspective, consistent with Aboriginal cultural values and practices
- life coaching.

A key feature of MTAL is the delivery of life coaching. The Life Coach assists tenants and households to understand what success looks like for them and to identify goals to achieve that success; inspires them to imagine more and to achieve more; empowers them with the practical tools to do so; motivates them to sustain focus; and steers them towards success. Other resources and supports are called in as necessary.

Coaches also assist with service coordination and work closely with, but independent from, tenancy managers. The success of the role in facilitating positive outcomes for tenants and their families, has depended on AHV's ability to recruit a small but highly capable and committed Wellbeing Team.

Since MTAL's commencement the program has delivered some significant achievements. In particular, the concept of life coaching has proven to be transformative for participating tenants. AHV has been working with approximately 50 tenants and household members at different times, with Life Coaches supporting and encouraging program participants to achieve personal goals and aspirations. These include preparing 20 tenants to be 'job ready'; supporting 12 tenants into employment (full-time and casual) and another 10 in undertaking further education. These are potentially life-changing experiences for MTAL participants and underscore the importance of maintaining and expanding the program.

In recognition of the significant and positive outcomes achieved through MTAL, the program was awarded the 2019 Australian Housing Institute Professional excellence in housing award.

## Conclusion

*More Than a Landlord* is a program grounded in evidence; professionally delivered consistent with cultural values; evaluated and found to be effective, life-changing and to pass cost benefit tests. The program supports psycho-social wellbeing, reduces trauma and anxiety and helps Aboriginal Victorians identify and exercise their latent strengths and capabilities. It finds the sweet spot where housing support and psycho-social support intersect to build stability, participation and real hope for a better future. With additional resources the program could be extended to benefit hundreds more Aboriginal families in a way which would reduce demand on acute mental health and other tertiary services. Unfortunately, *More Than a Landlord* also remains, that most fragile of program initiatives, a successful pilot program.

It would be refreshing in Australian public policy if — when we identified programs that tick the boxes for success — we brought them to scale and made them available to those who could benefit. Despite the many recent reform miracles in the Australian public policy landscape wrought by a global emergency over recent months, this one appears, at least in the case of *More Than a Landlord*, still to be a bridge too far.

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# A Different Future for Supporting Victorians Experiencing Mental Health, Housing and Homelessness

Thomas Johnson Manager, Advocacy and Public Policy, Uniting Vic.Tas

Uniting believes that affordable, safe, and secure housing is an essential human right. Secure and affordable housing fundamentally underpins people's capacity to live dignified and healthy lives with access opportunities and an ability to contribute to their communities.

Uniting Vic. Tas is the community services organisation of the Uniting Church in Victoria and Tasmania. It was created in 2017 from the merger of 24 entities: 21 UnitingCare agencies, Wesley Mission Victoria and two divisions of the Synod of the Uniting Church in Victoria and Tasmania. Together Uniting Vic.Tas consists of more than 6,000 people delivering over 500 programs and services to people experiencing disadvantage, including children at risk, aged and carer services, disability and mental health, employment services, alcohol and other drug services, housing, homelessness, family violence and early learning.

We run 13 dedicated homelessness programs across Victoria in both rural and metropolitan areas. These services are the intake and assessment point for government-funded homelessness services in South-East Melbourne, Sale, Horsham, Stawell and Ballarat.

As providers of services for disadvantaged and vulnerable consumers throughout metropolitan and regional Victoria, we see large numbers of people presenting at our services who are experiencing either homelessness or housing insecurity in conjunction with poor mental health.

*People like **Josh***, a 16-year old who has a history of abandonment, trauma, emotional abuse, criminal activity, alcohol misuse and attachment issues. Josh has been at significant risk of homelessness due to relationship breakdown with his family. His mother has significant mental health issues and undiagnosed intellectual disability, which has led to extended periods of time where she has excluded Josh from the family home. Josh has no siblings and is estranged from his father who no longer wishes to have contact with him and isn't prepared to offer him accommodation.*

*With Uniting's support, Josh has set up a caravan outside his mother's home. He is attending specialist mental health services, alcohol and other drugs, youth support services and is supported by youth justice. He is also actively exploring future education and training opportunities.*

*Through family mediation, Josh and his mother are reconnecting. His mother is addressing her mental health, which has been a significant barrier to providing a stable home environment for Josh.*

***Amy*** is a 42-year-old woman who came to Uniting for help with her mental health issues. These are coupled with a history of trauma, and disengagement with mental health supports. Because of her poor communication and engagement skills, Amy has trouble finding a stable home environment — her mental health impacts her relationships with co-tenants, housemates and family. Amy also refuses to take prescribed medication.*

*Amy has experienced significant barriers as she tries to access mental health services — long waiting times, limited outreach and high costs of private treatment. The bouncing between psychosocial and clinical support has meant that her mental and physical health have deteriorated.*

*Amy no longer has a relationship with her family, nor does she have the life and living skills to engage with services to make an application to the National Disability Insurance Scheme (NDIS). When we met Amy, we brought together homelessness and NDIS support coordination teams to work with her to make some changes in her life. Amy has now secured supported residential service accommodation and applied to the NDIS. Amy is eagerly awaiting the outcome of her NDIS application which will provide the framework she needs on her journey to supported independent living.*


These are just two stories that show the undeniable connection between housing, homelessness and mental health. People experiencing poor mental health are more likely to end up homeless, while the experience of homelessness or insecure housing leads to worse mental health outcomes.

As a community service provider, our staff are always striving to make a difference and work with individuals to bring about real change. At the same time, we have to work at a systemic level to address some of the root causes of these issues, such as a lack of social and affordable housing solutions and the decline in community mental health services as a result of the move to the NDIS.

We have had two opportunities in the last 12 months to put forward our position on these more systemic issues — the Victorian Legislative Assembly Legal and Social Issues Committee Inquiry into Homelessness in Victoria and the Royal Commission into Victoria's Mental Health System. In both documents we highlighted the link between mental health and housing instability.

We are asking the Victorian Government to:

- develop a Youth Homelessness Action Plan to ensure young people are receiving the specialist services they need, including access to safe, stable and affordable accommodation, help to engage in employment, education and training, and support to maintain connection to family
- ensure that funding is enough for any child wanting to remain in care between the ages of 18 to 21 to do so
- improve transition planning to ensure every young person leaving care is adequately prepared to live independently and follow up is made.
- reinstate funding to community mental health services affected by the roll-out of the NDIS
- invest in low barrier-to-entry services (such as drop-in centres) that can act as soft entry points into mental health and housing services, while also addressing social isolation
- develop a broader definition of the mental health system and fund initiatives that coordinate linkages between the various policy areas and supports necessary, such as housing, to prevent and manage mental illness
- reshape government policies to address housing insecurity for people with lived experience of mental illness
- scale up successful models of consumer and recovery-oriented housing
- make greater use of tenancy sustainment services and capacity building in the housing sector to recognise and appropriately respond to the early warning signs of a mental health crisis.

Uniting will continue to advocate for these changes while we provide the practical support people need as they make their way toward a brighter future.

* These are real stories about real people. They have asked us to change their names to protect their privacy.

# From the Coalface: Reflections on Mental Health, Housing and Homelessness

Meg Ady, Community Health Registered Nurse, Bolton Clark*

An Ethiopian young woman with whom I have been working at a homeless youth refuge shows me in to her freshly painted public housing apartment. There is a picture of her parents on the wall, who are no longer alive. The smell of spicy beans cooking in the kitchen wafts through the whole space. We are revisiting her goal directed care plan, and she says the anxiety and sadness and longing for death which were her daily patterns are no longer bothersome. She has grief and loss issues she continues to work through with a psychologist, but the poignancy of mental distress left her as she slid the key into the lock of her new home, her permanent address, her own place in the world.

The experience of seeing a young person securely housed is sadly quite uncommon in my role as a homeless youth nurse. When it does occur, the containment and security of home means that mental health issues become a smaller part of the big picture, and not a driving, energy sapping daily factor.

The norm for the homeless young people with whom I am privileged to work, is to feel a deep sense of unworthiness. Being hurt and used and mistreated is what they expect, and being homeless and abused and neglected and having things not work out is what they think they deserve. Words like fat and ugly and horrible feel natural and comfortable, whereas the idea they are valuable and worthwhile and smart and gorgeous doesn't make sense to them.

In the process of planning care, some people already have established diagnoses. They might write down in the goals column of their care plan 'help for depression, feeling less anxiety', or ask me to write down for them 'borderline personality disorder', or 'complex post-traumatic stress disorder'. Other times there has not been contact with the mental health system. Nightmares, fear of people and being in public, a sense of danger, voices saying awful things, wrists cut in response to unbearable pain, are all things people have written down, on their goal directed care plan, wanting some help, not really believing there's any available.

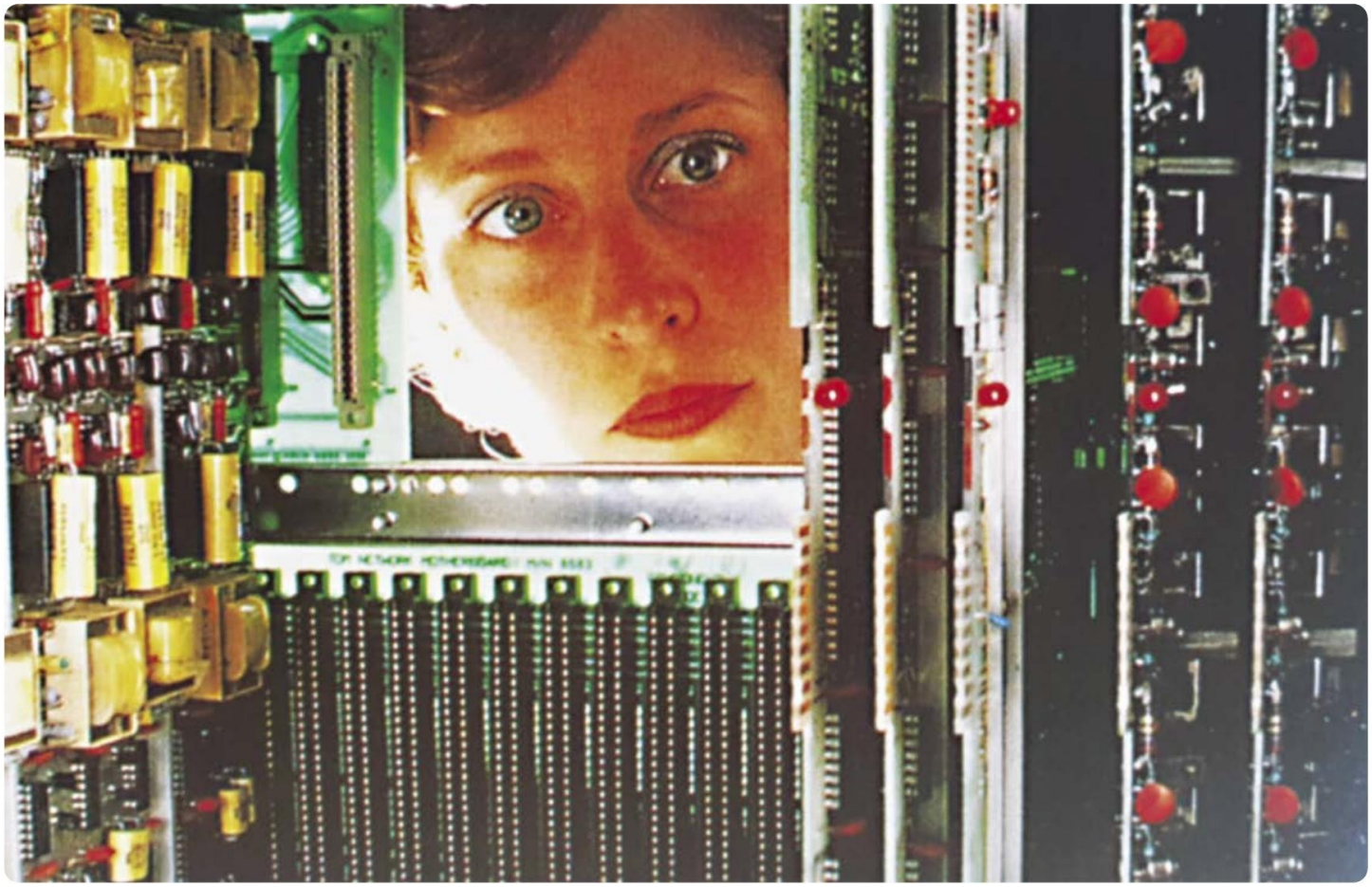
The lack of control people feel around housing makes processing trauma, and coming to terms with the difficult elements of their story very challenging. *'I don't know where I am going to go after my refuge exit date,'* a young woman whispers, looking at the ground, her thick brown hair falling over her face. *'They want me to look for shared private rental, but I can't handle sharing, with my mental health. I'll lose my temper, and get kicked out again.'* She said she had never in her life felt listened to or understood, and that she desperately wanted a place of her own, but couldn't afford anything she had looked at thus far.

Bearing witness to such deep vulnerability and fear is a sobering privilege. Tears wet her face, as she says, *'There's nothing for me in this world. No person, no place, nothing.'* As I sit with her, as she cries, I wish there were enough housing programs for all the people who are longing for a place of their own. I can't make her any promises — her housing worker at the refuge is already working hard to try and find her something.

She tells me her favourite place in the world is the Great Ocean Road, and that she went to Lorne last year, with some friends. She doesn't know when she might get to go there again. She is anxious, and we talk together through a breathing exercise, imagining she is floating in the ocean she visited, looking at the waves rhythmically pounding the beach, the birds soaring high in the blue sky, the cliffs tall and austere and crumbly. She says having this visualisation at her disposal makes her feel a little safer, a little more peaceful. We book a doctor's appointment, for a mental health assessment, and talk about phone support services, which she says make her feel shy, and counselling at Northern Centre Against Sexual Assault, which she is going to consider, and things which have helped her with her anxiety and depression.

Sometimes clients share traumatic, awful things which have happened to them, and which mean they find it difficult to trust people, and to feel safe in the world. Often, they have been diagnosed with borderline personality disorder, and believe this means there is something wrong with them. Their sense of mattering and being of value is deeply wounded. We talk about healing, feeling safe, soothing oneself when triggered, finding ways of hope and healing through all the complex issues on their plates.

It would be so lovely if an actual, real, safe home could be available to people experiencing homelessness who are struggling with mental health issues. I rarely meet a homeless person who is not struggling with mental health issues. Connecting people with good doctors, counsellors, psychologists and psychiatrists is a positive thing, but for most, there is still a gaping hole in their lives. Perhaps the most significant solution to people's mental health issues would be a safe, secure space, a window from which they could contentedly watch autumn leaves fall, a place to call home.



Since Covid-19 lockdown, in March this year, there has been a marked increase in people with whom I work trying to end their life, taking overdoses of pills, attempting to jump in front of trains and cars. The sense of being overwhelmed by their personal lives, and by the collective international experience of helplessness we are together facing, brings into sharp focus the impact of privilege on housing and mental health.

My last client for the day is an anaemic young woman, couch surfing at her boyfriend's. She is wrapped in a blanket, as there's no money to warm the room, and she is very cold. Her blood draw results indicated low iron stores, and I am bringing her the iron tablets suggested by her doctor, and a food package from Igniting Change. She is in tears. *'Every step I try to take to get out of this situation ends up with it all being worse,'* she says. *'I wouldn't ever actually do anything to harm myself, but today I just want to be dead.'* We work out a safety plan as we walk together through autumnal streets, and she talks about her feelings and thoughts and hopes and fears. She speaks of the way she feels when her boyfriend yells at her. *'Some people get to live in big, warm houses, like palaces, not surrounded by needles and yelling and dirt and poverty. And some people get to live here, in this shit-hole.'* Her words linger in my mind later, as I unlock my own front door, embraced by the warmth of central heating. My privilege creates a buffer against uncertainty. She only gets to stay in that cold house for as long as her relationship with her boyfriend is working. Beyond that, she doesn't know what is happening next. I happened to be born into a family which supported me through graduate school, meaning I can shut my front door, and be consoled by order and predictability and sustenance and peace.

Some people's lives are treated as being more valuable than others. Responses around the world to the Covid-19 pandemic exemplify this. Judith Butler, in *Frames of War: When is Life Grievable?* says: *'One way of posing the question of who "we" are in these times of war is by asking whose lives are considered valuable, whose lives are mourned, and whose lives are considered ungrievable.'* It is deeply unfair that I get to go home to a warm house, to process the complexity of Covid-19 in comfort and peace, whilst the young person I have left behind is cold, and wouldn't have had food for dinner if it wasn't for Igniting Change putting together a package for her. There are so many steps to be taken to establish stable housing and good mental health support. This ambiguity and uncertainty is something I can neatly leave at work, and which I don't have to hold, or resolve, or experience, because of my own privilege. Processing this unfairness, seeking to treat my clients with respect and honour, and advocating for them to have housing and health support, are all small steps towards justice.

The words of Tracy Kidder, in *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, a Man Who Would Cure the World*, are comforting in the face of injustice, homelessness and mental health complexities. Speaking about Paul's work in Haiti, he says: *'He's still going to make these hikes, he'd insist, because if you say that seven hours is too long to walk for two families of patients, you're saying that their lives matter less than some others', and the idea that some lives matter less is the root of all that's wrong with the world.'*

* Bolton Clarke Homeless Persons Program is co-located at Anglicare Preston.

# Mental Health and Housing, Together for Recovery: A Story from the Homeless Outreach Mental Health Service

David Pruden, HOMHS, Inner West Area Mental Health, cohealth,
Chris Platt, Program Manager AOD Treatment Services and HOMHS, cohealth,
Leanna Helquist, AOD and Homelessness, Leader, cohealth

cohealth's Homeless Outreach Mental Health Service (HOMHS) walks alongside consumers on their journey to recovery. The HOMHS uses a trauma informed and recovery approach to care or in other words uses the strengths, experience and expertise of the person to work towards their recovery. Based in the inner north west of Melbourne the interdisciplinary team of workers from cohealth, Inner West Area Mental Health Services and Launch Housing have the honor of sharing in people's stories and walking with them towards their recovery.

It is the stories of resilience and survival which are powerful and motivating to the team. It is also how the team learn to improve their care and through reflective practice adapt this to benefit others.

The stories of the HOMHS consumers exemplify that wraparound services which are person-centred, assertive, coordinated and holistic are the key to unlocking the door to recovery.

The following story shows that for full recovery to be achieved, both tailored supports plus housing is needed.

## Part 1:

*Patrick is 45 years old and lives with a diagnosis of schizoaffective disorder, poor sleep, as well as other conditions, as a result of over 30 years of homelessness. Over the years Patrick has needed frequent hospital admissions to manage his health and keep him safe. However, the lack of follow up care and Patrick's chaotic life on the streets meant that soon after discharge he would become unwell again.*

*When unwell Patrick can have delusions, be unpredictable, intimidating, vulnerable, and experience extreme moods and emotions. To help cope, Patrick uses a range of illicit substances, alcohol, cigarettes and lots of caffeine. He didn't eat all the time as getting food was hard when surviving the streets. Patrick has gone through all the housing options, none worked. Sleeping rough was the only safe option. Patrick spent most days sorting out the important things, sourcing substances, seeking ways to reduce the isolation and when he felt able; accessing food programs, health services and sorting out his court and Centrelink issues that never seemed to go away.*

*During another inpatient admission, Patrick accepted 'just a trial' of some help from the HOMHS. Engagement with Patrick was at his own pace. Over time Patrick was able to build some trust with the service and create a care plan. The goal of the care plan was to feel included. To achieve this over time Patrick and the HOMHS team worked on his physical and mental health, housing needs, AOD and homelessness and corrections support, financial support, psychosocial and living skills support as well as a National Disability Insurance Scheme (NDIS) application.*

*Patrick's life improved. Diet, sleep, physical and mental health, income and court matters had been sorted out and he was using less. However, Patrick remained sleeping rough. HOMHS tried all usual housing options; supported housing with good providers, arranging for Patrick to have trials in different locations and types of accommodation. None of these solutions helped. Housing was an ongoing barrier due to Patrick's beliefs, preferences and decline in mental health and feelings of safety when housed. The team and Patrick were stuck. Despite improvements in Patrick's wellbeing he was still sleeping rough and requiring intensive support to keep him stable. The journey was only halfway done.*

## Part 2:

*Patrick has now been housed for several months. It is still 'early days' and the transition will be long, but everyone is feeling optimistic that securing appropriate secure housing is another significant step towards recovery. The team and Patrick are positive about this because Patrick's health is being kept stable by changing the care to be responsive to Patrick's needs and feeling in this new situation.*

*Patrick is learning new skills and although he doesn't always think this is great, is generally happy about being more independent. Patrick is also starting to feel safe in his new home. Patrick still uses substances sometimes but 'this is a lot less than before' and 'sometimes I sleep'. Patrick still receives very regular and holistic support from HOMHS and the goal to feel more included has not changed.*

*The next steps are to fully enable Patrick's NDIS plan and continue to seek opportunities for social inclusion. At this point the team will start to reduce hours of support provided to Patrick and this will commence the final phase to Patrick's recovery.*

In preparation for this *Parity* article the team undertook a reflection of Patrick's journey.

This is what they found:

- Patrick has incredible resilience. Personal attributes which have enabled his recovery include Patrick's joy, humor, warmth, spirituality, value in interpersonal relationships and interest in drawing.
- Patrick is integral and has the role of expert in the team.
- Working in an interdisciplinary team with different skills and professional backgrounds means that we can challenge and learn from each other and get creative about achieving Patrick's goals.
- Being really clear on the goal and Patrick's care plan meant that over time Patrick's feelings of self-worth improved which has been the turning point in his journey including his engagement in services, housing and associated health outcomes.
- Taking the time to work with Patrick to find out what type of housing was going to work for him. And doing all the work to find an environment that was supportive and considered Patrick's physical, mental health and social needs.
- The flexible and assertive approach which included regular follow up and monitoring of his wellbeing, so concerns were identified early and enabling Patrick to develop skills to solve these.

Critical to a person's recovery is addressing both a person's mental health and housing needs; you cannot have one without the other. Patrick's story is different from the Housing First approach. This is because of the limited access to permanent housing stock and that for some, including Patrick, standard housing options don't work.

Patrick's mental health was stabilised as much as possible so that suitable housing could be secured. We hope Patrick's story illustrates that both mental health and housing are essential requirements for a person to have good health and feelings of wellbeing and safety. Services which work with consumers to empower, and include them, forge a pathway to recovery.

**Author's note:**

1. While this article is based on someone's true circumstances, some changes have been made to protect their identity.
2. No two people or recoveries are the same, however the hard work and dedication of the consumers and staff are the same.

# Housing is Good Mental Health Care

Dr Andrew Hollows, Chief of Staff, Launch Housing

An important part of the policy story about housing, homelessness and health is the need to address mental ill-health for people experiencing homelessness.

The current Royal Commission into Victoria's Mental Health System[1] and the recent Productivity Commission's Mental Health Inquiry[2] have highlighted the urgent need for housing to improve the mental healthcare of people experiencing homelessness. This article draws on our formal submissions to both.

## Housing is Good Mental Healthcare

To state the obvious, housing is good mental healthcare. This point is well made by the Productivity Commission[3] which observed how 'housing is a fundamental contributor to preventing poor mental health and promoting recovery for people with mental illness'. We know from our own practice experience that mental illness both contributes to and is exacerbated by the stress and trauma of homelessness. This group, especially those with chronic needs, often cycle through acute mental healthcare and exit to homelessness, only to return repeatedly to hospital-based care, and sometimes the prison system. Along the way, they incur a high mental health cost to themselves and a high financial cost to governments

But people's access to good mental health care when they need it is thwart. The extraordinary fact is that many people experiencing homelessness, including those with high needs, do not access or use mental health services. This point is well illustrated in the Trajectories project[4] by AHURI and MIND Australia. The ability to secure mental health assessments and other clinical health interventions in a timely manner is crucial. And even when mental healthcare is provided this can sometimes be episodic and haphazard. The uncertainty and transience of homelessness, including rough sleeping, is certainly a contributing factor.

## Discharge from Institutional Care

One key issue is ensuring no exits into homelessness for people discharged from institutional care. It is for this reason that Launch Housing supports the recommendation in the Productivity Commission's Interim Report[5] that 'State and Territory Governments should commit to a formal policy of no exits into homelessness for people discharged from institutional care'. We support the provision of 'step down' programs, or programs that support the timely transition to appropriate housing when exiting hospital following a mental health episode.

There is considerable overlap between the use of specialist homelessness services, such as Launch Housing, and patterns of hospital usage by people experiencing homelessness. This is especially distinct for those with multiple and complex health needs (such as mental illness, substance use difficulties and physical health problems) who frequently use hospital and specialist homelessness services over an extended time period.

An ongoing problem is the practice of inappropriate hospital discharge. Post-discharge care is often not an option for patients with 'no fixed address'. As a result, homeless patients face either longer inpatient admissions or are discharged when too unwell for the challenges of living on the streets. The chronic shortage of affordable housing in Victoria results in more than 500 people being discharged from acute mental health care into rooming houses, motels and other homeless situations each year.[6]

Better 'step-down' or medical respite services would drastically improve discharge processes. Medical respite enables people who experience homelessness to recuperate after hospital in a more home-like environment.[7] A systematic review of American research[8] showed that medical respite programs reduce future hospital admissions, inpatient days, and hospital readmissions. They also result in improved housing outcomes.

## Permanent Supportive Housing

A further critical need is for an increase in the number of permanent supportive housing options for those who are prone to episodes of mental ill-health and are heavy users of health, criminal justice and crisis-related homelessness and housing services. Permanent supportive housing ensures the provision of ongoing, long-term housing coupled with supportive services for individuals and families experiencing chronic homelessness.

The critical components of permanent supportive housing are long-term housing matched with voluntary supportive services including access to mental healthcare and medical services. Evaluations of this approach demonstrated that it is an appropriate model to assist people with chronic experiences of homelessness who need support to access and sustain their housing.[9] And it also makes financial sense for governments. The evaluation of Common Ground Brisbane represented a cost saving to the Queensland government of almost $15,000 per person per year.[10]

A review of the literature by Launch Housing shows there are a number of complementary elements:

- Safety and security for tenants is paramount — The successful delivery of supportive housing depends on creating an environment where safety is both a perception and a reality. Providing a safe living environment for vulnerable tenants is critical.[11]

- Support services are accessible and flexible, and target housing stability; support services not only cater for tenants' diverse needs, but also retain flexibility to cater for changing needs over time.

- Clarifying the optimum target groups for scatter-site and congregate models is a critical issue.

- Effective and clear governance is a critical success factor.

- Design — There are specific design elements[12,13] that include the importance of independence and privacy, the smart use of private and communal spaces and 'designing-in' security and safety.

## Educational Support for Children

A further issue when considering mental health and homelessness is the need for educational support for children with mental illness. It is important, as recommended by the Productivity Commission,[14] that 'the education system should review the support offered to children with mental illness and make necessary improvements'.

Our practice experience confirms that children who experience homelessness and family violence are particularly vulnerable to mental health issues as well as multiple forms of disadvantage including: increased exposure to family violence, poverty, poor physical health, and emotional and behavioural difficulties. Transience and uncertainty mean that access to education is severely disrupted, leading to disengagement and learning difficulties.

As a response, Launch Housing developed the Education Pathways Program (EPP). This is an innovative specialist early intervention program which includes a multidisciplinary team comprising social workers, a psychologist, volunteers, and a speech pathologist who provide valuable cognitive and educational assessments, counselling and classroom support. All the children engaged in the EPP experienced substantial learning delays. However, only 23 per cent met the criteria for financial assistance under the state-funded Program for Students with Disabilities — Intellectual Disability (PSD-ID), those remaining young students missed out.

Without financial support to access intensive assistance with education, the gaps in learning will not only remain, but will be exacerbated as the children get older, putting them at increased risk of ongoing mental ill-health and social exclusion.

A recent (internal) evaluation found that the EPP had delivered tangible and effective outcomes for primary school-aged children up to 12 years of age experiencing homelessness, by supporting their engagement/re-engagement with mainstream education.[15] This was achieved by EPP staff accompanying children to school in the mornings on a walking school bus, which encouraged interaction with their peers, a sense of belonging, and helped develop social skills.

Accordingly, there is an imperative for government policies to recognise children experiencing homelessness as a unique group that require tailored and intensive support to overcome significant educational disadvantage.

## Summary

There are, of course, many other issues to consider when looking at the complex picture of mental health and homelessness. But in many instances the underlying solutions are very clear: key healthcare intervention for someone experiencing homelessness is access to affordable, stable accommodation and community support to maintain their housing whilst dealing with mental health issues.[16] Without a place to live it is nearly impossible to take care of one's mental health needs.[17]

With the current Royal Commission into Victoria's Mental Health System there remains an opportunity to ensure the fundamental role of housing is addressed when implementing changes to the mental health system.

**Endnotes**

1. For Launch Housing's submission to the Royal Commission into Victoria's Mental Health System see: *https://www.launchhousing.org.au/thecommission/*
2. At the time of writing the final report by the Productivity Commission was still being prepared: *https://www.pc.gov.au/inquiries/current/mental-health#report*
3. Productivity Commission, *Interim Report 2019*, Chapter 15, p. 541.
4. See: *https://www.ahuri.edu.au/research/trajectories*
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16. See: Wood L et al 2019, 'Hospital collaboration with a Housing First program to improve health conditions for people experiencing homelessness', *Housing Care and Support*, vol. 22, no. 1, pp. 27–39
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# The Relationship Between Homelessness for Individuals with Severe Mental Health Issues and Disabilities, and Housing Opportunities

Nadia Di Girolamo, Project Officer/Occupational Therapist
and Jessica Dobrovic, Senior Analyst, Hutt St Centre

Homelessness can and does affect anyone. Not only does the total number of people affected by homelessness continue to grow annually, the populations being affected by homelessness are also growing. In the past few years, the Hutt St Centre (Adelaide, South Australia) has seen a significant increase in the number of females, families and tertiary educated individuals using support services. Further, in South Australia and New South Wales there has been a significant increase in people with a disability accessing homelessness support services.[1] People with severe mental health issues and disabilities generally require significant supports to live independently and a lack of support can often impact their abilities to obtain and maintain their housing.

Obtaining housing in the current climate is becoming increasingly difficult, and this is reflected in the changing face of homeless individuals visiting the centre. Housing affordability, appropriateness and availability continues to be a barrier to ending homelessness for people who come through our doors. The Anglicare *Rental Affordability Snapshot*[2] for 2020 identified nine properties across Australia within the private rental market that were affordable for someone on Single Jobseeker payment, and three properties across Australia that were affordable for someone on Single Youth Allowance. This highlights a system where, even prior to including comorbidities, it is extremely difficult to secure housing outside of the public and social housing sectors. For people with disabilities and mental health issues, it can be even more difficult if there are environmental factors that need to be considered for housing to be appropriate, for example, housing modifications.

To further understand the relationship between mental health, housing and homelessness, Hutt St Centre has implemented assessment and triaging tools, and coordinated projects to further understand the way in which disability and mental health matters impact systemic issues related to homelessness. What this process has highlighted, is how important understanding the broader experience of homelessness is to addressing and ending homelessness. Through improving our understanding of people experiencing homelessness with data collection and continuous improvement projects, the Hutt St Centre has shifted its support models to better suit individualised needs. The process of improved understanding has also contributed to viewing health beyond the biomedical model, and understanding the social, psychological and emotional elements of health, and how this influences longevity and appropriateness of tenancies.

## Tenancy Suitability

For people who experience mental ill-health or live with a psychosocial disability, property availability and suitability play a significant role in the success or failure of tenancies. A large number of Adelaide's available public housing stock are high-density properties and close-living flat groups. While reflective of broader housing stock in the inner city, this type of housing can result in people (particularly people with mental health issues) finding significant difficulties in maintaining their tenancy. The overarching environment in many of these high-density living arrangements can be noisy, untidy, and at times feel unsafe – which is not conducive to feelings of wellbeing or security. For those who live with mental health conditions these environments can be triggering and exacerbate symptoms such as paranoia, hypervigilance, insomnia and anxiety.

Lack of appropriate housing results in failed tenancies and high numbers of people opting to leave their properties. Alternatives to these high-density housing options are scarce and often unaffordable, with only three per cent of private rental properties identified as affordable for individuals on government incomes.[3] This results in a system where people experiencing homelessness are competing for the same properties as the rest of the population; applying for properties in the private rental market can feel daunting and further entrench feelings of hopelessness and helplessness in an already vulnerable population, especially if there are continual application rejections.

For those who have high needs, the push towards/change to individualised disability funding has also made accessing appropriate supports and housing difficult. Many disability housing options are now only available to people with National Disability Insurance Scheme (NDIS) packages, which further decreases suitable housing options for those who still have complex needs but are unable or unwilling to access the NDIS.

## Mental Health Support in Tenancies

The Aspire Program provides an example of longer-term support enabling the addressing of the broader psychosocial determinants of homelessness. As the first social impact bond in Australia to focus on homeless, individuals experiencing homelessness are able to receive three years of support. Through developed understanding of the individualised experience

of people in the sector, Aspire's foundation is that a house is not the only solution to the experience of homelessness. People who experience homelessness often become disconnected from their family and community and find it very difficult to obtain or maintain activities. To address this, engagement navigators work alongside other frontline workers to provide information, planning, linkages and outreach work related to employment, education and community activities. These activities focus on improving psychosocial wellbeing and can include many tailored interventions such as: gardening, nutrition related activities, attending local community groups, physical activities and art. Results have indicated that once an individual is engaged in meaningful activities in the community their health and wellbeing increases significantly.

The Aged City Living (ACL) program is another example of how longer-term case management programs can benefit people who experience homelessness and poor mental health. The ACL program has an aged focus; working with people aged 50 and over who are homeless or at risk of homelessness. The program employs case managers, diversional therapists, an outreach support worker and an occupational therapist to work holistically with clients to improve their independent living skills and connect them with their communities.

The ACL program is not time limited, which allows time to build relationships and trust with clients- an approach that is integral when working with clients with severe mental health issues. A diverse, multidisciplinary team allows clients to focus on multiple goals or work on larger goals with input from several staff members. A good example of this is working with clients with hoarding disorder: the case manager will work with the client on tenancy issues resulting from the hoarding and coordinate supports, the outreach worker will work regularly with the client to 'let go of' and minimise the items in the home and the occupational therapist will work with the client from a safety perspective to help eliminate hazards and falls risks in the home. The team will also work on connecting the client with mainstream supports such as the NDIS and My Aged Care.


## NDIS and Mental Health

The NDIS is a good example of a system that has great potential to provide long-term and sustainable supports to people with severe and persistent mental health issues. However, as it currently stands, much more work needs to be done to make the system inclusive for those who are the most vulnerable and marginalised. Whilst the addition of 'psychosocial' disabilities within the umbrella of the NDIS has been inclusive in theory, the high-level self-management skills that are required to independently navigate the NDIS often seem at odds with a client's abilities, as these are often the very skills that their disabilities impair. The NDIS classifies people experiencing homelessness as a 'vulnerable and hard to reach' population, yet there are no NDIS specific assertive outreach or liaison roles in the homelessness sector to assist in facilitating NDIS access and support.

For those who experience what is considered 'chronic homelessness' as a result of their mental illness, a timelier or 'triaged' pathway onto the NDIS would be beneficial as access to supports often has a large impact on housing offers and tenancy sustainability. The health system is currently engaging with 'Health Liaison Officers' (HLO) whose role it is to improve the interface between the NDIS and mainstream services. These roles are non-client facing and primarily support health and hospital staff to transition complex needs clients from acute settings onto the NDIS. The purpose of these roles is to ensure that clients do not stay in acute settings for lengthy periods of time once medically stable simply because their supports are insufficient in the community. The role assists staff to ensure client have appropriate and timely access to NDIS services to support them to live independently in their communities. A similar liaison role within the homelessness and/or mental health sector has potential to work with front-line staff to give clients timely access to NDIS supports and ensure that they are housed; they have the necessary supports in place to assist them to not only maintain their tenancy but thrive in their communities.

## Conclusion

People experiencing homelessness who have severe mental health and disabilities face significant barriers to obtaining and maintaining housing, and obtaining long-term support when in housing. Tenancies available for people experiencing homelessness aren't able to provide a broad range of tenancy types and options for people with diverse needs. Programs such as Aspire and ACL can work to address tenancy maintenance and support participants to connect with longer term supports. However, more work needs to be done within larger systems such as the NDIS to afford people with complex needs the same access and opportunities to housing and supports as the broader community.

**Endnotes**


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# Mental Health, Housing and Homelessness: A Workshop to Commit, Coordinate and Collaborate

Stephanie Macfarlane, Homelessness Health Program Manager, Priority Populations, South Eastern Sydney Local Health District (SESLHD),
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and Jessica Wood, Senior Project Officer, Homelessness, Department of Communities and Justice, South Eastern Sydney and Northern Sydney

People experiencing, or at risk of homelessness often experience disproportionate levels of poor mental health, with reduced access to coordinated community based care.[1] Although the health and housing systems are designed to be responsive to vulnerable people with multiple needs it can be difficult to integrate ways of working across two large complex government systems. This presents challenges for the delivery of joined up, person centred care.

At a policy level in New South Wales, the Housing and Mental Health Agreement (HMHA) sets out objectives to improve housing outcomes and the mental health and well-being of people with mental health issues who reside in social housing, or who are homeless or at risk of homelessness.[2] The HMHA articulates a number of mechanisms by which these objectives can be achieved, including joint interagency responses. However, many of the systems and structures laid out in the original agreement have changed dramatically since the HMHA's introduction and the outcome of a recent review is still pending. As such, the value of continuing with existing joint responses is contingent on robust governance, ongoing commitment to participation by key stakeholders and effective processes for escalation.

To strengthen integrated responses at a systems and individual client level, South Eastern Sydney Local Health District (SESLHD) and the Department of Communities and Justice (DCJ) Sydney, South Eastern Sydney and Northern Sydney (SSESNS) District organised a joint Mental Health, Housing and Homelessness Workshop. The Workshop aimed to identify opportunities for improvements in planning and coordination for people being discharged from mental health units who were experiencing homelessness on admission or who lost a tenancy during admission and are at risk of discharge to homelessness. It also aimed to improve coordination of support to people in social housing who are experiencing mental health issues and whose tenancy is at risk.

The structure and focus of the Workshop was informed by a series of consultations facilitated by the Homelessness Health Program Manager SESLHD and Senior Project Officer DCJ SSESNS and undertaken with SESLHD Mental Health Service managers, clinicians and DCJ housing staff.

The consultations demonstrated that there were a number of barriers and enablers shared across the two organisations that the participants were able to unpack.

Shared barriers included:

- lack of cross-agency structures to enable good communication, escalation and case coordination
- consistent consent processes across agencies to facilitate discussion of clients.

Shared enablers included:

- cross sector capacity building initiatives, for example, Mental Health First Aid
- commitment to flexible service delivery by each agency
- good local working relationships
- information sharing in formal and informal settings.

The Workshop presented an opportunity for frontline staff and managers from both organisations to work together to develop a shared agenda and shared solutions. Through the delivery of presentations about other innovative models of care, as well as small group work and larger idea generating activities, a set of service delivery commitments were articulated; that is a commitment to:

- work together to reduce homelessness
- deliver client centred practice
- challenge existing ways of working and build innovative models of care
- build and enhance relationships.

The first action after the Workshop was the establishment of the Mental Health, Housing and Homelessness Working Group. Membership of this group includes senior managers and consumer/peer representatives from SESLHD Mental Health Service, the SESLHD Homelessness Health Program Manager as well as senior representatives from DCJ SSESNS in the Housing and Homelessness streams. The role of the group is to oversee the development, implementation and evaluation of improvement initiatives. Focus areas include:

- Designing, implementing and evaluating initiatives that strengthen communication, escalation and referral pathways between the two agencies.
- Improving data collection in relation to people experiencing, or at risk of homelessness accessing mental health services.

- Identifying opportunities for collaboration between SESLHD Mental Health, DCJ and other relevant partners, including specialist homelessness services and other non-government or community managed organisations.

Although Covid-19 has delayed some of the Working Group's activity, there have been a number of achievements to date:

- Advocacy to the Ministry of Health regarding the inclusion of 'homelessness' as an option for discharge delay data collection within NSW Mental Health Units.

- Development of a process within SESLHD mental health inpatient units to improve identification of and responses to homelessness and risks of homelessness.

- Development of a communication pathway between SESLHD Mental Health and DCJ staff at Local Housing Offices.

- Plans to establish new, and enhance existing cross-agency case coordination and communication structures to prevent tenancy loss and/or discharges to homelessness.

- Strengthened relationships and issue management through the regular meeting of the Working Group.

Evidence suggests that the interaction between mental health and housing systems is complex, and that poor integration and coordination leads to poor outcomes for an already vulnerable cohort.[3] The Workshop has demonstrated that a partnership approach can enhance commitment, coordination and collaboration to deliver joined up services. It is anticipated that the Mental Health, Housing and Homelessness Working Group will continue to work together on shared activities and solutions. In the coming months, we will continue to implement and reflect on our identification and communication pathways and incorporate consumer input to strengthen ongoing evaluation.

**Endnotes**


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# The Impact of the Living Environment on the Mental Health of People Living with Mental Ill-health

Nadine Cocks, Consumer Researcher and Consumer Consultant, Elise Davis, Research and Evaluation Manager, Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia

The living environment is important for general mental health and wellbeing. Existing research suggests that if the basic requirements for housing such as access to natural light, private open space, safety, cleanliness and maintenance are denied this can adversely affect mental health and wellbeing,[1] The impact of a substandard living environment for people with mental ill-health is not well understood. A recent study carried out by Mind Australia in collaboration with the Australian Housing and Urban Research Institute (AHURI) focused on examining the housing and mental health pathways of people with lived experience of mental ill-health. Trajectories included qualitative interviews with people with severe mental ill-health to explore their living situation and mental health.

This paper draws on data collected from 86 participants recruited from the following areas Melbourne, Wangaratta, Sydney, Bathurst, Brisbane, Mackay, Adelaide, Berri, Hobart and Perth. The findings highlighted that many participants were living in temporary accommodation that not only did not meet the requirements mentioned above, but were poorly maintained, unsafe and substandard. The findings from Trajectories demonstrated that there is a relationship between peoples' mental health and their living environment.

Some characteristics of the built environment seemed to directly influence mental ill-health such as location, neighbourhood and stigma; quality of housing and maintenance; and safety and security.

## Location, Neighbourhood and Stigma

Neighbourhood characteristics can benefit people's sense of identity in communities. In Trajectories, most participants wanted housing in areas they were familiar with and had established social connections near friends, family and amenities. However, people did often not have a lot of choice in the area that they lived and cited problems with people with mental illness and substance abuse issues being placed together.

> *'There is a problem with people with mental illness being in public housing where there's drug use, criminal activity, domestic violence etc. Everybody deserves to have a roof over their head, you can't just lump people like that all into one type of housing.'*

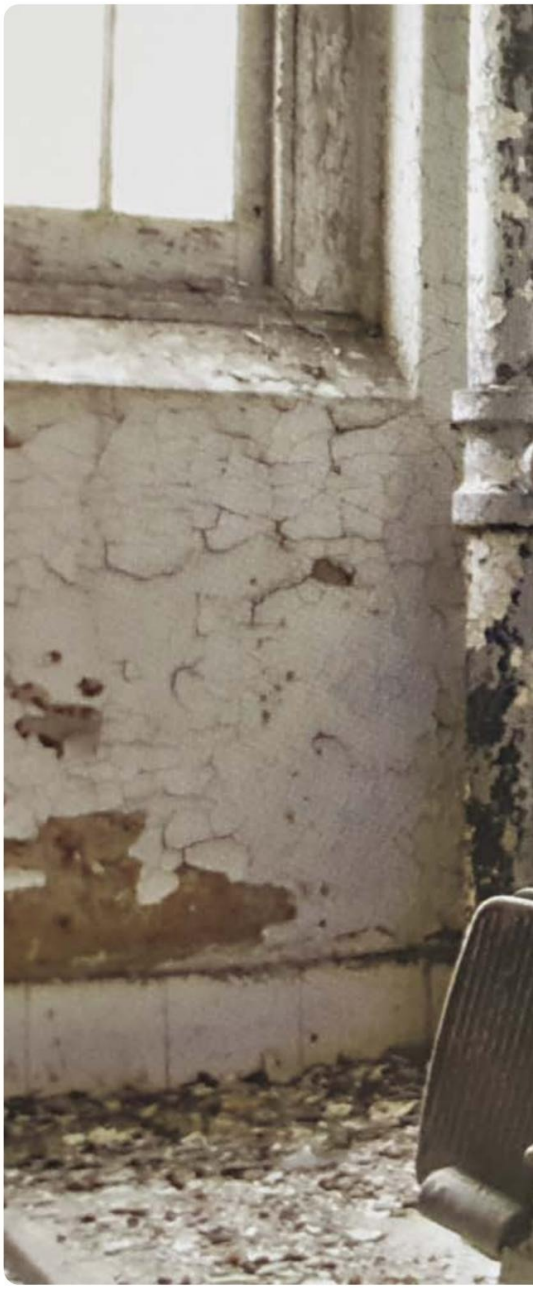
Stigma around mental ill-health was also evident in neighbourhoods, particularly smaller areas. Not feeling welcome in your own community has a negative impact on mental health and can contribute to isolation which further impacts on mental health.

> *'At* [a particular area]*, where people started finding out about my illness, they would literally walk across the street to avoid me because it was that type of mentality.'*

## Quality of Housing and Maintenance

Participants referred to aspects of the quality of housing that impacted on their mental health. For example, living in dark damp places had a negative effect on mood. Also, living in small cramped spaces made people feel like things were closing in on them. On the other hand, access to fresh outdoor air and green space had a positive impact on mental health. Having a space outdoors to retreat to from living indoors with access to a garden was important for the wellbeing of people living with mental health issues.

> *'Don't put me in a one-bedroom freaking room where you've got everything, the lounge room and kitchen together. I can't do that. It plays with my head. The* [housing service] *doesn't seem to understand. Where I am now is good because I've got my*



*own backyard, I can go out and have a breathe off if I want.'*

Maintenance issues also had a negative impact on mental health, particularly when the person had little control over when and how they were managed. Participants reported that tardy and inadequate responses to housing maintenance impacted both on their mental health and sense of wellbeing, more so when delivered by tenancy managers who were rude or unsympathetic to the tenant's situation.

*'I've got a dead bird squatted in my range hood that's been there for six weeks. They kept saying, "It will be done by the end of the week." I rang up them this week and said if it's not done by tomorrow, I'm going to a lawyer.'*

## Safety and Security

Participants in this study reported that a home was somewhere where they could feel safe and secure, a base where they could carry out their life from. Feeling safe was particularly important for people who had experienced past trauma because if they felt unsafe, they would retreat.

*'It was just a flimsy door that anyone could break in. Certain people did. They were always breaking in, I just spent my whole time locked in the room.'*

In summary, these results highlight the importance of living environment to the mental health and quality of life of people with mental ill-health. Substandard and unsafe housing and living environments can have particularly damaging effects on the lives of people with mental ill-health. Further information about Trajectories can be accessed at: https://www.ahuri.edu.au/research/trajectories


## Acknowledgements

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**Endnote**


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# What's Essential? Housing First: Best Practice and Reform in Assertive Outreach Services Supporting People Sleeping Rough Throughout COVID-19

Beth Fogerty, Regional Manager, Gippsland, Gisella Weiss, Assertive Outreach Worker, Pathways to Home and Rosie Frankish, Housing Programs Coordinator, Wellways Australia Limited

The enormity of the housing and homelessness crisis in Australia cannot be overstated. While the numbers of people experiencing homelessness are increasing, the availability of safe and affordable housing options for people is in high demand.[1] Health and homelessness services are faced with the agonising realities this predicament presents every day, whilst acknowledging the greatest cost is to those who are experiencing homelessness themselves. Evidence of this crisis is well documented and has served as a point of advocacy to increase the housing and support options available to this population group.

State and federal governmental policy and funding have not responded at the scale, speed nor longevity of what is required to support the volume or individualised needs of people experiencing homelessness in Australia. The government response to the Covid-19 health pandemic saw an injection of essential funding into specialist homelessness services to ensure those sleeping rough could access crisis accommodation; reducing the risks of exposure to Covid-19. While a welcomed addition, evidence suggests housing alone is not enough to support those who experience homelessness. Research suggests that individualised support is paramount to housing tenure and positive health outcomes.

The Covid-19 health pandemic has presented limitations for those placed in emergency accommodation to receive the individualised support to sustain tenancies, and the transitional plan to support these individuals into long-term housing options as Covid-19 restrictions ease is unclear. In the face of these challenges, this pandemic has evidenced the positive impact that flexibility and collaboration can make in service responses to people experiencing homelessness. There exist clear examples of collaboration between mental health, homelessness and community services to deliver face to face service to people sleeping rough in the community resulting in service excellence. Continuing to meet this level of service excellence must continue, especially ones which draw upon evidenced based models to support the transition of individuals into sustainable housing, alongside support.

There is a growing body of literature evidencing housing and support as the most effective model in supporting people experiencing homelessness and mental health issues to obtain and sustain a home. This model is known as Housing First.[2] Housing First identifies housing is the primary need that must be provided, without readiness conditions, and once achieved, individualised client directed supports are implemented to support them to maintain tenure and wellbeing. Whilst indisputably effective, the housing and homelessness system is not resourced to operate from a Housing First framework, rather it's paved upon housing readiness and prioritisation of need, leading to service responses being driven by crisis, and given the high demand for housing, often resulting in unmet need. The Australian Institute of Health and Welfare[3] reported that in Australia between 2018 to 2019 specialist homelessness services reported a total of 92,300 (253 per day) unassisted requests. Three in four of these requests included the need for accommodation support, and this need was unmet due to no accommodation being available. This unmet need has increased by 6,200 people since 2017 to 2018. So, what are the implications of this increased need and approach in the face of a health pandemic?

The Covid-19 governmental response to homelessness acknowledges the importance of those who are homeless to obtain accommodation to avoid infection. This recognition saw millions of dollars injected into homelessness services to facilitate hundreds of people who are homeless into emergency accommodation across Victoria. This is an outstanding achievement by those services who facilitated this response to ensure those who are most vulnerable are off the streets, however, the complex issue of service provision to people whilst living in this accommodation remains.

Health and homelessness services have responded rapidly and flexibly to the needs of these individuals to obtain the essential housing and healthcare services that are required, but it is clear that the work is just beginning. What will happen once the Covid-19 urgency dissipates and services can no longer fund people to live in short term accommodation?

A thorough transitional approach focussed on housing and health based support is essential to addressing this issue, the foundations of which must be implemented now whilst people are 'settled' in accommodation. Whilst exploring housing options, it's important long term and sustainable options are considered, thus to ensure the best housing outcome. As such, we must explore housing options beyond the social housing system such as the private rental market to achieve greater rapidity in the housing response, choice and opportunities for community engagement.

Subsidised private rental housing and support programs evidence promising efficacy in supporting the needs of people who are homeless with mental ill health, both to secure housing and sustain improved wellbeing. Utilising a Housing First approach, Wellways Doorway Program supports people who are homeless with mental ill health to access a private rental property in a community of their choice, that is safe and sustainable. Once this is achieved, the individual is supported with their self-directed recovery and health based goals. Doorway is delivered as a consortium between four major hospitals in Victoria and real estate agents in the community.

The Doorway program has supported 152 people to obtain their own home in the private rental market.[4] Doorway has evidenced that housing is an essential component to increased wellbeing with an independent evaluation evidencing a reduction in clinical mental health and emergency health services as a consequence of having a home.[5] The outcomes of Doorway evidence that health and mental health recovery based support that is directed by the person who has experienced homelessness, is a crucial element to facilitating sustainable housing tenure, and improved wellbeing. Whilst housing and support is evidenced as the best practice approach, Covid-19 parameters have presented challenges to deliver the 'support' components to individuals experiencing homelessness.

The health pandemic has presented barriers for community agencies' capacity to provide support to those experiencing homelessness, with many services reorienting to telehealth supports for non-urgent face to face contact to ensure the wellbeing of staff and community members. While taking this measured approach reduces the potential of exposure to Covid-19, a more targeted approach was and is required to support people sleeping

rough in the community. Many of those who experience homelessness have limited community and service based supports. This highlights the essential nature of assertive outreach services on the ground to support individuals who are experiencing homelessness, a service which provides direct face to face support, in building trust in care and support to enable successful tenancies.

Wellways Pathways to Home program, an assertive outreach Housing First program funded through the Victorian Rough Sleeping Action Plan, has delivered assertive outreach to people rough sleeping in the eastern suburbs of Melbourne since February 2019. When the health pandemic hit, Wellways expanded its face to face services to support those most vulnerable within our communities to be educated about Covid-19, stay safe and healthy, and to access accommodation supports.

At 6am Monday to Friday, the assertive outreach team scale the suburbs of Maroondah for people rough sleeping seeking to meet the housing and health based needs of these individuals. Since March 2020, the team have identified and supported twenty-eight people who were rough sleeping in the community, and supported fifteen of these people into safe accommodation and ensured their immediate healthcare needs are addressed.

The Pathways to Home team are also providing people with pre-set up mobile phones, food and taxi vouchers, clothing, self-care items and Personal Protective Equipment (PPE) to address their immediate needs. Wellways' decision to increase the volume of outreach over the State of Emergency period was carefully considered, however solidified by the acknowledgement that the more outreach and health interventions provided to people sleeping rough will correlate to more lives of vulnerable community members being saved. However, delivering face to face services in these unprecedented times has presented challenges; physical distancing (aka social distancing), transfer of items from one person to another, and the availability of PPE to undertake the work to name some. In the face of these challenges, it is clear community and service collaboration is essential to undertake this work successfully.

Working in assertive outreach during a health pandemic, while challenging, has evidenced the success of collaboration. The work has seen the strength of Pathways to Home partnerships with the local council and homelessness services thrive, with the knowledge that positive outcomes are best achieved together as a community. An example is when services worked together to encourage the local council to facilitate a collaborative showering program to ensure people who are homeless have access to a shower, with the homelessness agencies sharing their brokerage and PPE resources to meet service demands across the region. This collaboration extends to local communities; the local pharmacy who offered their limited supply of PPE to resource the service to undertake this important work and the concerned local community members that contact our service to connect us with people sleeping rough in their community. Such partnerships are invaluable within health and homelessness service delivery, but essential in the midst of a global pandemic.

There is much to learn from working within a health pandemic, namely the results that can be achieved through collaboration and flexibility in service operation. With the acknowledgement of what's possible, we must leverage off these learnings to inform service resourcing and practice for the future that best serve people who are homeless. The Covid-19 response for homelessness reflects that housing is an essential component to enable the health and well-being of individuals; this is a Housing First approach. In turn, we must consider alternative housing options outside of the social and crisis housing system. Such foundations should be led by best practice evidence, lived experience, and sector consultation to map the needs of people experiencing homelessness, thereby identifying multiple housing and support options being resourced to meet the varying needs of people experiencing homelessness. This will require the sector and community to expand our approach to housing and support programs that can imagine more and a better life for people experiencing homelessness.

It is also essential we acknowledge the strengths of what individual services have had capacity to deliver throughout this challenging period, enabled through increased funding and collaboration between services and sectors. We must take the learnings from these experiences to inform service provision for the future. This is an opportunity for the housing and homelessness sector to reform, enacting the 'hopes' of best service delivery into deliverables. Let's not see this as a 'Covid-19' homelessness response, but rather THE response that services must be resourced to provide to people in the community experiencing homelessness. When we meet people experiencing homelessness, colleagues, stakeholders, or politicians defaulting to the statement *'I/we can't do …'* let us remind them that indeed we can, as we once did, way back in 2020 during Covid-19. The health pandemic evidences that as a community we can do more to support people experiencing homelessness, and we must, because everybody deserves the opportunity to have a good life, and housing is an essential component to this.

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# Housing Support for Mental Health in a Changing Policy Context

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Since 2003, New South Wales (NSW) has developed and expanded a housing support model for people with chronic mental illness — the Housing and Accommodation Support Initiative (HASI). It is a partnership model between government mental health and housing, and contracted accommodation support providers.

Since the results of the initial HASI model were described in *Parity* in 2008, the policy context has changed extensively, which has affected key elements of HASI. Among broader policy changes are the extreme shortage of affordable housing; a greater focus on recovery and holistic support; integration with National Disability Insurance Scheme (NDIS) and other services; and consumer participation in how the program is organised. This article draws from recent HASI evaluations to describe how the contextual policy changes have affected the program.

## NSW HASI Programs

HASI currently serves about 3,000 people in five programs: Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI); HASI Plus; CLS for Refugees; and Youth CLS. Each program provides psychosocial support, accommodation support and clinical mental health services. The aim of the programs is to support people with mental illness to participate in the community, to improve their quality of life, maintain stable housing and assist in their recovery in the community. All consumers have a diagnosis of serious mental illness, and a third have additional diagnoses.

The formal partnership is between NSW Health, Local Health District (LHD) mental health services, community managed organisations (CMO) and NSW Communities and Justice (DCJ). In this era of integrated care, other partnerships at the local level are with community housing providers, Aboriginal services, NDIS providers and other social services.

A feature of HASI is the strong clinical focus through partnerships. Many consumers attribute their mental health improvements to HASI support to make choices about how to manage their medication and medical appointments.

## Affordable Housing

One change since HASI began is that there are no program-wide, formal mechanisms to provide or prioritise social housing for HASI consumers. Consumers are supported to find and maintain housing in the community. Only HASI Plus provides housing, as part of a planned transition of about two years to other stable housing in the community. In practice the housing approach is that HASI supports the participants to pursue applications for social or private housing and rental assistance. It supports them through the challenges of finding and keeping safe, secure and affordable housing in a market where suitable housing is in short supply. This change reflects the shortage of social housing and competing priority tenants. Over half of CLS-HASI consumers (55 per cent) live in social housing, even though no dedicated HASI housing or specific priority is available.

HASI also supports people to keep their housing if they already have housing when they enter the program. This change recognises that support to sustain a tenancy is a good measure to support mental health recovery.

An impact of the changes is that people are supported to find housing in the social or private market, live with family and friends or live in disability housing. This approach works best when the CMO builds strong links to local housing contacts to advocate for accelerated access. One consumer said:

> *I actually didn't have anywhere* [to live] … *But* [HASI] *said … they would stick around and still see me through but the contact [with Housing] … stopped …* [HASI] … *appealed, I got this* [housing]

If the CMO does not make strong housing links, it is difficult to find affordable, stable housing, and delay can be detrimental to other recovery goals.[1] These housing approaches reflect similar adjustments to programs that started out with a Housing First goal internationally,[2] recognising that the tight housing market is unlikely to change.

## Recovery and Holistic Support

The second change since the early 2000s is how embedded recovery-oriented practice and policy has become. HASI began when practices to support personal recovery were in early development. The progress is reflected in reforms such as the National Mental Health Commission and National Mental Health Report Card 2012, National Framework for Recovery Oriented Services 2013, Living Well — NSW Mental Health Strategic Plan 2014 and the National Mental Health and Suicide Prevention Plan 2017. These policies emphasise wellbeing, consumer and carer participation, and the shift to community, integrated care and physical health. They represent the shift beyond addressing only mental health symptoms to holistic support.

The shift is evident in HASI practices, where consumers explain that CMOs now support them to be more independent. They support them to build confidence to clean their home or organise home care services, rather than clean it for them. A consumer said: *'I wouldn't have been able to get started off without them.'*

CMO staff are familiar with the language and intention of recovery but have found that putting recovery principles into practice can be difficult. They work within the service constraints of HASI that limit their time and opportunity to provide individual support. In line with recovery, HASI programs focus on supporting independence and some people leave the program eventually. This focus presents challenges for some staff who have varying skills to manage the tension between supporting consumer choice and assisting consumers to move towards longer term goals.

## Integration with NDIS and Other Services

The third contextual change is how other services are organised, particularly NDIS and home care. Some HASI consumers seem to benefit from the changes, irrespective of the wider questions about how the NDIS integrates with other mental health services. Two benefits are that some CMOs are assisting HASI consumers to access the NDIS where they are eligible; and that some consumers can transition from HASI to the NDIS where it is appropriate for them.

Some CLS-HASI consumers had NDIS support in 2018, either continuing from before they entered CLS-HASI or the CMO assisted them to apply for it. Some consumers said NDIS support helped them to become more independent at home or in the community — for example with personal care, transport, home care and shopping assistance. In the past CLS-HASI provided some of that support. NDIS funding for these activities freed up CLS-HASI capacity for more psychosocial support to be provided to others.

Where HASI works well it also assists consumers to access other mainstream support and social services in their community to improve their community participation — education, training and work. A consumer said:

> *The help and support I got from HASI was A1 … I wasn't on my own any more … As well as being involved in the HASI program I was also involved in the* [charity] *workshop as a volunteer, I went back to Centrelink and said I need help to get back in the workforce and they put me back into the Jobcentre, and I've been looking for jobs and they've got a job over here doing the cleaning of the common area, they're going to start a training program … I had the interview yesterday.*

Like housing, these opportunities rely on a CMO's understanding of how to assist people to successfully apply for the NDIS and supporting the consumer to understand how these supports can complement what they are receiving from HASI.

## Consumer Involvement

The fourth change in the policy context is embracing the expertise of consumers in the way that services are organised. Buzzwords like co-design, co-production, peer workers and peer support are now accepted in policy as expectations of quality services, no longer just fringe aspirations for the rights of people using services. HASI programs are also on that path, evidenced in CMOs employing peer workers and Aboriginal staff. The CMOs try to tailor support to the consumers' choices, including support in goal setting, with services offering flexible activities and, in HASI Plus, some services organising tenant meetings.

A recent expansion to HASI Plus includes co-design in its governance. The evaluations employ local lived experience researchers in data design, collection and analysis. As well as the direct benefit of informing quality support, the employment of peer workers has acted as a model for current consumers about future directions. A CMO staff said:

> *We've had some pathways developed for consumers in our program* [who] *worked through their recovery and have gone on to be a volunteer and have gone into paid employment within our organisation or paid employment within other peer organisations as well.*

Structures to support these new practices are still evolving to ensure that peers have career paths for increased responsibility and other staff can learn from the peer expertise.

## Effective Support to Live in the Community

The NSW HASI programs are a useful example of adapting housing support to the Australian context. They are subject to regular evaluations so as to add to the evidence base and are adapted to the policy context in other states. Even as they adapt to major social policy developments, a key feature continues to be partnerships between health, housing, clinical support and accommodation support. They offer personalised support that is recovery oriented, holistic and builds social connections. The support includes assistance to access other support — NDIS, housing, education and employment — as well as the opportunity to plan for and transition into sustainable other support.

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## HASI evaluation projects and publications

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HASI Plus *www.arts.unsw.edu.au/social-policy-research-centre/our-projects/housing-and-accommodation-support-initiative-hasi-plus-evaluation*

HASI 2005 and 2009 *www.arts.unsw.edu.au/social-policy-research-centre/our-projects/evaluation-housing-and-accommodation-support*

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# What Works?

Damien Patterson, Policy and Advocacy Officer, Council to Homeless Persons

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

## Housing First

Housing First is a model of housing and support for people with complex needs, including severe mental illnesses, who are experiencing or at risk of long-term homelessness. Housing First involves rapid access to long term housing, and ongoing and flexible support to sustain that housing and improve a person's health, well-being and social integration. A growing consensus exists that Housing First programs are effective at supporting the recovery and long-term sustainment of treatment outcomes for people with severe mental illnesses and co-occurring homelessness.[1]

> *'You need support to get your feet on the ground again. Instead of them taking you from hospital into a place and leaving you — then the problems will start again'*
>
> — John Kenney, Consumer / Advocate

Housing First programs have shown that residents with severe mental illnesses require far fewer days each year admitted to inpatient care compared to the period before they were housed.[2] A rigorous study of a major Victorian Housing First program identified a decrease in hospital and psychiatric unit bed days of 80 per cent.[3,4]

Remarkably, these improved outcomes for housed consumers were achieved without an increase in residents' use of community mental health care services. Improved outcomes instead reflected greater stability, improved consumer/clinician relationships, and resultant greater adherence to treatment plans.[5]

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

## Who is Housing First For?

Housing First is not intended as a response to all forms of homelessness or all forms of mental illness, as the model involves more intensive support than is needed by most people without a home. However, it is highly effective with people with severe mental illness, whose housing situation very commonly breaks down without adequate support. Research has demonstrated that Housing First can successfully sustain housing for 80 per cent of people experiencing homelessness and severe mental illness,[6] while recognising that there are those for whom residential clinical care is required on a short or long-term basis.

## What Types of Housing Form are Most Effective in Housing First Models?

Outside of residential clinical care, few people with severe mental illnesses and resultant difficulty gaining or sustaining housing, require their support or mental health treatment to be co-located with their housing. Indeed, scatter-site distribution of permanent housing within communities is at the core of the Housing First model.[7] Mental health consumers usually report that they feel greater control over their mental health supports when in independent housing located in ordinary community settings.[8] There is also a substantial body of evidence demonstrating that they achieve better mental health outcomes in these environments.[9]

However, some people with mental illness or complex needs welcome congregate forms of housing with on-site support services, where they can develop a supportive community with fellow residents.[10] However, congregate environments can be very challenging places to live if there are high concentrations of people with high levels of complexity. One study found that 11 per cent of people living with psychotic illnesses were living in supported accommodation, while only 2.8 per cent rated this as their preferred accommodation type.[11] Having choice in housing is a key principle of Housing First, which reflects that sustaining housing outcomes relies on people being able to determine for themselves whether independent or congregate housing will work for them, and to move between different forms of housing, if a tenancy in one form of housing fails.

## Housing First Requires Housing

Regular Parity readers will be aware of the ongoing challenge many Australian Housing First programs have had in obtaining housing. Yet housing is the essential element in any pathway out of homelessness. Studies consistently find that in order to achieve the very high success rates for which Housing First is known, rapid access to long term housing options are required.[12]

> *'My life was a mess until I got housing. Just moving from room to room to room. Dealing with people with their own mental health issues, and drug and alcohol*

*addiction and stuff like that is really, really hard. Getting housing helped me keep appointments, workers have helped me keep appointments. Sometimes that drops off, and a good worker keeps you on track and connected to your appointments and your networks and stuff like that.'*

— Nigel Pernu,
Consumer / Advocate

## Housing Requires Support

Nor is housing itself always sufficient to support people experiencing co-occurring chronic homelessness and severe mental illness. With 43 per cent of social housing tenancies ending within 18-months,[13] it is clear that alongside an ongoing housing subsidy, many people require longer support periods than are currently available in order to sustain their recovery and housing. Many people experiencing mental ill-health, including those experiencing homelessness alongside complex mental illnesses, will require intermittent multidisciplinary support,[14] with very flexible case periods. These elements of support are as important to Housing First as housing itself.

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

— Nigel Pernu,
Consumer / Advocate

In order to expand Housing First in Australia, a greater focus is required on integrated and long-term programs that are able to flex levels of support up and down in intensity for those with ongoing support needs. This is required both in homelessness services and in other disciplines, as part of a service delivery team, where housing workers can complement the work of other support providers. Wrap around team-based mental health recovery supports might include: peer support, clinical mental health and health treatment, disability support, primary care, housing, community legal services, and addiction support.

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

— Helen Matthews,
Consumer / Advocate

## Conclusion

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

— Jason Russell,
Consumer / Advocate

Housing First programs have shown remarkable success in sustaining the housing and recovery of people with co-occurring long-term persistent homelessness and severe mental illness. Yet the capacity of many Australian Housing First programs has been hampered by a lack of ready access to housing. An expansion of social housing in Australia could enable a more successful rollout of the Housing First model in Australia. Greater flexibility in case periods, and multidisciplinary approaches to supporting highly vulnerable consumers are equally as important to ensuring that Australians without a home with severe mental illnesses are able to achieve the astounding results that Housing First has achieved internationally.

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# Working Across Systems: Using Complexity Theory and Intersectionality to Eliminate Homelessness in the Mental Health sector in Aotearoa New Zealand

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Securing and keeping appropriate, affordable and sustainable housing plays an essential role in the recovery, resilience and independence of tāngata whaiora.[1,2] Nevertheless, since the international movement of deinstitutionalisation and the closure of psychiatric hospitals in the 1950s, homelessness has been recognised as a challenge for tāngata whaiora[3] around the world.[4,5] These challenges and the vicious cycle of homelessness and mental distress have affected the lives of tāngata whaiora since that time.[6]

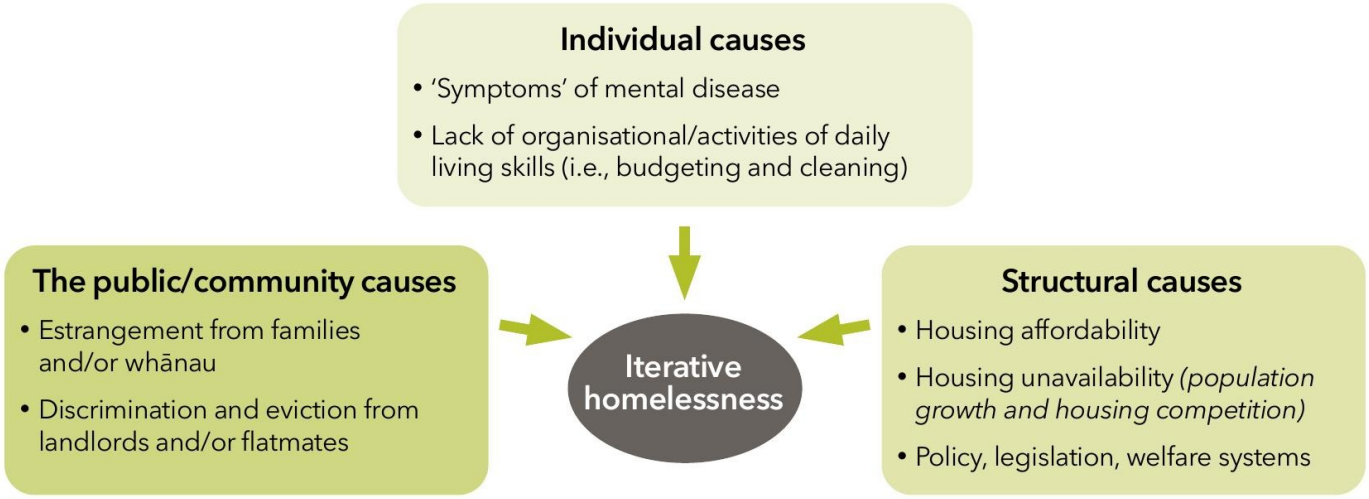
This article explores the nexus between homelessness and mental distress in Aotearoa New Zealand (hereafter referred to as Aotearoa). It demonstrates the value of utilising complexity theory and intersectionality to critically examine systems, policies and practices as well as to find systematic and whole-of-system approaches to address homelessness in mental health.

## Global Prevalence of Mental Distress and Homelessness

The United Nations estimated in 2005 that approximately 100 million people had no place to live worldwide, while one billion people lived in inadequate housing.[7] Although a global homelessness framework has been created by the Institute of Global Homelessness (IGH),[8] there is an absence of current global data on the number of homeless people around the globe.[9] In 2013, about 41,000 New Zealanders were either homeless or at-risk of severe housing deprivation in Aotearoa,[10] while the emergency housing 'turnaway rate' was between 82 and 91 per cent in 2017.[11] Māori and Pacific people have lower home-ownership rates and higher rates of overcrowding and street-homelessness.[12]

Internationally, tāngata whaiora are over-represented in the homeless population.[13] In Aotearoa, a 2001 national study estimated that 8,000 tāngata whaiora had housing difficulties, 2,000 were homeless or living in temporary or emergency accommodation, 2,000 were transient and 8,000 were at risk of homelessness.[14] Although the nexus between housing and mental health are recognised both nationally and internationally, there seems to be little current, and published social outcome data (that is, accommodation status) for tāngata whaiora in this country.[15]

The relationship between mental health and homelessness is complex, as these challenges are interconnected and have multifaceted causal factors.[16,17] Isogai[18] explains that mental distress is a 'both/and' view of cause and consequence of homelessness as these issues are presented as two sides of an equal, causal relationship that demonstrates the major perspectives of causes and consequences of homelessness and mental distress. Several scholars use terms such as *iterative homelessness*,[19] and *revolving door syndrome*,[20] to explain the vicious cycle of housing crisis among tāngata Whaiora both nationally and internationally.




Source: Isogai & Stanley-Clarke, 2017 [1]

Working across systems: Using complexity theory and intersectionality to eliminate homelessness in the mental health sector in Aotearoa New Zealand

A variety of approaches and policies have been implemented in the mental health, housing and homelessness sectors in Aotearoa. The mental health and addiction inquiry reported in 2018, providing recommendations to meet the mental health and addiction needs of New Zealanders.[21] Further, there has been targeted service development to break the vicious cycle, including; Housing First[22] Assertive Community Outreach Treatment and the Tamaki Wellbeing project — some approaches are targeted for mental health and addiction while other approaches (that is, Housing First) are for people experiencing homelessness in general.[23] Policies such as KiwiBuild were reset and a homelessness action plan was produced to address homelessness with specific focus on prevention, *increasing housing supply*, *support people* and *enabling the systems*.[24]

## Complexity Theory and Intersectionality

Complexity theory is both a theory and a conceptual framework to illustrate the nature of complex systems and changes in the behaviours of each system.[25] This theory can be used as an analytical framework to gain an understanding of how systems are self-organised and how their behaviours are developed through continuous feedback.[26] This theory asserts that social environments are complex systems where one little change in the system may lead to massive change in the whole system, or no change at all.[27]

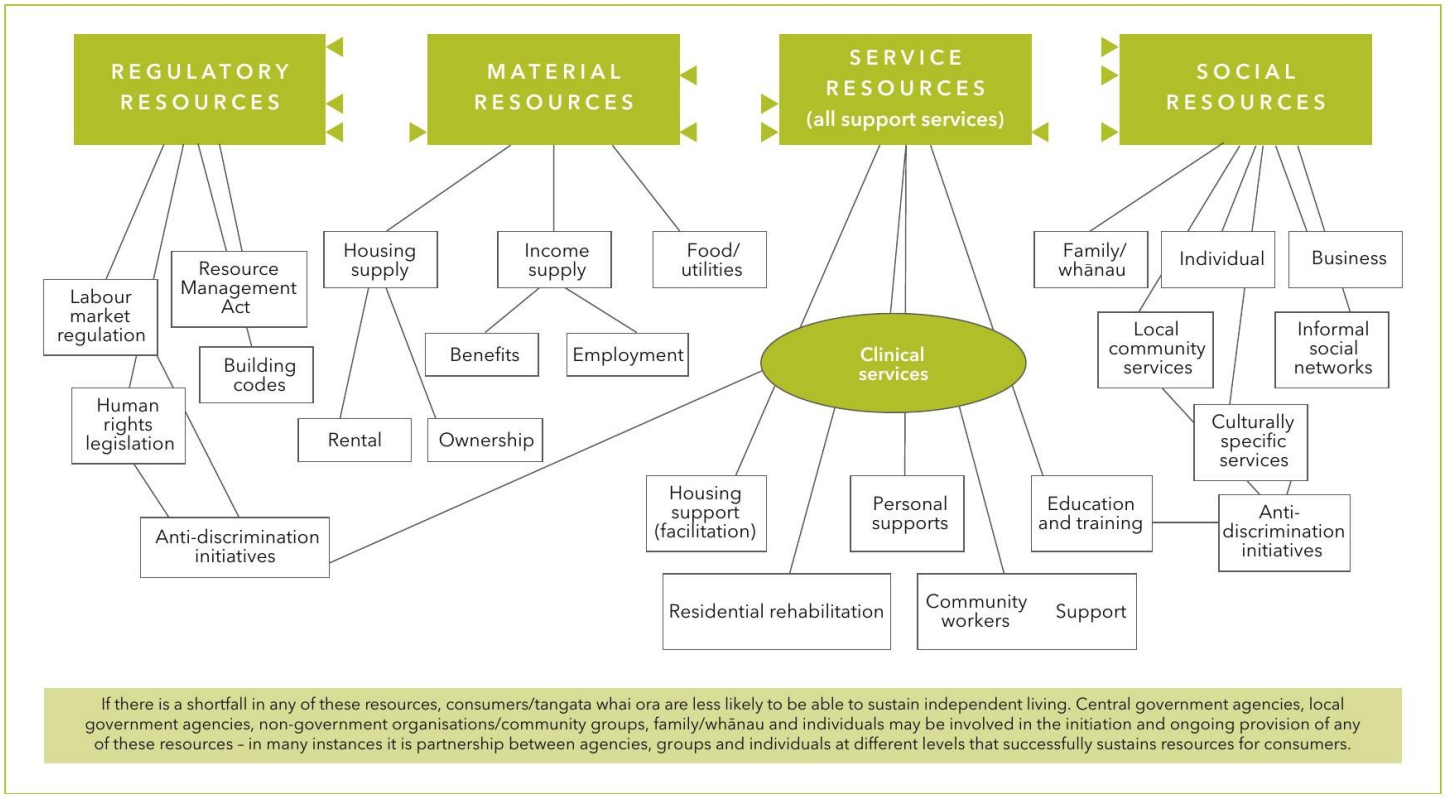
Intersectionality is a theory that examines multi-dimensional intersections and power dynamics between race/ethnicity, gender/sexuality, age, wealth, religion, nation, state, socioeconomics, geographical locations and social development.[28]

This theory supports providers and policy-makers to examine the interactions between locations, systems and processes, including any combinations of these factors, using a complex, flexible and multi-layered assessment of power locations.[29]

| Change in mindset and approach | |
|---|---|
| **From** | **To** |
| Competition | Partnership |
| Complicated | Complex |
| Linear thinking (cause and effect) | Systems thinking (both linear and horizontal – whole context) |
| Silo | Ecosystem/Complex adaptive system |
| Traditional boundaries | Relationships, trust and networks |
| Joined-up | Collective impact |
| Recovery model | Social determinants model |
| Service users/consumers | Citizens |
| Co-production | Citizen engagement (i.e., citizenship, place-based health and community development) |
| Sole/single vision, values, tasks, resources, power accountabilities, risks, decision-making and outcomes | Shared visions, values, tasks, resources, power accountabilities, risks, decision-making and outcomes |
| Prescriptive, detailed, and fixed Healthcare | Flexible, open, agile, adaptive and intentional |
| Local, indigenous or international – *either/or* | Cross-parties, cross sectoral and multi-agencies |
| Individual wellbeing | 'Glocal' (global–local)/ Third-space (a combination of local, indigenous and international components) – *and/both* |
| | Community and/or world's wellbeing |

Sources: Isogai & Stanley-Clarke, 2017,[1] Sanders et al, 2012,[32] Platform Trust and Te Pou, 2015,[33]

Table 1: Applications of complexity theory and intersectionality




Source: Robin Peace and Susan Kell, *Mental Health and Housing Research: Housing Needs And Sustainable Independent Living.*

Figure 2: Sustainability framework — A typology of resources necessary for consumers/tāngata whaiora to sustain independent living

## Discussion and Implications

Both complexity theory and intersectionality offer unique insights into the complex needs/problems of tāngata whaiora, their environment and the services they intersect with. Intersectionality allows tāngata whaiora, service providers and/or policy-makers to view how multiple dimensions of oppression cause issues such as homelessness for a population like Māori and Pacific people in rural areas, whereas complexity theory examines the interaction of large complex systems in social services and healthcare.[30] These theories illustrate that across all levels of systems of inequality and social issues are indistinguishably connected and that examination of how systems behave in a complex network of large systems in multiple sectors is required to understand these issues and inequalities.[31]

Both complexity theory and intersectionality support fundamentally collaborative practice among tāngata whaiora and their families, whānau and community members, service providers, policy-makers/funders, to re-conceptualise and/or refine practice, service delivery, policy and/or funding decisions at all levels. By creating an emergent set of relationships among these stakeholders via ongoing dialogue,[32] these theories encourage them to transform their mindsets and approaches to address these complex challenges at all levels — all social services and healthcare are strongly interrelated, and no single service delivery will make a difference in one system without making a difference in the other system.[33] Applications of complexity theory and intersectionality necessitate a change in mindset and approach in order to fully address the challenge of MH, homelessness and other complex problems.

A sustainability framework is an example that utilises these theoretical frameworks to address independent housing needs/homelessness among tāngata whaiora in Aotearoa.[34]

Despite little successful whole-of-system reformation and integration in the funding, IT and continuing care procedures systems in MH/A services internationally,[35] an integrated, whole-of-system healthcare service, under an alliance contracting framework at Canterbury District Health Board (CDHB) is another example that uses these theoretical approaches to map social and healthcare services within one united service and budget system, while being multi-funded.[36]

The place-based housing approach[37] is another example using complexity theory and intersectionality to explore and address the housing pressure in Hastings. Finally, 'A place to call home' is another example that uses these theories to end homelessness at a glocal level. This is a global initiative/campaign by the IGH to support 150 cities in various countries to eliminate street-homelessness by 2030 via cross-agency/universities, and glocal efforts.[38, 39] Nevertheless, due to weaknesses and over/under representation of interconnections in each model above, it is recommended to combine various kinds of models together and implement/prototype them to communicate and address the complexity in multi-sector.

Complexity theory and intersectionality are useful theoretical and analytical frameworks to examine the systematic issue of homelessness in the mental health and addiction sector. These theories offer the public/community members, tāngata whaiora, families and whānau members, policy-makers, funders


Source: Timmins & Ham, 2013

A pictogram of health care system in CDHB

and service providers opportunities to re-conceptualise, re-shape and/or refine existing approaches, networks/ relationships and systems into glocal/third-space, cross-sectoral, and whole-of-systems approaches in local communities to eliminate the vicious cycle of homelessness and mental distress in the mental health and addiction sector in Aotearoa and internationally.


## Acknowledgements

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* https://massey.academia.edu/SholsogaiI


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# Pathways from Acute Mental Health Care for Individuals Experiencing Homelessness

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## Background

There is a well-established body of literature that shows individuals experiencing homelessness have a higher prevalence of chronic disease, including mental illness, than those in the general population and the economic impact on the Western Australian (WA) health system is sobering.[1] WA Health data from the 2014–15 financial year indicates that there were 31,654 inpatient days and 5,048 Emergency Department presentations for patients coded as homeless or No Fixed Address, with average length per separation three times higher than that of non-homeless patients in the same year.[2] This equates to a conservative cost of $79 million to the WA health system in that year alone.[3] Conversely, some of the strongest evidence around reducing hospital demand has emerged for interventions targeted specifically to those who are homeless and have chronic mental health issues.[4]

The prevalence of mental health issues within the homeless population is extraordinary. Within a 1,070 homeless patient cohort identified over a one-year period at our hospital group, 91 per cent had documented contact with state funded mental health services. Data from the Royal Perth Hospital Homeless Team's first two and a half years of operations showed that 12 per cent of their 824-patient cohort (99 individuals) had a formal diagnosis of schizophrenia, over 10 times the world-wide population prevalence of one per cent.[5] However, hospital presentations for mental health among homeless people is only the tip of the iceberg; undiagnosed and under-or un-treated mental illness in individuals with no fixed address is common.

In spite of this, homeless patients in psychiatric inpatient and community mental health settings seldom have their most fundamental needs addressed, namely stable, suitable accommodation and appropriate levels of community support.[6] Without these basics in place, good mental health cannot be achieved.

## The Mental Health Homeless Pathway Project (MHHPP) in Perth is working to address this gap.

### The MHHPP Model of Care

In May 2019, the MHHPP was established to improve service delivery by the mental health services of the Royal Perth Bentley Hospital Group (RPBG) for patients experiencing homelessness.
The RPBG mental health service comprises 92 inpatient beds over three locations, two community outpatient clinics, a specialised Aboriginal mental health service and a small capacity mental health outreach service for rough sleepers.

Prior to the establishment of MHHPP, it had been identified that 30 per cent of inpatient mental health beds in RPBG were occupied by individuals experiencing homelessness. Many repeatedly cycled in and out of the mental health services. Others had long in-patient admissions (>28 days), occupying expensive inpatient beds because of a lack of any appropriate discharge options, largely related to housing.

The MHHPP is run by a Project Manager with a social work background and extensive experience in community homelessness services. She liaises with members of each of the RPBG mental health services to identify and assist their mental health patients experiencing homelessness.

### Key Elements of the MHHPP

- *Identify current RPBG mental health inpatients and outpatients experiencing homelessness*
- *Build and strengthen pathways to stable accommodation.*
- *Build collaborative partnerships with community organisations.*
- *Provide staff training and education.*

The MHHPP is an active participant of the 50 Lives 50 Homes Housing First Program, which to date, has permanently housed over 240 rough sleepers.[7] By being a partner of this program, MHHPP is able to refer individuals directly from the hospital to services that aim to rapidly house and provide wrap-around support to some of the most vulnerable rough sleepers in Perth.

### Hospital Use

In the one-year period (from 9/5/2019 to 24/4/2020) that MHHPP has been operating for, a total of 1,070 individuals with no fixed address were identified within RPBG. Of these, 870 had documented mental health service engagement and were considered 'in scope' for this project.

Hospital use has been calculated for the first 261 patients seen by MHHPP in RPBG hospitals during a two-year period prior to the project. These 261 patients accumulated a total of 1,936 Emergency Department presentations and spent 14,119 days admitted as an inpatient in the year before the MHHPP. In WA, the average cost of an Emergency Department presentation is $838, and each day spent in a psychiatric inpatient bed costs $1,475.[8,9] Based on these figures, for the 261 individuals they used approximately $22.5 million of hospital healthcare usage in a two-year period. If the averages for the 261 were consistent for the whole cohort of 870 in-scope individuals, this could amount to approximately $75 million in hospital use over two years.

### Outcomes

Of the 870 'in scope' individuals (No Fixed Address+mental health service use), 30 per cent or 257 individuals have completed the validated homelessness acuity triage tool, the VI-SPDAT (Vulnerability Index-Service Prioritisation Decision Assistance Tool), with 188 (73 per cent of responders) scoring over 10, indicating extremely high levels of chronicity and complexity in this group and their requirement for long term stable housing and long term community based supports.[10]

However, despite having identified 188 high acuity homeless individuals (VI-SPDAT 10+), only 32 of them (12 per cent) have been able to access accommodation options and/or community caseworker support in the homelessness community sector so far. This is partly due to long term underfunding of this sector, leading to a chronic shortage of homelessness case workers relative to the demand and acuity of the homeless population and the saturated capacity of the existing caseworkers. It is compounded by the lack of available, suitable and affordable housing which leads to caseworkers remaining engaged with clients over long periods of homelessness. Despite these difficulties, the MHHPP manager was able to directly assist 27 patients into long-term housing with appropriate supports.

The MHHPP manager has also trained 111 frontline mental health clinicians (social workers, mental health nurses) to administer the VI-SPDAT survey. This improved staff identification and needs assessments of their homeless patients, allowing appropriate services to be identified.

The MHHPP was able to resolve the situation of some patients with long inpatient stays because of the manager's extensive homelessness expertise. This is powerfully illustrated through the following case study:

## MHHPP Patient Case Study

***Background:*** *Dan is a male in his early forties with severe, treatment resistant schizophrenia and a long history of intimidation and aggression towards others. He was brought to hospital by the police in mid-2018. He was under the Mental Health Act after breaching his Community Treatment Order (CTO) due to non-compliance with anti-psychotic medication. As a result, Dan had become increasingly volatile and aggressive towards staff and residents in his group home and was threatening to kill a staff member there.*

***Presentations and length of stay:*** *Dan remained an inpatient for 11.5 months due to a lack of a suitable discharge option.*

***Outcomes:*** *The MHHPP commenced while Dan was still an inpatient. Dan's VI-SPDAT score was 14 indicating high acuity so he has been accepted into a Housing First program. He moved into a private rental and receives support through his community mental health provider and an after-hours support service. He is now receiving the Disability Support Pension and has an NDIS package with funding approved and a support plan. Dan reports enjoying activities such as fishing and going shopping.*

***Current situation:*** *Dan remains well, compliant with medication and has had no Emergency Department or inpatient admissions since his discharge from the mental health ward.*

### Why MHHPP is Needed

The Western Australian Office of the Auditor General reviewed the use of state funded mental health services from 2013–2017. Within the 212,000 cohort of state funded mental health services users, just 10 per cent of individuals used 90 per cent of all state funded mental health in-patient bed days. This 2019 report recommended rigorous review of this high use cohort to develop alternative *'pathways that enable these people to spend as much time as possible in the community and then move through more intensive services as they need to'*.[11]

While the Auditor General's report did not state the proportion of these individuals experiencing homelessness, we suspect that many homeless people are in this cohort. Within RPBG data, we have already identified that homeless individuals occupy 30 per cent of RPBG mental health inpatient beds at any one time.

If homelessness in mental health patients was rapidly addressed via much cheaper social inputs such as housing and supports, rather than expensive hospital care, the result would be better patient outcomes and considerably lower cost to the public purse. This situation highlights the divide between generally well-funded health services like hospitals, that are heavily impacted financially by social problems like homelessness, and the community homelessness sector which is chronically underfunded so cannot address the cheaper housing and support needs of the homeless population which would reduce their healthcare usage.

### Conclusion

Contacts with the hospital can often be the portal through which the road to housing and recovery begins.[12]

The MHHPP is an example of a service that is actively identifying and engaging with RPBG's homeless patients in their mental health services. The MHHPP is attempting to link them with appropriate services upon discharge to access the accommodation and support they require. We have identified that better patient outcomes and allocation of public services could both be achieved in this high-cost patient cohort by connecting mental health services to rapid access to the fundamental basics of good mental health and wellness, a stable and safe place to stay and appropriate supports to stay well.

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# A Helicopter View of cohealth's Mental Health and Homelessness Programs

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Every year, cohealth supports thousands of people whose mental health is inextricably linked with their lack of housing and social isolation.

They know that the experience of homelessness is different for everyone, which has an impact on the types and levels of support they need.

In a radical shift away from traditional service design and delivery, cohealth involves consumers of its services in a co-design process — in the planning, designing and delivery of the services that will benefit them.

This model ensures that individuals receive the most appropriate and effective care.

Underpinning their work is a holistic approach with wrap-around support. Doctors, nurses, oral health, mental health outreach, alcohol and drug counselling, physiotherapy, exercise physiology, podiatry, dietetics, nursing outreach, family violence counselling and case management, and homelessness case management and support are available to people experiencing homelessness or insecure/poor housing.

Created in 2014 via the merge of three well established community health organisations — Western Region Health Centre, Doutta Galla, and North Yarra — cohealth is steeped in history and community connection from its founding organisations. It is one of Victoria's largest community health organisations and has a long collaborative history of providing a range of specialist health and support services to people in Melbourne's CBD and inner Northern and Western suburbs.

cohealth has significant experience working with people who are homeless or at risk of homelessness, people who experience chronic or episodic mental illness, and people who use drugs or alcohol. cohealth's 950 staff located across 34 sites work together to ensure that services are delivered in a high quality, responsive and accessible way.

As well as offering a range of free primary health services for people experiencing homelessness or who are at risk of homelessness, cohealth provides a number of programs to respond to the social isolation, stigma and long-term health outcomes faced by many people experiencing homelessness.

Sometimes it is about making sure a person experiencing homelessness can access a hot shower, laundry facilities and a healthy meal. The Café Meals Program, for example, has operated for 13 years and provides healthy subsidised meals in local cafes for people with histories of homelessness.

Other times the work is about providing intensive clinical care and case management to people with a history of chronic homelessness and severe and enduring mental illness.

Their flagship homeless service — the Central City Community Health Service (CCCHS) — has been providing welcoming, centrally located community health services since 2012.

One of the key principles of CCCHS, like many of cohealth's programs, is the importance of partnerships and co-located service delivery. A wide variety of integrated services are provided by the suite of agencies working at CCCHS to respond to the physical and mental health needs of people experiencing homelessness, and to address the social isolation and exclusion they experience.

cohealth works well with complexity and understands multidisciplinary practice. Their collaborative approach to service delivery ensures that the consumer journey is not unnecessarily complex and that the consumer receives coordinated care.

The Homeless Outreach Mental Health Service (HOMHS), for example, based at CCCHS, typically provides long-term support to up to 30 clients per year. The HOMHS interagency multidisciplinary team offers assessment, integrated clinical treatment, recovery support, housing support and care coordination, scaled in intensity to meet each client's needs, values and goals.

Street Doctor, a mobile medical clinic, is staffed by a General Practitioner (GP), nurse and social worker. In general, outreach health services to people experiencing homelessness are provided by nurses. GP involvement ensures that many additional services can be provided at the time the patient presents, to ensure their immediate needs can be met in a timely way. The clinic regularly visits sites where people experiencing homelessness meet, responding to the complex health needs of people experiencing homelessness across inner and western Melbourne. It offers clinical assessment, blood tests, immunisations and wound care, and includes writing scripts, providing radiology referrals and preparing mental health care plans.

Similarly, the cohealth Kangaroos is a sport and recreation program giving people dealing with addiction, isolation, mental health issues and homelessness an opportunity to participate in structured sport and

enjoy all its inherent benefits including social connection, physical activity, teamwork skills and healthier lifestyle choices. In winter, the team is part of Reclink's Aussie Rules competition and in summer the team participates in cricket training and a Twenty20 competition. Through this program, cohealth is also able to link participants in to other health and support services.

This approach is mirrored in many of its programs.

In 11 older person's high-rise public housing estates in inner Melbourne, cohealth has placed workers on-site to help vulnerable and isolated tenants feel safe, independent, secure and connected to the community. These tenants often lack support from family and friends and may not be well linked with health and community services; many have mental illness and drug or alcohol dependence.

Out on Melbourne's streets, cohealth aims to disrupt the cycle of homelessness and equip rough sleepers with risk and safety strategies. Knowing that rough sleepers experience health and legal issues that can often trap them in the cycle of homelessness. cohealth recently worked with a 'lived experience' working group to co-design a resource to give rough sleepers important information such as their legal rights, where they can store their belongings and how to access community lawyers.

Learning from lived experience is vital. In Australia the peer workforce is being expanded to help transform services and systems. This is particularly prevalent in the mental health sector and is part of a worldwide movement to embed recovery-oriented practice and transform mental health services and service systems.

cohealth has a demonstrated track record of employing peer workers as a highly valued part of their community mental health teams, to use their lived experience knowledge and expertise as part of their work.

Peer workers draw on their lived experience of mental illness and subsequent recovery in conversations, documentation, decision-making and advocacy. They play a critical role in the delivery of services as outreach workers, recovery coaches and peer-led group facilitators.

Peer workers are particularly well placed to deliver hope, empowerment, self-management and social inclusion.

Peer workers can assist people to engage and participate in their own recovery; to work out what's important to them and the future they want for themselves.

Often they are more effective when it comes to quickly establishing rapport and building trusting relationships with service users.

The unique capability that peer workers bring to teams is expertise and resilience around their own recovery and skilfully sharing and disclosing lived experience to benefit consumers

They maintain a client-centred culture and are 'beacons of hope' for recovery for consumers in outreach teams.[1]

As Australia's mental health landscape changed and the full roll-out of the NDIS took place — cohealth recognised a golden opportunity to build 'peer workers' into their workforce in a more intentional, integrated way.

Peer workers are now embedded into many of cohealth's multidisciplinary support teams where they are respected and regarded as an essential part of the team.

They complement and enrich the existing cohealth workforce and are sustained in their role with ongoing supervision, reflection practice and training and development opportunities.

Peer workers make up part of the workforce for cohealth's recovery-oriented psychosocial programs for people experiencing homelessness and mental illness. The support offered at the Western Psychosocial Support Service and the Inner Melbourne Connections program is often provided by a peer worker who is employed within well-supervised and connected teams.

These programs help people in need of community based mental health support who are ineligible for the National Disability Insurance Scheme. The peer workers help consumers develop skills that help them build independence and improve wellbeing. Support is specific to the individual needs of each person and is focused on improving both mental and physical health. Consumers are also linked into health, disability and welfare services, and provided with access to recreation, education, employment and housing programs.

While the benefits of prioritising and care coordination of people experiencing homelessness or at risk of homelessness by agencies like cohealth are clear, the crux is a lack of affordable private housing and a critical shortage of social housing. An immediate and substantial increase in social and public housing is the single most effective solution to homelessness.

**Endnote**

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# The Royal Commission's 'Generational Change': Mental Health System Reforms Needed to Support Young People Experiencing Homelessness

Kate Torii, Manager, Research and Policy — Homelessness Justice and Family Services Division

The Royal Commission has set the task to 'effect generational change in the Victorian mental health system.' As the Commission listens to the concerns raised by Victorians and advice of experts to develop its final recommendations, this article discusses the reforms that are needed to better respond to the mental health challenges of young people experiencing chronic homelessness in Victoria.

It draws from MCM's submission to the Royal Commission,[1] and consultation with MCM's specialist youth mental health clinicians following the release of the Royal Commission's Interim Report in December 2019.

The Interim Report identified a number of access and navigation barriers that communities across Victoria face. Young people experiencing homelessness are among the most vulnerable communities facing barriers to support. A drastic re-think of the support system architecture is needed to not only address their mental health care needs, but also the range of supports to enable them to be on a pathway to recovery.

Much can be learnt from the experiences of homelessness services about engaging young people and supporting them to access and navigate complex systems.

As a specialist provider of youth homelessness services, and the state-wide youth Access Point to the homelessness service system, MCM supports a wide range of young people experiencing homelessness and other co-occurring issues in Victoria.

Over the last year, *54 per cent of the young people* who accessed Frontyard Youth Services had a prior mental health diagnosis. Within the youth homelessness client group, there is a cohort of young people who identify multiple needs at intake, including safety, drug use, mental health and justice issues. A review of Frontyard data from 2014 to 2017 found that *96 per cent of this cohort* had a mental health concern.[2]

Young people from Indigenous backgrounds, and young people who have had contact with Child Protection and the Out of Home Care system, are over-represented in this cohort.

Adverse Childhood Experiences (ACEs) are traumatic experiences that put people at increased risk of poorer lifelong outcomes in terms of mental health, health, early pregnancy, alcohol and drug abuse and ability to engage with education and employment.[3] A majority of the young people in the complex needs cohort have experienced some form of early trauma, including experiences of disrupted attachment, family violence, discrimination and intergenerational trauma.

Research shows that the more 'complex needs' cohort of young people experience more frequent homelessness service usage, are more likely to have experienced longer term and more frequent episodes of homelessness, and have little or no connection to family.[4]

Young people and their practitioners tell us about the range of barriers to accessing mental health supports, including:

- Falling through the gaps of area-based delivery of mental health services as a result of frequent moves between catchment areas, and being considered 'lost to follow up' when they can't be contacted by phone.

- Exclusion from accessing Prevention and Recovery Centres (PARCs) — the 'step down' clinical mental health services that offer short-term recovery in a residential setting following a hospital admission. This model stipulates having a fixed address to return to and has restrictions around substance use.

- Frequently turned away from services for not meeting eligibility criteria — for instance having substance use issues can be a barrier to receiving mental health treatment.

- Low levels of trust in mental health services — impacted by previous negative experiences of mandated rather than voluntary care.

- Not having a family member as a carer to advocate for their needs, help them to navigate complex systems, and manage medications after discharge from acute care. Australia's mental health system is dependent on an informal caring workforce that if paid, would cost $13.2 billion per annum.[5]

There needs to be a targeted and planned approach to engaging young people from this cohort, without which their mental health needs will continue to go unmet. A number of factors should be considered to ensure that this cohort of young people can be on a pathway to long term recovery.

Firstly, a mental health response for young people experiencing chronic homelessness and mental health issues should consider design features such as: the flexibility to enable 'drop-in' engagement outside of

the 9am–5pm appointment-based structure; assertive outreach; an alternative to area-based allocation of care for young people who experience transient living arrangements; and holistic supports that are able to address mental health issues alongside Alcohol and Other Drug (AOD) treatment and other psychosocial supports. Clinicians who work from a trauma-informed lens, and with non-judgmental approaches are particularly important for young people experiencing homelessness who continue to face stigma in mainstream services.

MCM's Check In service is an example of a program that works flexibly with young people experiencing chronic homelessness to engage with mental health care. It provides four phases of support: Crisis Intervention, Service Navigation, Counselling and Therapeutic Engagement. Relationships are at the heart of the Check-In model — it aims to attune to young people's presenting needs, remaining oriented to engagement as both a therapeutic tool and a service outcome. The key components of Check In — working flexibly with a young person to meet them where they are at, and respond to their situational and contextual need — should be considered in mental health system reforms.

A second important factor to consider is the need for better integration between mental health, AOD, homelessness, family violence and other social services systems to ensure the needs of young people with complex issues are supported. An understanding of the interaction between mental health issues, family violence and trauma, substance use and youth homelessness should underpin this.

One way to do this could be through a greater focus on community mental health responses and treating young people where they are — in the community and engaged with youth homelessness services. Strategies that support integration between sectors could include funded training to build the mental health understanding, knowledge and skills of the community-based workforce working with this cohort, as well as support and incentives for more mental health clinicians to work in multi-disciplinary teams in the community.

The Homeless Youth Dual Diagnosis Initiative (HYDDI) program is one example of a program that enables dual diagnosis specialists to work in youth homelessness programs. The program is highly valued by youth homelessness practitioners, however, it is under-resourced to meet the current level of demand for its services.

A third factor is housing. Secure housing is a fundamental human right, and an absolute necessity for young people experiencing entrenched homelessness and complex mental health issues to be able to address their health and wellbeing. For young people who have experienced trauma and years of instability and who may be experiencing acute mental health symptoms, further consideration should be given to a 'stepped' framework of housing that recognises different support needs at different stages of recovery. An adapted 'step-down' option from acute care is necessary for young people experiencing homelessness who are not eligible for access to the PARC model because they don't have a fixed address, and may have substance use issues.

In the medium to longer-term, there is a clear need for a range of housing options for young people who have diverse needs. Housing options that are integrated with therapeutic support and case management would benefit young people with higher needs, however, there is a gap in this type of response in Victoria.

Finally, a transformational change to Victoria's mental health system would capitalise on opportunities for early intervention much earlier in a young person's life. Childhood experiences of trauma and abuse in the home are contributing factors to the development of chronic mental health conditions as well as many young people's pathways into homelessness. The interim report notes that the most effective early intervention services involve and collaborate with families. Getting appropriate mental health supports to children and families, particularly those who have contact with Child Protection is a clear opportunity to intervene early.

An example would be Victoria's Cradle to Kinder program — an intensive, long term early childhood parenting support program for vulnerable young mothers. MCM leads the delivery of Cradle to Kinder in North Eastern Melbourne, Brimbank Melton and Western Melbourne and offers a therapeutic component through child-led family therapy sessions. The program engages a specialist clinician to work with families to address the effects of extreme trauma experienced by children, and supports parents to understand events from the perspective of the child.

Without access to targeted supports, experiences of homelessness during adolescence pose a high risk of developing into entrenched and chronic homelessness during adulthood. Addressing the needs of young people with the most complex mental health issues that intersect with experiences of homelessness, disability, substance use issues, and structural and societal barriers including poverty, social exclusion and discrimination must be an outcome of this generational change in the Victorian mental health system.

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# Somewhere Over the Rainbow, Considerations for LGBTIQA+ Homeless Persons

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Recent research indicates the prevalence of LGBTIQA+ persons within homeless populations, LGBTIQA+ people are 50 per cent more likely to experience homelessness when compared to their heterosexual counterparts.[1] LGBTIQA+ young people are at an increased risk of experiencing their first episode of homelessness by age 16, largely due to family conflict, family violence and/or being rejected from the family home due to disclosure of sexual orientation and/or gender identity.[2]

Erik, a young Vietnamese-Australian transgender male local to Melbourne left his family home at age 16 due to his parents' refusal to accept his gender identity.[3] Erik began to express his gender at age 14. He explained *'at that time it was really hard for my family because they were expecting I would be a girl all my life.'*[4] When Erik came out as transgender his family pressured him to return to Vietnam to undergo a conversion therapy program, two days before his flight Erik chose to make the hardest decision of his life *'which was to move out of home and leave the people I love most.'*[5]

Erik presented himself at Melbourne City Mission's Frontyard homeless youth service.[6] A year later Erik began living independently in transitional housing while completing Year 12 and volunteering at YGender, a youth advocacy support group for trans and gender diverse people.[7]

Sai Janan is a transgender Tamil woman from Kuala Lumpur in Malaysia. She bears scars on her arms from cigarette burns inflicted by an ex-boyfriend. Coupled with constant transphobic comments from her local community and her experience of family rejection; Sai chose to flee to Australia.[8] Sai arrived in Melbourne as an asylum seeker. With no income she found it difficult to find affordable accommodation, her only option being to share a tiny room in a financially exploitative private rental with three other transgender Malaysian women, each paying $350 in rent per week.[9] Eventually Sai presented at a Melbourne homelessness service for assistance. Her case was considered too complex and she was subsequently referred through to the Council to Homeless Persons.[10] Sai's assigned case worker was able to find an affordable private rental for her and the other women she was residing with, and they now live in Broadmeadows.[11] Another young transgender woman local to Melbourne shared her experience of applying for a rental property where she was given a cold reception and no application forms. She returned to the same real estate agency dressed as a 'man' and was encouraged to apply for the same property she was previously, indirectly denied.[12]

*Source:* Star Observer *February 2020* *(https://www.starobserver.com.au/news/national-news/new-south-wales-news/parade-float-shines-light-on-lgbtiq-homelessness-issue/192949)*

In the ground-breaking longitudinal study Journeys Home, a range of LGBTI participants were asked to describe their experiences of accessing homelessness services.[13] The study found lesbian and bisexual women were among the highest users of housing services, with bisexual males being found to have accessed homelessness services the least, though they were twice as likely to have accessed other welfare services.[14] The study also found lesbian, gay and bisexual people of all genders were approximately 30 per cent more likely to have accessed a mental health support service than their heterosexual counterparts upon intake.[15]

A lack of safety was found to be a common theme when describing a collective fear of other clients of the service and of staff.[16] Rooming houses were identified as particularly unsafe for LGBTI clients due to a significant risk of hate crimes such as phobic slurs and physical/sexual assault.[17] Due to a lack of competency surrounding safety and response for LGBTIQA+ communities; participants shared their experiences of staff using heterosexist language, inclusive of misgendering, concerns surrounding confidentiality and administrative barriers, such as having to provide identity documentation which may reflect the wrong name and gender. Participants reported that these experiences were harmful and burdensome.[18]

It is important to remain cognisant that it is the responsibility of an organisation to commit to safety and response for LGBTIQA+ communities by ensuring staff have access to professional development opportunities to equip them to work safely alongside rainbow service users.

*'What is most important is to cease legislating for all lives what is liveable only for some, and similarly, to refrain from proscribing for all lives what is unliveable for some.'*[19] When we consider the homelessness sector, we must consider what this looks like for LGBTIQA+ service users, particularly for transgender, non-binary and gender non-conforming folks.

The local homelessness sector in Melbourne has taken incredible strides towards LGBTIQA+ inclusion in recent years. Many organisations including the Family Access Network, Ozanam House (VincentCare), Elizabeth Morgan House, Frontyard Youth Services and Housing for the Aged Action Group (HAAG) provide and or advocate for safe spaces for LGBTIQA+ communities who have been rejected from their families, are escaping intimate partner/family violence and or are experiencing comorbidities of mental health and alcohol and other drug use.

In orientating the homelessness sector towards improved outcomes for LGBTIQA+ service users, sustainable, long-term solutions are required.[20] Innovative funding could facilitate services to provide a cross sector response, for example across family violence, AoD and mental health.[21] A focus on early prevention and response with LGBTIQA+ voices at the centre of this work could also serve to build resilience within communities and family systems whether they are of origin and/or chosen.[22]

Togetherness is key, when we examine models of service provision we realise that working in silos is not the answer. When services across sectors begin talking and building community of practices and alliances we stand a stronger chance of being able to address the needs of LGBTIQA+ people accessing our services.

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# Adelaide's Covid-19 Emergency Response: Understanding Experiences and Co-occurring Issues of People Sleeping Rough

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## Introduction

There is no doubt the Covid-19 public health emergency and its rapid, deep and wide economic fallout has impacted many aspects of our daily lives. The pandemic has required us all to re-evaluate our individual, family and community health and safety practices, including staying safe at home where we can. But what happens when you don't have a home?

Over recent weeks, that question has been posed repeatedly in communities across Australia, and internationally. We know from rich person-specific data held in some communities (so termed By-Name data) that people sleeping rough are some of the most vulnerable and at risk people in our communities.[1,2,3] People sleeping rough in Adelaide report a wide range of morbidities, including mental health, physical health, drug and alcohol related illnesses and, often, a simultaneous combination of these. Morbidities are cyclical in nature — they can cause, and be caused, by homelessness.

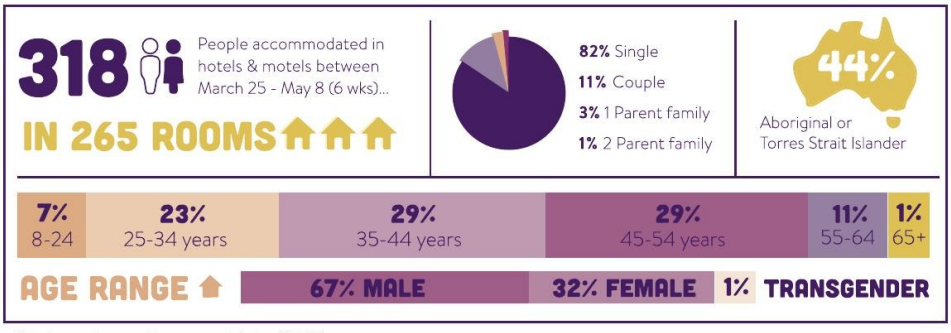
Concerns about the vulnerability of people sleeping rough was at the forefront of a rapid pandemic emergency response deployed by a collective of agencies, including government departments in Adelaide's central business district (CBD), known as CEARS, the Covid-19 Emergency Accommodation for Rough Sleepers response.

## Adelaide's Covid-19 Emergency Accommodation for Rough Sleepers Response

Commenced on March 24, CEARS is a short-term, temporary accommodation response for people sleeping rough, delivered by Neami National's Street to Home, Baptist Care SA, Hutt Street Centre and SYC, funded and overseen by the SA Housing Authority. The rationale for the response is clear and simple:

- ensure people sleeping rough have access to the information and facilities they need to practice basic hygiene and physical distancing to mitigate risks for Covid-19 infection and transmission among the community
- ensure people can access up to date health information and support.

Through the response, people sleeping rough have been safely accommodated in motels and hotels in and around the Adelaide CBD.




Data for people currently accommodated on 8/5/20

Figure 1: Core data about people supported through the CEARS response, March 25 – May 8 2020

There have also been additional responses specific to Aboriginal people from remote communities and youth sleeping rough, based on the understanding that these cohorts have particular needs. The response has provided enhanced opportunities for those sheltered by CEARS, and the services that support them. Additionally, support to access temporary accommodation has been extended to people experiencing homelessness across South Australia.

Providing people sleeping rough with accommodation has given space to address peripheral issues contributing to, and perpetuated by, homelessness. Generally, the primary focus for someone sleeping rough is survival and ensuring safety, not leaving much space to consider deeper or more complex issues. Providing a safe motel or hotel space is enabling some individuals to work towards ending their homelessness, not just focusing on their rooflessness.

## People Supported in the Response

CEARS is driven through deep multi-agency collaboration, via a Covid-19 response team. The response has resulted in more than 300 people being supported into temporary shelter and, importantly, connected with services and supports. Figures 1 and 2 provide core data about the people supported and the response, for the six short weeks since it commenced. The response is now adapting to transition people into longer-term housing.

CEARS was built by leveraging existing relationships between providers, government and business established over two years through the Adelaide Zero Project, the nation-leading effort to end rough sleeping

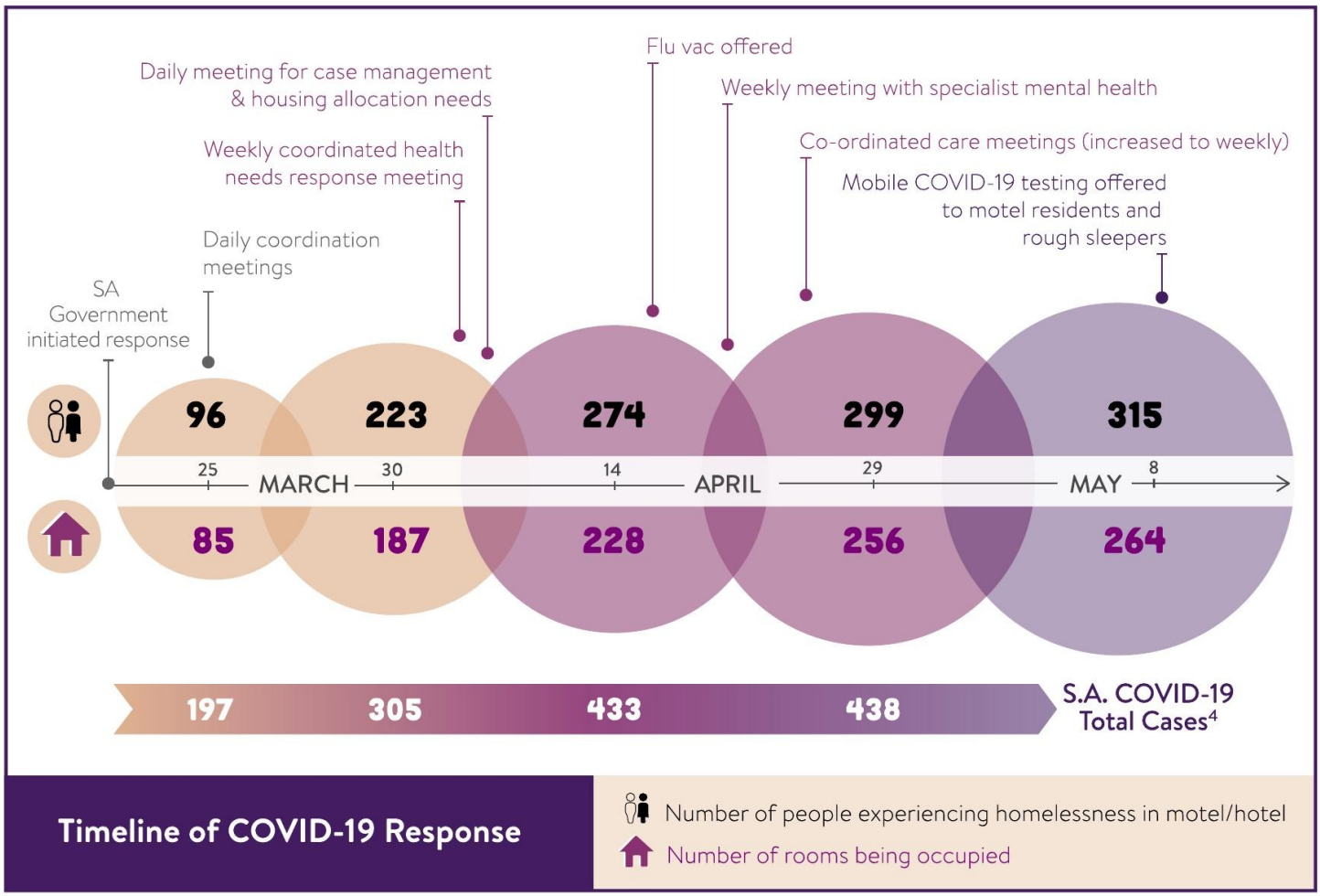



Figure 2: The CEARS response timeline, including intersections with supports provided and confirmed Covid-19 cases in SA, 25 March – 8 May 2020[4]

homelessness in inner Adelaide. Because of this, the response has been coordinated, collaborative, outcomes-focussed and efficient.

Motel and hotel owners in the city and surrounds have engaged enthusiastically in the response. They have been willing to learn how to better support this vulnerable population, to manage some of the challenges that have arisen and are playing a key role in keeping people safe. Together we have learnt that physical distancing is more likely if fewer people are sheltered at each motel or hotel, so we now have an upper limit of 15 at each.

## Health and Sleeping Rough

A cornerstone of CEARS has been the building of a Coordinated Health Response for the people accommodated, extending the work of Adelaide Zero Project's Coordinated Care Group. Data from the Adelaide Zero Project identifies the health vulnerabilities and complexities experienced by this group of people, with high rates of poor mental and physical health and substance use.

The Coordinated Health Response group is an extension of the traditional ways of working for the homelessness, mental health, drug and alcohol services, and housing agencies involved. This group focuses on addressing presenting issues, linking people with services, and gaining a better understanding of what housing and support they might need longer-term. Services are describing enhanced opportunities to connect with people around their health. When people feel safe and hopeful of a better future, attending to issues like their health becomes possible.

## Joe's Experience

Joe's story is one positive example of a health and housing outcome resulting from CEARS. Joe and his worker explain how obtaining accommodation through CEARS enabled him the space to focus on and address broader aspects of his health contributing to his homelessness experience:

*Before Covid-19, Joe had been sleeping in his car. Life was really tough and not being able to care for his son was taking a toll on both of them. He was sheltered in a city-based hotel early in the response.*

*During the time in the hotel, his worker was able to provide food prepared by Hutt St's meal centre. Joe was referred for emergency dental work through the oral homelessness program. He continued to attend Alcoholics Anonymous meetings and connect daily with his sponsor. He was supported to secure a private rental tenancy. He accessed bond support through the SA Housing Authority. The Aspire Program purchased a fridge for his new home set up and are providing ongoing support.*

*Joe is back at work and really happy to have his son with him — they are going to build a kitchen table together. Joe said, 'I feel like I have got my life back', and that he could not have done it without the assistance he received. Joe wanted everyone involved to know how grateful he is for the time in the hotel and the support he received while there. He feels that without that time and space in the hotel he would not have*

*had the chance to get his finances in order or be in the right headspace to work towards private rental.*

This is just one example of how safely accommodating people through CEARS has helped people address a broad variety of issues beyond homelessness. It highlights how, for some people, a range of issues need to be addressed to achieve a sustained housing outcome. There are dozens of similar stories among the people supported through CEARS.

## Learnings

While the CEARS response has required and delivered many learnings and adaptations, we have been able to leverage the infrastructure, processes and principles of the Adelaide Zero Project: collective action, coordinated response, data-informed decision making, a stance that homelessness is solvable, and the belief that everyone has a right to shelter and healthcare. Residents and businesses in the city, who have been central to the Adelaide Zero Project from the start, have engaged with this response, with willing engagement from motel and hotel owners. There is pride in the city around a humane and thoughtful response.

The Adelaide Zero Project maintains a By-Name List providing comprehensive, near-to-real time data including the vulnerabilities, health and housing needs of people sleeping rough in the Adelaide CBD. The existence of the By-Name List was a critical asset and starting point for CEARS, allowing services to quickly identify and locate many people as the public health crisis unfolded in Adelaide. While the 150 people sleeping rough on the By-Name List were the initial focus of sheltering activity, what emerged was a much greater need.

The pandemic shattered the thin veneer preventing people experiencing homelessness and housing instability from sleeping rough. Remote community and state border closures preventing people from returning home, has further complicated the situation. Unsurprisingly, CEARS expanded to support people presenting from outside central Adelaide with acute needs for shelter.

Having people safely accommodated in known locations has helped workers to rapidly connect people with necessary supports and services. The kaleidoscope of doorways, processes, responses and requirements of our systems to access help have been simplified. Time-consuming processes, for example gathering information and completing housing applications, have been managed more efficiently. People have described feeling less confused. The ideal of a 'wrap-around response' has become more achievable. Data on people's needs is guiding coordinated responses between health and social service systems, and is supporting both planning and advocacy for system-change to meet people's longer-term needs.

## Where to From Here?

The CEARS response serves as a template for future crises. It has demonstrated that rapid responses are not only possible but are effective for some of our city's most vulnerable people. Moreover, through the strong partnership between non-government organisations and the SA Housing Authority, there are now opportunities to truly end rough sleeping homelessness in Adelaide's central business district, and potentially beyond.

Of course, there still remain the challenges of long-term mental health support, poverty, and the appropriateness and availability of housing. However, the CEARS response has helped us to further understand the relationship between these critical needs. The response is also prompting service delivery reviews and a focus on opportunities to orient the housing and homelessness system in Adelaide to Housing First; both important considerations in the evolving reform landscape locally. We strongly support nationwide calls for economic stimulus through social and affordable housing as the country emerges from this crisis.

The Covid-19 pandemic presents opportunities to re-evaluate how we do things. It has demonstrated the impact that providing temporary accommodation alongside holistic, recovery-focussed and strengths-based case management can have for people. Individuals have reported that they feel seen for the first time in many years, and humbled because they had somewhere safe to be during Covid-19. Temporary stability and safety has helped many people to start to think about their futures. We cannot underestimate how impactful this response will be for the people supported in the months and years to come. Capitalising on this opportunity to the fullest extent remains our priority in the post Covid-19 landscape.

* All contributors are from Adelaide Zero Project Partner Organisations.

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# Community Development Approach to Eliminate the Housing Crisis in the Mental Health and Housing Sector

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Since deinstitutionalisation and the closure of psychiatric hospitals in the 1980–1990s,[1] housing, homelessness and mental health have been complex global challenges.[2] Despite the implementation of policy reformation/integration and best practices such as housing first, and assertive community treatment,[3] the vicious cycle of homelessness, housing crisis and mental distress (known as revolving door syndrome) still persist in Australasia. The aim of this article is to propose community development approaches as a complementary method to eliminate the revolving door syndrome in Australasia.

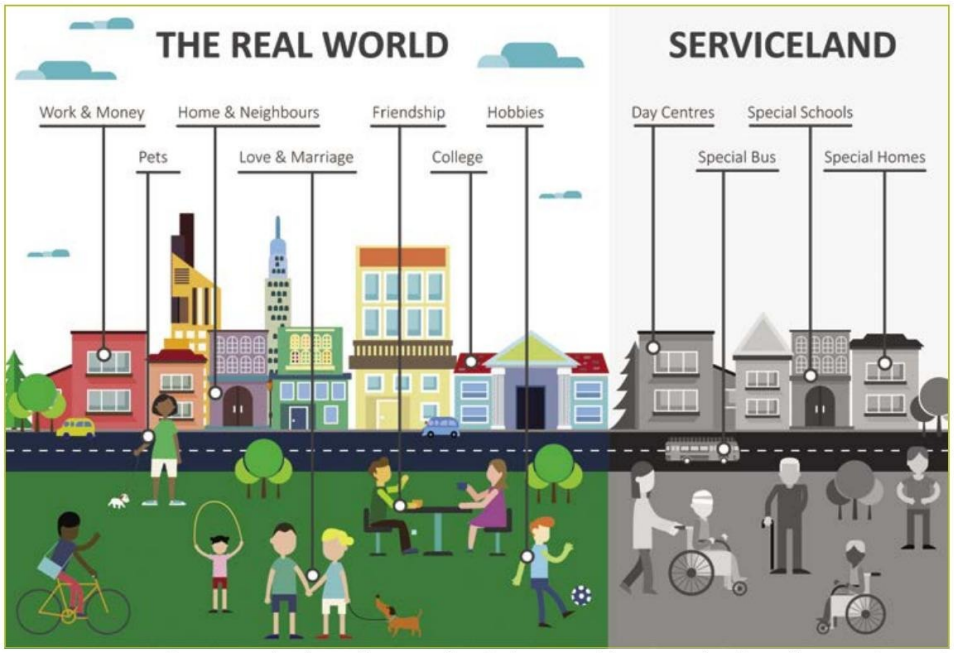
## Consumer Perspective of 'Home'

Several international studies have examined the notion of 'home' among tángata whaiora[4, 5, 6] Gonzalez and Andvig[7] describe 'home' in three themes — key to stability and thriving, mental health hub and base camp for connection and relationship among tángata whaiora while transitioning to 'home' is a turning point for them. Another study shows that many tángata whaiora prefer to live in an independent housing (either their own house or flat-setting), rather than living in a supervised setting with other tángata whaiora.[8] Social environment, such as support networks/neighbourhood interaction, plays a role in how satisfied people feel about their housing.[9]

## Challenges Within the Community

Despite the longstanding work in the mental health and housing sector,[10, 11] the revolving door syndrome continues in Australasia. In Aotearoa New Zealand (thereafter referred as Aotearoa), most of the current mental health and housing approaches used to address this challenge are either structural/policy or service-delivery/practices.[12] Yet, there seems to be a gap in addressing the public/community attitudes around mental health and housing-related stigma and discrimination. McKercher explains that little efforts have been made to develop mental health-related capacity and capability among citizens in Australia.[13] There has been a separation between 'the real world' and 'serviceland' where services/practices become the only solutions.[14]

In Aotearoa, community/the public factor is one of the main causes of homelessness amongst tāngata whaiora.[15] Passive and/or active housing-related discrimination, lack of housing choice and affordability are challenges for many tāngata whaiora in this country.[16] Isogai[17] illustrates two causalities of homelessness for




Source: graphic design by Kate Fulton & idea created by Pete Ritchie (Scottish Human Services).

Figure 1: the real world and serviceland


Big community [29]

these people; estrangement from families and whānau members, and/or flatmates/landlords (a family/whānau member refuses to take them to their home or denies their property rights after admission into the service), and mental health-related stigma and discrimination (landlords perceive tāngata whaiora as non-ideal tenants). Isogai [18] further observes that widespread misconception about homelessness creates another obstacle in the Housing First program as landlords and property managers are less likely to rent or sell their houses (that is, empty-investment/holiday homes [19]) to either housing providers or people experiencing homelessness due to such misconceptions. [20]

## A Call for Community Development in the Mental Health and Addiction Sector

The literature indicates that community development principles/approaches are necessary in the mental health and addiction sector in Australasia.[21, 22, 23] McKercher argues that consumer-led and community-focused commissioning approaches are necessary component in the mental health sector in Australia.[24] Duffy [25] explains that the seven-keys to citizenship (purpose, freedom, money, home, help, life and love) are essential for community opportunity development.

In Aotearoa, an 'On-track' report shows that organisations and systems need to use community development principles by working collaboratively and facilitating 'everyday democracy' among leaders and tāngata whaiora, their family and/or whānau members to create their own future.[26] A collaborative capability report indicates that citizenship engagement in community-led development and Whānau Ora is essential approach to allow citizens to have greater power over their own wellbeing. The He Ara Oranga report recommends wellbeing and community as a new approach.[28]

## Community Development Approaches

To break the vicious cycle, organisations are recommended to use community development principles/approaches (as a complementary to other mental health and addiction services/initiatives). One such community development approach is asset-based community development (ABCD), a communication methodology to build sustainable and powerful communities using the strengths, talents, and/or skills of local citizens.[30]

Using ABCD, organisations may establish an advisory group/council of tāngata whaiora experiencing homelessness as an initial stage of development within local communities.[31] Through an advisory group/council, organisations may adopt other community development principles and the seven-keys to citizenship [32] to produce various initiatives, including social/impact enterprises. Rākau Roroa/Tall Tree programme is an example of the ABCD approach in Aotearoa.

Human-rights community development is another approach that promotes human rights for tāngata whaiora creatively.[33] Under this

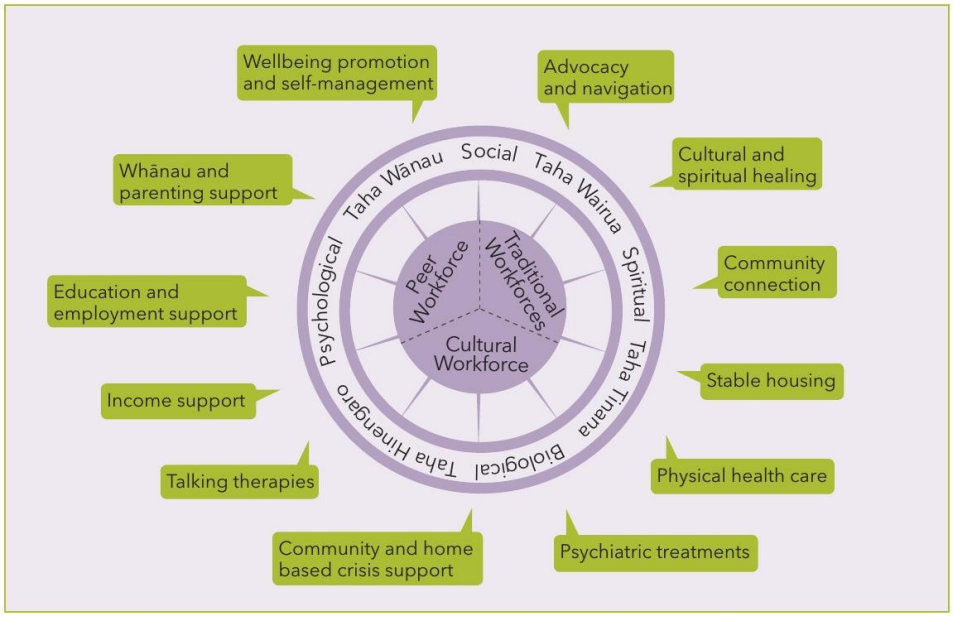



Figure 3: Big Community wheel of responses and workforces

approach, an organisation may use a tāngata whaiora leader/trainer/facilitator to strengthen the ability to identify and address human rights concerns in their communities. The Taku Manawa is an example of such an approach, which uses interactive, lived-experienced-led workshops in the community.[34] This approach supports community/workforce to transform to big community wheel of responses and workforces.[35]

Another community development approach is a locality-development model. Locality-development is one of three conceptual frameworks for community change that uses broad-based participation at local community level.[36] Using this model, organisations can co-develop community education workshops/forums, for example; ReThink programme,[37] and Housing forum [38] to support the public to address/manage 'symptoms' of mental distress and/or housing crisis amongst tāngata whaiora. Positive Mental Attitudes is another example of cross-sectoral, multi-agencies coalition to produce various community-led initiatives in Scotland,[39] aligned with the vision of 'On-track',[40] and local strategies by the Institute of Global Homelessness.[41]

Finally, the community-led development approach [42] of co-housing [43] is useful in breaking the cycle. The central focus of community-led development approach is self-determination of communities in identifying challenges and deciding strategies to address these challenges.[44] Under this approach, tāngata whaiora, architects, policy-makers, and/or providers/property managers may co-design, and co-produce housing of their choice.

As is shown above, community development approaches are useful approaches to eliminate the revolving door syndrome in Australasia.

* Sho Isogai (MRSNZ) Re-Creation Consulting (RCC) and country correspondent for Aotearoa at the International Association of Community Development (IACD) – https://massey.academia.edu/ShoIsogai

## Acknowledgements

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# Taking Care to Young People via cohealth's Mobile Health and Access Point (MhAP) Bus

Lanie Harris, Communications, cohealth
and Chris Platt, Program Manager AOD Treatment Services and HOMHS, cohealth

*NB. This article describes both how the MhAP program has operated pre-Covid-19, as well as the approach that it will engage to comply with Covid restrictions.*

cohealth's Mobile health and Access Point (MhAP) program is a mobile health service for vulnerable young people seeking to address their problematic alcohol and other drug (AOD) use.

The MhAP program is an initiative of cohealth and the Youth Support and Advocacy Service (YSAS), which is designed to address the systemic and practical barriers experienced by young people living in Brimbank, Melton and Wyndham. It has been funded since January 2017, operating three days per week from a variety of locations in the western suburbs where at-risk youth hang out.

The MhAP model provides a youth-friendly access point where young people can receive immediate AOD, medical and other support.

Although ostensibly the program is designed to provide AOD support to young people, in practice clients access a range of education, information and referrals addressing issues like depression, anxiety, domestic violence, sexual health care, physical/general nursing support, care coordination, needle syringe supplies and a range of problems that come from being homeless.

Young people, usually aged between 12 and 25, come to the bus to enjoy BBQs and other meals, art activities and performances.

The bus makes use of a multi-disciplinary team including a team leader, community nurse and two youth workers.

A significant proportion of the young people that drop-in to the bus are experiencing homelessness, most commonly in the form of couch-surfing. Of those clients who disclosed their housing status, nearly 25 per cent were not in stable housing, according to the 2018 evaluation.

The MhAP team offers an easy way for young people to find health and social support, taking the care to the clients rather than hoping they will travel to a cohealth site.

The informal, slow, deliberate and friendly nature of the program, embedded in an area familiar to young people allows for regular and ongoing support to be provided.

Here we give you an insight into how the MhAP program has helped three different clients:

***Cameron***, 13, regularly visits the bus, and after building a rapport with one worker confided that he and his sister were experiencing domestic violence. As a result, the team, along with Cameron's own youth worker, followed child protection guidelines and contacted authorities. They also regularly talk to a long-term mentor who has been arranged to help Cameron, as well as workers from his school who have been monitoring his safety. Cameron continues to visit the bus and is encouraged by staff to continue to attend his various meetings and to share any new safety or health related information.*

***Reggie***, 23, came to the cohealth MhAP bus in Sunshine where he told coworkers of his problematic drug use. Because he was injecting heroin and methamphetamine, he had lost his home but was most distressed because his young son had been removed from his care. Reggie accepted a fast-tracked direct referral into the Youth Support and Advocacy Service (YSAS) rehabilitation unit, which he attended for 21 days.*

*Reggie later advised coworkers that he had completed the program, found permanent, stable housing and ultimately his son was able to live with him again.*

*The MhAP bus provided a quick and direct referral pathway to treatment which may not have happened otherwise.*

***Mohammed***, an 18-year-old youth who lives with schizophrenia and autism has visited staff at the Melton bus stop. Recently, he became estranged from his family and homeless.*

*cohealth's MhAP program referred him to mental health services who helped him to find somewhere to live at a nearby supported facility, but he felt unsafe and left.*

*The cohealth team supported him as he settled into private accommodation which he found, offering advice on house etiquette. Mohammed also told staff that he was not taking his medication. The team helped him understand how important it was to comply and as a result, his mood has settled.*

* All names have been changed


## How will MhAP's service delivery change during the Covid-19 pandemic?

Since the Level 3 restrictions were introduced in Victoria, the MhAP bus has been taken out of operation. However, plans are currently underway to re-introduce the service in a modified way.

In the short-term, this is likely to mean that the bus will be replaced with a car, and a reduced team of staff offering brief intervention, care co-ordination, nursing support, and other health services as able.

The BBQs and interactive art programs that have proven so popular in engaging young people will likely be replaced, temporarily, with pre-packaged meals and low-contact engagement activities.

Rather than a broad-based, open door service, the MhAP program will employ a far more targeted response to assertively engage with the target cohort.

Once back on the road, the MhAP team are expecting to see the social and economic impacts of coronavirus reflected in the types of issues that people present with.

The high rates of unemployment may result in an increased rate of homelessness among the MhAP client group, though this is only a prediction at this stage.

# Mental Health and the GreenLight Supportive Housing Program

Olivia Killeen, Project Officer, Social Policy and Strategic Projects, Sacred Heart Mission.

The GreenLight Supportive Housing Program (GreenLight), now in its second year since inception, is an example of a new program delivered by a Victorian partnership consortia that is making a significant impact in helping people to settle into and sustain housing, keep out of the cycle of homelessness and address their mental health and wellbeing.

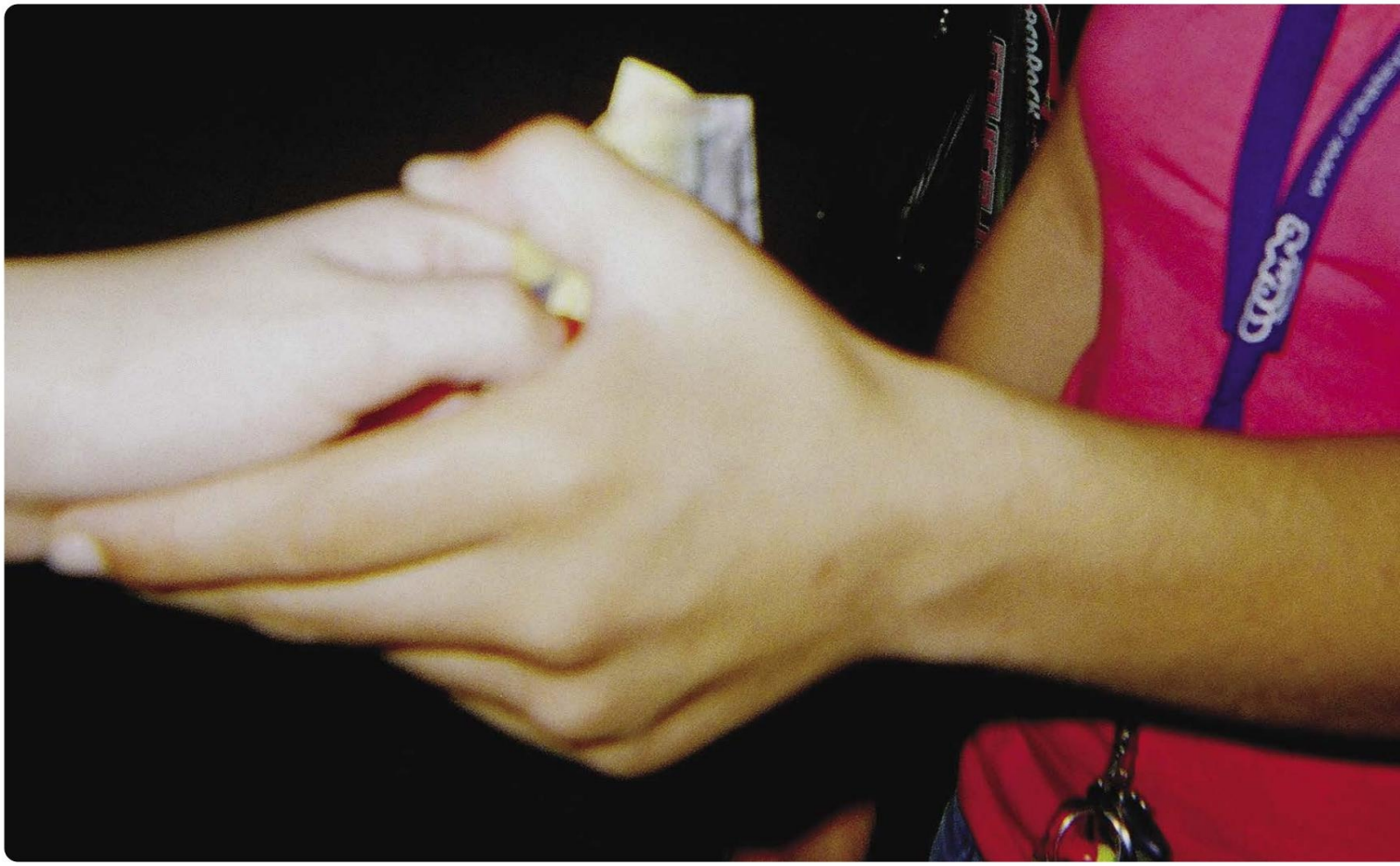
Sacred Heart Mission (SHM) partnered with VincentCare Victoria and the Salvation Army on this exciting program that was funded through the Victorian State Government's 2018 Homelessness and Rough Sleeping Action Plan.

GreenLight is grounded in trauma-informed care (TIC) principles. The 2015 Trauma and Homelessness Initiative confirmed that most of our clients have been exposed to multiple traumatic experiences prior to, and as consequence of, experiencing homelessness.[1]

Trauma informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.[2] The GreenLight model has unique features, and we have some early outcomes and case study data that highlights the benefits for clients involved in the program.

## Program Objectives

Led by SHM, the GreenLight sub-teams are multidisciplinary, and comprised of Team Leaders, Supportive Housing Workers (SHWs) and Peer Settlement Support Workers (PSSWs), based at each location, as well as Mental Health Clinicians (MHCs) who work across all three providers. The roles work together to support people to establish a home and social connection, assisting them to obtain and settle into their housing. An additional component



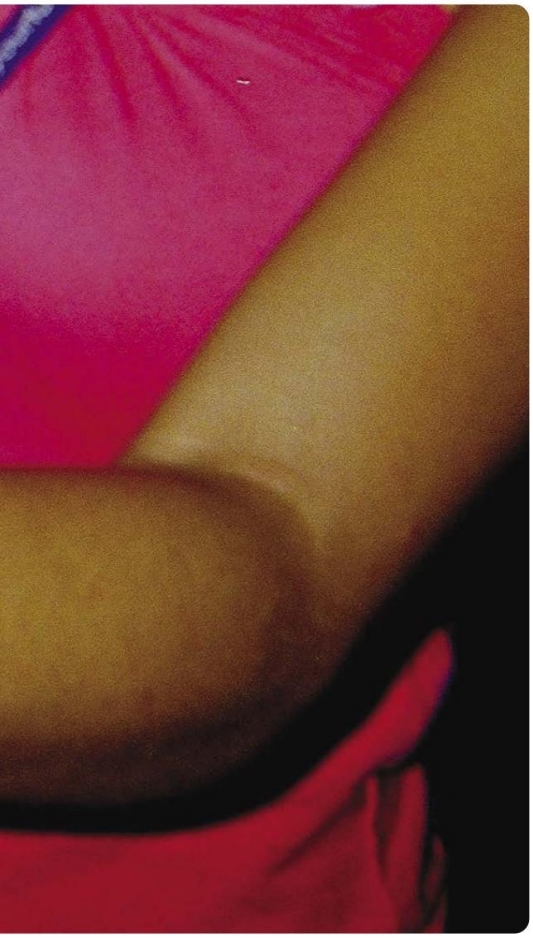
is to support people who have been in a tenancy for less than 18 months, and who are at risk of incurring breaches, or a Notice to Vacate. Neighbour relations are the highest risk to tenancies among GreenLight clients, and several have Tenancy Support Plans in place in relation to this. A high number of clients also have approved priority transfers.

## Supportive Housing Workers (SHW)

SHWs provide assertive engagement, brief intervention, case management and service coordination with people who have experienced chronic homelessness and/or primary homelessness. Their primary role is to provide person-centred services that are effective in achieving client goals and program outcomes.

## Peer Support Model

Integrated into GreenLight is the peer support model, which is relatively new to the homelessness sector. The PSSWs have a lived experience of homelessness, and an awareness of the complexities of this experience, such as impact on mental and physical health and wellbeing, employment, and social participation. These staff members provide supports to GreenLight clients who are socially isolated and help to bridge the power imbalance between staff and clients and upskill their colleagues in their understanding of trauma. These roles are also empowering for people who have experience as service users and may have experienced significant barriers into employment first-hand.
The experience of the peer support model within GreenLight will contribute to the evaluation of the Peer Support Resettlement Project currently being undertaken by Council to Homeless Persons (CHP).



The benefits that a PSSW can bring are highlighted through the experience of Will* who had experienced long-term homelessness and is deeply entrenched in the homelessness subculture. He discussed his past trauma and current frustrations with his housing with a PSSW, forming a peer relationship based on mutual interests. He has told the PSSW 'you understand', in relation to homelessness challenges. This is beneficial for both Will and the worker, who has felt that their lived experience is useful and valuable. Will has worked with his PSSW to improve his wellbeing and is exploring ways to improve his living situation — such as spending time in nature, creating artwork and visiting galleries. Being able to have a PSSW accompany him to activities has been very beneficial in assisting him to reconnect with things he likes to do and experience joy. This has prevented him from withdrawing into himself and becoming socially isolated and feeling claustrophobic in a small property by going out regularly and engaging in the community.

## Mental Health Support

The inclusion of Mental Health Clinicians (MHC) in the program recognises the challenges that people experiencing homelessness have in receiving mental health supports and addressing their mental health and wellbeing. These staff members provide mental health support and clinical expertise to staff and clients through the provision of primary consultation, staff training and capacity building, and systems navigation, and lead for service coordination in relation to multi-agency mental health response/services.

***Paul****

*How an MHC works to support the SHWs and PSSWs is illustrated through the example of Paul, a man in his mid-50s, who had lived in a shared rooming house for many years and was referred to GreenLight after moving into a self-contained property. He was worried about the increased costs living independently, was experiencing loneliness after leaving the more social rooming house and was experiencing suicidal ideation, relating to past events and regrets (such as drug addiction and losing contact with family).*

*The SHW supported him to apply Aboriginal philosophies of healing and recovery and engage in activities such yoga and swimming, to support his wellbeing. They linked him to the nutritionist at SHM's Hands on Health Clinic, who slowing built his confidence by learning how to cook meals on a budget and has shared this knowledge with his peers.*

*Paul identified that he didn't like the 'medical model' of mental health, so his SHW asked the MHC to take him shopping for furniture for his property, allowing them to link in in a gentler way and build rapport before exploring his mental health challenges together. They attended the Men's Shed together and looked at volunteering options — Paul has previously worked with cars and is interested doing this again. Having made the connection with the MHC first, Paul is more open to discussing his mental health. He has now completed drug and alcohol detox and is engaging with MHC support to help him to stay clean.*

*Mental health diagnoses are common for participants in the GreenLight program and having the combination of SHW and MHC role allows their housing and mental health supports to be linked and provided in a holistic way.*

***Fred****

*Fred is a client who has experienced significant trauma from an early age, alcohol abuse, long-term homelessness and has a diagnosis of schizophrenia. He was in psychiatric care when first engaging with the GreenLight program, after he had become extremely distressed in his housing and was being transferred to a lower-density property. The GreenLight team helped him to settle into his housing, but he was readmitted to hospital twice, after his mental health deteriorated.*

*The GreenLight team engaged with his housing provider to ensure the stability of his tenancy and worked with the hospital to ensure he attended follow up appointments post-discharge. He requires ongoing support to attend appointments, as well as art classes and GreenLight has discussed applying for the NDIS with him.*

*Fred has now commenced the NDIS application process, after eight months of working with GreenLight. Without this groundwork, achieved by intensive and flexible support, Fred has built trust and is open to receiving more long-term support. The situation experienced by Fred is not uncommon within GreenLight, and the MHCs spending at least half of their time assisting clients to access the NDIS.*

## Outcomes from the GreenLight

Within GreenLight, client outcomes are tracked over time using SHM's Trauma Informed Client Support Planning and Outcomes Tool (TICSPOT). SHM developed TICSPOT with client input, and it has been continually refined since 2014. TICSPOT is designed to collect client information across a range of outcome domains to show how things have changed for the client over their time in the program.

The outcome domains stem from the determinants of overall individual wellbeing: housing, health and wellbeing, independence, social inclusion and economic participation. It asks clients to rate how they are going from their own point of view to assist in engagement, goal setting and support planning. Workers also answer questions about how the client is tracking against his or her goals. Data is collected in the form of surveys, and is done at initial, review (3-monthly throughout intensive case management), and exit.

GreenLight had 149 clients referred into the program as of January 2020. When conducting outcomes surveys, across all three GreenLight sub-teams, workers reported that the primary focus of effort for clients was in housing (67 per cent) and health and wellbeing (62 per cent). After 12 months of the program, all five key outcomes domains (housing, health and wellbeing, independence, social participation and economic participation) have demonstrated improvements in the average client self-ratings, ranging between an improvement of 8 per cent (social participation) to 18 per cent (independence).

## Considerations of Trauma Informed Care (TIC)

TICSPOT measures the program's level of trauma informed care from the perspective of the client across six principles: belief in recovery, focus on strengths, promote connections, promote safety, trauma awareness and rebuilding control. Clients scored GreenLight's level of trauma-informed care at 82 per cent.

Workers also reported that permanent housing had remained steady over time, around 90 per cent, and the use of crisis or short-term housing and rough sleeping had remained low. We are looking forward to collecting the outcomes data for clients for the remainder of the program and seeing what further changes arise over this time.

GreenLight was funded as a two-year program, and we are hopeful that the program can continue after the initial funding period has concluded. By being able to provide flexible tailored support to people who have experienced long-term homelessness, chronic disadvantage, trauma and mental health issues, GreenLight has ensured that clients are able to maintain their housing, reduce their use of crisis housing and improve their mental health and wellbeing.

* Names have been changed for privacy reasons.

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# A Program at the Nexus of Mental Health, Homelessness and the Justice System

Michael Spencer, Program Manager-Forensic Mental Health, cohealth
and Lanie Harris, Communications, cohealth

A new cohealth program operating in Melbourne's north and west is a Victorian first, supporting clients who've had contact with the justice system to improve their mental health and wellbeing.

The association between incarceration and homelessness has long been recognised, with studies consistently revealing the over-representation of former prisoners in the homeless population and vice versa.[1]

A 2018 Australian Institute of Health and Welfare report found that one in two prison discharges expected to be homeless upon release.[2]

The relationship between homelessness and incarceration is made more complicated by the greater incidence of mental ill-health among the prison population. Almost half of prison entrants (49 per cent) reported having been told by a health professional that they have a mental health disorder, and more than one in four (27 per cent) reported currently being on medication for a mental health disorder.

Combine these statistics with the fact that people who've had contact with the justice system are less likely to have finished high school, more likely to have chronic physical health problems, more likely to have experienced trauma and more likely to have used illicit drugs, and arguably this is one of the most highly vulnerable groups of people in the general population.

Armed with this knowledge cohealth has developed a new program offering flexible mental health care for those with community corrections orders and parole orders.

The Forensic Mental Health in Community Health service (FMHiCH) offers a brief mental health treatment approach of four to eight sessions with clients who have mental health treatment conditions on their parole or corrections orders. This is delivered by a team of mental health clinicians and Care Coordinators. Referrals to the program come via Community Corrections and are received by a Senior Mental Health Nurse who provides a comprehensive assessment and then refers to a clinician or coordinator for treatment.

While many mental health services aimed at adult offenders struggle to gain traction, the cohealth FMHiCH program has found success by adapting to clients' needs.

For example, to counter low client attendance, senior nurses and clinicians will travel to the community correction sites to meet with clients rather than always meeting at cohealth locations.

Giving people one less place to get to is an engagement tactic that has proven successful in helping clients to stay in touch.

The cohealth team of 10 is based in Footscray and Collingwood and has been working with clients since December 2018.

They liaise with staff from 10 corrections centres in South Morang, Heidelberg, Reservoir, Coolaroo, Broadmeadows, Werribee, Sunshine, Melton, Melbourne and Fitzroy North. Clients, 80 per cent of whom are male, have committed offences ranging from drink driving and assault, to theft, breaking and entering, breaching apprehended violence orders, and sex offences.

Since the program commenced in December 2018, it has received 512 referrals from Community Corrections.

Of current referrals, clients range in age from 18 to 64. The most common reasons for referral include moderate depression and anxiety, the effects of trauma, and personality disorders.

The vast majority of people supported by FMHiC come from backgrounds of entrenched social and economic disadvantage.

Many have come from difficult family units where they have experienced neglect, abuse and violence. The clinicians, psychologists, social workers and nurses focus on wellbeing and the primary care that might help the clients live healthier lives.

For many of these clients, it is about having someone who simply listens. Some of them tell FMHiC staff that it's the first time in their lives that they've had a person to talk to.

cohealth's long-term goals for FMHiC clients is wellness and improved mental health, achieved by linking people to essential services, and in turn, that reduce the likelihood of people reoffending.

But the chronic shortage of social and affordable housing for people exiting prison, and particularly for those with complex mental health issues, undermines efforts to support people to transition back into the community.

For those exiting prison after an extended period of incarceration, adjusting to the outside world is overwhelming, as is the responsibility of coordinating one's own care.

Prior to exiting prison there may have been attempts to connect people to housing and other services. The success of these efforts relies, in the former, on the availability of housing and, in the latter, on an individual having the capacity to follow up referrals independently.

In rare cases where clients secure permanent, self-contained housing, there is rarely the sustained support attached to the housing that is required for people with complex needs to sustain a tenancy.

Those not lucky enough to access self-contained housing find themselves referred to rooming houses where they are forced to share their living quarters with upwards of 10 strangers, each battling their own demons.

It is not surprising that clients reject offers of rooming houses, instead opting to sleep in their car, or on the street where they feel they have greater control over their living space.

Due to the complex nature of clients engaged in the FMHiC, therapeutic interventions must be approached with extreme sensitivity. Factors such as trauma, homelessness and substance use can impact the effectiveness of counselling-based interventions so FMHiC staff work with clients based on their self-expressed needs.

For some, their needs may be as 'basic' as needing a new set of teeth. Responding to such an essential request is not just fulfilling a health need, but is part of the process of rebuilding a social identity that has been slowly eroded.

Some clients are unable to access housing and services because they don't have ID, nor a birth certificate enabling them to get ID. Helping them navigate the complex process of getting personal identity documents is a basic, yet essential, support service.

Clients referred to FMHiC often struggle to access services because their behavioural issues lead them to be banned. Traditional support systems have limited pathways for highly complex people, such as those with personality disorders who present as aggressive and disruptive, with physical representations of their mental ill-health. Perversely, the individuals with the direst need for support are often those that miss out.

The FMHiC program provides only a brief mental health treatment approach and is not designed as a long-term support solution. But the early clinical intervention model is showing positive signs of success only 18 months into the establishment of the program.

Although a formal evaluation is still underway, preliminary indications are that clients are engaging and are tapping into primary health care.

However, it is also clear that long-term success in improving the health and wellbeing of complex clients relies on broader system factors; including flexible and adaptive mental health plans and sufficient and appropriate housing.

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# Improving Mental Health Service Use Among Young People Experiencing Homelessness

Cameron Boyle, Senior Policy Analyst, Orygen

While homelessness can impact people of all ages, the burden of homelessness is one that falls disproportionately on young Australians. People aged 12 to 24 are less than 20 per cent of the Australian population, but comprise a quarter of individuals experiencing homelessness.[1]

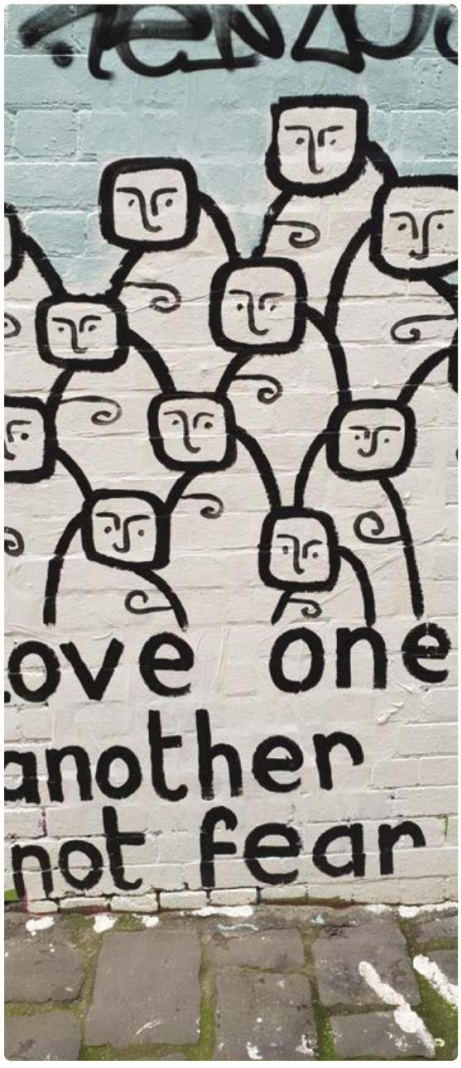
Experiencing homelessness as a young person also greatly increases the risk of further experiences of homelessness later in life. It has been estimated that almost three quarters of young people who experience homelessness in adolescence will experience homelessness in later life.[2]

## Relationship Between Mental Health and Homelessness

While there are many factors that lead to a young person experiencing homelessness, mental ill-health is often a key part of the narrative of many young people who experience homelessness. The onset of mental ill-health generally occurs in young people with 50 per cent of mental ill-health onsets before the age of 15 years, and 75 per cent by 24 years.[3] This period of a person's life is a time of key developmental milestones. If mental ill-health is left untreated, the trajectory and lifelong impacts of mental ill-health are borne by the individual, their families, their communities and society. This can lead to experiences of homelessness, but can also include: unemployment or underemployment, social exclusion, poor physical health, substance abuse and premature mortality.[4]

Mental ill-health is estimated to be a contributing factor in becoming homeless for one-third of young people who have experienced homelessness.[5] This is equivalent to other key risk factors for young people, including abuse, poverty and delinquency.[6] It is estimated that mental ill-health increases the risk of experiencing homelessness by 70 per cent.[7]

In addition to the role that mental ill-health can play prior to experiences of homelessness, a young person's mental health is also likely to be negatively impacted by the experience of homelessness. The challenges faced by a young person who is homeless can exacerbate, or contribute to the onset of, mental ill-health. As many as nine-tenths of young people experiencing homelessness have been estimated to meet criteria for diagnosis of at least one mental disorder.[8]




Trauma is also a common feature of youth homelessness. Firstly, trauma is a major risk factor for homelessness, with half to three-quarters of young persons who have experienced homelessness having experienced physical abuse and approximately a third will have experienced sexual abuse.[9,10] Trauma is also a large part of people's experiences of homelessness. Up to 83 per cent of adolescents experiencing homelessness were physically or sexually victimised after becoming homeless.[11] There is also a significantly increased risk that young people experiencing homelessness will witness traumatic events.[12]

## Mental Health Service Access for Young People Experiencing Homelessness

Although mental ill-health and trauma play a large role in youth homelessness, young people experiencing homelessness are unlikely to access support services. It has been found that only one-third of young people with mental ill-health who are experiencing homelessness will use mental health services.[13,14] Young people in general have a number of barriers which limit service use, including concerns about confidentiality, the cost of treatment, lack of transportation, or a belief that they can handle the issue themselves.[15]

The reason that lower rates of service use are so concerning among young people is that treatment of the underlying causes of homelessness (such as mental ill-health and trauma) is an important element in breaking the cycle of homelessness that can occur for young people.

The most common reason for low service use among young people experiencing homelessness is a lack of awareness of the services that are available to them.[16,17] Young people experiencing homelessness often lack experience in service navigation. Studies of people of all ages who have experienced homelessness have found that those who are newly homeless are much less likely to be aware of available services than those experiencing chronic or periodic homelessness.[18]

As a lack of awareness is a major reason underpinning low service use, it is vital for governments and service providers to work towards improved service awareness among young people experiencing homelessness, or at risk of homelessness. Educational and community programs for young people experiencing homelessness is one option that can increase recognition of existing services.[19] More proactive options to improve service awareness include outreach programs (a recent example of which can be seen in Melbourne with Hope Street's First Response Youth Service) or care coordinators for at-risk young people.[20]

While a lack of service awareness is an important factor, it is not the sole reason that underpins low service use among young people experiencing homelessness. In addition to the reasons limiting service use by young people generally, young people experiencing homelessness are less likely to use services due to a lack of coordination or communication between service providers, inflexible entry criteria, service complexity, and feeling devalued.[21,22]

## Involving Young People to Improve Service Use

Low service utilisation by young people experiencing homelessness can be improved if services are tailored for the needs of young people.[23] The specific factors which can improve service use include a focus upon personal relationships between staff and the young person, collaboration and integration with other services, and service accessibility (for example, through flexible entry criteria, after hours availability, and/or being located close to public transport).[24]

The best way to ensure that these factors are present in mental health services is for those services to be tailored for young people by involving young people in the development and delivery of those services.[25] As young people are disproportionately represented in the homeless population, as well as being a key at-risk cohort, it is vital for young people with lived experience of homelessness to have a voice in the services that are intended to respond to their needs.

A recent example of this can be seen with the Youth Affairs Council of Victoria who facilitated discussions with young people with lived experience as part of their submission to the Victorian Legislative Council's Inquiry into Homelessness in Victoria. By offering young people a stronger voice, we can intervene in early experiences of homelessness and mental ill-health and help young people towards a future of stable housing and personal wellbeing.

The issues raised in this article are only a small subset of the challenges facing young people experiencing homelessness. Orygen is currently developing a policy report on young people, mental health and homelessness, which has been drafted in consultation with stakeholders and researchers and will be available by August 2020.

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# Supporting Forgotten Populations: Outer Metro Melbourne and Supported Residential Services

Rajna Ogrin, Bolton Clarke Research Institute, Mary-Anne Rushford and Karyn Gellie, Bolton Clarke Homeless Persons Program (HPP)

## Introduction

Approximately 25,000 people are experiencing homelessness in Victoria.[1] Homelessness may mean:[2]

- being socially isolated, without the support network of family and friends
- the absence of a roof over one's head or living in unstable or unsafe conditions
- receiving a low income, having few independent resources and having reduced autonomy, life choices and prospects of self-support.

People experiencing homelessness are characterised by a lack of resources that can include one or all of the following: financial, social, emotional, physical, support systems and spiritual — having a sense of hope.[3] A lack of these resources further alienates and inhibits their ability to access required services.[4]

Homelessness is associated with chronic disease and medical conditions linked to premature death as well as mental health conditions, alcohol and other drug misuse, and high rates of chronic disease.[5] People experiencing homelessness have higher rates of cognitive impairment, smoking related morbidity and medication non-adherence compared with the general population.[6,7,8] They often do not seek health care due to the priority of other basic needs, not feeling their needs are listened to, a lack of trust and stigmatisation.[9]

These factors may influence decisions to delay accessing health services and specialist medical care until they are in crisis and their issue has become urgent.[10] This health inequality is socially determined and can lead to blame for individual choices rather than recognising disempowerment and a lack of control to make health choices.[11]

Assertive outreach and services that co-locate with other accessible services are important for increasing engagement of people experiencing homelessness.[12] These services recognise that addressing the social determinants of health and improving access to health care can reduce healthcare costs in the long-term.[13] The aim of these services is to support wellbeing, to stop the spiral into reaching crisis.

## Homeless Persons Program

The Homeless Persons Program (HPP) has been in operation in Melbourne for over 40 years, embedded within a large health and aged care provider, Bolton Clarke (previously known as, the Royal District Nursing Service, RDNS). The program aims to overcome barriers to healthcare and address the diverse health and social needs of this group. HPP utilise a community health nurse (CHN) model to deliver holistic primary healthcare and assertive outreach, either: fixed outreach, in the form of a nursing clinic co-located with a community agency or accommodation service; or mobile outreach, outreaching to public places, food programs, rooming houses, caravan parks, supported accommodation and other services.[14] The CHN operates as a first point of contact for people experiencing homelessness, their clients, with the client directing the care that they receive, increasing their engagement.[15]

There are two hidden populations within those experiencing or at risk of homelessness that were identified by HPP as being underserviced: People experiencing homelessness in outer metropolitan Melbourne;[16] and people living in Supported Residential Services (SRSs).[17] Both include people who are generally excluded from mainstream health support and have poor health outcomes. The HPP undertook two extension programs, to include people experiencing homelessness in Frankston, and SRS residents.

## HPP Extension to Frankston

In a three-year project funded by Gandel Philanthropy, the HPP service was expanded to Frankston, where the CHN co-located with a local existing service. Setting up the four day per week service consisted of:[18]

- mapping available services in the area, connecting with services and addressing service gaps
- connecting with the target group, using assertive outreach as well as a fixed clinic
- assessing the needs of people experiencing homelessness, referral to services, following up and advocating to support them to access the services they needed
- establish new contacts/ services to overcome gaps and facilitate client engagement.

People needing help were successfully engaged, and the HPP CHN was able to identify their needs and support them to address these needs. The success was only possible because of the high skill level of the CHN. This included:[19]

- clinical assessment skills
- being independent and resourceful

- attributes of empathy, caring, patience and being understanding

- knowledge about social aspects of healthcare (both physical and mental health, as well as drug and substance abuse issues) and system operation.

This approach led to engagement of people experiencing homelessness in Frankston, complementing local service provider support so that people experiencing homelessness could access the services they needed.[20] The position obtained ongoing funding, and an additional position was funded in an adjacent suburb (Rosebud).

## HPP in Supported Residential Services (SRSs)

SRSs are privately operated businesses that provide a shared living environment, shared or private bedrooms, meals and ongoing personal support to individuals of varying age range who have multiple chronic health conditions with varying support needs.[21] SRS residents are one of the most underprivileged and vulnerable population groups within our community,[22] particularly those living in pension-level SRSs. These are SRSs where 80 per cent of the residents are paying fees less than or equal to the maximum Age Pension.[23] Pension level SRSs can only provide low care options.[24]

A HPP CHN provided four days of care a week aiming to develop, implement and validate an ongoing service model including regular health assessments to address the health needs of SRS residents, underpinned by wellness and re-ablement.

The evaluation identified that the majority of SRS residents did not have a comprehensive understanding of their health and support needs, or knowledge of available services; health checks were insufficient to assess their needs. The HPP CHN provided treatment, transport, emotional support, and actively advocated to service providers on behalf of residents. HPP proposed to add a community care aid (CCA) for 32 hours a week, to work in partnership with the HPP CHN for practical support. The evaluation of this addition identified that:

1. HPP fills a need that is not being met by current services.

2. The CCA doubled the service capacity and reach of the CHN for SRS residents.

3. The HPP Team met SRS resident's needs, contributing positively to their health and wellbeing.

4. Ongoing HPP support is needed to ensure SRS residents are engaged and stayed engaged with external health, and other, services.

The HPP Team care was strongly supported, and funding has been continued.

## Conclusion

There are people experiencing homelessness that are outside of the previously known contexts; outer metropolitan Melbourne and SRSs are two examples. A human rights and social determinants of health ethos, going out to those in need where they are comfortable, and treating them with dignity and respect supports their engagement to take up services. These services provide great emotional and social support; helping them to work through their life's difficulties, which are considerable because of the social determinants of health that have led them to be in an environment that does not support their wellbeing. This approach goes some way to making things easier for them to access services and live a life with dignity.

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# Connections and Loneliness in Far West New South Wales During Covid-19 and Beyond

Jenna Bottrell, Mission Australia Program Manager

As many isolate at home due to the Covid-19 public health crisis, peer support workers at Mission Australia's Connections Program in Broken Hill have drawn on their own lived expertise and rapidly adapted to reduce the impact of restrictions and lockdowns on locals facing loneliness and mental health concerns. With these new ways of fostering social connection in place, the team is fine tuning their approach, with an aim to further adjust how the program will be delivered in a post-coronavirus future.

Originally funded by a one off grant from New South Wales (NSW) Health, the Connections Program was founded in 2018 by Mission Australia, the Far West Local Health District and GROW to link socially isolated people to community activities after hours when few services are open. With pilot funding ending in mid-2019 and after seeing significant improvements in the community from the work of the program, The Ivany Foundation now philanthropically funds Connections.

In the absence of other social connections, our Connections Program is important because we are equipped to respond to loneliness so we can help improve people's wellbeing and social connections, and so that everyone has someone to turn to – even during a public health crisis.

Every day, our team of five Connections Program peer support workers draw on their own personal experiences of mental health concerns and recovery to provide high quality support and mentoring to Broken Hill locals involved in the program who are feeling disconnected, isolated and facing mental health challenges. Of course, like many regional and rural areas, Broken Hill is a geographically isolated place and some residents experience that isolation as loneliness, sometimes alongside mental illness.

Now in the time of coronavirus and during this period of rapid change and new ways of connecting, our peer workers have continued to be great role models for wellbeing, hope and recovery. The model of peer support has certainly been useful when putting our Covid-19-necessitated program adaptations into action. Having our peer support workers on board has really helped our participants to gain their own sense of confidence and hope about their journey of recovery from mental ill health — even during Covid-19 restrictions — by talking to someone who can truly empathise with what they're going through.

Due to the impacts of Covid-19 lockdowns, new participants started to reach out for help from the program as restrictions exacerbated feelings of loneliness and isolation, with 140 people now receiving support from Connections at the time of writing.

When Covid-19 physical distancing measures were first put in place, we started to operate with smaller social groups on a booking basis only, ensuring that everyone participated in screening questions before participating in face-to-face social meet ups. This all changed when restrictions tightened and our usual meeting places closed. So to ensure the safety of everyone, we adapted the peer support model to provide phone support and group teleconference or Skype catch ups, as well as dropping off meals and bags filled with essential items and activities.

When dropping off meals for example, we have used this as an opportunity to connect, with our peer support workers following up with a phone call with the participant for a safely distanced 'dinner date'.

I'm the first to admit it hasn't been an entirely smooth road as we transitioned to these new ways of


*Left to right:* Morganna Baker — Peer Support worker Mission Australia, Jenna Bottrell — Program Manager Mission Australia, Lee-Anne Ryan — Peer Support Worker Mission Australia, Elliott Dunn — Peer Support Worker Mission Australia, Jane Talbot — Peer support Worker Mission Australia

*Left to right:* Lee-Anne Ryan — Peer Support Worker Mission Australia, Bronwyn Taylor — Minster for Mental health, Jenna Bottrell — Program Manager Mission Australia

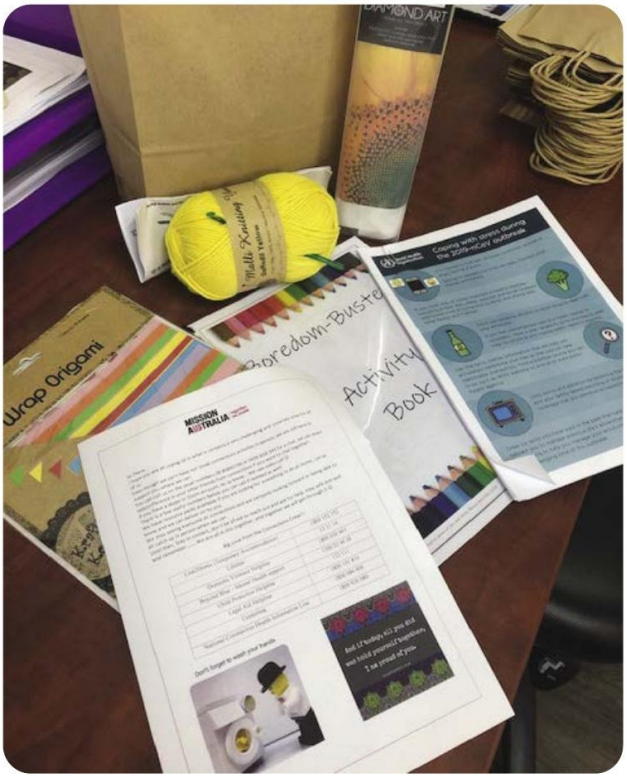
delivering this program. We also felt a hint of hypocrisy because we're delivering a program that is all about fostering social connections, at a time where 'social distancing' is mandated by governments.

Overall, our adaptions have worked well to nurture connections given the circumstances. Particularly at the start, our participants and our peer support workers enjoyed the sense of novelty while engaging in these different approaches to connecting with each other.

However, as restrictions continued for many weeks, we have noticed the sense of novelty wearing off, with some participants starting to question how long it will be until we can return to normal. They are telling us: 'I miss my friends and I miss seeing people.'

While most participants have been incredibly willing to adapt alongside us at this time, we know there have been some ups and downs for everyone. We remain concerned about the few who have found comfort in reverting back to their more reclusive behaviours. We also worry that the impact of lockdowns may have set some people back who have worked so hard to engage and create important social connections within our community.

There is also the issue of the increasing digital divide at this time, as it has become more evident that some participants don't have the financial means to access data and many don't own smartphones. In addition, some might have access to the technology, but they may not have the 'know how' to participate in a Skype video for example. For some, this lack of access and knowledge of how to use communication technology during restrictions has deepened their sense of isolation, disconnection and loneliness.




Post-coronavirus, we will take on learnings from this time, and our peer support workers will be focused on finding that balance between face-to-face support and socialising, while also equipping participants to be able to engage in technology-facilitated connection as needed. When it is safe to do so and as meeting places start to reopen, we will gradually scale up our face-to-face meet-ups.

After this is 'all over', we will ensure we talk with participants about their experience of Covid-19 lockdowns, and find out what the program did well and what we could improve upon.

As we have all been in a state of isolation, we hope this will increase everyone's sense of empathy and understanding of what it is like to be lonely and to not be able to access friends or family so easily. Everyone now has a story and experience of isolation, and we hope that this encourages more community and neighbourly connection which will help reduce loneliness and isolation for individuals in our communities.

What is clear to me during this experience, is that public health crisis or not, peer support is an effective and mutually beneficial way to help people recover by building confidence and knowledge for both the peer worker and the person receiving support. Workers with lived expertise are able to enrich the provision of mental health services by bringing skills and knowledge gained through their own experience and engagement with support services, so they can collaborate with others as they overcome life adversity.

*The Connections Program was recognised with an 'Outstanding Achievement in Mental Health Promotion Award' in the 2019 Mental Health Matters Awards run by Way Ahead — Mental Health Association NSW.*

# Yarra Drug and Health Forum: A Community Approach to Reducing Harm Associated with Homelessness, Mental illness and Alcohol and Drug Use

This article is co-authored by the members of the Executive Group of the Yarra Drug and Health Forum, Peter Wearne, (Chair) VACCHO, Janelle Bryce, cohealth, Hieng Lim, Neighbourhood Justice Centre, Sally Mitchell, Resident, Kevan Myers, Nexus Dual Diagnosis, Nick Wallis, Dancewize, Adam Willson, Fitzroy Community Health Service and Bernadette Burchell, Executive Officer Yarra Drug and Health Forum*

For over 20 years, the Yarra Drug and Health Forum (YDHF) has given a strong voice to the Yarra community to discuss and respond to drug and alcohol concerns in the City of Yarra.

The YDHF, auspiced by cohealth, recognises the multi-directional nature of homelessness, mental health and alcohol and other drug use issues, and is the only platform of its kind in Australia which uses community engagement to reduce harms.

The City of Yarra is a vibrant inner metropolitan municipality which is home to a diverse community of about 94,000 people.

The Wurundjeri-willam people of the Kulin Nation are the Traditional Owners of the land, and it is a place of special significance for the broader Aboriginal community, as a meeting place and as the first home of the Victorian Aboriginal Health Service, and Victorian Aboriginal Legal Service, and other Aboriginal organisations and services.

Yarra is also the location of several key community, health and housing services that grew up in response to the needs of a significant number of families affected by poverty and disadvantage.

The City of Yarra has become increasingly gentrified over the last 30 years and is now an affluent community, with some areas of significant socioeconomic disadvantage.

Concentrations of disadvantage are centred around the public housing estates and the emergency and social housing in the area, and there has been increased rough sleeping observed in recent years due to the decline of affordable housing options.

The municipality has its share of alcohol and drug related issues, with over 600 licensed premises providing a vibrant night-time economy with associated alcohol and drug use issues, and stimulating a significant street-based illegal drug market.

Thirty years ago, illicit drug use in the area — mainly heroin — was increasing, and street based injecting drug use was causing concern to other community members. Public perceptions of safety were low, and incidents of overdose and drug-related deaths were on the increase.

The Premier's Drug Advisory Council (PDAC) chaired by David Penington in 1996 called for coordinated local responses around illicit drug use, advocating for a public health response, rather than one of law and order.

The PDAC strongly advocated for harm reduction, for the community and for drug users themselves.

This required coordination, cooperation and collaboration between all the community stakeholders, including law enforcement agencies, health services, legal services, local government, alcohol and other drug treatment services, residents, traders and drug users themselves.

The Yarra Drug and Health Forum (YDHF) was established as a result of a community meeting of more than 80 community members concerned about local drug issues. The local community health service (now cohealth) was responsible for leading and supporting the initiative.

From its inception a strength of the YDHF has been in being an 'honest broker', working with community members whether they be traders, residents, local health services, drug users themselves, or the police to delve more deeply into the causes and impacts of drug and alcohol related issues in the area.

One of the aims of the YDHF has been to support the community to look beyond silos and work together to solve problems.

Since its inception YDHF has supported the voice of service users and their families as key contributors in this process.

By collaborating with research institutions such as Turning Point, Burnet Institute, the Penington Institute, and the University of Melbourne Criminology Department, YDHF has been able to bring information about evidence-based harm reduction strategies to the community.

There have been several key and many smaller achievements of the Forum over its history. A basic, yet vital, achievement has been the elevation of community understanding of a public health response to drug use.

More tangible successes include where a problem is brought to the

Bernadette Burchell, Executive Officer
Yarra Drug and Health Forum

attention of the Forum, leading to the activation of the relevant services and authorities to remedy the issue. For example, in the instance of a trader or resident reporting an increase in discarded needles and syringes near their business or home, the relevant service has acted quickly to pick those up and maintain surveillance of the area as part of regular clean-ups.

Another example is where family members or friends have been trained by local services to administer Naloxone in the event of a heroin overdose, supporting them to be able to save lives.

Sustained advocacy efforts from the Forum and targeted campaigns to reduce heroin-related deaths and public injecting resulted in the trial of a medically supervised injecting facility in the municipality.

The scope for the work of the Yarra Drug and Health Forum in the coming years will be influenced by the confluence of homelessness, mental health and substance use issues that impact the community broadly, and aren't amenable to resolution through the actions of one group or service.

These issues are being highlighted in the Royal Commission into Victoria's Mental Health System established in February 2019 to investigate deficiencies in the state's mental health system and the broader prevalence of mental illnesses and suicides in the state.

Some emerging estimates include:

- around 75 per cent of people with alcohol and substance use problems may have a mental illness.
- around 64 per cent of psychiatric in-patients may have a current or previous drug use problem.
- about 90 per cent of males with schizophrenia may have a substance use problem.

Further, a detailed study, undertaken by the Coroner's Office, of 838 Victorian overdose deaths occurring between 2011 and 2013 showed 49.6 per cent of deceased had both clinically documented drug dependence and a diagnosed mental illness (other than a mental illness relating to substance misuse).


It is most often alcohol and drug use in public spaces, where it is associated with antisocial or illegal behaviour, that presents the greatest challenges for the community, impacting as it does on the safety and wellbeing of others.

The behaviour of someone who is homeless who is extremely unwell, substance affected, and poorly engaged with health services can have a significant impact on the feelings of safety and wellbeing of other community members who are sharing the same public space.

This may bring the individual to the attention of the police. Distrust and a history of trauma or bad experiences can compound an encounter with the police and can quickly escalate into an arrest and a criminal justice response rather than a health response.

The rate of homelessness in Yarra is 95 per 10,000 of the population, the fourth highest rate for any Victorian municipality, and more than double that of the state average.

In 2016 there was 838 homeless people in Yarra, including 64 people experiencing primary homelessness (that is, living in tents, improvised dwellings, or sleeping out). In addition, there were 170 marginally housed persons.

As our awareness of the complex intersectionality between mental health, substance use, and homelessness develops, the Yarra Drug and Health Forum will bring together police, justice, legal, housing, health, mental health and drug and alcohol services, with community members and people with lived experience, to identify the gaps and problems, and mobilise the good will and resources in the community to work towards resolving them.

* www.ydhf.org.au

# Peer Workers in Mental Health and Homeless Psychosocial Programs — Melbourne's Inner North West

Leanna Helquist, AOD and Homelessness Lead, cohealth,
James Duffy, Program Facilitator Homeless Health and Support Services cohealth,
and Ben Quinn, Specialist Team Support Homeless Health and Support Services, cohealth

Launched in April 2019 by cohealth, one of Victoria's largest community health services, the Inner Melbourne Connections Program (IMCP) provides psychosocial support for those experiencing homelessness with intersecting mental health who are not eligible for the NDIS.

Research has shown that mental health issues are significantly higher in the homeless community than in the general population.

However, despite the increased need for services, people experiencing homelessness are frequently denied access because of strict eligibility requirements and often complex intake and assessment procedures.

The IMCP offers an alternative to the National Disability Insurance Scheme in order to address the inequity in service access and improve the health, social wellbeing and quality of life of program consumers.

Key features of the program are easy access via supported and warm referral options, assertive outreach and flexible program entry.

There is a focus on capacity building, integration and coordination with complementing services. The program is delivered using a holistic person-centred, recovery and trauma-informed approach. The staffing of the program has been purposeful, the program employs a mix of Mental Health Social Workers, recreation workers and a lived experience workforce.

The IMCP is being evaluated by Latrobe University and the learnings from the program will be used to inform the roll-out of future funding for those not able to access the NDIS. The evaluation will incorporate project planning, implementation and delivery, the types and breath of services provided, change in health and social outcome measures and effectiveness of the staffing including the lived experience workforce.

The benefits of employing people with a lived experience in health care teams are widely acknowledged. In the IMCP, peer workers are successful in developing quick and effective relationships with consumers through honesty, empathy and understanding.

These approaches empower both the worker and the consumer, deepening the impact of the program.

The IMCP employs two peer workers part time, whose roles involve:

- support consumer engagement with program
- support consumers to develop meaningful Goal Directed Care Plans

- providing one-on-one support
- plan, support and/or attend recreation outings and activities with consumers
- support consumers to establish and maintain their tenancy
- support consumers to attend appointments
- support consumers to engage with community.

Peer workers also take an active part in cohealth's organisational life, including regular participation in team meetings.

Their input drives a great deal of the actions of the program, because peer insights relating to client care and other team and organisational matters are highly valued, supported and encouraged.

The employment of people with a recent lived experience of intersecting mental health and homelessness in the IMCP has provided staff with many opportunities. Knowledge and skills have increased. Important vocational skills have been refined such as computer literacy, finance, telephony and other administration skills.

For every person, the benefits and learnings are unique and sometimes surprising. Some have developed more interpersonal skills, improved their health and wellbeing and over time most gain confidence in their own abilities.

Integrating people with lived experience into a team and new service is not always smooth. It requires persistent effort, and consideration of the needs of all staff.

Although at times there can be fragmentation, it is the way we work together that makes the difference. Relationships need to be strong, and support from leaders needs to be flexible and responsive.

This gives staff members the opportunity to seek guidance when they have questions in relation to their role or interpersonal relationships. It also enables people to raise personal issues which are impacting their wellbeing and experience at work. Supporting people in this way meets their immediate needs, helps clarify roles and expectations, provides access to professional development and improves the quality of services provided to consumers.

For lived experience workers to have a successful experience, team and organisational culture and fostering strong psychological safety is critical.

The IMCP at cohealth employs a framework to support peers in flexible ways. Some of these include having clear policies and procedures, recruitment processes which value lived experience, clear position descriptions and comprehensive onboarding.

cohealth provides a high level of supervision which is flexible and meets the goals of the person. We have a strong culture of learning and development, and in areas where people with a lived experience work, we have a higher ratio of supports in place.

All of these factors assist us to support peer workers to be successful with the focus on culture, transparency and wellbeing. Having good psychological safety means that staff are empowered to identify issues early so we can work together to resolve them.

Delivering the cohealth IMCP program together with a lived experience workforce has been an extremely successful experience that has allowed us to more expertly understand and meet the needs of the homeless community, as well as providing a meaningful and supported employment opportunity for people with lived experience.

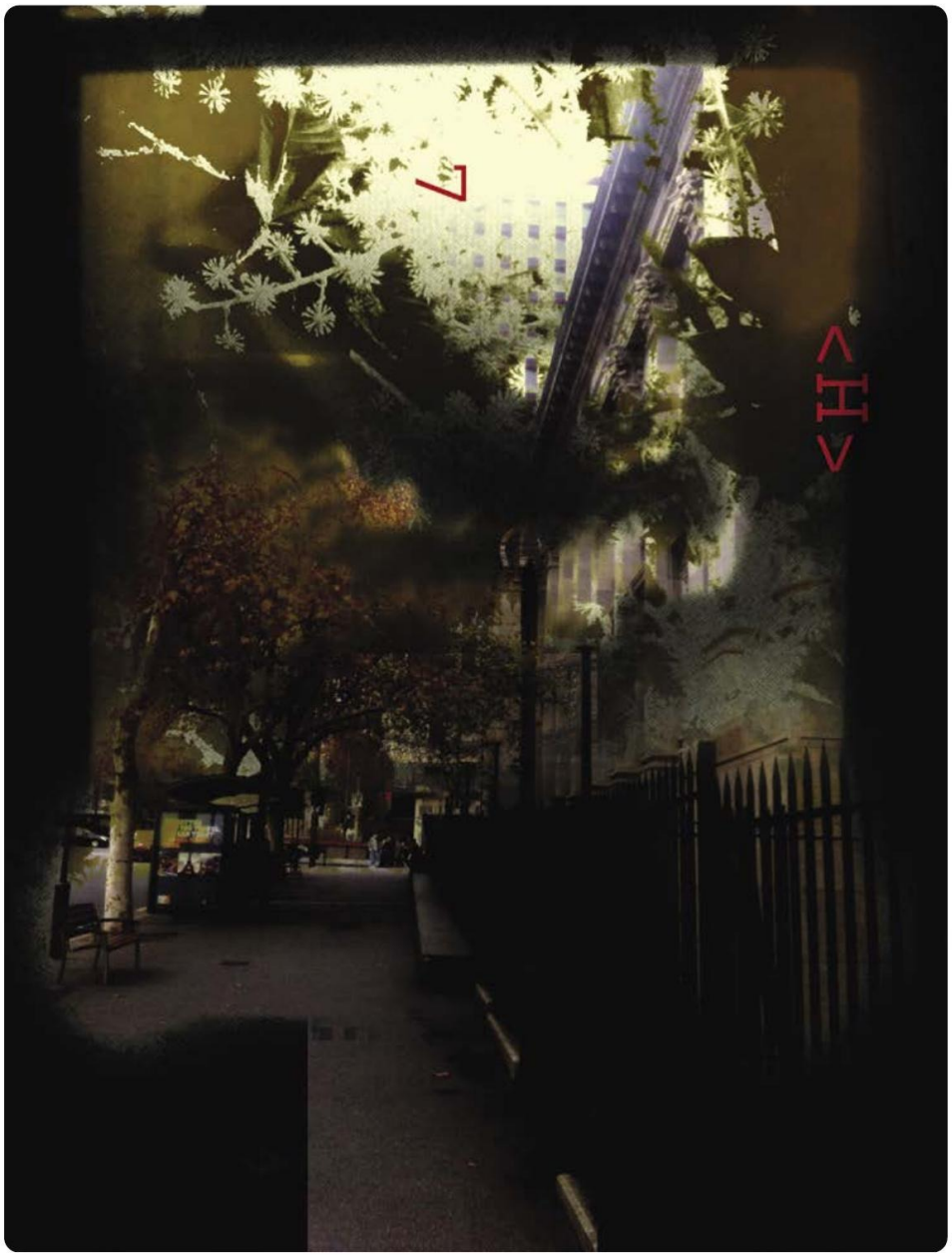


*Image by Henry Dowd*

# Homelessness and Mental Health: Support the Key to Making and Sustaining the Change

John Kenney, Graduate, Peer Education and Support Program (PESP), Council to Homeless Persons

There are many people with mental illness who are struggling with the adaptation into a home after experiencing homelessness, particularly if they have been rough sleeping for a long period of time.

I was without support for many years when I was without a home. When I was finally provided long term housing I struggled with the change from a life on the street to living in a home. I couldn't get my head around why people want to live in little boxes. There is so much more responsibility and the physical space made me feel boxed in. The feeling is overwhelming. I had a mental breakdown when I was first housed, it was all too much.

Unlike many others, I have been lucky enough to have support since I first moved in. This helped with adjusting to responsibilities of paying bills, buying food, accessing Centrelink income, accessing medical services and provided support for my mental wellbeing. The weekly check-ins to make sure I was OK were valuable for my health and sustaining my housing.

Without the support, I probably would have returned to life on the streets.

The other thing that has helped support my mental health and keep my housing secure is working. It is important to keep busy. For me, if I wasn't volunteering most of my time, I would feel isolated and withdraw from everyone.

People who are being housed after being without a home for a long time will be suffering trauma. There is potential for them to find the adjustment too much and leave the housing provided to return to homelessness. We need to make sure people receive the support they need when they need it, particularly when first moving in to a new home.

It is also important to support people to find employment or volunteering opportunities or to link in with activities people enjoy. Programs like Wintringham's over-50s activities group are valuable to prevent people being isolated and bored, which can lead to stress and depression.

Pets are another important consideration. My cat gives me comfort, as though she knows when I'm stressed and wants to help me through it. It's also a responsibility that can tie people to their housing. I have to keep returning to my home to care for my cat.

With ongoing support, my cat and meaningful volunteer roles with a range of organisations, I have been able to keep my housing for 12 years.

# What ways have people with a lived experience been engaged in the solutions?

Yumi Luff, Launch Housing, Peer Support Worker, Launch Housing Southbank.

I use my lived experience in homelessness as a Peer Support Worker with Launch Housing.

The relationships I have the privilege of building with clients, are developed through trust and story sharing. There are just some things you don't feel comfortable sharing with people unless you know that they have also endured having no fixed address. Sadly, these things are mostly traumatic experiences. For me, this fear of sharing our traumatic stories with workers, is that workers form part of 'the system'. From decades of accessing the system as consumers, most of us will tell you that the system doesn't work, and for those of us who have transitioned from consumers to workers, we have the ability to identify further ways in which the system lets people down. It's hard to share one's trauma, (which often involves reliving part of it), when you don't feel safe, psychologically or otherwise, in an environment.

Due to personally knowing the effects on the mind and body that constant hypervigilance can have, we, as peer workers instinctively address everything through a trauma-informed approach. People who experience homelessness spend extended amounts of time having to constantly protect and advocate for themselves, whether they are engaged in services or not. Many people experiencing homelessness deal with mental health issues and have to manage their symptoms the best way they know how.

Upon engaging with services, many haven't had the opportunity to unpack their trauma, nor have they had the opportunity to adjust any behaviours that they wish to change through modelling or otherwise. I'm confident in saying that upon entering our service, our clients' allostatic load 'score', ranks on the high, or very stressed end. This can mean that sometimes, when emotions are heightened and trauma revisits, all the stress and biological functions which have been set on fight or flight mode for years, can become too much and they understandably break down. This is when having a trauma-informed approach is most critical, in my opinion. Not adding to someone's trauma is a tenet of our work by default. It takes time, sometimes years to build resilience strategies for coping with stressful circumstances.

Our peer work is instrumental in creating safe spaces to give people the opportunity to address some of their psychological and physical wear and tear. The type of wear and tear that comes with not having a home.

We create these safe spaces by ensuring that our approach to our work is always culturally safe. Homelessness doesn't discriminate. We work with diverse people with diverse cultural values, and when we focus on celebrating this diversity, we create opportunities for people to come together and form a diverse community in which we respect differences and encourage individual expression of culture. Unfortunately, accessing a service can mean an already marginalised individual facing further discrimination, overt or otherwise. Our role as peer workers involves advocacy. When our clients disclose that they've had such an experience, we are not only there as peers to empathise and listen, we can use that information with their consent to advocate for changes within the system. This is also a learning opportunity.

Many of our clients don't have the language to describe their oppression, or how they were mistreated. They have the gut instinct that something was wrong, and we as workers, through talking about the experience, can assist our clients by providing information about their situation that they haven't ever been given before. This is empowering and leads to massive transformations for people. Seeing someone become empowered with knowledge and the drive it gives them to make changes is one of the most moving parts of the work that I do, and it's always humbling to bear witness to the magnificence and resilience of the human mind and body, in the face of lifelong hardships, often beginning in childhood.

I will always advocate for the co-design of policies and procedures within homelessness to include input from consumers and lived experience workers. We need more lived experience workers in crisis roles, management roles, admin roles, and board positions, and to include lived experience as a dimension in diversity policies and hiring practice. Our expertise can be put to use in areas of committees and organisations with no current lived experience representation.

# *'I think you can call it homelessness when you have nowhere that you call home.'*

Laura Button, Leadership Program Coordinator: Women Transforming Justice Project
Fitzroy Legal Service Inc.*

## Introduction

This article was written during the Covid-19 pandemic. For many this is a tough time. Politicians have urged Australia 'to pull together, we are all in this together' and yet despite the singularity of the external threat of Covid-19 we are differentiated in our experiences. Some of us have had lives that are shaped by multiple narratives of neglect, oppression, abuse and violence.

Our stories of adverse childhood link with our re-victimisation as women responding to violence and abuse. These experiences shaped our relationships with drugs and other survival crimes that have enabled us to live through homelessness and criminalisation.

The Women's Leadership Group is employed by Fitzroy Legal Service as a component of the Women Transforming Justice Project. We offer our views on homelessness and mental health through the voices of women whom the system has seen fit to criminalise. The women of the leadership group offer their varied personal experiences of housing instability, homelessness and its interplay with mental health, relationships, violence and the law.

## Homeless: What Do Our Experiences Tell Us?

### Sara

It doesn't matter where you are, it could be a car or even a house and you can still be unsafe; you may have no privacy or be told what to do in a house. I may not have been sleeping outside that night, but I was being abused inside the room.

### Jess

Homelessness is a pattern and a problem that was always building on top of me…it probably did sneak up on me, but when I took the goggles off, I could see my thought patterns.

### Nina

To me…homeless is a person who does not identify as having a home…. a home to me is a space you can call yours.

*A child, a small person*

*With wide eyes that*
*gradually lower lids*

*Screams that echo across*
*lounge rooms*

*That strip a child of voice or school*

*Slips into the abyss of alcohol or*
*the grip of grimmer masters*

*The story before the story; the*
*story of homelessness begins*

### Sara

I have been homeless many times, almost constantly from between the ages of 14 years until I was 27. I call it recurring homelessness. I remember coming home from school and finding that everyone in my family had left because we had been evicted. When my mum struggled with mental health I went into foster care and then I was a runaway. I would have moments of being housed but when that fell apart I never had anywhere else to go.

### Maya

My family is very oppressive of children. They don't want you to choose what you want to do. They are strict. Children rebel when families are oppressive.

### Nina

I was rebellious and struggling with my own identity. At school my peers showed me respect. I gained popularity from being headstrong, opinionated and forthright… My mother was facing her own challenging times and my father was an alcoholic and distanced himself from the family, leaving my mother to run the household.

*And in the leaving*

*The leaving behind of childhood*

*What lessons does the*
*street as parent teach?*

*Away from the social gaze who*
*feeds the hungry belly?*

*On What pillow does*
*your head lay?*

*What disappeared the pain*

*Of homelessness?*

### Sara

I have always been in 'co-dependent' relationships. By that I mean that if a man showed interest in me, I became really attached to him and lived with the idea that my world was him and I felt I would die without him. I had children with two of these men. Housing for me and my child relied on these men and then I would end up homeless because they wouldn't pay the rent and I would lose my children.

Homelessness forced me to engage in activities that prevented me from living in a house because my way of surviving was to sell drugs. I needed to be looking over my shoulder, watching for the cops or for someone wanting to roll me. I was constantly in fear that I might get bashed or I might not have paid the rent. All I was thinking about was the drugs, the police or eviction.

### Nina

My first experience of homelessness was at the age of 15 where my boyfriend and I lived in his car. After some time, we were able to stay

with friends on their couch. I was still going to school; I was ashamed to admit my situation to anyone.

Jacqui

I hid because I was concerned about being picked up by the police and returned to hostels. I didn't go to services even when I knew about them. There was fear of being taken back to where I didn't want to be.

*Searching for safety*

*In the twilight, what was it*

*That numbed your distress?*

*What sneaked up and held you*

*In anxiety's long reach?*

Sara

Being homeless was never a surprise. I always knew it was the next thing. It was more a question of when. It was stressful. Sometimes I would just want to die. My choice was abuse or homelessness or drugs. Until I knew something other than this, I used drugs to survive.

*I have never really felt safe.* Occasionally if I was at someone's house who I trusted I would have a sleep but that didn't happen often. More frequently I would be woken up by people having sex with me or the place being raided, being thrown out and told to leave. When I moved to selling drugs, I became numb, protected from having to use my body to seek a roof or money. Drug dealing offered me more control of circumstances and lessened my vulnerability.

Maya

While I was homeless my focus was always on surviving. I wasn't paying attention to my mental health. Thought I did at times have people who looked after me, they weren't the right people. The trauma effects how I perceived things.

Surviving was a big adrenalin rush which made it harder to be around places that were safe.

While I was homeless, I learnt to know how to manage myself through my life. I 'blend with the clouds' and always stay aware. I know how to protect myself in multiple situations. I have survived by being humble and grateful for being alive. Being grateful

for the little things means that I am less on people's radar, less of a target in the crowd and not so visible.

Jess

I suffered anxiety, depression, suicidal thoughts, and anger. I didn't know how to process the anger and hatred. This led me to do things I'm not proud of. I hurt people and I hurt myself. I hated myself and regretted the things I did. My mental health was shaped by my environment and who I was around. In this environment I always had to be tougher to survive.

Nina

My survival tactics were living in denial, having a naïve approach to my situation and surroundings thus benefiting my mental health and emotional state…I used drugs and alcohol as an escape from my reality. This became a common practice; it would provide for the moment a numbness to what was really happening for me.

Jacqui

It's that flight or fight thing and you just survive. I look back now and think about how young I was. I was only a baby at the time. It has made me who I am and has given me some of the values I hold now.

*The carceral feast*

*This lived experience what words*

*Would you say at the government's behest?*

Sara

The government and services need to provide more housing. You cannot have a 20-year waiting list. People will die. The housing crisis is perpetuating violence, death, putting people at risk and increasing vulnerability. Lack of housing enables people to be sexually abused, financially abused and children to be removed. You cannot get a house without a job, and you cannot get a job without a house. Centrelink is not enough. We need a living wage.

Jess

You can see by the way the government spend money that the government seems to prefer to lock people up. You can see what the government isn't doing. They're not preventing this happening. Where is the housing?

Nina

The government could be a lot more on the ball…not just filling out forms but actually reading the situation. I felt like they used to just come in and think …' ok, there's food on the table, she has clothes so everything's fine'. They didn't look beyond the general façade of things.

Jacqui

I never had any supports from service systems…the seed had never been planted that they were available to me.

## Conclusion

In concluding, we are interested in supporting a broader understanding of what contributes to women's homelessness. We share experiences of being criminalised and we work to address the way that both services and governments can be supported to understand that it is homes that will dignify us.

* A merger of Darebin Community Legal Centre and Fitzroy Legal Service

*The Women's Leadership Group is a central component of the Women Transforming Justice Project, administered by Fitzroy Legal Service and funded by the Victorian Legal Services Board. The Women's Leadership Group seeks to centre the voices of women with lived experience of incarceration and criminalisation and reduce the number of women on remand in Victoria.*

# The Difference That Peer Support Work Can Make

Joal Presincula, Peer Support Worker, Launch Housing*

Homelessness almost never occurs in isolation. The experience happens alongside, trauma, suffering, poverty, neglect, abuse, violence, family breakdown and estrangement, drug and alcohol use — and as the consequence and effects of, stigma, hospital admissions, diagnosis and finally, mental ill health.

I know what it is like to live without a home to call your own — the lack of safety — having the security of your own space — the stigma of homelessness — the lack of self-esteem and the feelings of poor self-worth. I know what it is like to distrust anyone who isn't me — because when you are in a position where you are forced to rely on yourself and only yourself, you forget that you can trust others. I know what it is like to distrust systems. And I know what it is like to go through the housing system and come out the other side.

Today, I work as Peer Support Worker for Launch Housing, in crisis accommodation and concurrently, am working in a final of a Pilot Project called the Peer Resettlement Project. The first project of its kind in Australia – offering Peer Support in an outreach capacity to long-term rough sleepers who have gained safe and affordable housing through housing first program, Melbourne Street 2 Home.

## What is a Peer Support Worker in Homelessness?

While lived experience roles and peer support workers have been around for many years in the Mental Health and Alcohol and other Drugs (AOD) sectors, homelessness has just caught up. The research strongly suggests that peer support workers will be helpful, indeed — vital — in how a service user experiences their support — and our work is speaking for itself.

I am the first successful homelessness Peer Support Worker in Australia. By this I mean that I am the first person who has been successful in delivering Peer Support to those currently experiencing homelessness, working on the front line, and have been doing so for almost two years.

## How does a Peer Worker differentiate from other workers?

I am not a housing support worker, or case manager, although I work alongside a multi-disciplinary team with AoD workers, Nurses, Occupational Therapists, Counsellors, Wellbeing officers and Outreach Support Workers. Peer roles sit within multi-disciplinary teams and complement the hard work of the larger team.

We focus on connection as our number one priority. This is a very different way of working with people experiencing homelessness. Connection is our greatest strength. When a consumer meets us for the first time, it often goes like this:

> *'Hi, I'm Joal, your Peer Support Worker.'*
>
> *'What's a Peer Support Worker?'*
>
> *'I'm someone who has lived in places like this too and has been homeless myself. I've gone through the system like you are now and have come out the other end.'*
>
> *'Wow…. You don't look like you were homeless!'* We both laugh. *'So you must GET it, then!!'*
>
> Nods head. *'Yep. I get it.'*

Trust and connection is built instantly. Mutuality is created and a strong foundation is established to build whatever we collectively decide is beneficial for the time we spend together.

I will never forget one of my favourite first meetings with a client.

When she said, *'Wow, so you get it then!'* It was followed with:

> *'So… there is an end to this then? I'm not going to be homeless forever? It feels like I've been on this roller coaster forever and that it will never end — but meeting you today. Wow. This is going to finish for me one day!???'*

That is when I seek to validate how hard it must be to feel that way, but offer my insight and hope that, yes, 'this' will in fact end one day.

That was a moment when I really saw the potential of Peer Support roles.

We are the hope holders — the courage bringers — the safety providers and the listeners. We are the real-life face and embodiment of hope for people trying to navigate a broken system.

In our work, we don't come into the support space with a set agenda. We come with open hearts and open ears. We don't have any specific outcomes in mind, as such. Any work we do, we do in agreement through discussion, disclosure, in a safe space and with consent.

While trust is built almost instantly with people — we can never forget we are working with people who have suffered trauma and many other causes that have led them to be without a home.

*How do you navigate the disclosure of trauma in a peer space?*

With closeness, comes disclosure of this nature. Peer Workers will, by default, hear details of trauma and even though we are not trained counsellors, we do all kinds of brief interventions in our daily work and we are always working through a trauma informed lens.

Due to the nature of our work, it is important we focus on our self-care and are vigilant that we do not take on the 'counsellor' role. This is something the peer work can often slip into. This has also been known to happen in the AoD and Mental Health sectors.

Speaking of disclosure, we are lived experience workers after all, and by the very nature of peer work, it is presumed that we will dip into our past trauma while working in the role, since we have a history of being without a home. However, I don't think Peer Workers should feel any pressure to disclose any part of themselves they feel uncomfortable with, just like any other worker.

I like to use a term called 'purposeful disclosure' when discussing this topic and navigating the assumption that we must talk about our past. Purposeful disclosure is where Peer Workers only disclose a part of their lived experience, when and if it is helpful in context of the conversation. Such disclosure can foster connection, promote recovery and wellbeing, build courage or provide hope for the person with whom we are working, or give context to the work of our team mates.

This factor of 'purposeful disclosure' is what differentiates us from consumer consultants and consumer participation. Peer Workers are sometimes confused with the consumer consultants and consumer participation, but the roles are very different and should not be confused.

## How do you fit within a multi-disciplinary team and why is this best practice for Peer Workers?

While the role of Peer Support Worker is varied, what we do best is be 'peer' to both the people we are supporting, as well as the Case Managers and other support workers in our teams. This can be rewarding when your team believes in your worth and has grasped the value of the Peer Worker role. But it can


also be challenging, being a conduit between the service user and service provider. It works when the team realises we are complementing each other's work and working towards goals for our shared client. The beauty of this professional peer dynamic lies in the realisation that someone else in the organisation, knows the client the way they know their client.

Peers can play sounding board, to talk through barriers to support, provide secondary consults where appropriate, and share responsibility for our joint client.

## Advocacy and Peer Support Worker perspectives on service delivery

Advocacy and peer work go hand in hand. You cannot separate the two. We are advocates for our clients and no one else knows best practice and can pick up on service gaps more than someone who has been there themselves.

This is a strength that is not to be feared. If utilised wisely, it will be in the best interest for both consumers and workers to listen to Peer Workers perspectives on service delivery.

Co-design is always best practice.

## Does speaking about trauma impact you as a Peer Worker? How do you navigate vicarious trauma?

We are lived experience workers. We have a trauma history and I see the impact of minority stress and where that can play out in the workplace. However, this is not something that devalues us as professionals but rather is something to always be mindful of on our peer journey. We need to look after our own mental health and wellbeing as much as any other worker, especially if we are to provide high quality support. To do this – we also need to be supported. An understanding by management of the compounding stressors of minority stress on Peer Workers, is vital to our success in the role.

Supportive supervision is crucial to our overall professional development and reflective practice in this difficult space.

In saying this, burnout is real. Self-care, time away from work when needed without judgement and the ability to be open and honest with management does impact the success of the role.

## Why is Peer Support Work successful?

What I love most about Peer Support Work is that there is no power imbalance and safety with connection is key.

Both Launch Housing and CHP recognise and understand the discipline of Peer Support Work and the expertise that is required to undertake it. Peer Support Workers are successful because we work as a team creating safety, fostering connection and building the foundation on which Peer Support Work in the homelessness sector can grow and develop.

* Joal Presincula – Peer Support Worker, Launch Housing Southbank, AoD and Wellbeing Team, Launch Housing Inner South Outreach Team – Melbourne Street To Home, St Kilda Council to Homeless Persons (CHP), Peer Support Resettlement Project (Pilot), outposted to MS2H, Peer Education and Support Program (PESP/CHP) Graduate of 7+ years

Opinion 1

# Carl Rogowski

Senior Manager Opportunities and Development

# Tom Dalton

CEO Neami National

## Ending Street Homelessness: The Crisis Amidst the Crisis

Homelessness is solvable. We know this, at least in the Australian context, because in 2020 we achieved what was previously deemed too complex, too costly, too 'wicked' to address — we have, largely, housed most of the people rough sleeping across our capital cities and regions. We now have an unprecedented opportunity to ensure that access to this most fundamental of human rights transcends the immediate health concerns posed by Covid-19.

The accommodation in which many of Australia's most vulnerable homeless find themselves is, like this opportunity, temporary. Neami National's (Neami's) hope is that this emergency accommodation is increasingly viewed as transitional, that Australia's leadership recognises this as the first step in the nation's shift to a new paradigm where homelessness is no longer expected or accepted.

Covid-19 forced Australia to respond to street homelessness for what it is: a matter of individual and public health. Liberated from the discourse of housing affordability and personal responsibility, we now see efforts across jurisdictions to transition as many vulnerable people as possible into stable, long-term housing. The health of individuals impacts the health of society and, briefly perhaps, we are positioned to harness the political motivation crucial to developing funding frameworks and systems that will address Australia's unnecessary housing crisis. What must be cultivated is the acknowledgement that such a response is desirable not only in the context of a global pandemic but as baseline social policy.

Neami's experience and nation-wide presence provides insight into many of the interventions implemented across the country and the extent to which they might translate into longer-term solutions. Working with a range of consortia partners, Neami staff are heavily involved in the Covid-19 response for people rough sleeping, most directly in Adelaide, Sydney and Geelong. Staff in each location emphasise the importance of existing foundational initiatives, particularly the data available from Registry Weeks and the implementation of By Name Lists that:

- identify people by name and provide tailored support
- provide a real-time picture of people rough sleeping in particular locations
- support assessment of individual housing or support interventions required to facilitate an exit from homelessness.

Adelaide's By Name List, the most advanced in Australia, was developed by members of the Adelaide Zero Project (AZP), which aims to achieve functional zero street homelessness through a collective action approach supported by the South Australian Housing Authority (SAHA). The AZP sits within the Institute of Global Homelessness' effort to end street homelessness by 2030, with Adelaide one of the initiative's *Vanguard Cities*. Neami's Street to Home team, involved in the development of the AZP's By Name List, are collaborating closely with SAHA, Hutt St Centre, Baptist Care SA, SYC and the wider AZP to support Adelaide's rough sleeping population into temporary accommodation. As at 12 May 2020, 435 adults and 27 children were accommodated in motels in Adelaide, with many more supported across South Australia.

The level of individual need experienced by people rough sleeping is clearly demonstrated through this established By Name List data, which indicates that 81.6 per cent of rough sleepers reported mental health issues.[1] In addition:

- 76.7 per cent of rough sleepers reported physical health issues

- 79.2 per cent of rough sleepers reported substance abuse issues
- 54.9 per cent of rough sleepers report a combination of physical, mental and substance abuse issues[2]

Neami's experience in Sydney, Geelong and through partnerships with services around the country suggests that these whole-of-health impacts of rough sleeping are typical of the experience across Australia. In the context of the current crisis, they highlight that people experiencing homelessness require not only immediate but ongoing support to address long-term housing and health needs. Notably, South Australia's response extends beyond *immediate* health needs, helping people to access services and achieve *long-term* accommodation, improved physical and mental health and positive financial and community participation outcomes.

Established data systems and service relationships also feature in Australia's most recently announced Vanguard City, Sydney. Supporting system-level change, Neami Way2Home contributes to efforts by the End Street Sleeping Collaboration, comprising government, NGOs and the private sector. The emergency response in New South Wales has supported over 7,000 people state-wide, with very few people left rough sleeping in Sydney itself.

Looking ahead, Neami was recently commissioned by the Department of Communities and Justice to coordinate STEP-Link, a service supporting people rough sleeping who have been rapidly moved into emergency accommodation. STEP-Link identifies immediate needs, provides pathways into longer-term housing and offers support that helps people sustain new tenancies. Funded to 30 June 2021, STEP-Link aims to connect people with public and other housing options, including subsidised private rental.

The immediate response in Sydney is proving effective, opening the space for discussion about how these gains will be consolidated as the crisis focus shifts. Secure

housing options are lagging behind demand and expanded post-crisis support measures will ultimately require further funding. Nationally, we also need to be watchful that any reduction of rental eviction restrictions is implemented slowly to avoid the possibility of a large influx of people new to rough sleeping once the moratorium ends.

In Victoria, supported by a government commitment of $8.8 million for four pop-up facilities to provide health care and supported accommodation, as well as the repurposing of aged-care facilities to assist with self-isolation, Launch Housing has temporarily housed 970 people, mainly in central Melbourne. Regionally, the City of Greater Geelong partnered with Neami to open specifically designated areas with safe shower, washing machine and phone charging facilities for people rough sleeping, with 95 people supported into temporary accommodation.

Longer-term, Victorians accessing accommodation through emergency initiatives are becoming increasingly anxious about what happens next — for example, the Housing Establishment Fund (HEF), which assists eligible clients to access and/or maintain private rental housing or emergency short-term accommodation, received a $6 million increase, yet no plan has been articulated for what happens to accommodation options once the additional funding is expended. A longer-term focus, drawing perhaps on the wealth of information and data compiled through the recent Royal Commission into Victoria's Mental Health System, would resolve much of this anxiety and reassure vulnerable Victorians that their health is important irrespective of the current crisis.

A longer-term focus does appear a likely outcome of the response in Western Australia, where a six-month taskforce project to move rough sleepers into hotel accommodation

is being undertaken by Ruah Community Services and Uniting Care West. It appears likely that learnings from this project will contribute to the Western Australian 10-year Strategy on Homelessness 2020–2030, *All Paths Lead to a Home*, which has a Housing First philosophy and a five-year Action Plan to end rough sleeping by 2025, now augmented by innovation around new ways of investing in housing and the possibility of fast-tracked funding.

The emergency response in Queensland has also seen significant progress in accommodating people rough sleeping. Micah Projects and Communify Queensland have facilitated hotel placements for around 700 people, with a total of around 1,500 people supported across the state. The Department of Housing and Public Works are now tasked with providing pathways into secure, longer-term housing.

While recognising the differences in approach and level of success achieved across jurisdictions, if Australia is to capitalise on the incredible progress made in addressing street homelessness over the past few months we must:

1. ensure those people currently housed in emergency accommodation are provided pathways into long-term housing and the post-crisis support needed to maintain tenancies

2. address crucial upstream issues, like the end of the moratorium on rental evictions, to minimise the influx of people new to rough sleeping

3. draw on existing research and analysis[3] to re-design social policy to leverage the current opportunity for large-scale Federal investment in public housing and support within a broader program of government investment designed to kick-start Australia's post-Covid economy.

In many ways, these priorities remain unchanged from the pre-Covid world. What has changed is the emerging opportunity to evolve Australia's housing and homelessness response to ensure that recent progress results in positive, long-term housing outcomes for large numbers of vulnerable Australians. We now have clear evidence of how quickly, collectively and effectively our communities and service systems can move when the political will to do so exists.

The challenge is to be vocal in our collective call for this political will to extend beyond the immediate and into the long-term, to insist that street homelessness, a glaring individual and public health issue long before Covid-19 forced our hand as a nation, be regarded as such and that the current suite of emergency interventions remain embedded within established initiatives that are now much advanced due to the global crisis. With such an array of complex, negative outcomes to assail Australia, and the world, for years to come, opportunities to derive overwhelmingly positive individual and social changes should be vigorously pursued and celebrated.

Collectively governments, in partnership with community organisations and with broad public support across the country, have demonstrated that street homelessness can be a thing of the past. We owe it to ourselves, as a society striving for health and prosperity, to safeguard and build on this progress so that one crisis isn't allowed to resume simply because another has ended. This is Neami's hope, and we look forward to making a continuing contribution to make this hope a reality for Australia.

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# Bronwyn Pike

## CEO Uniting Vic.Tas

## Shaping a Fairer, More Equitable Post-Covid-19 Society

*'The test of our progress is not whether we add more to the abundance to those who have much, it is whether we provide enough for those who have too little.'*
— US President Franklin Roosevelt

As Australians, we're at our best in times of crisis, whether it's pulling together during wartime or the community's response to natural disasters, such as during the bushfires across Victoria and New South Wales last summer.

Our nation has also risen to the challenges of Covid-19. The strong lockdown measures have meant we have largely avoided the terrible death toll witnessed overseas.

While the measures helped 'flatten the curve' and limit the spread of the virus to ensure our health system coped, the pandemic has been devastating for the economy.

Already we have seen a million Australians lose their jobs. Many are struggling to pay bills and put food on the table. Mental health issues, alcohol and drug addiction, homelessness and family violence are already on the rise.

We have seen families and individuals who have never needed emergency relief or housing support are coming to us to ask for help. In some communities, homeless numbers have doubled, but we fear this is just scratching the surface.

Unless there is a monumental shift in the way we treat our most vulnerable, this will only get worse.

Those who have been hit the hardest by this crisis are the most vulnerable people in our society: the homeless, the elderly and people with disabilities and mental health issues.

Like most of us, they are feeling scared, alone, isolated and hoping they won't be forgotten.

As the impacts of Covid-19 will continue to drive disruption and transformation for years to come, it is timely to start a conversation about what a future Australia could and should look like.

We have a once-in-a-generation opportunity to create a new normal. A chance to hit the reset button.

The question is how can we work together to create a new way forward, to create a fairer and more caring society, a society that leaves nobody behind?

During the Covid-19 crisis, both State and Federal Governments demonstrated that if there is enough collective will, they can be nimble. They can come together to respond quickly in times of crisis and provide support where it is needed most.

Over the last few months we've been told to stay home, but what if you don't have a home?

While people commonly associate homelessness with sleeping rough, it is so much more. There are families sleeping in cars as well as people couch surfing or in many other temporary forms of accommodation.

During the Covid-19 pandemic, we have seen examples of governments and hotels working together to house thousands of homeless people providing them with something most of us take for granted — the safety, security and dignity of a roof over our head.

For too long, homelessness has been put in the too hard basket. Viewed as an issue which will always be there and will never be resolved.

But, the response to this pandemic has shown that nothing is impossible. We have all had to change, to adapt, to find solutions to problems which only a few months ago would have seemed insurmountable.

Ensuring everyone in our society has housing security — a safe and secure roof over their heads — must be our goal. As long as we work together, it can be done.

These are extraordinary times. While much is being done by governments to address the immediate health and economic impacts of the virus, the hard work is only just beginning.

State and Federal governments need to work together to carefully plan a society which supports our most vulnerable — the people who will find it most difficult to bounce back.

We must not allow the gap between the rich and the poor to widen. For this to happen, we must all work together to address inequality.

We have to change our way of looking at the unemployment safety net. For too long, we've viewed people as 'dole bludgers', but as Covid-19 has demonstrated, it should be viewed as income support for the tough times, support to help people until they get back on their feet.

We can't suddenly wind back the JobSeeker payment to pre-Covid-19 levels which plunge people back into poverty.

We must demand our governments work together, as they have demonstrated with the National Cabinet, to invest more in essential community services including social housing, aged care, child and family services and mental health and drug and alcohol support.

Our lockdown lives have been slower and simpler, we have held our families close and we have learnt to appreciate the little things more. We have re-discovered the basics, the simple life and we've been more caring towards one another. We can't afford to let this spirit go.

Our post-pandemic life will be different, very different, but we have an opportunity to create a better society, a fairer society, a society which puts the wellbeing of its most vulnerable at its core.

Opinion 3

# Professor Eóin Killackey

## Head of Functional Recovery in Youth Mental Health, Orygen

### The Need for an Early and Integrated Response to the Intersection of Homelessness and Mental Illness

There is a long acknowledged association between homelessness and mental illness. People with a mental illness are more likely to be homeless than the rest of the population, and people who are homeless are more likely to be diagnosed with a mental health condition.

Irrespective of the direction of cause and effect, conversations concerning homelessness and mental illness often focus, explicitly or otherwise, on those who have well established illness and who have, or have had, some connection to mental health services. However, while the longevity of mental illness means that it continues to be prevalent among adults and the elderly, the bulk of the onset of mental illness occurs among young people. Approximately half of mental ill-health onsets occur before the age of 15, and 75 per cent occur by 24 years of age.[1]

The early onset of mental ill-health in this phase of life is important because adolescence and early adulthood involves enormous biological, social and vocational development. The onset of mental illness in this phase of life can, and often does, disrupt many aspects of these developmental processes. While these disruptions can be mild, mental ill-health can lead to more severe impacts, including experiences of homelessness, unemployment or underemployment, social exclusion, poor physical health, substance abuse and premature mortality.[2]

Due to the severe and long-lasting consequences of mental ill-health, there is a need to intervene early to minimise these impacts. Early intervention approaches focus on detecting early symptoms and offering sustained and comprehensive evidence-based care during the crucial early years of mental ill-health.[3] Early intervention in mental health was originally focused on patients with psychotic illnesses, such as schizophrenia, and studies have found that early intervention improves outcomes in a range of domains, including hospitalisation rates, involvement in school or work, and symptom severity.[4] More recently, the early intervention approach has expanded to other areas of youth mental health such as depression, anxiety and personality disorder.

As noted above, there is a bidirectional conferral of vulnerability between experiences of homelessness and mental illness. Therefore, early intervention efforts in mental health must include a focus on stable and safe accommodation. Similarly, interventions with young people experiencing homelessness and unstable accommodation need to be proactive in promoting the mental health of those they work with. Addressing this bi-directionality is important because early experiences of homelessness as a young person greatly increase the risk of further experiences of homelessness later in life. It has been estimated that almost three quarters of

young people who experience homelessness in adolescence will experience homelessness in later life.[5] Studies have found that one fifth of people who have one episode of homelessness will go on to become chronically homeless.[6,7]

Identifying young people who are at-risk of experiencing homelessness increases the likelihood that they will avoid homelessness or exit homelessness.[8] Accordingly, solutions for homelessness which are directed at young people have a higher chance of resulting in meaningful change.

While responses to the intersection of mental illness and homelessness must necessarily address a variety of domains, an emphasis on early intervention for young people vulnerable to either mental ill health or homelessness is paramount. In order to achieve this, there are three key priorities which should be considered:

Improving access to mental health care for young people. Young people with mental ill-health often don't access necessary services. Services such as headspace have been successful in providing youth-focused mental health care, but improving service awareness especially among vulnerable and marginalised groups such as young people vulnerable to homelessness and integrating youth services would further improve the effectiveness of mental health care for young people.

Helping young people find a stable and safe place to live. Attending to employment, school, mental health or nearly any other aspect of life is made significantly more difficult if there is no stable or safe accommodation from which to launch efforts on these other areas of functioning. Young people are more likely to be in unstable living situations, and approaches which support maintenance of tenancies are vital for young people.

Ensuring greater integration including co-location of the services young people with intersecting needs, such as mental health and housing, have. This includes making housing accessible for young people with mental ill-health. Young people transitioning from homelessness, or at-risk of homelessness, often have complex needs around mental health, education or employment. This reinforces the need to integrate support programs into housing for young people.

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Opinion 4

# Dr Catherine Robinson

Social Research and Analysis, Social Action and Research Centre, Anglicare Tasmania, Adjunct Associate, Professor, School of Social Sciences, University of Tasmania

## Home: A New Normal

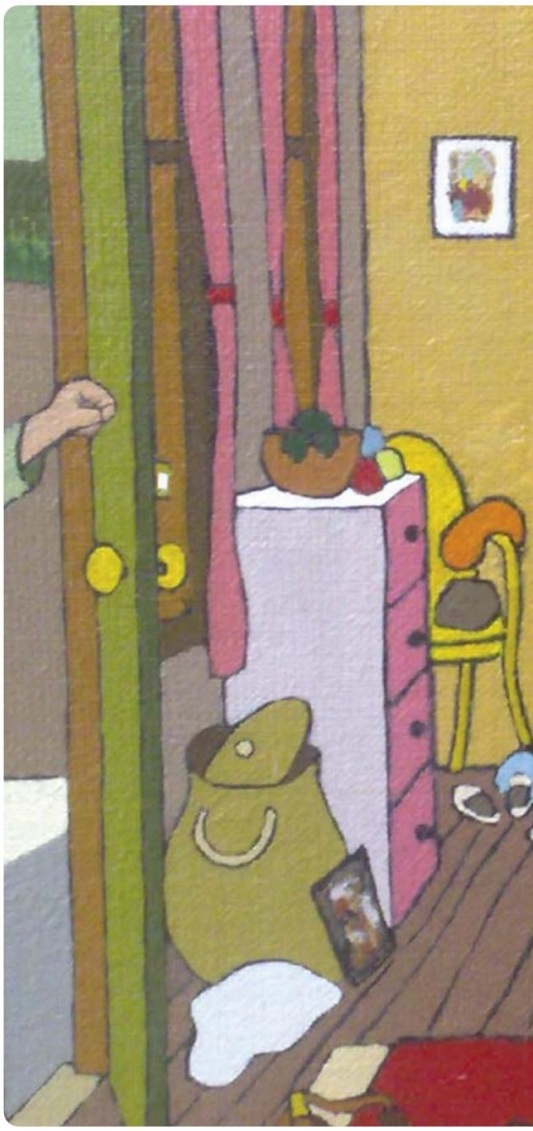
Over the years, my work on homelessness has focused on themes of home, displacement, vulnerability and care and on the way in which trauma is formative of physiologies which long carry and reproduce a raw suffering to which housing only partly responds. As I have discussed elsewhere, it is also work which has led to what I think are vicarious but permanent scars that so many professionals in this field carry and to which I have not been immune.[1]

No matter its specific focus, my work has also inevitably sought to highlight how welfare systems are made lame by their inability to acknowledge that people are not divided by areas of agency responsibility or apportionable by their presenting issues. The key project which I think set this particular research course was an Australian Housing and Urban Research Institute project which examined the relationship between homelessness and mental illness.[2] In this project, I landed on the term 'iterative homelessness' to capture my sense that for many of the participants experiencing homelessness and mental ill-health, there was no clear pathway into, through or out of homelessness. Instead what participants described was a lifelong ricochet between all manner of housing types and forms of homelessness, punctuated by repeated experiences of violence. Trauma emerged as central in this work, the relentless trigger of episodes of homelessness and of periods of acute or worsening mental illness and distress.

Now working on the less well-recognised issue of unaccompanied child homelessness, I meet children already at sea on this cyclical journey and immediately think of those in their 50s and 60s from past projects who could only lament the curse of life that they had been burdened with and were yet to effectively end. How life itself could become experienced as such a curse is even more understandable when you engage in life story work with children who experience homelessness alone, without a parent or guardian.[3]

At the Social Action and Research Centre, Anglicare Tasmania, my current project 'Dead inside' specifically explores the mental ill-health of unaccompanied homeless children. The project troublingly takes its working title from the words of a 14-year-old girl. It works to identify the systemic barriers faced in providing this group with effective mental health care. And the main barrier to mental health service provision already emerging in this work? The service risk children pose as unaccompanied and as homeless.

In the case of children who experience homelessness alone, the adequate provision of social care requires housing and also requires all manner of supports which usually remain invisible within family units and unpaid maternal workload. When these supports breakdown, the community is exposed to what children look like and what they need when they are without the private provision of physical and emotional sustenance and active support to access life-sustaining services — in particular, health and education. It is not enough at the point of intervening in their homelessness to ask about access to housing. Needed are questions about their access to care in absence of home.



When one's starting point is child homelessness, it is somehow easier to think about the broadened infrastructure of care which enables one to be at home — in shelter, place and community. In part this is because, in the current era, whilst it still seems allowable to acknowledge the vulnerabilities of children, we are strongly embedded in a Western culture which has encouraged us to imagine that the 'successful' adult is an independent, self-reliant being. This forced hero shot of the adult human makes tackling the actual reality of our vulnerability to each other and to our unequal social structure difficult.

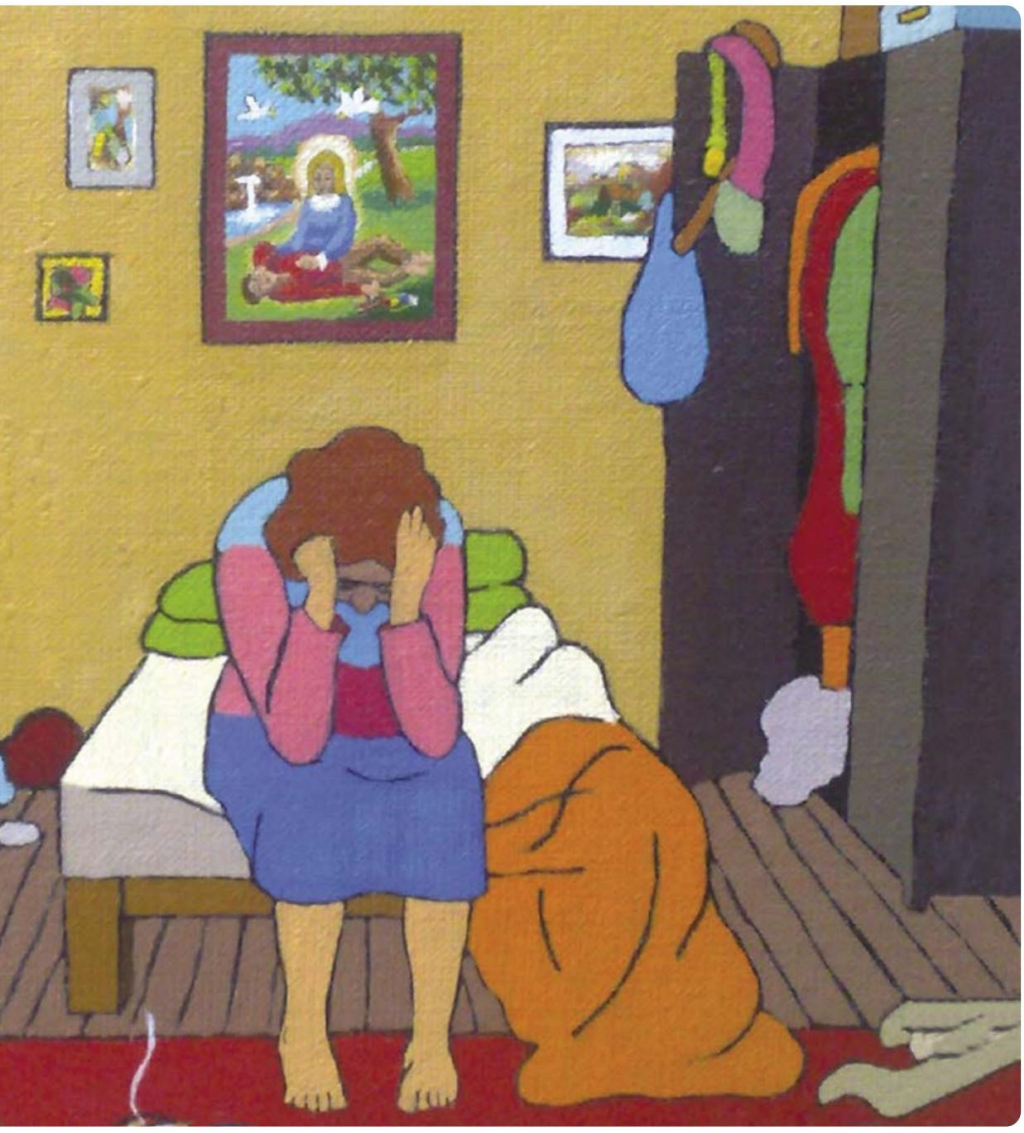
The impacts of Covid-19 have forced us to confront and re-engage with our interdependence in new ways and we might look to renewed efforts to systemically address child and youth homelessness to inform our broader thinking about ending homelessness for all.[4] This is far from risking an infantilisation of those experiencing homelessness, and instead can take the form of a re-energised emphasis on the well-established need for whole-of-government commitment to get and keep people homed.

What my work on homelessness and mental ill-health in both the child and adult space has taught me is the need to ask about what infrastructure of care is in place for the lifelong survival of any individual. It has taught me that home is built on multiple pillars, of which safe, affordable, flexible housing is one. For some, housing will be the only or last pillar needed. For others, it will be the first. And indeed, I think we could usefully re-name Housing First approaches to reflect what they try to become — Home First approaches which activate a full infrastructure of care for those who need this.

So while housing is an essential pillar of home, for those who experience mental ill-health, adequate mental health care and support will be another essential pillar. While agencies and services play games of systemic chicken — trying to force mental health investment and treatment before housing (adults) or housing before mental health investment and treatment (children) — the ricochet continues.

Witnessing the recent unique collaboration of health and housing agencies in the face of rough sleeping and Covid-19 gives me hope. As Arundhati Roy has argued, we must actively grip the rupture that Covid-19 has offered and at all costs resist a return to normality.[5] Human services are delivered with a particular conception of the human in mind. So for human services to change, we need to change what we think a human is. If we think humans should and can be self-reliant then we'll only help them conditionally. If we think of humans as segmented service delivery issues, we will continue to provide untimely and uncoordinated care.

There is scope to create a new normal and re-commit to an idea of humanity as both universally and uniquely vulnerable. There is scope to create a new normal in which home is the outcome that health, housing and education agencies must together accountably deliver. he inevitable post Covid-19 wave of homelessness and mental health crisis can be met, home first.



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Opinion 5

# Karyn Walsh

## CEO Micah Projects Queensland

## If Not Now, When?

During the Covid-19 pandemic, many people from all walks of life have shared how uncertainty, fear, isolation and social distancing have impacted on their quality of life, mental health and wellbeing. In addition, many people have also been stood down from employment or their lost jobs and are now without income.

While these realities are not new for those of us who witness the impact of homelessness on people's lives, the circumstances and scale of the current situation, are of a new order. These new realities have hit hard on already overstretched homelessness and mental health systems, systems that have also faced their own challenges of providing services during this time.

As a result of the impacts of Covid-19, many people who are dependent on both systems have had limited access to their normal network of services. Their even greater social isolation and disconnection has compounded their already existing stress and anxiety resulting in further despair and hopelessness. The uncertainty of the duration of the Covid-19 pandemic has left many people without that sense of a 'light at the end of the tunnel' they that often rely on.

The dual experience of being without a home and living with the realities of a pandemic has left many people with even greater levels of anxiety and feelings of despair and hopelessness. People experiencing homelessness have been faced with disruption to basic services for food, personal hygiene, healthcare, emotional support and have had the added fear of compromised safety. Being without a home has taken place against a backdrop of actual or potential fines for non-compliance with social distancing regulations. Those dependent on couch surfing and the households that shelter them have been faced with fines for having too many people present and having visitors.

At the same time across Australia, over 5,000 people have been placed in emergency accommodation in hotels, short-stay apartments or motels as governments enacted national emergency measures to enable public health directives to 'stay at home' and maintain personal hygiene and permit the required social distancing.

While getting a roof over each person and family's head was the right thing to do, it has not come without the enormous stress of being placed in a strange place, with the uncertainty of not knowing for how long, or knowing what comes next.

Our phones, and I am sure those of many specialist homelessness services, have not stopped ringing. Each phone call is from a distressed person, sometimes suicidal, often in tears and often experiencing violence from their partners, the stress of an old debt or being in conflict with an acquaintance. Some people have been found by strangers sitting on a step in a public space in tears, not knowing what to do. For many, the use of drugs, both legal and illegal, is a constant companion to mitigate the pain and the sense of hopelessness that has a much longer and lingering presence than Covid-19. Likewise, many living in this world of unpredictability and entrenched poverty are also living with unresolved trauma to which the dark cloud of the personal, social and economic reality of Covid-19 has been added.

Covid-19 has not stopped domestic violence or the incredible isolation of a diagnosed mental illness. Mothers are still birthing and facing the isolation of not having family around them to be that needed source of reassurance. Other mothers stuck in a motel, are living through the heartbreaking loss of a child to the child protection system. People are still being released from prison into a world at a standstill with nowhere to go and no one to go to. Others have made the journey through rehab only to walk out into the world of trying navigating homelessness while hoping they do not relapse before they find a place to stay. Some families are struggling to sustain the demands of supporting their autistic child without access to services, or to support a partner who has just been discharged from a mental health stay in hospital. Many feel they are living in a pressure cooker and don't know how to turn off the pressure.

Our workers, like many others, have been out on the streets, in motels and doing home visits and maintaining connection as best they can. These workers also deserve the recognition given to all front

line workers who are working tirelessly to ensure the safety of the most vulnerable and the safety of community from this virus.

Community nurses and support workers deal with the hundreds of people needing somewhere to stay and assistance to manage their health while services are disrupted, as well as educating people on what is expected and why it is needed. Many people with acquired brain injury, impaired capacity and intellectual disability are without access to the internet and information and need support and assistance to live with the disconnection that comes with not being able to read.

As a nation, we have not yet embraced or understood the extent of the impact of homelessness or the public health issues that have resulted from the failure to bring about the change that is needed to give our most vulnerable Australians a home. Unfortunately, there is no sense of urgency to respond to homelessness.

We know it is about the inadequate supply of affordable housing. However, we also know that it is also about the fragmented systems that create an inflow into homelessness; the lack of integration and connection between housing supply, design, and affordability with the tailored and specific services that a diverse population of people need, including people living with mental illness.

Of the 600 people who we screened going into emergency accommodation, over two hundred disclosed that they had been taken to hospital against their will in the past six months. To me this signals the urgency of the need for governments and community to take investing in a housing first approach seriously. Every department responsible for human services should be partnering with housing departments and providers to design a supportive housing system in Australia. Our most vulnerable citizens — people across the lifespan from birth to death, men women children, have been neglected for far too long.

The current Emergency Accommodation Rapid Response has made visible the extent of couch surfing and rough sleeping as people have contacted services seeking accommodation. At the same time the economic impact of Covid-19 is already increasing the numbers of homelessness due to unemployment and the loss of income. In Australia, people with a mental illness and those with disabilities have been left behind for far too long.

More than ever, there is a need for investment into housing coupled with all other relevant services; health, including mental health, addiction, intellectual and physical disability, child protection, family support children's services and corrections. They all need to come together and create a plan that will see the most vulnerable housed in safe affordable and appropriate housing with built in services for their safety, wellbeing and quality of life.

We need to stop pretending to undertake co-design and do it with the voices of people with lived experience of homelessness, as well as family and friends. We need to listen to the practitioners and clinicians who work every day to support people. We have the evidence of what works — we just need to make it happen.

We know we need investment, both into rental subsidy in the private market and new housing that is coupled with tailored support.

While the Australian Government's Mental Health and Wellbeing Pandemic Response Plan is clearly welcome, its implementation needs to give priority to investment into integrated homelessness housing and mental health responses to address the accessibility of services, the complex mental health needs and the needs of vulnerable populations.

Every local community needs a Mental Health and Housing Plan. Now is the perfect time for national, state and territory governments and local communities to tackle this as a priority.

We need all our parliamentary and government leaders across this country to commit to give everyone a home that will ensure their safety, and the safety of the whole society and community. If we do this, then we can say we have learnt the lessons of this pandemic and that we are prepared to work for a for future in which everyone has a home and there is a real safety net that does not leave anyone behind.

Opinion 6

# Sarah Pollock

Executive Director Research and Advocacy, Research & Advocacy, Mind Australia

## A Crisis Provides Opportunity for the Commission

A key issue to watch when the Royal Commission into Victoria's Mental Health System hands down its final report in February, is the recommendations it provides to address housing security for those experiencing mental ill-health.

The assurance that comes with security of tenure and the associated feelings of safety and stability are crucial in helping people recover from mental ill-health. Having a safe, secure place to live is the foundation for mental health, as our Trajectories research showed.

According to the Australian Institute of Health and Welfare, in 2017–18 about one in three people aged 10 and above who sought help from a homelessness service in Australia reported mental health issues. Many of them have exited state psychiatric services and custodial institutions.

Hospitals and community mental health services sometimes having had little choice but to discharge people into unsuitable accommodation, such as rooming houses or motels, or even homelessness.

This can lead to a relapse that can send the individual concerned back into hospital, often as part of a wider cycle through the social service system, adding to their levels of despair, pain and trauma.

This situation partly has its roots in deinstitutionalisation in Victoria the 1980s and 1990s. While the structural move to community-based care was a welcome reform, there was insufficient consideration to where people were going to live, placing the onus on families and informal carers to provide housing even when this may not be best option for the individual or their family.

Achieving better outcomes for people experiencing mental ill-health means looking at housing not just as an infrastructure issue, but also a health intervention to enable people to live fulfilling contributing lives.

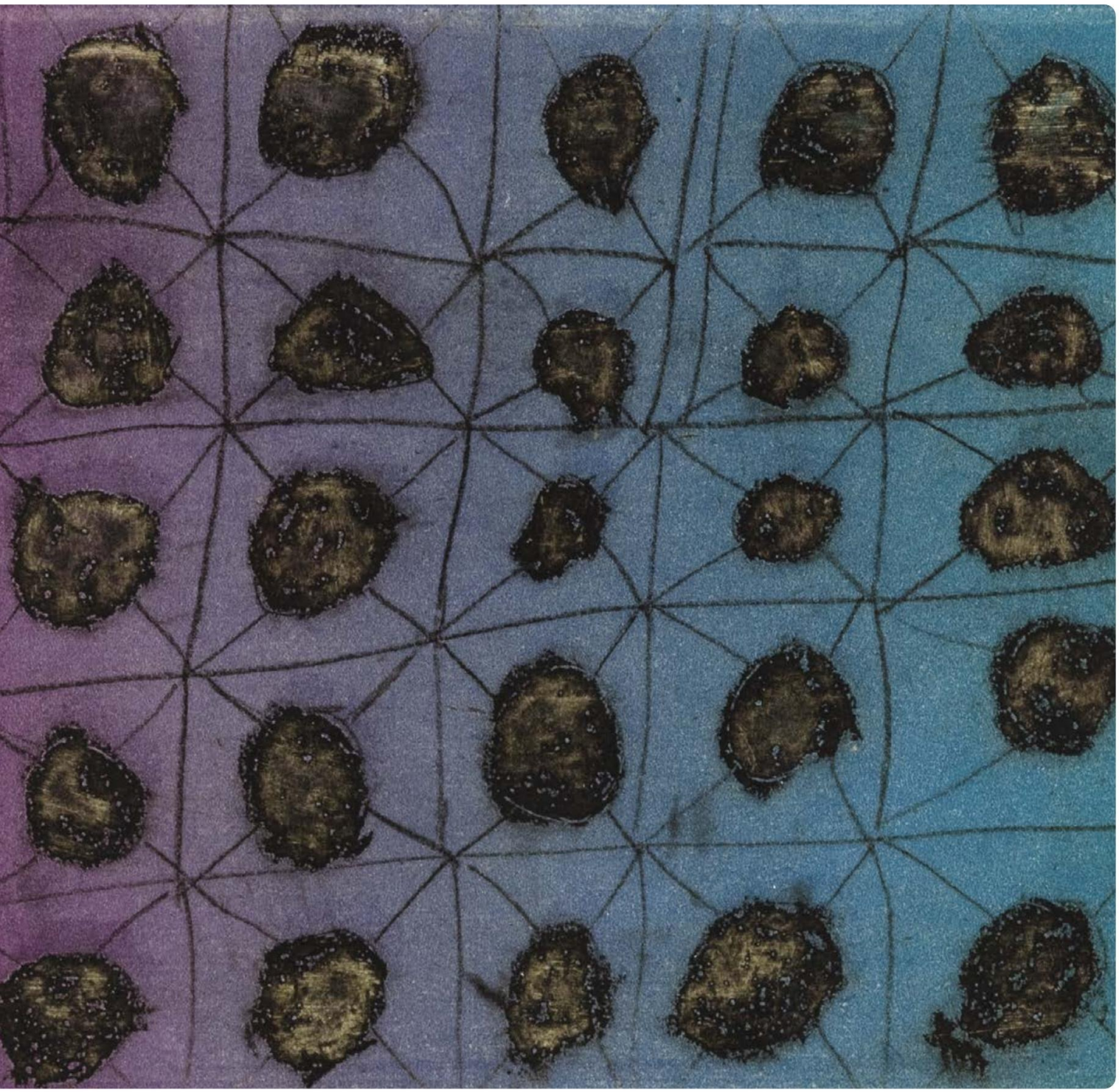
The interim report from the Royal Commission into Victoria's Mental Health System failed to provide any recommendations to address housing, but we were provided hope that the final report would address this issue.

We think that Covid-19 has amplified the concerns around housing security, financial stress and mental health — demonstrating to the public and our decision makers what the Trajectories report laid bare — that they cannot be considered in isolation.

With the appointment of Australia's first deputy chief medical officer for mental health we now have recognition that mental health is as important as physical health. And with the issue of homelessness now

seen as a health concern to the wider community, we finally have some public understanding that what is good for the individual is good for a fairer and more equitable community.

This awareness from Covid-19, coupled with the once-in-a lifetime Victorian Royal Commission and Productivity Commission inquiry into mental health, provides an unprecedented opportunity to act and finally deliver reform — a spectrum of safe and affordable housing for people experiencing complex mental health and those at risk, and a more integrated, caring system.



When the Royal Commission hands down its findings in February we will be looking for a housing and mental health strategy with a clear recognition that housing is the foundation for mental health.

The strategy must include recommendations to address the following three groups of people.

Solutions for people who have housing, but need help to maintain tenancy to assist people to stabilise their housing and prevent them from experiencing homelessness. This includes mental health training for real estate agents and landlords and assistance to maintain a tenancy such as budgeting, tenancy advice, resolving rent arrears and assistance to improve a person's financial situation such as help to find employment.

Housing options for people who need a medium-term intensive housing response that combines accommodation and support. Mind advocates for housing whereby supported accommodation is provided to people for a period of two to five years following a period of serious illness to enable them to stabilise.

Housing for people who need specialised long-term housing and support. The Trajectories research shows that having access to stable, appropriate accommodation can be a circuit breaker which enables people to stabilise.

It is no exaggeration to say the Royal Commission is a once in a generation opportunity to improve Victoria's mental health system. Improved accommodation and housing must be central to this effort.

# Laura Collister

CEO, Wellways Australia

This edition of *Parity* is concerned with the issue of homelessness for people with mental health issues and how we, as a sector, respond effectively to these issues to support those in need. When considering how to effectively respond to these issues, it is no surprise that the principles of Housing First are espoused as sensical and best-practice. Providing people with stable and secure housing is fundamental to addressing homelessness. Given homelessness has risen by 14.7 per cent in recent years and the scarcity of suitable housing, increasing the availability of housing stock for this population group is an urgent health issue. However, providing bricks and mortar is not enough for many people with mental health issues.

Mental health support, based on a sound understanding of recovery, is also fundamentally important for people with severe mental health issues. For most people, this includes clinical treatment usually provided by adult mental health programs, and non-clinical psychosocial support provided by non-government organisations. The Victorian State Government has recognised the criticality of this approach and funded numerous initiatives over the years to integrate mental health treatment and support with the provision of housing.

Programs such as Secure Tenancies and Melbourne Streets to Home are examples of this approach. In this edition, we read about the Doorway program run by Wellways Australia, delivered in partnership with four hospitals which successfully combines clinical and non-clinical mental health support with access to housing via the private rental market. This approach is well established as good practice and has evidenced positive outcomes for this population group. While efficacious, formal treatment approaches alone are not enough to break the cycle of homelessness, connection to community is an essential ingredient to assisting people to build independent and thriving lives.

Building a home in the community is more than the provision of bricks and mortar and mental health support and treatment. Creating a home means meaningfully connecting to and belonging to the community — making it your community. This feeling of connection and belonging changes one from an identity of 'a homeless person', to one of neighbour, customer and friend. It is fundamental to recovery, described by Neil Barringham that a powerful factor in facilitating recovery is connectedness, acceptance, and respect shown by loved ones and community allies.

This point was recently brought home to me as a member of an inner-city community in Melbourne. In 2018, it was announced that a number of small homes would be built to house people who are experiencing homelessness. They were to be built in relatively small clusters along a main road. Many community members, my neighbours, loudly voiced their disapproval of the proposal. They mobilised an email group determined to oppose the development raising concerns about the disruption to community harmony and wellbeing that could be caused from 'homeless' people residing in their community.

This response took me off guard for two reasons. Firstly, because I believed I lived in an inclusive community who would support such an important movement, and secondly, that I felt our attitudes to homelessness had evolved. Evidence of which is with another local group dedicated to welcoming refugees into our local community; a group of volunteers who freely donate items, share skills and support new arrivals into the area. Given the warmth shown by the community in this instance, I am left to wonder why it is that this development for homeless people was not welcomed in the same way? It is clear that further education about homelessness and mental health to community members is required to achieve attitudinal shifts. And such change is important, as what I do predict is that far from feeling welcome these new neighbours will be viewed by many with distrust and fear. In my experience, there are local neighbours who are willing to reach out and welcome these new community members, and there is evidence of this kindness. We need to activate this kindness in other community members who could be more reluctant.

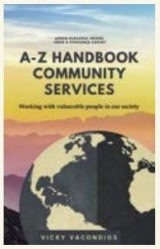
A key question for our sector is how do we effectively connect with community to harness the resources and good will that do exist to create welcoming communities.

There is evidence about how to do this. Corrigan[1] talks about meaningful contact — that is direct and positive contact with people with lived experience to reduce stigma and discrimination. He argues that this is more effective than high profile media campaigns or celebrity endorsement. This approach encourages community mutuality driven by real people with real experiences.

We are seeing good work occurring in the sector to support people experiencing homelessness and mental health issues — that is a combination of best practice in housing and support (Housing First). In my view, we must spend equal effort in changing local community attitudes and creating community connection and belonging. It is this that will ultimately enable people to build a life beyond one defined by homelessness and mental health issues.

**Endnote**

1. Corrigan PW and Lundin R 2001, *Don't Call Me Nuts!: Coping with the Stigma of Mental Illness*, Recovery Press, Illinois.




## A-Z Handbook Community Services

### Working with vulnerable people in our society

While this handbook is for all who work in the community sector and with vulnerable people, anyone can benefit from it, including student's in TAFE and Universities. The book is based on the experiences I, as a mother of three, had with homelessness and domestic violence sector. The services I came into contact with included, Housing, Domestic Violence, Woman's refuges, family, youth, GP's, counsellors, psychiatrists and psychologists, including the justice system for intervention order's and a divorce.

I was stuck in a vicious cycle. I didn't think living in a garage with a sink, bed, wardrobe and an outside bathroom was classified as 'homelessness'. Now I know! My first point of contact with a service provider was when I was 23. Since then, and after deciding to turn my negative experiences into something positive, I have gained substantial knowledge of the community sector – from the other side – a client's point of view.

Change is possible. Our experiences in life do not define us or our individual journeys – we are all at different stages in life. After seeing the other side of the community sector, I believe service workers need to be reminded to practice self-care, positive thinking and remember their focus: the needs of our community.

You can purchase an eBook via Amazon.com. You will need to have a Kindle account. Unfortunately the paperback is not being delivered to Australia so if you would like to purchase paperback/s for yourself and your organisations staff, you can send me an me an email at, hanbook@mail.com

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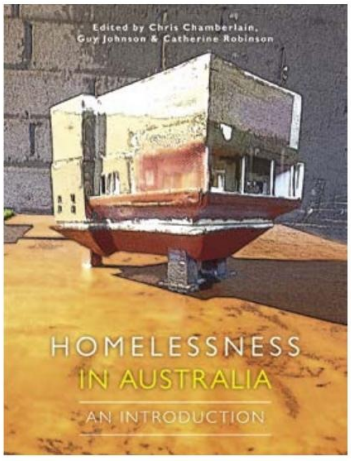
# Homelessness in Australia: An Introduction




*Homelessness in Australia: An Introduction* provides thought-provoking, up-to-date information about the characteristics of the homeless population and contemporary policy debates.

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*Homelessness in Australia: An Introduction* is published by New South Press in association with the Victorian Council to Homeless Persons, one of Australia's leading peak homelessness advocacy bodies.

*Homelessness in Australia: An Introduction* contains 14 chapters.

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