HOMELESSNESS
AND
MENTAL HEALTH
LINKAGES:

Review of National and International Literature

May 2005

Prepared for:

Australian Department of Health and Ageing

Prepared by:

St. Vincent's Mental Health Service (Melbourne)
&
Craze Lateral Solutions
Bungendore NSW

ISBN: 0 642 82897 0
Online ISBN: 0 642 82898 9
Publications Approval Number: 3822

Print Copyright

© Commonwealth of Australia 2006
This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Canberra ACT 2600 or posted at http://www.ag.gov.au/cca

Online Copyright

© Commonwealth of Australia 2006
This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Canberra ACT 2600 or posted at http://www.ag.gov.au/cca

Disclaimer
The opinions, findings and proposals contained in this Report represent the views of the authors and do not necessarily represent the attitudes or opinions of the Commonwealth, State or Territory governments.

TABLE OF CONTENTS

EXECUTIVE SUMMARY IV

1. REVIEW OF NATIONAL AND INTERNATIONAL LITERATURE 1

1.1 INTRODUCTION 1
1.2 DEFINITION OF HOMELESSNESS 3
1.3 DEFINITION OF MENTAL ILLNESS 7
1.4 PREVALENCE OF MENTAL ILLNESS AMONG HOMELESS PEOPLE 8
1.4.1 International Studies 9
1.4.2 Australian Studies 9
1.5 RISK FACTORS FOR HOMELESSNESS 11
1.5.1 Individual characteristics 11
1.5.2 Social Factors: 15
1.6 INTERSECTORAL COLLABORATION 20
1.6.1 Models of Intersectoral Collaboration 20
1.6.2 Factors Inhibiting Collaboration 22
1.6.3 Factors Promoting Collaboration 23
1.7 EVALUATION OF INTERSECTORAL INTERVENTIONS FOR PEOPLE WHO ARE HOMELESS AND LIVING WITH A MENTAL ILLNESS 23

2. CONSUMER PERSPECTIVE 26

2.1 INTRODUCTION 26
2.2 CONSUMER HOUSING OPTIONS AND PREFERENCES 26
2.3 COMPARING PERCEPTIONS OF CONSUMERS AND SERVICE PROVIDERS 31
2.4 BARRIERS TO SERVICE USE BY HOMELESS PEOPLE WITH SEVERE MENTAL ILLNESS 31
2.5 PROMOTING CONSUMER INVOLVEMENT 32
2.6 SUMMARY 32

3. PRIORITY GROUPS 33

3.1 INTRODUCTION 33
3.2 PEOPLE WITH DRUG AND ALCOHOL ABUSE 33
3.3 YOUTH AND CHILDREN 34
3.4 OLDER PEOPLE 36
3.5 ABORIGINAL AND TORRES STRAIT ISLANDER CONTEXT 37
3.6 PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS 39
3.7 WOMEN EXPERIENCING DOMESTIC VIOLENCE 40
3.8 JUSTICE ISSUES 40
3.9 ACQUIRED BRAIN INJURY 41
3.10 INTELLECTUAL DISABILITY 42
3.11 SUMMARY 42

4. CONCLUSION 43

5 BIBLIOGRAPHY 44

EXECUTIVE SUMMARY

This literature review was funded by the Commonwealth Department of Health and Ageing and builds on a previous project which was funded by the Commonwealth Departments of Health and Ageing and Family and Community Services. It concentrates on evidence relating to linkages between the Supported Accommodation Assistance Program, mental health and other service sectors as they respond to the needs of people who are homeless and living with a mental illness.

Definitions of homelessness and mental illness are contentious. However, there is general agreement that homelessness is more than houselessness (Baum & Burnes, 1993; Daly, 1996) and includes concepts such as isolation (Lipton & Sabatini, 1984), the adequacy of facilities (Chamberlain, 1999) and marginalisation (Scott, 1993). The face of the homeless person has changed over time. It is no longer only the face of the older man, drunk and a loner. Now young people, women, families and indigenous people are among the homeless. Researchers have coined the term the 'homeless career' suggesting that there is a typology and a career trajectory among young people ending in chronic homelessness (MacKenzie & Chamberlain, 2003). Among the elderly, there is a new term 'the new homeless'. This term describes people who had previously never had a homeless episode in their lives, having led conventional lives although close to the poverty line. These people now find themselves in older age more vulnerable to the changes in availability of low cost housing and consequently experience homelessness for the first time (Lipmann, Mirabelli & Rota-Bartelink, 2004).

Definitions of mental illness may cover a broad concept such as mental health care problems (National Community Advisory Group on Mental Health, 1994) or clinical definitions such as psychosis, depression and substance use disorders (American Psychiatric Association, 1994).

The estimated prevalence of mental disorders among people who are homeless varies, reflecting the area in which the research was conducted, the definition of mental illness and the methodological approach. Despite these limitations there is consistent evidence that people who are homeless have a much higher prevalence of mental illness than the general population.

Current research highlights the interaction between individual and structural factors as contributing to the high rate of mental illness among people who are homeless. However, the direction of causality between risk factors and homelessness varies and may be unclear. Drug abuse, social isolation and mental disorders are plausible consequences as well as causes of homelessness. The constant fear, danger and victimisation may contribute to people becoming emotionally distressed and the development of ongoing depression and anxiety. There is also evidence that severe mental disorders, such as psychotic illnesses, are a risk factor for, rather than a consequence of homelessness. Hallucinations, thought disorder, paranoia, anxiety, loss of motivation or interest in their own welfare, and other disability may contribute to an increased vulnerability to homelessness (Herrman & Neil, 1996). Research evidence also indicates that effective treatment for people with psychosis early in their illness can prevent homelessness.

This review highlights the importance of effective collaboration between treatment and support agencies of various sorts in responding to the needs of homeless people living with mental illness. It also reveals how little information we have about approaches to intersectoral collaboration or the factors that inhibit or promote collaboration. The World Health Organisation (1997) has provided a framework for promoting intersectoral collaboration. This includes the willingness of sectors to work together, a capacity to undertake the proposed action, well-established existing relationships, and a well-planned activity that can be implemented and evaluated.

Research findings indicate that homelessness among people with mental illness is preventable. Studies reveal that if community psychiatric services or primary health care services are accessible, homeless people will both use and gain benefit from clinical treatment and clinical support services (Herrman, 1996; Bachrach, 1995; Buhrich & Teeson, 1996). Accessible treatment options for substance abuse are critical but are often not available or sufficiently flexible. Services most likely to be used by homeless people with mental illness are those that have adapted service delivery and treatment approaches to reflect the experiences and reports of their homeless clients (Herrman, 1996, Goldfinger & Schutt, 1999).

Evaluation of various intersectoral approaches in responding to the needs of homeless people with a mental illness demonstrates that residential stability is an attainable goal when service systems are well-integrated, substance abuse treatment is part of a comprehensive treatment approach and there is a range of housing choices with flexible support available (Herrman, 1999). This then highlights the need for a systemic approach to facilitate greater collaboration between agencies that deliver mental health services, drug and alcohol rehabilitation and housing services. The key government policy documents all recognise the need for collaboration, but further work is needed to translate this into initiatives that will make a difference at the service delivery level.

Evaluations of consumer preferences for housing demonstrate that most adults with a mental illness prefer to live independently rather than in a group home (Schutt & Goldfinger, 1996). Australian research has confirmed this finding with the least preferred housing options being shelters, crisis accommodation and hospitalisation (Browne & Courtney, 2004; Freeman, Malone, & Hunt, 2004; Owen, Rutherford, Jones, Wright, Tennant & Smallman, 1996). Within the international literature there are a number of models proposed for providing housing for people with severe mental illness: these include supported housing and a continuum of care model. In a comprehensive review of proponents for both approaches, Rog (2004) found that once housed people with severe mental illness who were homeless stay housed with supports and are less likely to be hospitalised regardless of the specific housing model. The key was having access to affordable housing (Rog, 2004). For people who are homeless and mentally ill as well as other groups in the community such as families, any stable housing has a dramatic improvement on outcomes, such as residential stability, use of institutional settings, such as hospitals, detoxification facilities, the criminal justice system and so on (Rog, 2004).

There are a number of challenges for research to contribute further to the understanding of homelessness and mental illness. Research into homelessness and mental illness will benefit from collaboration between researchers from a diversity of disciplines and a wider use of ethnographic and other qualitative methodologies. As well as further research to understand the nature and extent of the

problem, there is a need for more evaluative research that can identify the impact of innovative programs related to homelessness and mental illness.

1 REVIEW OF NATIONAL AND INTERNATIONAL LITERATURE

1.1 INTRODUCTION

In an affluent and western democratic country such as Australia, despite universal health care and comprehensive social security systems some people are still homeless. Homelessness is a difficult and complex social issue that often has devastating consequences for those affected by it. Despite the traditional image of homeless people as older men or street kids, there are increasing numbers of single women, families and young people joining single adult males in homelessness. Indigenous Australians are especially over-represented in the homeless population (AIHW, 2004). Social policy commentators have consistently recognised homeless people as the most marginalised section of Australian society. Many people experiencing homelessness face a range of problems, including unemployment, substance abuse and mental health problems. People with a severe mental illness may be the most vulnerable and disadvantaged persons within the homeless population.

The prevention of homelessness and the provision of adequate housing is a crucial social policy issue facing Australia. The Supported Accommodation Assistance Program (SAAP) is Australia's primary service delivery response to homelessness. SAAP is a jointly funded Australian and state and territory government program assisting people who are homeless or at risk of becoming homeless (including women and children escaping domestic violence) to achieve the maximum possible degree of self-reliance and independence through a range of support and transitional accommodation services. The Australian Government has a policy leadership role and state and territory governments are responsible for the day-to-day management of the program.

Since May 2000, the National Homelessness Strategy (NHS) has been the focus of the Australian Government's response to the problem of homelessness by setting the framework for future policy and program development in this area. The NHS provides a strategic approach to the prevention and reduction of homelessness across Australia through means of prevention and early intervention. The following objectives were identified to help achieve this outcome:

- to provide a strategic framework that will improve collaboration and linkages between existing programs and services, to improve outcomes for clients and reduce the incidence of homelessness;[1]
- to identify best practice models, which can be promoted and replicated, that will enhance existing homelessness policies and programs;
- to build the capacity of the community sector to improve linkages and networks; and
- to raise awareness of the issue of homelessness throughout all areas and levels of government and in the community.

The NHS seeks to achieve these objectives in a manner consistent with the following four themes:

[1] Targeted homeless programs such as the Supported Accommodation Assistance Program (SAAP), Reconnect and the Job Placement Education and Training Program (JPET) are delivered under the banner of the NHS. In addition, the Strategy includes liaison with Australian government programs that provide services and support to people who are disadvantaged including the Personal Support Program, Assistance with Care and Housing for the Aged and Partnerships Against Domestic Violence.

- Working Together in a Social Coalition;
- Prevention;
- Early Intervention; and
- Crisis Transition and Support.

In October 2000, the Minister for Family and Community Services (FACS) appointed a new Commonwealth Advisory Committee on Homelessness (CACH) for a three-year term and requested CACH to provide advice on the development of the NHS. Consequently, CACH developed a discussion paper *Working Towards a National Homelessness Strategy*. National consultations on the paper resulted in the publication of a revised paper, *Working Towards a National Homelessness Strategy: Response to Consultations* in 2003. This document calls for greater collaboration and co-operation between private and public stakeholders, and across Government departments and portfolios to create an integrated and comprehensive response to the income, employment, health, housing and family relations needs of people who are homeless. A new CACH was appointed in January 2004 and the Minister specifically requested CACH to provide advice on mental health/substance abuse as causes of homelessness. The Australian Government has extended the NHS for a further four years from 1 July 2005.

Within the mental health sector, the Third National Mental Health Plan 2003-2008 also identified the need for a whole-of-government approach to meet the mental health needs of all Australians requiring partnerships with the housing, education, welfare and justice sectors. The plan identifies the need for increased access to appropriate, long-term supported accommodation and calls for greater links with housing departments. One of the key directions stated in the plan is to strengthen the capacity to respond to the needs of people with mental illness who are homeless (p.21). This plan builds on the key themes of “partnership' and 'service reform' from the Second National Mental Health Plan.

SAAP also stresses the need for integration and collaboration between SAAP and other service systems. In the 2004 National Evaluation of SAAP IV, which was endorsed by all Australian Government, State and Territory Community Services Ministers in July 2004, the authors state that 'SAAP needs to develop much stronger connections with income security, employment and educational agencies, while at the same time improving collaborative arrangements with mental health, drug and alcohol, housing and child protection services' (p39). SAAP V, the new SAAP agreement currently under negotiation, will be seeking opportunities to maximize linkages between SAAP and mental health agencies.

While there seems to be a uniform call for integration and collaboration it is not clear from the reports cited above how this is to be achieved and who will be responsible in ensuring that it happens. This literature review aims to summarise the international and Australian literature describing the prevalence and characteristics of homelessness, in particular homeless people with a mental illness, and to provide examples of how partnership between various sectors have produced positive outcomes in people's lives.

1.2 DEFINITION OF HOMELESSNESS

While much has been written about homelessness over the last two decades there is no consistent definition of the term, although there is a general consensus among researchers that the term homeless refers to something more than just ‘house-less-ness’. (Baum & Burnes 1993; Daly, 1996). This is reflected in the following excerpt:

> *‘The term ‘homeless’ is actually a catch word, a misnomer that focuses our attention on only one aspect of the individual’s plight: his lack of residence or housing. In reality, the homeless often have no job, no function, no role within the community; they generally have few social supports. They are jobless, penniless, functionless, and supportless as well as homeless.’* (Lipton & Sabatini, 1984, p.156)

This view of homelessness emphasises the person’s alienation and lack of social support networks. (Baum & Burnes, 1993). This isolation is reflected in the high proportion of homeless people who have never been married and have little or no contact with friends or family (Lam & Rosenheck, 1999; Thornicroft & Breakey, 1990). A person alienated from society may not actively seek help or support from government and welfare agencies.

> ‘A homeless person is without a conventional home...She/he is often cut off from support of relatives and friends, she/he has few independent resources and often has no immediate means and in some cases, little future prospects of self support.’ (Council to Homeless People, 1988)

The concept of home is at the heart of the term homelessness. The term home has been used by various disciplines (sociology, anthropology, psychology, architecture, history, geography, philosophy) to define a structure, a place or dwelling, a family or group of people, a country or birthplace, an organization or building, a place within that defines a person’s sense of self, a refuge from the outside world, a haven (Mallet, 2004). Within an Australian context the term home resonates as the Australian dream, a free-standing house with a backyard occupied by a single family. This is one view of home. Another view as expressed by indigenous people is not the dwelling but the land from which one comes, and from where one’s ancestors camped and lived (Mallet, 2004). A phenomenological approach to understanding home acknowledges that home may be located in the physical place (house, apartment, institution) but it is also the lived experience that occurs in this space, the expression of social identity and meanings. In this frame homeless and home are not opposite terms but exists in a dynamic and dialectic relationship (Mallet, 2004).

This is encompassed in the following quote…

> 'We make our homes. Not necessarily by constructing them, although some people do that. We build the intimate shell of our lives by the organization and furnishing of the space in which we live. How we function as persons is linked to how we make ourselves at home. We need time to make our dwelling into a home...Our residence is where we live, but our home is how we live (Ginsburg, 1998 p.31).

The relevance of this sentiment in understanding the issues faced by people who are homeless and have a mental illness will be demonstrated throughout this literature review. People are faced not only with a lack of appropriate shelter but also with the lack of social connection and opportunity for meaningful activity.

The definition of homelessness can also reflect approaches to resource allocation and program development to meet the needs of homeless people and the varying government philosophies, policies and priorities. Experience from overseas illustrates this point. In the USA, definitions of homelessness within social policies have been narrowed over time. Several decades ago homelessness encompassed all people living in substandard housing (Daly, 1996). More recent definitions refer to homelessness as a more basic lack of shelter, including people living in public and private shelters and institutions providing temporary accommodation (Daly, 1996). At the same time, public monies are being spent on large shelters and the provision of food, clothing, medical attention and other immediate needs rather than the provision of low-cost and adequate housing and providing supports to those vulnerable to becoming homeless (Rickards, Leginski, Randolph, Oakley, Herrell, & Gallagher, 1999).

In Australia, during the past decade two definitions of homelessness have emerged. One is a cultural definition of homelessness formulated from the work of Chamberlain (1999) and used by the Australian Bureau of Statistics to systematically enumerate the homeless population.

Primary homelessness: *people without conventional accommodation such as those who 'sleep out', or use derelict buildings, cars, railway stations for shelter.*

Secondary homelessness: *people who frequently move from temporary accommodation such as emergency accommodation, refuges, and temporary shelters. People may use boarding houses or family accommodation just on a temporary basis.*

Tertiary homelessness: *people who live in rooming houses, boarding houses on medium or long-term where they do not have their own bathroom and kitchen facilities and tenure is not secured by a lease.*

Marginally housed: *people in housing situations close to the minimum standard*

(Chamberlain, 1999)

The above definitions reflect an interpretation of cultural standards in Australia about what is deemed 'adequate housing'. It would be generally accepted that a single person or couple could expect to have a least a room to sleep in, private bathroom and kitchen facilities, and some sort of secure tenure (Chamberlain, 1999).

The other definition below was developed for the purposes of the Supported Accommodation Assistance Act (1994) to determine who is eligible for services.

A person is homeless if, and only if he/she has inadequate access to safe and secure housing. A person is taken to have inadequate access to safe and secure housing if the only housing to which a person has access:

(a) damages or is likely to damage a person's health; or
(b) threatens a person's safety; or
(c) marginalises the person by failing to provide:
(i) adequate personal amenities; or
(ii)economic and social support that a home normally affords; or
(d) places the person in circumstances which threaten or adversely affect the adequacy, safety, security and affordability of that housing.

In this definition emphasis is placed on a person's subjective view of their housing situation. Under this definition a person residing in a rooming/boarding house who considers this to be his/her home would not be deemed homeless. The definition also includes people who are living in conventional housing but for whatever reason their accommodation may be detrimental to their health, for instance they may be at risk of domestic violence or of eviction because rent is too high; these people are at risk of homelessness and are eligible to receive assistance from a SAAP service provider (Chamberlain & MacKenzie 2003). The benefit of such a definition is that it allows welfare agencies to assist a person who is at risk of homelessness.

There are several ways to sub-classify homelessness. People may be transiently, episodically or chronically homeless (Arce & Vergare 1984). In other words, homelessness may comprise a series of states that exist along a continuum of time and place, and entry to or exit from the homeless state is usually part of a process rather than a single jump. This notion of a continuum has been developed further in the recent work of Mackenzie and Chamberlain (2003) who coined the phrase 'homeless career'. According to this concept the person passes through various stages before developing a self-identity as a homeless person. The first typology is the youth career that focuses on teenagers forced to leave their family home before establishing themselves financially. They usually stay with friends, 'couch surfing', without their parents' permission. They tend to still be at school when the first episode of homelessness occurs, then with time they may drop out of school and enter a homeless sub-culture. The second typology is adult homelessness. Mackenzie and Chamberlain (2003) describe three pathways to entering adult homelessness:

1. housing crisis career whereby poverty and accumulating debts, lead to a loss of accommodation;

2. family breakdown attributed to domestic violence; and

3. transition from youth to adult homelessness.

The last pathway is a continuation of youth homelessness to adult homelessness. The profile of these young adults is one where the person has drug and alcohol and/or mental health problems, has had a significant number of contacts with the juvenile justice system, is unemployed, extremely poor and highly marginalized (MacKenzie & Chamberlain, 2003). The aim of such a typology is to draw attention to the exit points and the opportunities for creating early intervention points to prevent chronic homelessness. One such intervention could be to assist people before they lose their accommodation, through financial counselling, emergency relief or application for public housing. In relation to youth homelessness, intervention points can occur while the person is still at school and may focus on family reconciliation where appropriate. With respect to family breakdown, early intervention points may be problematic because people may return to the family home for periods of time and then be forced to leave again due to violence or abuse. In such situations there is a crisis intervention aimed at providing secure and stable accommodation (MacKenzie & Chamberlain, 2003).

Thus while the definition of homelessness varies, there is a growing consensus that, at least within Australia, cultural standards of adequacy and acceptability are important definitional components. Further, homelessness is not viewed as a single state, but varies as a continuum over time and place.

Prevalence estimates vary over time, and this depends at least in part on the method used in the study, and on the definition of homelessness. In Australia in 1985, the Federal Department of Housing and Construction estimated that 40,000 people slept outdoors and 60,000 people were housed inadequately (Coopers, Lybrand & Scott, 1985).

Counting the Homeless (2003), estimated the number of homeless people in Australia using 2001 Census data. The study suggested that 100,000 people were homeless across Australia on Census night and that many of the homeless people move from one form of temporary shelter to another with:

- Nearly half, 49%, staying temporarily with other households;
- 14% were in improvised dwellings, tents or sleeping out; and
- Another 23% were staying in boarding houses (Chamberlain & MacKenzie, 2003).

Fourteen per cent were accommodated in SAAP agencies, including for example, hostels, refuges, night shelters and other types of emergency accommodation. The traditional view of the homeless person as an older single male has been challenged by this report with a significant proportion of people (36%) aged between 12-24 years. Amongst people aged 35 years or older men outnumber women three to one however the overall proportion of women is 42%, a substantial group compared with that of thirty to forty years ago (Chamberlain & MacKenzie, 2003). Families although a minority (9%) still constitute a sizable proportion (comprising 9,543 parents and 13,401 children). The study reported that on Census night between 60% and 70% of homeless people had been homeless for six months or longer. The study also suggested that the assertion that the homeless population is fairly evenly spread

across the country is incorrect. The census data indicates that there are between 40 to 50 homeless people per 10,000 of the population residing in the Southern States. In Western Australia and Queensland between 65 and 70 per 10,000 people have been estimated as homeless. The Northern Territory continues to have the highest rate of homelessness in the country, 288 per 10,000 people, largely due to indigenous people living in improvised dwellings. This rate is substantially lower than in 1996 when it was reported as 523 per 10,000 people; this reduction was largely due to a change in the definition of what constitutes an improvised dwelling (Chamberlain, 1999; Chamberlain & MacKenzie, 2003).

1.3 DEFINITION OF MENTAL ILLNESS

Definitions of mental illness reflect a continuum from the broad definition of mental health care problems to narrower clinical definitions.

The National Community Advisory Group on Mental Health (1994) defined mental health care problems as:

> *Problems associated with mental illness which if not addressed result in severe disadvantage, continued dependence on mental health treatment and crisis services, and which severely curtail the ability of the individual to live independently in the community to their fullest potential. The problem and the need associated with the problem are understood by reference not only to diagnosis, but also to diagnosis in the context of impact on life circumstances. Problems associated with behavioural and/or personality disorders fall within this definition (p.10).*

In contrast, within a clinical context, mental illness can be defined as a clinically recognisable set of symptoms (relating to mood, thought, or cognition) or behaviour that is associated with distress and interference with functions (that is, impairments leading to activity limitations or participation restrictions). Mental illnesses discussed in relation to homelessness include:

- dementia, delirium and other organic mental disorders;
- schizophrenia, bipolar disorder and other related psychotic disorders that are characterised by hallucinations, delusions, thought disorders, behaviour disturbances;
- mood disorders, especially depression;
- anxiety disorders;
- substance use disorders; and
- personality disorders that are characterised by enduring patterns of behaviour that are inflexible and maladaptive and cause distress or interference with functions. (American Psychiatric Association, 1994)

The concept of 'serious' or 'severe' mental illness' has been used in some studies of homeless people with a mental illness (Breakey & Thompson, 1997). While there is no agreed definition of these terms, researchers are generally referring to psychotic disorders such as schizophrenia and bipolar disorder that are characterised by a loss of sense of reality, auditory or visual hallucinations, thought disorder, and delusions. Other researchers have used more inclusive definitions that include a wider range of mental disorders such as depression, anxiety and substance use disorders (Teeson et al, 1998). The diversity of

definitions used by researchers makes it difficult to compare the prevalence rates identified by various studies.

The understanding of mental illness within the community sector is variable, with some staff reporting that the clinical terminology used within the clinical mental health sector is judgmental or 'blames' the victim. This leads, not only to poor relationships between the sectors, but may impede access to treatment (Econsult & Neil, 1994).

For the purpose of this project, it is necessary to distinguish between people living with psychotic disorders such as schizophrenia and people living with the more common disorders such as depression and anxiety. This is not to suggest that there is no overlap between these disorders or that people with depression and anxiety are not severely affected or disabled by a mental illness. Rather, research suggests that the causal relationship between homelessness and mental illness may differ for these two groups, and therefore such a distinction can better inform strategies for the prevention of homelessness among people living with a mental disorder, as well as mental health treatment and support services for people who have become homeless.

1.4 PREVALENCE OF MENTAL ILLNESS AMONG HOMELESS PEOPLE

Mental illness and homelessness are intertwined in terms of cause and effect. It may be that the experience of being homeless, the constant fear, danger and victimisation results in people becoming emotionally distressed. At a societal level, lack of employment options, housing, stigma and discrimination may all interact with the individual risk factors that lead to homelessness. This may in turn exacerbate the original condition. While a person with a pre-existing illness may be more vulnerable to becoming homeless by the nature of their illness, there is also evidence that severe mental disorders, such as psychotic illnesses, are a risk factor, rather than a consequence of homelessness (Herrman & Neil, 1996). Hallucinations, thought disorder, disorientation, paranoia, anxiety, loss of motivation or interest in their own welfare, and other disabilities may contribute to an increased vulnerability to homelessness (Breakey & Thompson, 1997).

People with problematic drug or alcohol use and schizophrenia are less likely to remain in stable accommodation than those without drug and alcohol problems. (Caton, Shrout, Eagle, Opler, & Felix, 1994). Homelessness can occur both as a direct consequence of established mental illness or as a result of problems with coping, social withdrawal and poor occupational performance that characterise the early phases of schizophrenia. The loss of accommodation itself may be less important than the ability of the individual to escape from the condition once it has arisen.

There is strong indirect evidence that severe mental illness can increase the risk of homelessness, independent of long-term hospital stay. A quarter of all severely mentally ill people seen by clinical teams in the London-wide Homeless Mental Health Initiative had lost their permanent accommodation following eviction for disturbed behaviour or non-payment of rent that was a direct result of their mental illness (Craig & Timms, 1995).

1.4.1 International Studies

Within Western communities since the early 1980s, there has been mounting concern about the plight of people who have a mental illness and are homeless. This gave rise to a number of prevalence studies in major cities. The prevalence estimates varied according to the location of the study and the particular group of homeless people selected. A broad consensus is that approximately one third of people who are homeless have a significant mental illness (Breakey & Thompson, 1997; Lezak & Edgar, 1996). One typical example of such a prevalence study conducted in Baltimore found that 35% of men and 48% of women had a major mental illness. This estimate included people suffering from schizophrenia, major depression and other affective disorders (Breakey & Thompson, 1997). Folsom & Jeste (2002) reviewed 33 international published studies to examine prevalence rates of schizophrenia in homeless populations. The rates ranged from 2 to 45%. Ten studies judged as being methodologically more rigorous yielded a prevalence range from 4 to 16% with a weighted average prevalence of 11%. More recently a study conducted in the Santiago County public mental health facility found that 15% of people utilizing the service in the past 12 months were homeless. Of the 1,569 patients who were homeless, 20% were diagnosed with schizophrenia, 17% with bipolar disorder and 9% with depression. The study found that people abusing substances were four times more likely to be homeless and those without private health insurance were twice as likely to be homeless. People with a diagnosis of schizophrenia or bipolar disorder were more likely to be homeless compared with those diagnosed with major depression (Folsom, Hawthorne, Lindamer, Gilmer et al., 2005).

In Great Britain, the Survey of Psychiatric Morbidity conducted by the Office of Population Censuses and Surveys (OPCS) included the first nationally representative survey of psychiatric morbidity among homeless people. The aim was to include a representative sample of homeless adults including single people and families aged 16-64 years. People who were homeless were defined according to their accommodation circumstances. These included:

- residents of hostels;
- residents of private sector including leased and short-life accommodation (PSLA);
- adults in night shelters; and
- people who sleep rough and attend day centres.

This survey identified that 43% people living in night shelters and 47% of people sleeping rough had at least one symptom of psychosis (Gill, Meltzer, Hinds & Petticrew, 1996).

1.4.2 Australian Studies

In Australia, the prevalence of severe mental illness among marginally accommodated people seems to have increased over time. In 1985, Doutney, Buhrich, Virgona, Cohen and Daniels reported a schizophrenia prevalence of 15% among people living in a refuge for homeless men in Sydney. In 1987, a Melbourne study sampled 382 people who were living in marginal accommodation (private hotels, rooming houses, crisis accommodation and special accommodation houses). In the month immediately prior to the interview 18% had experienced psychosis and 12% had a current mood disorder. Among residents, the lifetime prevalence for a psychotic disorder was 22% and for a mood disorder 25% (Herrman, McGorry, Bennett, van Riel, Wellington, McKenzie & Singh, 1988).

In 1997 as part of the National Survey of Mental Health and Wellbeing, the Study of Low Prevalence Disorders (Jablensky, McGrath, Herrman, Castle, Gureje, Morgan, Korten, 1999), conducted a specific survey of rooming houses, boarding houses, special residential accommodation and crisis/emergency accommodation in the local government areas of Yarra and Boroondara in Melbourne. In this sample there was a high lifetime prevalence of 42% (95% CI=37-47) of people with psychosis. About 40% of people had a lifetime diagnosis of schizophrenia (39% males and 53% females). In terms of alcohol abuse or dependency 43% of men and 20% of women had a lifetime diagnosis. (Herrman, Evert, Harvey, Gureji, Pinzone & Gordan, 2004). In a similar study in Sydney in 1997, 210 homeless people were interviewed. A homeless person was defined as someone who had spent the previous night in an emergency shelter, outdoors, any space not designed for shelter, hotel, motel, friend's place or experienced uncertainty of accommodation for the next 60 days, did not have permanent housing or was a recipient of homeless services. It was found that 23% of men and 46% of women were diagnosed with schizophrenia in the past 12 months. Of the people interviewed, 49% of men and 15% of women were diagnosed with problematic alcohol dependence/abuse (Hodder et al, 1998; Teesson, Hodder, & Buhrich, 2004). These proportions are not dissimilar to those reported in Melbourne by Herrman et al (2004) and would seem to indicate over the past 10 years there is still a substantial proportion of people with severe mental illness living in marginal or sub-standard accommodation. Both Herrman et al (2004) and Teesson et al (2004) state that despite contact with community mental health services, early intervention strategies, reduction of long stay hospitals and provision of community care there is still a lack of appropriate accommodation to meet the needs of people with severe mental illness.

Regardless of how homelessness or mental illness is defined, it seems certain that homeless populations have a much higher prevalence of schizophrenia and other severe mental disorders than the general population. Studies from Australia, Britain, USA and a number of other countries have reported a range of rates reflecting different methods of sample selection, measurement of symptoms and definitions of mental illness (Craig & Timms, 1995). Nonetheless it is possible to conclude from studies that between one quarter and one half of adult homeless persons across western cities are experiencing severe and perhaps chronic mental illness.

Prevalence studies will not illuminate whether the onset of a mental illness preceded or followed the onset of homelessness. Furthermore mental illness is likely to affect the duration as well as the onset of homelessness. In a study of homeless people in Melbourne, life charts were constructed from the information obtained at interview and from state records of service use. For many respondents there was evidence that severe mental disorder preceded sustained periods of homelessness or living in marginal accommodation, even when residence in these settings was episodic. Only a small number of respondents appeared to have become homeless before becoming mentally ill (Herrman, McGorry, Bennett, Varnavides, and Singh, 1992). This is consistent with recent evidence of the onset of homelessness among a cohort of patients in the USA followed up after first hospital stay for psychosis (Herrman, Susser, Jandorf, Lavelle & Bromet, 1998). Research evidence indicates that while there is a high prevalence of mental illness among people who are homeless, at least for some individuals, homelessness is an outcome of the mental illness. Importantly, early, effective treatment for people with psychosis is likely to prevent homelessness.

It is important to note that most homeless people are not mentally ill. Many advocates for homeless people are understandably emphatic about this point. However it is helpful neither

… to (ignore) the presence among the homeless of those who would profit from treatment, nor to be foolish enough to think that the problem of homelessness will be solved in the absence of attention to the pressing social, welfare and housing issues that affect all homeless people. (Koegel, Burnam & Farr, 1988).

1.5 RISK FACTORS FOR HOMELESSNESS

Current research highlights the interaction between individual and structural factors as contributing to the high rate of mental illness among people who are homeless. However, the direction of causality between risk factors and homelessness is less clear. Drug abuse, social isolation and mental disorders are plausible consequences as well as causes of homelessness. The constant fear, danger and victimisation may result in people becoming emotionally distressed and the development of a mental illness. There is also evidence that severe mental disorders, such as psychotic illnesses, are a risk factor, rather than a consequence of homelessness (Herrman & Neil, 1996). As stated earlier, hallucinations, disruption of thoughts, disorientation, paranoia, anxiety, loss of motivation or interest in their own welfare, and other disability may contribute to an increased vulnerability to homelessness (Breakey & Thompson, 1997).

In addition, lack of employment opportunities, limited housing options, stigma and discrimination associated with having a mental illness may contribute to the risk of homelessness, while also being a consequence of the homeless state.

More recently the debate about individual and structural risk factors has shifted to a focus by researchers and policymakers on the continuum that crosses over individual and structural issues. The concept of a continuum enables us to examine factors that precipitate homelessness, the causes and consequences of homelessness as well as the factors that may inhibit or exacerbate the homeless trajectory (Greenhalgh, Miller, Mead, Jerome, & Minnery, 2004).

A coherent response to the general problem of homelessness requires an understanding of the interaction between individual characteristics and social factors (Main, 1998). Risk factors for homelessness will be examined in terms of the individual and structural associations of homelessness, the interaction between the two, and the influence of a mental illness on these risk factors.

1.5.1 Individual characteristics

1.5.1.1 Demographic Factors

Relevant individual characteristics include demographic factors, gender, childhood experiences, social networks, physical health, substance use and mental illnesses. Prevalence studies of homeless people are consistent in suggesting that the risk of homelessness is higher in men than women, higher in the age group 30-39 years than in other age groups and higher in poorly educated people.

Workers and writers in the area debate whether or not the number of mentally ill among homeless people is growing, and whether or not hostels for the homeless have to cope with younger and more disturbed mentally ill people. Recent studies from the UK have examined the social disablement of men in hostels for the homeless. In a random sample of 101 men living in four long-stay hostels, 13 with 'psychotic personal behaviour problems' had levels of social disability similar to patients in a long-stay hospital ward (Hamid, Wykes & Stansfield, 1995). Very few of these men were in contact with any psychiatric services. Other work in England has shown that the social disablement of these men can be reduced to a great extent with adequate psychiatric treatment (Marshall, 1993).

The limited available data suggest that in recent decades the incidence of homelessness has increased, and that some of the demographic risk factors have changed. Over the last three decades, more young people, women, families and ethnic minorities are using shelters, and are more likely to be homeless. There are no adequate explanations for these changes, although speculation included changes in the population structure, the general scarcity of low-cost housing, changes in traditional family networks in western urban areas and changes in welfare and psychiatric services (Susser, Moore & Link, 1993; Craig & Timms, 1995).

In comparison with homeless men, a higher proportion of homeless women have a mental illness. Tacchi & Scott (1996) noted that homeless women are often less visible than homeless men, and that many more research studies have described homeless men than women. They found that a high proportion of homeless women (78%) had a disruptive early home life. A further 32% had a personality disorder, and 53% experienced some psychological distress as measured by the General Health Questionnaire (Tacchi & Scott, 1996). Relatively more homeless women than homeless men have experienced some level of physical or sexual violence (Tantam, 1991; Hodder et al, 1998). Adams, Pantelis, Duke and Barnes (1996) found that British women hostel residents were more likely to be homeless because of a breakdown in family relations, rather than discharge from psychiatric hospital.

Generally a lower proportion of homeless women abuse alcohol than men (Herrman et al, 2004; Teesson et al, 2004; Hodder et al, 1998) although, the proportion of alcohol abuse among homeless women is still significantly higher than in the general female population.

Herrman et al, (2004) points out that even though homeless women are a minority, their disability profile is just as severe as in men. Homeless women were more likely to have been in relationships in the past and this breakdown may have been a contributing factor to their homelessness. Women reported greater difficulties in their social relationships than men and were more likely to be socially withdrawn and isolated yet still desired opportunities to make friends.

1.5.1.2 Childhood experiences

Research suggests that homeless people have a high incidence of disruptive childhood experiences including foster placement and running away from home. For instance Ezra Susser and colleagues (Susser, Struening & Conover, 1987) found that 23% of newly homeless men in New York City reported a history of out-of-home care in childhood. This has been confirmed in other studies which found that deprived circumstances and disrupted childhood experiences were associated with the risk of homelessness. Studies of women

resident in shelters in the USA and UK reveal that up to a third report abuse during childhood and two-thirds report major family disruption (Scott, 1993).

Caton, Shrout, Eagle, Opler and Felix (1994) found that people living with schizophrenia, substance abuse and personality disorder were more likely to have a background of family disorganisation such as parental instability, poverty, and violence as well as a childhood history of placement in foster care or group homes, experience of physical abuse and runaway episodes. Similarly Sullivan, Burnam, and Koegel (2000) also found that homeless people with mental illness had higher levels of childhood instability, abuse and violence than homeless people without mental illness.

1.5.1.3 Social networks

Homeless men and women are marginalised and characteristically have no or few social contacts. This disaffiliation may be a both a cause and a consequence of their homeless state. For homeless mentally ill individuals, the networks are further restricted and social isolation is typical (Lam & Rosenheck, 1999; Thornicroft & Breakey, 1990).

Using the data from the Study of Low Prevalence Disorders, Evert, Harvey, Trauer & Herrman, (2003) found that people with psychosis who were socially isolated, that is, had no friends or family, were more likely to live in marginal accommodation compared with people who had either friends and/or family in their social networks. Further, when their social functioning was described based on a person's accommodation, it was found that people residing in institutional settings and in marginal accommodation were more likely to report difficulties socialising, were more likely to be socially withdrawn and less likely to have intimate friends compared with people residing in their own or rented homes. People residing in marginal accommodation were also more likely to report a decline in their social functioning in the past 12 months (Harvey, Evert, Herrman, Pinzone, & Gureje, 2002).

Lehman, Kernan, De Forge and Dixon (1995) compared the quality of life measures of people who were homeless and had a severe mental illness, with a domiciled group of people with mental illness. Homeless people were significantly more dissatisfied with their living arrangements, their family relations, finances and daily activities.

Researchers have not considered the needs of families and carers. In particular for people whose mental illness precedes homelessness, consideration of the factors that enhance the ability of families and carers to provide ongoing support to a person living with mental illness offers an important opportunity to prevent homelessness. The breakdown of family links is likely to increase the chances of homelessness for an individual with severe mental illness.

Within the Australian context a unique study was conducted in Sydney and Brisbane interviewing people with mental illness to collect their retrospective 'accommodation biographies' (Robinson, 2003). An important theme that emerged from people's stories was the overwhelming grief at the breakdown of family relationships. Lack of family acceptance or understanding of the person's mental illness was one reason for leaving the family home. For many the family home was a place that sexual abuse and/or violence forced them to leave. Where the family home was the site of aggression, emotional and physical abuse, participants felt that this contributed to their mental illness. More women (48%) than men

(11%) cited violence as a reason to leave their accommodation. Most participants were not in a current relationship although 40% had one or more children. People revealed that they were struggling with custody and care issues. Without appropriate accommodation or a place to meet, many did not see their children at all adding to the trauma and grief of their lives (Robinson, 2003). Hoffman & Rosenheck (2001) also found family fragmentation in homeless people's lives. In this study the authors found that homeless mothers separated from their children were more likely than mothers with children in their care to have serious substance abuse problems. Factors that predicted family reunification were receiving housing assistance, fewer psychiatric hospital admissions, and a positive relationship with their primary clinician. Non-mothers were more likely to describe poorer social support networks, feeling close to fewer people and having a poor therapeutic relationship with their primary clinician. The authors suggest that programs for homeless mothers with severe mental illness may assist in the reunification of families where appropriate and, subsequently positively affecting the health of the mother and children.

1.5.1.4 Physical Health

Homeless people often have poor physical health and sometimes are in pressing need of medical attention. A study of a cohort of homeless men using a large shelter in Sydney showed cognitive impairment of at least mild degree in over 40% and severe impairment in over 25% (Teesson & Buhrich, 1993). A recent study of homeless people in Sydney, Hodder et al, (1998) reported that 50% of people had a chronic physical condition. The disorders most often reported were liver problems, asthma, high blood pressure and hepatitis B or C. A relationship between poor health and low income was also found by Trevena, Nutbeam & Simpson (2001) who randomly sampled homeless people attending lunch at the Exodus Foundation in Sydney. Homeless people reported fair/poor physical health and a more serious illness pattern than the general population of Sydney. Most common health complaints among homeless people were diseases of the digestive system, depression, refractive errors, common cold, bronchitis, drug and alcohol dependency and diabetes type II.

1.5.1.5 Substance Use

A dual diagnosis of psychiatric and substance use disorders appears to be a particular risk factor for homelessness (Susser et al, 1993). Prevalence of drug and alcohol abuse among people who are homeless and have a mental illness has been consistently reported by researchers (Herrman et al, 2004; Teeson et al, 2004; Teeson & Proudfoot, 2003; Hodder et al; 1998; Herrman et al 1989). Schizophrenia, bipolar disorder, depression, alcohol abuse and drug abuse each have a lifetime prevalence that is more than twice as high in homeless people as in the general population.

In 1989, 5% of homeless people were using illicit substances in Melbourne (Herrman, McGorry, Bennett, van Riel, & Singh, 1989). A decade or so later the rates for both alcohol and drug use have substantially increased both in Melbourne and Sydney (Herrman et al, 2004; Teesson et al, 2004). Among homeless males living in Melbourne, 43% had alcohol abuse in their lifetime, 25% had used cannabis and 30% had used other illicit substances. Although not as high as their male counterparts a substantial proportion of females (20%)

also had alcohol abuse while 13% had used cannabis and 13% had used other illicit substances (Herrman et al 2004). In Sydney, Teeson et al (2004) reported similar rates with 49% of men and 15% of women abusing alcohol in the last 12 months. A further 22% of males and 18% of females used cannabis while 34% of males and 44% of females had used other illicit substances in the past 12 months. Alcohol and/or drug abuse has been identified as a risk factor in unstable housing (Lipton, Siegel, Hannigan, Samuels & Baker, 2000; Bebout, 1999; Dickey, Gonzalez, Latimer, Powers, Schutt, & Goldfinger, 1996). While it is difficult to draw any conclusions about the increased use of drugs over time, these studies do indicate that there is an association between homelessness and drug and alcohol use.

A complex range of individual factors has been associated with the risk of homelessness, some of which are also associated with mental illness. Mental illness itself appears to increase the risk of homelessness. Other key risks identified within the research include disrupted childhood experiences, loss of social networks and drug or alcohol use (Booth, Sullivan, Koegel & Burnam, 2002). An understanding of these factors provides some direction for the development of prevention and early intervention programs.

1.5.2 Social Factors

While individual attributes contribute to the problem of homelessness for people living with mental illness, broader social processes are also of key importance. The risk of homelessness is affected by social processes involving the labour market, housing policy, welfare policy and health care systems. The role that personal risk factors play in homelessness can be fully understood only in the context of broader social processes. For instance when housing is scarce, it is more likely that the disabilities of a person with mental illness will lead to homelessness. Again, when access is restricted to mental health care and supported housing, the risk of homelessness for a person with mental illness may be increased (Susser et al, 1993).

Psychiatric and medical surveys of homeless people have a great influence on public attitudes to the homeless (Hamid et al, 1995). The public attitude in its turn influences policy-making and service provision for homeless people. There is a need for further studies to assess the needs of homeless people so as to better inform policy and resource distribution. This echoes Leona Bachrach's (1987) plea for the importance of recognising and defining the sub-group of homeless mentally ill people.

1.5.2.1 Deinstitutionalisation

Historically, institutions have failed to deliver quality care for those most in need in the community. However there is a widespread perception that the move from institutional to community-based care has not produced optimal outcomes for mentally ill people. While there is little direct evidence to support the belief that the rise in homeless mentally ill people directly mirrors the rundown of the asylum, there can be little doubt that deinstitutionalisation in a wider sense plays an important role (Lamb, 1984; Bachrach, 1992). The dilemma of deinstitutionalisation was expressed clearly a decade ago by British sociologist Kathleen Jones (1982) in her examination of the work of Andrew Scull, a radical theorist from California.

If it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do? (Jones, 1982).

British commentators have responded recently by noting that there has probably been an overestimation of the numbers of people who become homeless as a direct result of hospital closure (Wykes & Carson, 1996). The TAPS study (Team for the Assessment of Psychiatric Services) of the discharge of long-stay psychiatric patients from Friern Hospital in London reports that few people drifted into homelessness following hospital closure when appropriate housing and adequate support was provided (Leff, Trieman, & Gooch, 1994; Leff, Trieman, Knapp & Hallam, 2000). Recent studies that have paid attention to the details of past care suggest that relatively few of the homeless mentally ill have experienced a prolonged hospital stay. Most appear instead to have experienced many brief periods in hospital over a number of years, interspersed with periods when psychiatric care has been virtually non-existent (Timms & Fry, 1989).

A number of studies note that it is not the long-term patients who have become homeless, rather the people with short stays or no prior psychiatric hospitalisation (Cohen, 1994). In Edinburgh there has been a large reduction in the number of occupied psychiatric beds over a decade. This reduction does not seem to be associated with high rates of psychosis among the roofless (Newton, Geddes, Bailey, Freeman, McAlvery, & Young, 1994). The prevalence of schizophrenia among hostel residents in Edinburgh was lower in 1992 than in 1966, even after taking into account potential confounding factors. It is unlikely that deinstitutionalisation has been associated with an increase in the prevalence among the homeless there (Geddes, Newton, Young, Bailey, Freeman, & Priest, 1994).

The debate about needs is best differentiated clearly from the debate about pathways to homelessness. Otherwise the unintended effect of advocacy for community care may be to obscure the needs of the homeless mentally ill sub-group. Researchers and advocates have emphasised that the existence and size of this group is most likely not directly linked to closure of the large hospitals. It is not acceptable and probably not effective, to suggest the simplistic solution of a return to the asylum system. What is required instead, is the development of a flexible range of preventive, management and accommodation services for people with severe mental illness.

Many studies have shown that flexible, alternative accommodation services are a successful option for people with severe mental illness (Brown, Ridgeway, Anthony & Roger, 1999; Coulton, Holland & Finch 1984; Livingston, Gordon, King & Srebnick 1991; Carling, 1993). These studies indicated that supported housing can reduce hospitalisation. Supported housing is most effective when the tenant chooses the housing option, and when that option is linked to flexible support that can vary according to need. An evaluation of the closure of a long-stay psychiatric hospital in Sydney demonstrated the clinical effectiveness of deinstitutionalisation when adequate community resources are available (Hobbs, Tennant, Rosen, Newton, Lapsley, Tribe and Brown, 2000).

It is clear that homelessness among severely mentally ill people is related in part to the failure to provide adequate care outside of hospital settings (Craig & Timms, 1995), and that adequate community based resources provide a clear alternative method of homelessness prevention.

1.5.2.2 Mental Health Services

Homeless mentally ill people with psychotic disorders tend to have high rates of previous contact with traditional psychiatric services, but typically have poor current contact and low rates of psychotropic medication use (Herrman et al, 1992; Marshall 1993; Hamid et al, 1995). It has been shown that specialist services for homeless people, including outreach services, can encourage helpful service contact (Marshall 1993; Geddes et al, 1994; Buhrich & Teesson, 1996). The Study of Low Prevalence Disorders showed clearly that the majority of people with serious mental illness and who were homeless were in contact with some form of specialist mental health services. A major part of treatment received included psychotropic prescribed medication for psychotic symptoms (72% males and 80% females). In contrast, a minor part of the treatment was attendance at a rehabilitation or day program (10% males and 20% females) (Herrman et al, 2004). Homeless mentally ill people will also use accessible primary health care (Herrman et al, 1992; Herrman et al, 2004) and about 50% of people had contact with an emergency department (Herrman et al, 2004).

Caton (1995) compared a group of 100 homeless men with schizophrenia and a group of men who had schizophrenia and were never homeless. This study found that the two groups did not differ on patterns of service use or treatment. The homeless men were more likely to have been discharged against medical advice and had less adequate discharge arrangements for housing and financial support. The most inadequate discharge plans were made for people with schizophrenia, personality disorder and a history of substance abuse.

Research evidence indicates that effective treatment for people with psychotic disorders early in their illness can prevent homelessness (Herrman et al, 1998). Studies also reveal that accessible mental health services or primary health care services will be used and will benefit people who are homeless and living with a mental illness (Herrman at al, 2004; Burich & Teeson, 1996). Accessible treatment options for substance abuse are critical but are often not available or sufficiently flexible. This point was particularly poignant in the Study of Low Prevalence Disorders whereby high rates of drug and alcohol use did not translate into high use of drug and alcohol services. Herrman et al (2004) found that among homeless people with a lifetime diagnosis of psychosis, only 7 per cent of males and none of the females had been in contact with a specialist drug and alcohol service despite a high proportion of males (43%) and a proportion of females (20%) reporting alcohol abuse/dependency. Given that alcohol and drug use is a risk factor for homelessness this under-utilisation of specialist services is of particular concern.

Services most likely to be used by homeless people with mental illness are those that have adapted service delivery and treatment approaches informed by the experiences and reports of their homeless clients (Herrman, 1996; Goldfinger & Schutt, 1999). An understanding of people's accommodation histories is also an important component of the continuity of care of people with psychosis as demonstrated by Holmes, Hodge, Bradley, Bluhm, Hodges, et al (2005) who found that in a inner Melbourne mental health area, people with a history of

homelessness had shorter periods of engagement with services than those without homeless episodes.

1.5.2.3 Economic Factors

Cohen (1994) identified government policy and socio-economic variables as playing a dominant role in the creation and mitigation of homelessness. Economic factors such as high living costs, competitive demands for housing by the middle class, unstable and low-paying employment and tight housing markets may tip people over into homelessness. Cohen (1994) examined the differences in being homeless in London and New York, and points out that in both countries there is continued political debate about whose responsibility it is to provide care and shelter. The governments in both Britain and the US prefer voluntary and private housing arrangements.

Ball & Havessy (1984) asked people why they were homeless. Reasons ranged from not having enough money to pay for a room in a boarding house, to being evicted by the proprietor or family/friends because of unusual behaviour. Respondents cited that their primary problems were lack of material resources, employment opportunities, privacy and personal and physical protection. Concerns about social, medical and psychological problems were secondary. Permanent, affordable housing and linkage with financial entitlements or other legitimate sources of income were high priorities for this group.

Susser and colleagues (1993) note that the data indicates only a partial overlap between the causes of homelessness and of poverty. Important risk factors for homelessness, for example, being male and aged 30-39 years, are not risk factors for poverty. The interactions between economic and other systemic factors on homelessness have not been fully explored within the literature and there is a need to better understand their impact on the problem of homelessness. A recently published study based on the 1996 National Survey of Homeless Assistance Providers and Clients may further illuminate the previous point. A total of 2,974 people were asked about their recent loss of housing and continued homelessness. Regardless of whether a person had a mental illness or not, the most common reasons cited for recent loss of housing were financial and interpersonal problems. With respect to reasons for continued homelessness, insufficient income and lack of employment were given regardless of mental illness status (Mojtabai, 2005).

By comparison, and regardless whether a homeless client of SAAP had a mental illness or not, Australian data from the SAAP National Data Collection 2003-04 reported that: "…the most common main reasons clients gave for seeking assistance were domestic violence (in 20% of support periods), financial difficulty (14%), usual accommodation not available (11%), eviction or the ending of previous accommodation (10%) and relationship or family breakdown (9.2%) … reasons varied considerably according to the composition of the assisted client group : for example, unaccompanied males aged 25 and over most commonly cited financial difficulty (21%) or that their usual accommodation was not available (12%) as their main reasons for seeking assistance. For unaccompanied females aged 25 and over, the most common reason was domestic violence (39%)" (AIHW 2005, pp 30-1).

1.5.2.4 Housing

> *One of the biggest obstacles in the lives of people with mental illness is the absence of adequate affordable and secure accommodation. Living with a mental illness – or recovering from it –is difficult even in the best circumstances. Without a decent place to live it is virtually impossible. (Human Rights and Equal Opportunity Commission, 1993, p.337)*

The availability of housing and housing policies impact upon the rate of homelessness. While there is some evidence that there is a decline in the availability of low-cost housing (Yates & Wulff, 1999; Wulff & Yates, 2000; Horn, 2002; ACOSS, 2003; Greenhalgh, Miller, Minnery, Gurran, Jacobs & Phibbs, 2004), the relationship between housing availability, housing policy and homelessness is complex and beyond the scope of this literature review. However, it is important to note, that homeless people with a mental illness are at greater risk of discrimination in a competitive housing environment and therefore may be disproportionately affected by housing policies.

The complexity of pathways in and out of SAAP programs is documented in a number of homelessness research studies, data collections and the national evaluations of SAAP III (1998) and SAAP IV (2004). These evaluations found significant differences in outcomes for SAAP clients. For example, while three quarters of clients were living in housing that could be classified as independent at the conclusion of SAAP support, half had been living in independent accommodation prior to that support. Programs providing medium-term housing were proportionally more likely to achieve independent housing for SAAP users, than programs providing transitional or crisis housing. Not surprisingly, a longer duration of support was associated with more likelihood of independent housing than a short duration of support.

It is unclear from this data whether the higher rate of independent housing at exit from SAAP programs reflects different client groups accessing different service systems, or whether different programs result in different outcomes. It is plausible that homeless people with more complex needs disproportionately use crisis and short-term support services and are less likely to achieve independent housing. Equally, it is plausible that programs focused on longer-term support and medium-term housing are more likely to assist people to achieve independent housing. More research is needed to clarify these issues.

With respect to low-cost housing, an important component is the private for profit rooming/boarding house sector. Despite varying definitions of what constitutes a boarding house in different parts of Australia, there is clear evidence that the number of houses and beds is declining and few are being replaced (Greenhalgh et al, 2004). This decline directly impacts on the availability of low cost private rental stock, crisis accommodation and SAAP programs. Agencies rely on boarding house stock to place people in accommodation. Fewer boarding houses reduce the options available for crisis accommodation and this in turn creates a greater demand for accommodation. This has implications for the SAAP program as a small proportion of clients exit SAAP into boarding houses (Greenhalgh et al, 2004). The profile of the boarding house resident has changed substantially over time. Once it was a place of residence for transient workers, those seeking work and immigrants, now it is a place that accommodates people who have been de-institutionalised, who have either psychiatric or

physical disabilities, abuse substances, and are vulnerable to the pressures of maintaining stable, secure and affordable accommodation (Greenhalgh et al, 2004). Greenhalgh and colleagues found that the Government is not in a position to replace low cost accommodation provided by boarding houses with a substantial increase in the public housing stock. Yet the decline in the number of boarding houses is related in part to operational costs, gentrification of inner city areas and lack of incentives to maintain and update facilities to meet building and health regulations. This may well be a contentious issue as a number of advocates and consumers assert that boarding houses are the least desirable option in terms of long-term housing (see section on consumer choices) yet service providers clearly utilize boarding houses as a viable option for housing their clients.

An option was proposed in the context of the National Evaluation of SAAP IV. The evaluator, Dr Tim Wyatt of Erebus Consulting Partners, argued that in the current SAAP, which is Australia's main programmatic and policy response to homelessness, inherent tensions exist between crisis accommodation and longer-term support, the 'easily addressed' needs of many homeless people and the 'seemingly intractable and complex needs' of a significant minority, the provision of generic services and targeted services, and between a focus on preventing problems and treating symptoms. In acknowledging such programmatic and service delivery tensions, the evaluator discusses a view that sees "… crisis accommodation and transitional support as one element of a broader and more holistic response to homelessness by government and the community. It acknowledges that maintaining a 'safety net' is important but that there is a need for a strong transitional housing strategy, and that the balance between preventative and reactive solutions must change (Erebus Consulting Partners, 2004, p.49).

The plight of homeless people with psychiatric disability warns against complacency in spite of vastly improved system of service delivery. Australian society still generates homelessness in new ways which are as disturbing and dehumanising as the old. The need to develop strategies to prevent the onset of homelessness and to intervene early is vital to reduce, if not eliminate, homelessness."
*"The availability of appropriate, secure and affordable housing for all Australians is a key factor determining the prevalence of homelessness in Australia. Affordability is linked to the adequacy of social security payments to cover the real cost of housing, as well as the availability of employment to reduce dependency on social security payments. (*Bu, 1998 *p. 312)*

1.6 INTERSECTORAL COLLABORATION

1.6.1 Models of Intersectoral Collaboration

The Working Together: Intersectoral Action for Health (World Health Organisation, 1997) report documented current knowledge and practice in intersectoral health care. The report

identified many of the complexities associated with intersectoral work and concluded that the following conditions were conducive to promoting effective intersectoral action:

- the health sector must be willing to work with other sectors and organisations
- intersectoral action is supported by the wider community and/or builds on existing policy initiatives
- sectors/agencies involved have the capacity to undertake the proposed action
- relationships between those involved are already established and strong enough to enable the participants to undertake and sustain action;
- planned action is well conceived, and can be implemented and evaluated; and
- provision has been made to sustain outcomes

In addition, good practice in intersectoral collaboration must be supported by evidence and appropriate resource levels.

Not all community organisations have either the capacity or the will to meet the complex needs of homeless people with a mental illness. It is essential that the governments continue to monitor service gaps and where necessary support institutional strengthening so organisations can meet these needs, add incentives to encourage services to respond to needs or provide the required services themselves.

The Planning and Linkages Framework developed for the SAAP Co-ordination and Development Committee (SAAP Coordination and Development Committee, 1998) provided a framework for collaboration that clarified the responsibilities at the National, state/territory and local levels. While the framework was not developed to respond to the specific issues of mental illness within SAAP, it assisted the development of linkages by ensuring that the various jurisdictions are aware of their responsibilities. These responsibilities included:

National

- national program outcomes
- strategic policy and planning
- performance measurement

State

- establishing population needs and determining priorities
- service development and planning
- outputs, performance indicators, promotion of best practice
- facilitating service integration
- consultation with service providers

Local

- delivering services
- planning and linking with local services
- developing and maintaining service networks
- developing formal protocols

Many reports have stated that responses to homeless people with a mental illness require a whole-of-government approach. To achieve this it is essential that there is clarity and agreement regarding the responsibilities of government at each level.

This approach was further progressed through the SAAP IV Bilateral Agreement 2000-2005 between the Australian Government and each State and Territory Government, through the SAAP IV strategic themes of "Integration" and "Working Together" A review of the effectiveness of the strategic themes was undertaken in late 2003 as part of the National Evaluation of SAAP IV. This review found that, while state and territory governments and service providers have worked to integrate service delivery to their SAAP clients, focus group discussions reflected that "…integration has only partially been achieved at this stage with many jurisdictions continuing to report difficulties providing linked-up services to homeless people or those at risk of homelessness, particularly those with mental health and serious drug and alcohol problems, due to a lack of integrated service delivery with those sectors responsible for assessment and treatment…" *(Szirom et al, 2004)*

1.6.2 Factors Inhibiting Collaboration

There are difficulties in generating a whole-of-government response to the needs of homeless people with a mental illness. Not only does policy development require co-ordination across National, state/territory and local boundaries, but it is also reliant on the development of relationships between government departments. The difficulties of cross-program linkages within SAAP have been identified in the National Evaluations of SAAP III (1998) and SAAP IV (2004). In particular, the need for better government co-ordination in the development of policy and planning frameworks relating to intersectoral approaches has been stressed in these evaluations.

In its submission to the SAAP IV National Evaluation, the Australian Federation of Homelessness Organisations (AFHO) presented evidence that the numbers of homeless people presenting to SAAP services with mental health problems was increasing and that there was a greater demand from people with drug and alcohol dependence. The submission noted that there was a continuing systemic inability of mental health and drug and alcohol services to meet the demands for service resulting in clients falling through the "safety net".

The authors of the SAAP IV National Evaluation, however, did acknowledge that there had been progress in this area, but there continued to be structural issues in relation to policy co-ordination and implementation between agencies. While SAAP and mental health are key players in the area, consideration of the role of other departmental areas such as housing, disability, drug and alcohol, employment, vocational training and education, income support, Aboriginal and Torres Strait Islander health, aged care, domestic violence and sexual assault services and child care is also important.

Systemic features of problematic linkages include:

- unclear responsibility/accountability
- lack of a clear mandate
- lack of a culture of collaboration, and structure and systems to support it
- responsibility shifting
- eligibility criteria unclear or restrictive
- gaps between services (Ernst & Young, 1996)

1.6.3 Factors Promoting Collaboration

The complexity of Commonwealth and state/territory responsibilities and the sectorisation of services across multiple departments provides challenges in developing an effective whole-of government approach to the problem of homelessness and mental illness. Research on models of intersectoral collaboration is not yet well developed, although the World Health Organisation (1997) provides a useful framework to understand the conditions conducive to developing effective linkages. These conditions suggest that it is essential to:

- engage with consumers and the broader community on the issues of intersectoral collaboration;
- acknowledge that intersectoral collaboration is important at all levels of policy development;
- provide resources that allow collaboration to develop;
- encourage and support the development of service standards that promote collaboration;
- support local initiatives that respond to the need to promote collaboration; and
- promote research that examines the longer-term outcomes of different approaches to collaboration.

1.7 EVALUATION OF INTERSECTORAL INTERVENTIONS FOR PEOPLE WHO ARE HOMELESS AND LIVING WITH A MENTAL ILLNESS

People who have a mental illness and are homeless are not a homogeneous group – they are likely to have a variety of complex needs that require a range of services. These services may include housing, substance abuse treatment, health care and income support or job training. This level of complexity requires a multifaceted response, and no single agency can meet all these needs at present. Most services have evolved to cater to a particular need such as housing, or drug and alcohol rehabilitation, or mental health, or primary health care. Each sector has evolved independently of the other, with its own funding source, service eligibility requirements, geographical boundaries, treatment or service philosophies and administration policies. In order to gain access to each of these systems, the homeless person is required to negotiate various forms, eligibility requirements, transport arrangements and waiting lists (Randolph, Blaskinsky, Leginski, Parker & Goldman, 1997). While there are many descriptions of 'best practice', there are few well-designed evaluations of programs that use intersectoral approaches in responding to the needs of people who are homeless and living with a mental illness.

In order to address a lack of integration and inter-agency cooperation, a number of ACCESS demonstration projects have been funded in the USA with the aim of preventing homelessness among the mentally ill (Randolph, Blasinsky, Morrissey, et al., 2002). These demonstration projects have developed various models of inter-agency cooperation and different housing programs to meet the needs of the homeless and mentally ill and are among the first longitudinal, experimentally designed studies of housing and service interventions for this population. These programs concluded that homeless adults who have severe mental illnesses, often thought to be beyond the reach of existing outreach services, are willing to accept psychiatric treatment and can remain in community-based housing with appropriate support.

Key findings included:

- Homeless people with severe mental illnesses will use accessible, relevant community psychiatric treatment services.
- Residential stability is an attainable goal for most people with severe mental illness.
- Formerly homeless people with severe mental illnesses are an important resource.
- Substance abuse is a major factor in homelessness among people with severe mental illnesses.
- Housing stability, appropriate psychiatric treatment, and increased income lead to an improved quality of life.
- Consumer needs and self-reports about preferences should be considered when making decisions about housing.

The policy implications identified by these ACCESS demonstration projects included:

1. Service systems must be integrated at all levels to remove barriers and promote efficient use of services: psychiatric services with housing, social services, substance abuse treatment and the criminal justice system.
2. Substance abuse treatment must be an integral part of comprehensive psychiatric services for people with severe mental illnesses.
3. A range of housing options is required. Independent living with the availability of support services is both possible and preferred by most people with mental illnesses. Because this does not meet the needs or preferences of everyone, however, other choices may have to be considered.
4. Preventive health care and education are critical, especially relating to the risks of HIV/AIDS, tuberculosis and smoking.
5. Longer-term follow-up studies should focus on how to sustain early gains. (Herrman, 1999).

A follow-up study of these projects examining inter-agency collaboration was conducted by Morrissey and colleagues (Morrissey, Calloway, Johnson & Ullman, 1997). One of the main findings of agencies receiving ACCESS funding was that they were poorly integrated and fragmented, resulting in a perception that they were inaccessible to people who were homeless and suffered severe mental illness. Inter-agency links most often took the form of information sharing or client referral. Only one per cent of agencies were involved in joint funding arrangements. Most agencies had their own funding source and were not dependent on each other. As a consequence, agencies acted more autonomously in their inter-agency relationships and pursued their own interests rather than collective goals.

The ACCESS agencies were better connected to the services in their immediate locality, compared to other agencies in the collaborative network. As this is a longitudinal study, an evaluation of the number and type of linkages between agencies can be made. It may be that close links between a small group of service providers may serve client needs better than efforts to link up an entire service network. Alternatively, integrated services within one agency may outperform those involved in multiple service links.

A recent evaluation of the ACCESS program found that all the demonstration sites delivered improvements in terms of client outcomes. Services that formed part of the experimental sites, that is, had contacts with other services and exchanged client information, did deliver better housing outcomes for clients than those that were not integrated. However system integration made no difference to clinical outcomes, service use or perceived quality of life

(Rosenheck, Lam, Morrissey, et al, 2002; Goldman, Morrissey, Rosenheck et al., 2002). Another ACCESS demonstration project found that service providers could effectively link people who have a mental illness and are homeless into community mental health services. A three-year longitudinal study found that community mental health services could engage hard-to-reach homeless people and that this reduced the number of days hospitalised. The effect continued after the intervention was terminated (Rothbard, Min, Kuno, & Wong, 2004).

A collaboration between the Centre for Mental Health Services and the Centre for Substance Abuse Treatment in the United States was initiated in response to the high proportion of people who have mental illness and drug abuse and are homeless. The two organisations came together in a jointly funded and administered agreement to document and evaluate the effectiveness of their homeless intervention strategies. To facilitate this process a cross evaluation steering committee was formed with management from both centres present. Responsibilities included development of common data measures, design of cross-site analysis, and policies on data sharing (Rosenheck, Resnick, & Morissey, 2003). Recent evaluations have demonstrated that clients that were independently housed showed a greater decrease in their alcohol consumption and greater decrease in their drug use compared with clients in unstable housing (Mares & Rosenheck, 2004).

2 CONSUMER PERSPECTIVE

2.1 INTRODUCTION

In any discussion of intersectoral linkages, an understanding of consumer views is essential if effective strategies are to be identified. Both homelessness and mental health policy have identified the importance of a consumer perspective in the development of policy and services. Achieving consumer input into service planning, delivery and evaluation is a complex task. People with a mental illness are often using services at a time of vulnerability. Service providers may be threatened by consumers' views, or believe that they can fully represent the consumer voice. Continuing coordinated efforts by policy makers, service providers and researchers are required to ensure that the consumer voice is part of the discourse on homelessness and mental illness and informs the approach to developing effective intersectoral collaboration.

2.2 CONSUMER HOUSING OPTIONS AND PREFERENCES

Australian housing options

Before discussing consumer preferences in relation to housing, it is important to first describe the type of accommodation available to people with a serious mental illness. The accommodation types traditionally available have included institutional accommodation such as the long stay wards in large psychiatric hospitals (a remnant of the 'asylum'), nursing homes and more recently, community care units (replacing the old psychiatric institutions in some states of Australia). People living in institutional accommodation or in a setting with intensive professional support often represent the most 'unwell'. At the other end of the continuum, supported housing options include the provision of independent public housing with flexible support offered by psychiatric disability support outreach workers.

Essential components of supported housing are security of tenure, affordability, and reliable support provided by adequately trained and resourced staff. Outside the psychiatric service system, accommodation options available in the community that offer people more independent living, that is affordable on a pension but without the same level of professional assistance, include rooming and boarding houses and hostels. This type of accommodation is characterised by a lack of secure tenure, little privacy, shared kitchen and bathroom facilities, and in many cases poor living conditions. In terms of Chamberlain's definitions, this would be classified as tertiary homelessness (Chamberlain, 1999).

Hostels tend to be larger and more institutional in nature. They usually house people with some sort of disability and are often privately run for profit. This environment can foster a sense of dependency as staff regularly manage residents' meals, medication and finances. For the purposes of the Study of Low Prevalence Disorders, rooming and boarding houses and hostels were defined as marginal accommodation (Harvey et al, 2002). This reflected the description of boarding homes and hostels as the new institutions as defined by the Human Rights and Equal Opportunity Commission report into human rights and people with a mental illness (1993). Emergency accommodation and shelters for the homeless (often run by charities and other non-government, not for profit service providers) are also housing options for people with serious mental illness although they only provide short-term crisis

accommodation. At the other end of the spectrum, stable and secure housing that is characterised as tenant or owner-occupied include public rental (public housing), private rental or privately owned home or family home.

Forty years on from de-institutionalisation, consumers prefer community living to hospital living (Davidson, Hoge, Godleski, Rakeldt & Griffith, 1996; Newton, Rosen, Tennant, & Hobbs, 2001). It is not surprising that given a choice, people with a serious mental illness, like most other people in the community, prefer to reside in their own home (Browne & Courtney, 2004; Freeman, Malone, & Hunt, 2004; Rog, 2004). Similar findings reported by another Australian study found that among adults with mental illness, the most preferred housing option was their own home, followed by public housing, private rental – alone and then family home, boarding house (alone) and boarding house (shared), above unsupervised group home. The housing options on the bottom of the list included shelter, crisis accommodation, long-term hospitalisation and being homeless (Owen, Rutherford, Jones, Wright, Tennant & Smallman, 1996). The main finding was that people prefer to live on their own or with someone of their choice, and not with other mental health consumers. Only one person had a strong preference for living in a group situation.

The higher ranking for a not-for-profit boarding house over a supervised psychiatric residential facility is interesting, as boarding houses have been considered disadvantageous for people with psychiatric illness. Attributes that were most valued were shelter, safety, privacy and provision of food. Preferences were not related to demographic characteristics, symptom levels or functioning.

Browne & Courtney, (2004) compared people with schizophrenia living in private rental or their own home, with people living in a boarding house and found that boarding house residents had less access to social support, meaningful activity and work, and reported a lower global level of functioning even though there was no difference between the groups based on their psychiatric illness or symptom levels (Browne & Courtney, 2004). The finding from the Low Prevalence Disorders painted a similar picture when comparisons were made based on a person's residence. People living in their own or rented home were more likely to be engaged in an occupation such as paid work, study or home duties. They were less likely to report difficulties in relating to others and engaging in social activities whereas people residing in marginal accommodation (includes boarding house and hostel residency) were more likely to report difficulties in these areas and less likely to have friends or intimate relationships.

People residing in boarding houses had lower levels of self-care and higher scores on antisocial compliance relating to friction and violence between residents (Browne & Courtney, 2004). Hostel residents have also expressed this fear of victimisation. Horan, Muller, Winocur, & Barling (2001) compared the responses of people diagnosed with schizophrenia living in either a hostel or boarding house. Hostel residents were more likely to report victimisation than boarding house residents. Boarding house residents expressed a greater satisfaction with life in general and with their living situation in particular. Boarding house residents seemed to have more money to spend on themselves but in terms of social contacts, opportunity for employment or other activities there were no differences between the two groups of residents. The picture of their daily lives was consistent with the findings of Davidson et al (1996) who described the life of people with serious mental illness living in the community as lacking meaningful activities, sitting around drinking coffee and smoking, and having minimal contact with family or friends. Although these aspects of life in the

boarding house environment are similar to aspects of institutional life, the important difference is the perception of freedom in the community setting. Freedom has been echoed by a number of other studies as an important aspect of people's living arrangements. Freedom for former residents of psychiatric hospitals meant being able to make choices about how to spend one's time, being free to move about, and having independence and control over one's own life (Newton, Rosen, Tennant & Hobbs (2001).

Sutherland, Carter, & Champion (2004) described the Housing Option Project for people with mental illness in the Northern Territory. They identified choice, accessibility and availability as important factors in finding appropriate accommodation for people with mental illness. The barriers discussed in relation to choice included:

- a limited private rental market,
- discrimination in relation to obtaining rental properties,
- long public housing waiting lists, and
- insufficient psychiatric specific independent living accommodation.

Non-payment of rent was a frequently cited reason for homelessness among people with a mental illness.

The project authors recommended greater collaboration between Centrelink and landlords to encourage direct debit of money for rent. Simply obtaining accommodation was not sufficient as a number of supports on a practical and emotional and psychological level needed to be in place in order to assist the person to maintain long-term housing. The type of support and level of complexity has been described by O'Brien, Inglis, Herbert & Reynolds (2002) who point out that the level of support may vary considerable over time depending on a person's illness and severity of symptoms. Examples of linking support services to assist people maintain their accommodation are detailed in Reynolds, Inglis & O'Brien (2002). The main point being that access to and maintenance of stable housing depends on:

- Availability of affordable, secure housing – establishment of housing, furnishing, etc.
- Ongoing access to a range of tailored supports (e.g. coping skills, crisis prevention plan, social networks and skills)
- Mechanisms to assist the individual to engage in service systems (e.g. clinical support – psychiatrist, psychologist, specialist mental health services, primary care, allied health, drug and alcohol, residential rehabilitation)
- Flexibility to respond to crisis associated with mental illness.

Other factors at play in this model are income support, employment services and ongoing housing assistance. The backdrop to all of this is having a supportive environment consisting of family, friends, neighbours and a community that is aware and accepting of people with mental illness (Reynolds, Inglis & O'Brien, 2002 p.13).

Housing and support services need to be responsive to a person's social and psychological needs as well as the practical ones (Freeman et al., 2004). After finally being housed, a

person who has been homeless for a period of time will need time to adjust. For some, residing in an independent apartment may assist with adjusting to normal social routines and feeling part of the neighborhood while, for others, being alone may add to a sense of isolation and disconnection from the people around them (Yanos, Barrow, Tsemberis, 2004). Qualitative research indicates that people housed after long periods of being homeless felt safe for the first time, felt they fitted into the community where they now lived, and described themselves as feeling human again. Being housed improved their self-esteem, hope and interest in the world around them, and translated into actions such as showering, looking after the place, having a set of keys and independence (Yanos et al, 2004). A minority however reported the stresses of being housed - there was a huge adjustment to being alone, people reported that being in the shelter they were surrounded by people, whereas now they had to learn to cook for themselves and to negotiate their environment. The theme of fitting into their local community was very important: there needed to be a good fit between the person and their environment. Mares, Desai & Rosenbeck, (2005) found that people regardless of their psychiatric diagnosis or substance abuse preferred living in their own place, and that the higher the economic status of their neighborhood, the higher the satisfaction in levels of safety, cleanliness and privacy.

Overseas housing options – Continuum of Care versus Housing First Program

In the United States, the continuum of care approach to housing functions as an extension of the mental health treatment system. This model relies heavily on staffed group housing arrangements and the underlying philosophy is that people with major mental illness cannot live successfully in independent housing in the community. Clinical decision making influences decisions about housing match, taking into account factors such as containment and the need for structure. (Bebout, 1999). Enrolment in this type of residential program is dependent on participant’s involvement with mental health services and a commitment to abstain from drug/alcohol use. Health professionals assess clients’ “housing readiness” and this determines the type of living arrangements offered, gradually moving the person from supervised to independent living. Some studies have had successful results using such a model. Goldfinger and Schutt (1999) found that people who were homeless and were assigned to a supported housing placement achieved greater housing stability than those who were assigned to independent apartments. Schutt and Goldfinger (1996) asked people who were homeless and living in a temporary shelter what their housing preferences would be. Ninety-two percent wanted to leave the shelter even if taking psychotropic medication was part of the condition for housing. A further 77% wanted some sort of staff assistance. The majority (87%) of those with mental illness preferred to live independently rather than in a large group home (Schutt & Goldfinger, 1996). If they were to live in a group home the respondents preferred a small group to a large one. People with substance abuse problems were most likely to identify independent living as their preferred housing option. The data from the USA demonstration projects corroborates these findings, showing that more than 80% of mentally ill homeless people prefer living alone to living in groups. In contrast, clinical staff favoured group living placements for most of the participants. Individuals seemed more willing to accept on-site staff to living with peers. These findings point to the need to understand further how homeless people and clinicians make judgements about appropriate housing, and how these decisions are related to outcomes (Goldfinger & Schutt, 1999).

In contrast to this approach, the 'Housing First Program - Pathways to housing' provides consumers with immediate housing without the prescribed sobriety or participation in a mental health program. The program offers independent apartments without assessing readiness and without making housing availability contingent on treatment services. An evaluation of this program found that, after 5 years, 88 per cent of program's tenants remained housed, whereas only 47 per cent of the residents in the city's residential treatment system remained housed (Tsemberis & Eisenberg, 2000). The key difference with this approach was that people who entered the program did not have to engage in a treatment service for either their mental health or addiction problems. The priority was to establish housing whereas the linear approach required the client to sign up to a treatment regime before being housed. Both the continuum of care and the pathways to housing approaches provided case-management to people with severe mental illness. Assertive Community Treatment (ACT) teams have been credited with increasing tenure in community housing, reducing psychiatric hospitalisation, and increasing engagement and retention rates in treatment services. Unlike the clients of the traditional ACT teams, clients in the pathways to housing approach were allowed to choose the frequency and type of service they received, and a harm minimisation approach was utilised for individuals with a dual diagnosis. The teams offered housing, money management, vocational rehabilitation, and mental health and substance treatment. Clients could refuse clinical services without jeopardising their eligibility for housing assistance (Gulcur, Stefancic, Shinn, Tsemberis, & Fischner, 2003).

Results from a randomised control study whereby participants recruited from the streets or from hospital were randomly selected into either the continuum of care model or the housing first model, showed success for the housing first approach in reducing both homelessness and hospitalisation. Participants recruited to the housing first model were housed earlier, spent more time in stable housing and spent fewer days hospitalised than in the continuum of care program over the 24-month study period. People recruited from psychiatric hospitals spent more time in hospital during the study period than those participants recruited from the streets. Choice was a significant component in differentiating between the two models. Where clients could choose which services to take up, service uptake was not a barrier to stable housing. Money management was an important component of the housing first approach as it ensured that rent was paid, preventing the diversion of rent money to other uses. The Housing First Program was particularly effective for people recruited from psychiatric hospital whereby the time spent hospitalised decreased by more than half during the first year of the study (Gulcer, et al., 2003).

In summary, within the international literature there are a number of models proposed for providing housing for people with severe mental illness. These include 'housing first' and a transitional housing model. In a comprehensive review of proponents for both approaches Rog (2004) found that, once housed with adequate supports, people with severe mental illness who were previously homeless were less likely to be hospitalized regardless of the specific housing model. The key was having access to affordable housing (Rog, 2004). Studies of persons who are homeless and mentally ill, as well as other groups in the community such as families, have found that having any stable housing has a dramatic improvement on outcomes in relation to residential stability, use of institutional settings, such as hospitals, detoxification facilities, the criminal justice system and so on (Rog, 2004).

2.3 COMPARING PERCEPTIONS OF CONSUMERS AND SERVICE PROVIDERS

It is generally recognised that it is important to involve consumers in their own treatment plans. When intervention is externally imposed, it is more likely to be rejected than a plan with solutions based on a client's preferences. Few studies have examined the correspondence between a consumer's perception and that of the service provider with respect to their needs (Rosenheck & Lam, 1997a).

As part of the ACCESS demonstration project in the USA, 1,482 consumers were contacted. Consumers were asked what their three most important needs were. The same question was posed to their outreach workers. It was found that among consumers, their top three needs were long-term housing, mental health services and dental services. Among outreach workers the top three were mental health services, long-term housing and financial support.

The greatest differences between workers and consumers were perceptions about the need for mental health and substance abuse treatment. The service provider was more likely to identify this as a needed service than the consumer. The consumer, on the other hand, was more likely to identify dental and medical services as well as long-term housing and financial assistance as their most important needs. Where there was consumer-provider agreement about the need for a service, this did not translate into a greater use of that service than when there was no agreement.

The providers in this case were mental health professionals and, therefore, it is not surprising that they would nominate mental health care as the consumer's greatest need. It also illustrates that these professionals underestimated the client's need in other areas such as dental, medical and long-term housing. When the service provider assessed a need for substance abuse treatment, and the client did not, there was an increase in use of the service. This was also true of medical and long-term housing. When the service provider and not the client identified these as important needs, there was an increase in service use (Rosenheck & Lam, 1997a).

2.4 BARRIERS TO SERVICE USE BY HOMELESS PEOPLE WITH SEVERE MENTAL ILLNESS

A total of 1,828 people were surveyed in the ACCESS study. People reported four main barriers to service use:

- Did not know where to obtain the service (32.4%)
- Not able to afford the service (29.5%)
- Seeking service was too confusing, too much hassle or had to wait too long (27.1%)
- Sought but service was denied (16.5%)

A further 35% never sought a service and 27% were in the process of applying for a service (Rosenheck & Lam, 1997b). The study found that prolonged contact with outreach workers could facilitate access to services and help overcome related barriers. It was also found that those who were contacted in shelters and on the streets and those with more severe symptoms of mental illness were more likely to encounter barriers (Rosenheck & Lam, 1997b).

2.5 PROMOTING CONSUMER INVOLVEMENT

The mental health sector has become increasingly sophisticated in promoting consumer involvement. Consumer participation has been promoted in mental health planning at both the national and state level. In addition 63% of mental health services have a formal mechanism to involve consumers (National Mental Health Strategy, 1998).

The recognition of consumer rights and the principle of consumer involvement was enshrined in the National Mental Health Policy and affirmed in the Second and Third National Mental Health Plans. In the evaluation of the Second Plan, there was general agreement that much had been achieved in this area, including:

- establishment of peak national and state bodies;
- allocation of funds for consumer led projects; and
- inclusion of consumers in all national working groups on national strategic issues.

Despite this positive evaluation, a number of concerns were expressed by consumers, including restrictive definitions of mental illness by services, continuing high levels of discrimination particularly by mental health professionals, and lack of consumer involvement in the private psychiatric sector (National Mental Health Strategy Evaluation Steering Committee, 1997).

SAAP, as Australia's main policy and programmatic response to homelessness, has developed a strong focus on promoting positive outcomes for consumers, while recognising the difficulties inherent in measuring such outcomes. The SAAP Memorandum of Understanding 2000-2005 continues the commitment to consumer-focussed service delivery, including the development of flexible service delivery models that are culturally appropriate and able to respond to people with complex needs. During SAAP IV (2000-2005), there has been significant and varied research work undertaken to better understand these issues, with a recognition that people with a mental illness are among the most vulnerable and marginalised of homeless people. The SAAP IV research projects will inform further policy development and service delivery. Information on these projects can be found at www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/housingnewsaap_research.htm

2.6 SUMMARY

There is a need to ensure that consumers are involved in the development of intersectoral collaboration and that consumer views inform service models. There is evidence that consumers generally prefer independent living to shared housing models. While further research is required to better understand the barriers for consumers in using services and identifying effective strategies for promoting consumer involvement, the work to date through the SAAP IV research projects and through the Third National Mental Health Plan provide a good basis for this understanding to be translated into appropriate policy and service delivery responses.

3 PRIORITY GROUPS

3.1 INTRODUCTION

Both SAAP and mental health services have acknowledged that the issues associated with homelessness and mental illness varies between different population groups. The Australian Government's *National Homelessness Strategy* Discussion Paper (2001), for instance, identified indigenous Australians, young people who have been in care, people who have been in the juvenile justice system, victims of violence, people with substance abuse and mental health issues, families living in caravans and people living in boarding houses as groups at particularly high risk of homelessness. Similarly, the Third National Mental Health Plan identified the need to provide continuity of care to people across the lifespan improving the co-ordination of services between child and adolescent, general adult services, and aged care services. The Plan also identified the importance of linkages between mainstream mental health services and specific populations that may encounter challenges in accessing services because of cultural, linguistic or geographical barriers. Improved linkages were specified between mental health services and services for Aboriginal and Torres Strait Islander people, forensic services, transcultural services, youth services, drug and alcohol services and homeless services.

This section is not intended as a comprehensive discussion of homelessness and mental illness within these sub-populations. Rather, it is intended to highlight some of the specific mental health issues that are relevant to particular groups within the population. In addition, it should be noted that these are not mutually exclusive groups. The reality for individuals is that there may be a range of issues contributing to and maintaining homelessness and/or mental illness.

3.2 PEOPLE WITH PROBLEMATIC DRUG AND ALCOHOL USE

The Third National Mental Health Plan acknowledges the importance of fostering partnerships in collaboration between mental health clinicians and the broader health and community sector, including drug and alcohol services. This consolidates the gains made by the Second National Mental Health Plan which included a special focus on people with problematic drug and alcohol use. Resulting from this Plan, a National Co-morbidity Project linked the National Drug Strategy and the National Mental Health Strategy. The project aimed to highlight the deleterious effect of co-morbidity and to develop appropriate strategies to respond to the needs of people with a mental illness and problematic drug or alcohol use. Despite the collaborative intentions outlined in these policy documents, people who suffer from a mental illness and have a co-existing drug or alcohol problem, have difficultly accessing services (Teeson & Proudfoot, 2003). People with a dual diagnosis of schizophrenia and substance use disorders often have complex needs and represent a highly disabled group (Teeson & Proudfoot, 2003).

In Victoria, 'The Homeless & Drug Dependency Trial' is an example of agencies working together to engage people using Melbourne's inner city crisis accommodation services who are homeless and have a drug dependency problem. The model utilises a harm minimisation approach and engages services from mental health, drug and alcohol and housing sectors (Rayner, 2003).

Issues associated with drug and alcohol use have been prominent within many reports of SAAP including 'Homelessness among Older People: A Comparative Study in three countries of Prevention and Alleviation' (Lipmann, Mirrabelli and Rota-Bartelink, 2004), 'Housing Options for People with a Mental Illness' (Sutherland, Carter & Champion, 2004), 'People with High and Complex Needs' (Bisset et al, 1998) and 'Accommodating Homeless Young People with Mental Health Issues' (National Youth Coalition for Housing, 1999). These reports concluded that substance use was a major problem among people who are homeless and living with a mental illness.

The 'Not Welcome Anywhere' report (McDermott and Pyett, 1993) was a Victorian project that investigated the relationship between mental illness and problematic drug or alcohol use. While not specifically addressing the issue of homelessness, it was one of the first reports to document the complex association between mental illness and substance use. The report concluded that there were major difficulties within the service system responding to mental illness and problematic drug and alcohol use. It also found that:

- people with a mental illness and problematic drug or alcohol use were falling through the service net because of administrative and service boundaries;
- less than half the agencies in the mental health sector were providing services to people with a mental illness and a problematic drug or alcohol problems; and
- there was a lack of supported housing for people with continuing substance abuse and dependence.

The report argued that integrated 'whole of life' services that can respond to the complexities of peoples needs were essential to respond effectively to the challenges of mental illness and problematic drug or alcohol use.

3.3 YOUTH AND CHILDREN

Issues related to youth have been well documented in a number of reports. These include: 'National Youth Coalition for Housing' (National Youth Coalition for Housing, 1999); 'Youth Homelessness: Four Policy Proposals' (Chamberlain & MacKenzie, 2004); 'Making a Place to Belong: Homeless young people, support, accommodation and exclusion' (Keys, Mallett, & Marven. 2005); 'Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems' (Szirom, King & Desmond, 2004) and 'Dual Diagnosis and Young People' (Davis 2003). The report 'Accommodating Young People with Mental Health Issues' (National Youth Coalition for Housing, 1999), concluded that:

- mental health problems among young people are a serious issue;
- early detection and treatment will reduce both the length and severity of illness;
- mental health issues are prominent among youth SAAP services;
- many young people are reluctant or unable to use mental health services;
- program restraints within SAAP restrict the ability of services to respond effectively to the needs of young people with a mental illness;
- longer term housing strategies are required; and
- there is a need for greater collaboration and cooperation between services.

These issues are magnified in those young people who have substance abuse or dependence problems as well as mental illness. The prevalence of these issues has been highlighted by Kamieniecki (2001) who reviewed the literature in relation to psychological distress among

young people. He found homeless youth were twice as likely to experience a psychiatric disorder during their lifetime compared with housed youth. Homeless youth also had higher rates of mood and substance-use disorders than housed youth.

Homeless young people with a dual diagnosis face a difficult challenge in their journey towards recovery. Consultations conducted by Szirom, King and Desmond (2004) identified the lack of stable housing as the most significant barrier to access and provision of services such as drug and alcohol rehabilitation and mental health services. A lack of appropriate housing increased the likelihood of contact with the juvenile and criminal justice systems. Informants to these consultations noted the increase in the number of young people presenting with mental health and drug/alcohol problems. Other complicating factors were homelessness, poor physical health, and family and relationship problems. There was a lack of training and specialist expertise in identifying, engaging and treating the young people with a dual diagnosis and there were few specialist centres that provided services specifically for young people. In terms of strategies for overcoming systemic barriers, people focused on a solution orientation, on strength-based interventions that highlighted a person's resilience and on working with families to facilitate reconciliation where appropriate. When it came to housing issues the following quote captures the problem:

> ”You can't give what you haven't got. I can get some of my clients into some program just by pushing the friendships and alliances I've built up over the years of being in the sector. Most [clients] I can do little for in terms of housing – it's just not there” (Tasmanian Youth Worker) cited in Szirom et al (2004).

Davis (2003) also points to a lack of appropriate accommodation for people with a dual diagnosis, noting that young people are often discriminated against in the private rental market, and that some accommodation services exclude people with a dual diagnosis. This means there is nowhere for young clients to exit to. Both Szirom et al (2004) and Davis (2003) call for greater collaboration and partnerships between mental health services, drug and alcohol services and departments of housing. These partnerships require people to share their skills and knowledge and to have an agreed approach on how to work effectively with young people. Szirom et al (2004) and Chamberlain and MacKenzie (2004) stress the need for early intervention, which should occur when young people are perceived as at risk of homelessness, for instance when they are alternating between living 'in' and 'out' of home. Secondly, there may be opportunities to intervene while young people are still engaged in the school system, in order to assist them to make the transition to independent living (Chamberlain & MacKenzie, 2004). Dadd (2001) cited in Teesson and Burns (2001) calls for a lifespan approach with interventions tailored for different ages, for example family interventions targeting preschool, childhood and adolescence.

Doherty, Blewett and Cresswell (1999) argue that the number of young women in SAAP services who were in SAAP services as children is increasing, suggesting that the impact of abuse and violence as children has continued into adult life. WESNET in a submission to the National Evaluation of SAAP III (1999) provided recommendations for early intervention for children and young women including that:

- children be recognised as SAAP clients in their own right and that this be reflected in SAAP funding priorities, the national data collection and in client-worker ratios; and

- SAAP growth funds be used to expand the number of child support workers in women's services as well as in youth and generalist services.

More recently the impact of homelessness on children's welfare has been examined by two Victorian reports. Hanover Welfare Services conducted a longitudinal study following the progress of 42 families over a period of two years recruited from crisis support agencies (Kolar, 2004). The findings from this study emphasis the importance of stable housing on children's development and wellbeing. Improvements in children's behaviour, health and in family relationships were attributed to stable housing. Gordon (2004) interviewed a small number of parents, children and support workers from transitional housing services. Families who were in transitional housing were awaiting public housing. A number of children expressed their anxiety of moving from place to place and the disruption this caused in their lives. As one child put it, "It wasn't good moving around. Every time we moved I get sad because I hate moving…" (Robert aged 10, Gordon, p.16). The loss of friendships and social networks was particularly important for families living in rural areas. Both reports call for long term and sustainable housing that provides a safe and secure environment for parents and their children.

3.4 OLDER PEOPLE

Issues for older people have not been prominent within SAAP policy, perhaps reflecting the fact that only 16% of SAAP clients were reported to be aged over 45 years (AIHW, 2005).

One report identified that older people often have very poor or non-existent access to mainstream services. The reasons for this included:

- older people are not identified as a special needs group;
- weekly charges within hostels equivalent to 85% of income leave inadequate disposable income;
- entry age limits do not meet the needs of prematurely aged people; and
- Home and Community Care (HACC) services are generally not available to people living in SAAP funded services (Econsult & Neil, 1994).

While this report does not explicitly consider the needs of older people who are homeless with a mental illness, it is likely that many of the problems faced by older people within SAAP services generally, are accentuated in the presence of a mental illness.

While in the main, HACC policy has paid little attention to the issues of homelessness or mental illness, there is considerable scope for this program to respond to the needs of homeless people with a mental illness. The latest version of the HACC minimum data set includes fields for public place or temporary shelter in the housing field. In addition, within Victoria and South Australia there are additional fields to identify supported residential facilities.

A number of reports highlight the plight of older homeless people. These include 'Housing options and independent living: sustainable outcomes for older people who are homeless' authored by Judd, Kavanagh, Morris and Naidoo (2004). This study demonstrated that low-income older people who do not own their own homes, who have an itinerant history and are dependent on the private rental market or insecure accommodation are at risk of

homelessness. Unexpected life events such as the death of a spouse, relationship crisis, decline in health, or an increase in rent can jeopardise accommodation arrangements. The shortage of public and community housing meant that options for older people ranged from private rental, nursing home, homeless shelter, boarding house, retirement village or living with family or friends. Despite these options, the report stated that there was not enough affordable and adequate housing available (Judd et al, 2004). Based on SAAP data Lai (2003) found that among older men the main reason for seeking SAAP assistance were financial reasons, substance abuse, and/or having recently arrived in the area without supports. Older men were more likely than younger men to seek assistance because of their itinerant lifestyle or psychiatric illness. Older women on the other hand were more likely to cite domestic violence, financial difficulties, being in the area without support and psychiatric illness as the reasons for seeking assistance. Older clients were less likely to be case-managed than younger clients. They were also more likely to have lived in their own homes before seeking SAAP assistance.

Through Wintringham residential services or outreach workers, Lipmann, Mirabelli & Rota-Bartelink, (2004) identified and interviewed 125 people who were aged 50 years or older. About three quarters of the sample were males and one-quarter female. About half were divorced or separated, 30% single and never married and 17% widowed, reinforcing the view that absence or breakdown of relationships can trigger homelessness. Men previously homeless were less likely to have been in paid work during their adult life and had stopped working at a younger age than men not previously homeless. As their last accommodation before becoming homeless, over half had been in private rental sector and only 19% were in their own home compared with 78% of older people in Victoria. People who were reliant on the private sector rental market and those living in inner urban boarding houses were vulnerable to eviction as a consequence of re-development or sale.

The authors elaborated on the term 'the new homeless': that is, people who had no previous experience of being homeless before their current episode. The 'new homeless' were characterised as people who had always managed on low incomes, led fairly normal lives and were not the stereotypical "loner" or heavy drinker. Lipmann et al (2004) found that 60% of older people in the sample fell into this category. The most common reasons for triggering homelessness were marital/relationship breakdown, other family problems, drug/alcohol problems (reported by men more often than women), and moving to a new area. Half of respondents said they couldn't look after the physical condition of their housing any more. The study found that a small but substantial proportion of people aged 75 years or more became homeless as a result of housing and tenure problems. This was attributed to the change in low cost housing stock and the gentrification of the inner urban areas.

3.5 ABORIGINAL AND TORRES STRAIT ISLANDER CONTEXT

The effects of colonisation, dispossession, disempowerment and successive policies and practices of past governments have led to a deep and lasting impact in indigenous communities, families and individuals. These impacts have been well documented and include poverty, low self-esteem, a poor sense of emotional and social well-being, welfare dependency, high levels of family violence and substance abuse, poor physical health and low levels of educational attainment. The impact of colonisation has also weakened the social, physical and psychological supports and structures that give meaning to many

indigenous people's lives. As a consequence homelessness, never before a feature of traditional indigenous life, is now a critical issue. Keys Young (1998) reported on five distinct types of indigenous homelessness:

- spiritual forms- separation from traditional land or from family;
- overcrowding;
- relocation and transient homelessness;
- escaping an unsafe home or situation; and
- lack of access to any stable shelter, accommodation or housing.

SAAP has recognised that the risk of becoming homeless is much higher among Aboriginal and Torres Strait Islander people than it is for non- Aboriginal people. These risks relate to low economic and social advantage and lack of access to affordable and secure housing (Department of Family and Community Services, 1999).

After housing stock availability, the key factors identified by the Keys Young report to address the problems of indigenous homelessness were availability and access to mental health and disability services. As well as accessing mainstream mental health services, indigenous people access social and emotional well-being services within Aboriginal Community Controlled Health services.

The 'Ways Forward' report (Swan & Raphael, 1995) identified the core components of specialised mental health care, including the need for accommodation for Aboriginal people with mental illness living in communities. The report argued that such accommodation services should be developed by Aboriginal people, be consistent with their culture and values and linked to family support mechanisms.

Strategies suggested for promoting collaboration as a response to the needs of indigenous people who are homeless to improve emotional and social well-being include:

- establishment of Commonwealth based and state/territory based Indigenous advisory groups within program areas;
- establishment of a cross-portfolio Senior Indigenous Officers Group in each State and Territory to encourage a more coordinated approach to service delivery;
- appointment of dedicated Indigenous policy workers and liaison workers to drive program improvements, increase the focus on indigenous issues within a service, increase the accessibility of services to indigenous people and promote collaboration between mainstream and Indigenous services;
- within regions with sizeable numbers of Indigenous people, the establishment of Indigenous Advisory Committees within health, mental health, and SAAP, etc.; and
- development of a more flexible and integrated funding and planning approach to service delivery in rural and remote communities whereby SAAP, housing, employment, health, mental health and other services can be provided in a way that communities themselves assess as best meeting the needs of their members (Keys Young, 1998).

The Minister for the Australian Government Department of Family and Community Services (FaCS), Senator Kay Patterson, identified indigenous homelessness as a priority issue for discussion and advice by CACH at the inaugural meeting of the new Commonwealth Advisory Committee on Homelessness (CACH) in March 2004. FaCS has prepared a paper on

Indigenous Homelessness on behalf of CACH as the basis for National Homelessness Strategy (NHS) consultations during 2005.

The Australian Government has put in place new structures to provide services for Aboriginal and Torres Strait Islander people and communities. The Government's Indigenous programs are now administered by mainstream agencies, but under a 'whole-of-government' approach. These changes (from 1 July 2004) follow on from the Government's decision, announced on 15 April 2004, to abolish the Aboriginal and Torres Strait Islander Commission (ATSIC) and the associated service-delivery agency, Aboriginal and Torres Strait Islander Services (ATSIS).

At thirty sites in metropolitan and regional Australia, former ATSIC-ATSIS offices have become multi-agency Indigenous Coordination Centres (ICCs). Over time ICCs are bringing under the one roof staff working in the main agencies administering government programs and services for Indigenous people. ICCs will be the main engine for coordination of Indigenous-specific programs in the regions, where the new arrangements are focused. They will work with local Indigenous communities and negotiate regional and local agreements for effective partnerships and shared responsibilities.

The Department of Immigration and Multicultural and Indigenous Affairs' Office of Indigenous Policy Coordination website at http://www.oipc.gov.au provides information on Indigenous Community policy and services and has a contact list for the ICCs.

3.6 People from Culturally and Linguistically Diverse Backgrounds

There has been a focus on the needs of people from a Cultural and Linguistic Diverse Background (CALD) within both homelessness and mental health policy. Homelessness policies have identified the problems experienced by people from CALD accessing SAAP programs and promoted the development of culturally relevant services. Similarly the need for culturally relevant services has been acknowledged within mental health policy. For example, the Mental Health Promotion and Prevention National Action Plan identifies people from diverse cultural and linguistic backgrounds as a priority population group and the framework for the implementation of the Plan specifically focuses on the needs of the Australian multicultural community (Australian Health Ministers, 2004).

In an evaluation of mental health services for CALD communities, a range of factors were identified as major barriers to access to timely and appropriate mental health care. These included:

- language
- information
- communication
- stigma
- cultural differences between client and clinician (Long, Pirkis, Mihalopoulos, Naccarella, Summers & Dent, 1999).

While these issues were identified within a mental health context, it is likely that they are equally relevant within the homelessness context.

The problems of homelessness and mental illness are magnified in the context of language and cultural difference. Promotion of intersectoral cooperation should support services that are responsive to the linguistic and cultural backgrounds of homeless people with a mental illness.

3.7 WOMEN EXPERIENCING DOMESTIC VIOLENCE

In a submission to the National Evaluation of SAAP III (1999), the Women's Services Network (WESNET) recommended the development of linkages between SAAP and mental health services in responding to the needs of women experiencing violence (Department of Family and Community Services, 1999). Linkages are necessary to respond not only to the mental health problems that may arise in the context of exposure to violence, but also to respond to the needs of women with mental illness who may themselves experience domestic violence.

While there has been some attention to the issues of violence to women with a mental health problem, much of this has focussed on women who experience violence within the mental health sector. In its submission to the National Evaluation of SAAP IV (AFHO 2003), the homelessness service providers' peak body - Australian Federation of Homelessness Organisations (AFHO) – quoting other research, noted that

> "…*As well as the direct impact of violence itself on the woman and her children, violence against women has serious consequences for their physical and mental health. There is evidence that domestic violence is a factor in at least one in four suicide attempts by women. Abused women are more likely to suffer depression, anxiety, psychosomatic symptoms, eating problems and sexual dysfunction…"*

The SAAP National Data Collection (2003-04) indicates that the main reason given by people for seeking support from all SAAP services was primarily due to domestic violence. The data shows that 48% of those people escaping domestic violence were females with children and 39% were unaccompanied females over 25 years old who identified domestic violence as their reason for entering a SAAP service.

Women with psychiatric disability who also have substance abuse problems often have difficulty accessing either SAAP or mental health services and there is a lack of counselling for children (Econsult & Neil, 1994).

3.8 JUSTICE ISSUES

People within the justice system are amongst the most marginalised and stigmatised people within our community. This marginalisation is intensified in the presence of a mental illness. A recently released discussion paper on forensic mental health issues highlights many of the complexities associated with providing support for people with the justice system who have a mental illness. However while this report recommends a model of care that includes post-release support, it provides no discussion on the housing and support needs of ex-prisoners

with a mental illness, many of whom will become homeless (Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, 1999).

In June 2001 the Australian Health Ministers Advisory Council National Mental Health Working Group formed a Forensic Expert Reference Group (the Group) to progress the national forensic agenda. One of the Group's objectives was to develop the *National Statement of Principles for Forensic Mental Health.*

The aims and objectives of the Principles (which have been endorsed by the Australian Health Ministers' Advisory Group Mental Health Working Group) are to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services. While states and territories are responsible for the delivery of forensic mental health services, the services should be delivered within a framework provided by nationally agreed principles.

Individual jurisdictions will need to review their current systems, identify gaps, and develop plans or proposal for working in partnership with corrections and justice areas to implement the Principles. These plans will be considered under the framework of the National Mental Health Strategy in the context of the mid- and end- of term evaluation of the National Mental Health Plan 2003-2008. A research report commissioned by the SAAP National Coordination and Development Committee (CAD), by Matthew Willis of the Australian Institute of Criminology (2004), examined the challenges and disadvantages ex-prisoners face in returning to the community and how these may contribute to the experience of post-release homelessness. The findings of the report point to the social disadvantage faced by ex-prisoners in finding appropriate accommodation. Discrimination, having a criminal record, being blacklisted were cited as inhibiting factors in gaining private rental accommodation. Further the effects of institutionalisation were felt strongly by ex-prisoners as they had to re-learn skills to adjust to everyday life in the community. For ex-prisoners, homelessness can increase the risk of re-offending. Study participants who were in stable accommodation were more positive and realistic about their future compared with those in less stable and less supportive environments (Willis, 2004).

3.9 ACQUIRED BRAIN INJURY

People with acquired brain injury who are homeless and living with a mental illness have complex needs. The presence of co-morbid factors such as acquired brain injury have traditionally been outside the scope of mental health services. This has led to a lack of services for people with acquired brain injury despite the high rate of mental disorders reported by people with acquired brain injury (ABS, 1996) and the lack of alternative service systems to respond to their needs in many areas.

In a submission to this project, the Head Injury Council of Australia expressed the following concerns:

- acquired brain injury often magnifies the risk factors associated with homelessness;
- there is no national data on the number of people with an acquired head injury who are homeless, although estimates of between 10% and 30% in specific geographic regions have been made (Hodder at al, 1998; Byrne 1997; Heads and Tails, 1999).
- people with acquired brain are often denied access to mental health services;

- many people with acquired brain injury also have associated drug and alcohol problems; and
- there is a lack of appropriate, supported accommodation for people with acquired brain injury.

3.10 INTELLECTUAL DISABILITY

There has been little focus on the interaction between homelessness, mental illness and intellectual disability in either policy or research. The report on "complex" needs identified intellectual disability as a major issue among SAAP users with complex needs, although it is unclear whether there were additional problems with mental illness confounding the difficulties. Similarly to people with acquired brain injury, people with intellectual disability have often fallen through service gaps. Work by Ecumenical Housing and Thomson Goodall (1999) provided a framework on how SAAP services should respond to people with high level needs requiring a complexity of service provision.

3.11 SUMMARY

The reality for many people is that they have multiple problems contributing to their homelessness, not only mental illness but also problematic drug and alcohol use and acquired brain injury or intellectual disability. They may come from a CALD background or recently released from jail. Perhaps they are escaping violence or have a young child in their care.

The complexity of need underscores the requirement to engage with sectors beyond SAAP and mental health services. It also illustrates the limitations of a sectorised approach to treatment, support and housing for people with multiple and complex needs.

4 CONCLUSION

The review of national and international literature suggests that:

- the prevalence of mental illness among people who are homeless is substantially greater than that found in the general population;
- for some people the experience of homelessness may contribute to the development of a mental illness, especially depression and anxiety;
- a psychotic disorder is a risk factor for homelessness;
- effective treatment for psychotic disorders can prevent homelessness;
- residential stability for people who are homeless and living with a mental illness is possible if appropriate housing, effective treatment and flexible support is available;
- stable and secure housing does produce positive benefits in terms of people's mental health and general wellbeing;
- drug and alcohol services need to be integrated with clinical mental health services when responding to the needs of people who are homeless and living with a mental illness;
- effective models of intersectoral collaboration incorporate consumer perspectives and preferences;
- specific strategies need to consider particular at risk population groups.

It is important that policy and service responses to people who are homeless and have a mental illness reflect the best evidence available. While there is some information about the issues of homelessness and mental illness, there are still many gaps in the literature. For instance, there are few longitudinal studies of the homeless population that could be used to determine whether the prevalence of mental illness among people who are homeless has changed over time.

The complex methodological and ethical problems associated with research into homelessness, limit the scope of research. Local variation in prevalence is likely to reflect differing structural conditions and the challenge is to design research studies that define and identify these structural conditions and their impact on the prevalence rates. Such studies are likely to depart from the standard quantitative research methodologies and require more qualitative, including ethnographic, approaches. Such research would assist with both the design and evaluation of programs aimed at preventing the problem of homelessness and mental illness.

This approach implies that such research needs to include both consumer and provider views and requires collaboration between researchers from diverse areas of training and disciplines, service users, providers and policy makers.

As well as further research to understand the nature and extent of the problem, there is a need for more evaluative research to assess the impact of innovative programs related to homelessness and mental illness to understand better how programs can sustain change over time.

5 BIBLIOGRAPHY

ACOSS (2003). *Homes for all: A blueprint for Australia*, the ACOSS Federal budget housing priorities statement 2004-05.

Adams, C., Pantelis, C., Duke, P., and Barnes, T. (1996). 'Psychopathology, social and cognitive functioning in a hostel for homeless women', *British Journal of Psychiatry*, vol.168, pp.82-86.

American Psychiatric Association (1994*). Diagnostic and statistical manual of mental disorders: fourth edition (DSMIV)*, American Psychiatric Association, Washington.

Arce, A. and Vergare, M. (1984). 'Identifying and characterising the mentally ill among the homeless', in H. Lamb (ed.), *The Homeless Mentally Ill: a Task Force Report of the American Psychiatric Association*, American Psychiatric Association, Washington, pp.75-89.

Australian Bureau of Statistics (ABS) (1996). *Occasional paper counting the homeless: Implications for policy development*, cat. no. 2041.1

Australian Federation of Homelessness Organisations (AFHO) *AFHO Submission to the National SAAP Evaluation (Dec 2003)* Web Reference:
http://www.afho.org.au/2_projects/saap4_evaluation/saap4_evaluation.htm

Australian Institute of Health and Welfare (1997). *SAAP National Data Collection Annual Report 1996-97 Australia*, Catalogue Number HOU 10.

Australian Institute of Health and Welfare (2003). *Homeless People in SAAP*: *SAAP National Data Collection Annual Report 2002-03 Australia*, Catalogue Number HOU 91.

Australian Institute of Health and Welfare (2005). *Homeless People in SAAP*: *SAAP National Data Collection Annual Report 2003-04 Australia*, Catalogue Number HOU 126.

Australian Health Ministers (1998). *Second National Mental Health Plan*, Mental Health Branch, Department of Health and Family Services, Canberra.

Australian Health Ministers (2003). *Third National Mental Health Plan*, Mental Health Branch, Department of Health and Family Services, Canberra.

Australian Health Ministers (2004). *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia,* Department of Health and Ageing, Canberra.

Bachrach, L. (1987). *Leona Bachrach Speaks: Selected Speeches and Lectures*, Jossey-Bass, San Francisco.

Bachrach, L. (1995). 'Boundary busting and the mentally ill homeless population', *Psychiatric Services*, vol.46, pp.875-889.

Bachrach, L. (1992). 'What we know about homelessness among the mentally ill: an analytical review and commentary', *Hospital and Community Psychiatry*, vol.43, pp.453-464.

Ball, F.L. and Havessy, B. E. (1984). ‘A survey of the problems and needs of homeless consumers of acute psychiatric services’, *Hospital and Community Psychiatry*, vol.35, pp.917-921

Baum, A.S. and Burnes, D. W. (1993). *A Nation in Denial - The Truth About Homelessness*, Westview Press, Boulder.

Bebout, R. (1999). ‘Housing solutions: the community connections housing program: preventing homelessness by integrating housing and supports’, *Alcoholism Treatment Quarterly,* vol.17, no.1/2, pp.93-112.

Bisset, H, Campbell, S. and Goodall, J. (1998). *Appropriate Responses for Homeless People whose Needs require a High Level and Complexity of Service Provision: Final Report*, Department of Family and Community Services, Canberra.

Booth, B., Sullivan, G., Koegel, P., and Burnam, A. (2002). ‘Vulnerability factors for homelessness associated with substance dependence in a community sample of homeless adults’, *American Journal of Drug & Alcohol Abuse*, vol.28, no.3, pp.429-452.

Breakey, W.R. and Thompson, J.W. (1997). *Mentally Ill and Homeless: Special Programs for Special Needs*, Harwood Academic Publishers, Amsterdam.

Brown, M., Ridgway, P., Anthony, W. and Roger, E.S. (1999). ‘Comparison of outcomes for clients seeking and assigned to supported housing services’, *Hospital and Community Psychiatry*, vol.42, no.11, pp.1150-1153.

Browne, G. and Courtney, M. (2004). ‘Measuring the impact of housing on people with schizophrenia’, *Nursing and Health Sciences*, vol. 6, pp.37-44.

Buhrich, N. and Teesson, M. (1996). ‘Impact of a psychiatric outreach service for homeless persons with schizophrenia’, *Psychiatric Services*, vol.47, no.6, pp. 644-646.

Burke, P. (1998). ‘The poverty of homelessness’ in R. Fincher and J. Nieuwenhuysen (eds.), Australian *Poverty: Then and Now*, Melbourne University Press, Melbourne, pp.293-313.

Byrne, B. (1997). *SRS Socialisation Facilitation Project*, Caulfield General Medical Centre, Melbourne.

Carling, P. (1993). ‘Housing and support for persons with mental illness: emerging approaches to research and practice’, *Hospital and Community Psychiatry*, vol.44. no. 5, pp.439-449.

Caton, C.L. (1995). ‘Risk factors for homelessness among schizophrenic men: A case-control study’, *American Journal of Public Health,* vol. 84, no.2, pp.265-70.

Caton, C.L.M., Shrout, P.E., Eagle, P., Opler, L. and Felix. A. (1994). ‘Correlates of co-disorders in homeless and never homeless indigent schizophrenic men’, *Psychological Medicine*, vol.24, pp.681-688.

Chamberlain, C (1999). *Counting the Homeless: Implications for Policy Development*, Australian Bureau of Statistics, Canberra.

Chamberlain, C. and MacKenzie, D. (2003). *Counting the Homeless 2001,* Australian Bureau of Statistics, Cat. No. 2050, Canberra.

Chamberlain, C., and MacKenzie, D. (2004). *Youth Homelessness: Four Policy Proposal*, AHURI.

Cohen, C. I. (1994). 'Down and out in New York and London: A cross-national comparison of homelessness', *Hospital and Community Psychiatry*, vol.45, no.8, pp.769-76.

Commonwealth Advisory Committee on Homelessness (1998). *Issues Paper 4: Preventing Homelessness among People with Mental Health Care Problems*, Department of Family and Community Services, Canberra.

Commonwealth Advisory Committee on Homelessness. (2001). *Working Towards a National Homelessness Strategy. A consultation paper*. Department of Family and Community Services, Commonwealth of Australia, Canberra.

Commonwealth Advisory Committee on Homelessness. (2003). *Working Towards a National Homelessness Strategy: Response to Consultations*. Department of Family and Community Services, Commonwealth of Australia, Canberra.

Coopers & Lybrand and Scott W. D. (1985). *Study into Homelessness and inadequate housing vol.1*, Department of Housing and Construction, Australian Government Publishing Service, Canberra.

Craig, T and Timms, P. (1995). 'Homelessness and schizophrenia', in S. Hirsch and D. Weinberger, *Schizophrenia*, Blackwell Scientific, Oxford, pp.664-684.

Daly, G. (1996). *Homeless - Policies, strategies, and lives on the street*, Routledge, New York.

Davidson, L., Hoge, M., Godleski, L., Rakfeldt, J., and Griffith, E. (1996). 'Hospital or community living? Examining consumer perspectives on deinstitutionalisation', *Psychiatric Rehabilitation Journal*, vol.19, no.3, pp.49-58.

Davis, C. (2003). *Dual Diagnosis and Young People*, NSW Association for Adolescent Health.

Department of Family and Community Services (1999). *Supported Accommodation Assistance Program 2000-2005 Memorandum of Understanding*, Department of Family and Community Services, Canberra.

Department of Family and Community Services (1999). *National Evaluation of the Supported Accommodation Program (SAAP III)*, Department of Family and Community Services, Canberra.

Department of Family and Community Services (2000). *National Homelessness Strategy: A Discussion Paper*, Department of Family and Community Services, Canberra.

Dickey, B., Gonzalex, O., Latimer, E., Powers, K., Schutt, R. and Goldfinger, S. (1996). 'Use of mental health services by formerly homeless adults residing in group and independent housing', *Psychiatric Services*, vol.47, no.2, pp.152-158.

Doherty, D., Blewitt, S. and Cresswell A. (1999). 'Single women and homelessness' in *Council to Homeless Persons, There's No Place Like Home: Proceedings of the 2nd National Conference on Homelessness Melbourne 19-21 May 1999*, Council to Homeless Persons, Melbourne, pp.75-82.

Doutney, C., Buhrich, N., Virgona, A., Cohen, A. and Daniels, P. (1985). 'The prevalence of schizophrenia in a refuge for homeless men', *Australian and New Zealand Journal of Psychiatry*, vol.19, pp.233-238.

Econsult, and Neil, C. (1994). *SAAP and other Government Programs*, Australian Government Publishing Service, Canberra.

Erebus Consulting Partners. (2004). *National Evaluation of Supported Accommodation Assistance Program (SAAP IV) Final Report: A report to the SAAP National Coordination and Development Committee*, Department of Family and Community Services, CanberraErnst & Young (1996) *Commonwealth/State Disability Agreement Evaluation: The Linkages Study, Supporting Paper 3,* Australian Government Printing Service, Canberra

Evert, H., Harvey, C., Trauer, T. and Herrman, H. (2003). 'The relationship between social networks and occupational and self-care functioning in people with psychosis'*, Social Psychiatry and Psychiatric Epidemiology*, vol.38, pp.180-188.

Folsom, D. and Jeste, V. (2002). 'Schizophrenia in homeless persons: a systematic review of the literature, *Acta Psychiatrica Scandinavica*, vol.105, pp.404-413.

Folsom, D., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., Garcia, P., Unutzer, J., Hough, R. and Jeste, D. (2005). 'Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental heath system' *American Journal of Psychiatry*, vol.162, pp.370-376.

Freeman, A., Malone, J. and Hunt, G. (2004). 'A statewide survey of high-support services for people with chronic mental illness: assessment of needs for care, level of functioning and satisfaction, *Australian and New Zealand Journal of Psychiatry,* vol.38, pp.811-818.

Geddes, J., Newton, R., Young, G., Bailey, S., Freeman, C. and Priest, R. (1994). 'Comparison of prevalence of schizophrenia among residents of hostels for homeless people in 1966 and 1992', *British Medical Journal*, vol.308, pp.816-819.

Gill, B., Meltzer, H., Hinds, K. and Petticrew, M. (1996). *OPCS Surveys of Psychiatric Morbidity in Great Britain Report 7 - Psychiatric morbidity among homeless people*, HMSO, London.

Ginsburg, R. (1999). 'Mediations on homelessness and being at home: In the form of a dialogue', in Abbarno, G.J.M. (ed.), *The Ethics of Homelessness*, vol.86, Amsterdam: Rodopi.

Goldfinger, S.M. and Schutt, R.K. (1999). 'Housing placement and subsequent homelessness among formerly homeless adults with mental illness', *Psychiatric Services*, vol.50, no.5, pp.674-679.

Goldman, H., Morrissey, J., Rosenheck, R., Cocozza, J., Blasinsky, M., Randolph, F. and the ACCESS National Evaluation Team (2002). 'Lessons from the evaluation of the ACCESS Program', *Psychiatric Services*, vol.53, no.8, pp.967-969.

Gordon, R. (2004). *Children in Transition: Report for Council to Homeless Person*, Department of Family and Community Services, Canberra.

Greenhalgh, E., Miller, A., Mead, E., Jerome, K, and Minnery, J. 2004). *Recent International and National Approaches to Homelessness: Final Report to the National SAAP Coordination and Development Committee*, Department of Family and Community Services

Greenhalgh, E., Miller, A., Minnery, J., Gurran, N., Jacobs, K. and Phibbs, P. (2004). *Boarding Houses and Government Supply Side Intervention*, AHURI.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S. and Fischer, S. (2003) 'Housing, hospitalisation, and cost outcomes for individuals with psychiatric disabilities participating in continuum of care and housing first programmes', *Journal of Community & Applied Social Psychology*, vol.13, pp.171-186.

Harvey, C., Evert, H., Herrman, H., Pinzone, T. and Gureje, O. (2002). *Disability, homelessness and social relationships among people living with psychosis in Australia,* Low Prevalence Disorder Component of the National Study of Mental Health and Wellbeing, Bulletin 5, Department of Health and Ageing, Canberra.

Hamid, W.A., Wykes, T. and Stansfield, S. (1995). 'The social disablement of men in hostels for homeless people: I: Reliability and prevalence', *British Journal of Psychiatry*, vol.166, pp.806-808.

Heads and Tails (1999). *Issues Impacting Upon People with Acquired Brain Injury: A Community Consultation by the Public Guardian of NSW*, Office of the Public Guardian, Sydney.

Herrman, D.B., Susser, E.S., Jandorf, L., Lavelle, J. and Bromet, J. (1998). 'Homelessness among individuals with psychotic disorders hospitalized for the first time: findings from the Suffolk County mental health project', *American Journal of Psychiatry*, vol.155, no.1, pp.109-113.

Herrman, H., McGorry, P., Bennett, P., van Riel, R. and Singh, B. (1989). 'Prevalence of severe mental disorders in disaffiliated and homeless people in inner Melbourne', *American Journal of Psychiatry*, vol.146, pp.1179-1184.

Herrman, H. (1999). 'Homelessness in mentally ill people: understanding the risks and service needs', *The Journal of the Mental Health Foundation of Australia*, vol.1, no.1, pp.7-16.

Herrman, H. and Neil, C. (1996). 'Homelessness and mental health: lessons from Australia', in. D. Bhugra, (ed.), *Homelessness and Mental Health,* Cambridge University Press, London, pp.244-264.

Herrman, H., Evert, H., Harvey, C., Gureji, O Pinzone, A. and Gordan, I. (2004). 'Disability and service use among homeless people living with psychotic disorders', *Australian and New Zealand Journal of Psychiatry*, vol.38, pp.965-974.

Herrman, H., McGorry, P., Bennett, P., van Riel, R., Wellington, P., McKenzie, D. and Singh, B. (1988). *Homeless people with severe mental disorders in inner Melbourne*, Council to Homeless Persons, Melbourne.

Herrman, H., McGorry, P., Bennett, P., Varnavides, K. and Singh, B (1992). 'Use of services by homeless and disaffiliated individuals with severe mental disorders: A study in Melbourne', in. B. Cooper and R. Eastwood (eds.), *Primary Health Care and Psychiatric Epidemiology*, Tavistock/Routledge, London.

Hobbs, C. Tennant, C., Rosen, A., Newton, L., Lapsley, H., Tribe, K. and Brown, J. (2000). 'Deinstitutionalisation for long-term mental illness: a 2-year clinical evaluation', *Australian and New Zealand Journal of Psychiatry*, vol.34, pp.476-483.

Hodder, T., Teeson, M. and Burich, N. (1998). *Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Use Among Homeless People in Inner Sydney*, Sydney City Mission, Sydney.

Hoffman, D. and Rosenheck, R. (2001). 'Homeless mothers with severe mental illness and their children: predictors of family reunification', *Psychiatric Rehabilitation Journal*, vol.25 no. 2, pp.163-169.

Holmes, A., Hodge, M., Bradley, G., Bluhm, A., Hodges, J., Didio, L., and Markulev, N. (2004). 'Accommodation history and continuity of care in patients with psychosis', *Australian and New Zealand Journal of Psychiatry*, vol. 39, pp.175-179.

Horan, M., Muller, J., Winocur, S. and Barling, N. (2001). 'Quality of life in boarding houses and hostels: A residents' perspective', *Community Mental Health Journal*, vol.37, no.4, pp.323-334.

Horn, M. (2002).'Increasing homelessness: evidence of housing market failure in Australia', *Just Policy,* No. 25.

Human Rights and Equal Opportunity Commission (1993). *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness - Volume* 1, Australian Government Publishing Service, Canberra.

Hurlburt, M.S., Hough, R.L. and Wood, P. (1996). 'Effects of substance abuse on housing stability of homeless mentally ill persons in supported housing', *Psychiatric Services* vol.47, no.7, pp.731-736.

Hurni, A. (2004). *New Models of Interagency Support for Long Term Homeless Men,* Department of Family and Community Services, Canberra.

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V. and Korten, A. (1999) *People Living with Psychotic Illness: An Australian Study 1997-98*, National Survey of Mental Health and Wellbeing Report 4, Commonwealth of Australia.

Jones, K. (1982). 'Scull's dilemma', *British Journal of Psychiatry*, vol.14, pp.221-226.

Judd, B., Kavanagh, K., Morris, A. and Naidoo, Y. (2004). *Housing Options and Independent Living: Sustainable Outcomes for Older People who are Homeless,* AHURI.

Kamieniecki, G. (2001). 'Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review', *Australian and New Zealand Journal of Psychiatry*, vol.35, pp.352-358.

Keys, D., Mallett, S. and Marven, M. (2005). *Making a Place to Belong: Homeless Young People, Support, Accommodation and Exclusion*, Key Centre for Women's Health in Society, University of Melbourne, Melbourne.

Keys Young (1998). *Homelessness in the Aboriginal and Torres Strait Islander context and its implications for the Supported Accommodation Assistance Program (SAAP)*, Department of Health and Ageing, Canberra.

Koegel, P., Burnam, A. and Farr, R. (1988). 'The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles', *Archives of General Psychiatry*, vol.45, pp.1085-1092.

Kolar, V. (2004). *Home First: A longitudinal study of outcomes for families who have experienced homelessness*, Hanover Welfare Services, Melbourne.

Lai, R. (2003). *SAAP Monograph – Older SAAP Clients*, Department of Family and Community Services, Canberra.

Lam, J.A. and Rosenheck R. (1999). 'Social support and service use among homeless persons with serious mental illness', *International Journal of Social Psychiatry* vol.45, no.1, pp.13-28.

Lamb, H. (1984). 'Deinstitutionalisation and the homeless mentally ill', *Hospital and Community Psychiatry*, vol.35, pp.899-907.

Leff, J., Trieman, N. and Gooch, C. (1996) 'Team for the assessment of psychiatric services (TAPS) project 33: prospective follow-up study of long-stay patients discharged from two psychiatric hospitals', *American Journal of Psychiatry*, vol.153, no.10, pp.1318-1324.

Leff, J., Trieman, N., Knapp, M. and Hallam, A. (2000). 'The TAPS project: a report on 13 years of research, 1985-1998', *Psychiatric Bulletin*, vol.24, pp.165-168.

Lehman, A.F., Kernan, E., De Forge, B. and Dixon, L. (1995). 'Effects of homelessness on the quality of life of persons with severe mental illness', *Psychiatric Services*, vol.46, no.9, pp.922-926.

Lezak, A.D. and Edgar, E. (1996). *Preventing homelessness among people with serious mental illnesses - a guide for states,* Delmar, New York, http://www.prainc.com/nrc/papers/prevent/prevent_toc.htm.

Lipmann, B., Mirabelli, F. and Rota-Bartelink, A. (2004). *Homelessness Among Older People: A Comparative Study in Three Countries of Prevention and Alleviation*, Wintringham.

Lipton, F.R. and Sabatini (1984). *Constructing Support Systems for Homeless Chronic Patients. The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association*, American Psychiatric Association, Washington, DC.

Lipton, F.R., Siegel, C., Hannigan, A., Samuels, J. and Baker, S. (2000). 'Tenure in supportive housing for homeless person with severe mental illness', *Psychiatric Services* vol.51, no.4, pp.479-486.

Livingston, J., Gordon, L., King, D. and Srebnick, D. (1991). *Implementing the Supported Housing Approach: A National Evaluation of NIMH Supported Housing Demonstration Projects*, Centre for Community Change Through Housing and Support, Vermont.

Long, H., Pirkis, J., Mihalopoulos, C., Naccarella, L. Summers, M. and Dent, D. (1999). *Evaluating Mental Health Services for Non-English Speaking Communities*, Australian Transcultural Mental Health Network, Melbourne.

Main, T.J. (1988). 'What we know about the homeless', *Commentary*, vol.85, pp.26-31.

Mackenzie, D. and Chamberlain, C. (2003). *Homeless Careers: Pathways in and out of homelessness*, A Report from *The Counting the Homeless* 2001 Project.

Mallett, S. (2004). 'Understanding home: a critical review of the literature', *The Sociological Review*, pp62-89.

Mallett, S., Rosenthal, D., Myers, P., Milburn, N. and Rotheram-Borus, M. (2004). 'Practising homelessness: a typology approach to young people's daily routines', *Journal of Adolescence* vol.27 pp.337-349.

Mares, A. and Rosenheck, R. (2004). 'One-year housing arrangements among homeless adults with serious mental illness in the ACCESS program' *Psychiatric Services*, vol.55, no.5, pp.566-574.

Marshall, J. (1993). 'Psychiatric morbidity in homeless women', *British Journal of Psychiatry*, vol.160, pp.761-769.

McDermott, F. and Pyett, P. (1993). *Not Welcome Anywhere: People who have both a Serious Psychiatric Disorder and Problematic Drug or Alcohol Use*, Victorian Community Managed Mental Health Services, Melbourne.

Morrissey, J., Calloway, M., Johnson, M. and Ullman, M. (1997). 'Service system performance and integration: A baseline profile of the ACCESS demonstration site', *Psychiatric Services* vol.48, no.3, pp.374-380.

Mojtabai, R. (2005). 'Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness', *Psychiatric Services*, vol. 56, pp.172-178.

National Community Advisory Group on Mental Health (1994). *Lets Talk About Action: Redressing Human Rights Abuses, Discrimination and Inequity in the Community's Response to the Plight of People with a Mental Illness*, National Community Advisory Group, Canberra.

National Mental Health Strategy (1998). *National Mental Health Report 1997*, Department of Health and Ageing, Canberra.

National Mental Health Strategy (1999). *Mental Health Promotion and Prevention National Action Plan*, Mental Health Branch, Department of Health and Ageing, Canberra.

National Mental Health Strategy Evaluation Steering Committee for the Australian Health Ministers Advisory Council (1997). *Evaluation of the National Mental Health Strategy: Final Report*, Mental Health Branch, Department of Health and Family Services, Canberra.

National Youth Coalition for Housing (1999). *Accommodating Homeless Young People with Mental Health Issues*, Department of Family and Community Services, Canberra.

Newton, J.R.,. Geddes, J.R., Bailey, S., Freeman, C., McAlvery, A. and Young, G. (1994). 'The mental health problems of the Edinburgh roofless', *British Journal of Psychiatry*, vol.165, pp.761-768.

Newton, L., Rosen, A., Tennant, C. and Hobbs, C. (2001). 'Moving out and moving on: some ethnographic observations of deinstitutionalization in an Australian Community', *Psychiatric Rehabilitation Journal*, vol.25, no.2, pp.152-162.

O'Brien, A., Inglis, S., Herbert, T., and Reynolds, A. (2002). *Linkages between Housing and Support – What is Important from the Perspective of People Living with a Mental Illness*, AHURI.

Owen, C., Rutherford, V., Jones, M., Wright, C., Tennant, C., and Smallman, A. (1996). 'Housing accommodation preferences of people with psychiatric disabilities', *Psychiatric Services* vol.47, no.6, pp.628-632.

Randolph, F., Blasinsky, M., Leginski, W., Parker L. and Goldman H. (1997). 'Creating integrated service systems for homeless persons with mental illness: the ACCESS program', *Psychiatric Services* vol.48, no.3, pp.369-373.

Randolph, F., Blasinsky, M., Morrissey, J., Rosenheck, R., Cocozza, J. and Goldman, H. (2002). 'Overview of the ACCESS Program', *Psychiatric Services*, vol.58, no.8, pp.945-948.

Rayner, K. (2003). *Making Change Possible: Sharpening the Focus on Homelessness and Substance Use within Crisis Supported Accommodation Services in Inner Melbourne*, Victoria, Hanover Welfare Services.

Reynolds, A., Inglis, S. and O'Brien, A. (2002). *Effective Programme Linkages: An Examination of Current Knowledge with Particular Emphasis on People with Mental Illness*, AHURI.

Rickards, L.D., Leginski, W., Randolph,F., Oakley, D., Herrell, J. and Gallagher, C. (1999). 'Cooperative agreements for CMHS/CSAT collaborative program to prevent homelessness: an overview', *Alcoholism Treatment Quarterly* vol.17, no.1/2, pp.1-15.

Robinson, C. (2003). *Understanding Iterative Homeless: The Case of People with Mental Disorders,* AHURI.

Rog, D. (2004). 'The evidence on supported housing', *Psychiatric Rehabilitation Journal,* vol.27. pp.334-344.

Rosenheck, R. and Lam, J. (1997a). 'Homeless mentally ill clients' and providers' perceptions of service needs and clients' use of services', *Psychiatric Services*, vol.48, no.3, pp.381-386

Rosenheck, R. and Lam, J. A. (1997b). 'Client and site characteristics as barriers to service use by homeless persons with serious mental illness', *Psychiatric Services* vol.48, no.3, pp.387-392.

Rosenheck, R., Lam, J., Morrissey, J., Calloway, M., Stolar, M., Randolph, F. and the ACESS National Evaluation Team (2002). 'Service systems integration and outcomes for mentally ill homeless persons in the ACCESS program, *Psychiatric Services*, Vol.53 pp.958-966.

Rosenheck, R., Resnick, S., and Morissey, J. (2003). 'Closing Service System Gaps for Homeless Clients with a Dual Diagnosis: Integrated Teams and Interagency Cooperation', *Journal of Mental Health Policy & Economics,* vol.6, no.2, pp.77-87.

Rothbard, A., Min, S., Kuno, E. and Yin-Ling, I. (2004) 'Long-term effectiveness of the ACESS Program in linking community mental health services to homeless persons with serious mental illness', *Journal of Behavioural Health Sciences & Research*, vol.31, no.4, pp.441-449.

SAAP Coordination and Development Committee (1998). *Planning and Linkages Framework*, Department of Family and Community Services, Canberra.

Schutt, R.K. and Goldfinger, S.M. (1996). 'Housing preferences and perceptions of health and functioning among homeless mentally ill persons', *Psychiatric Services* vol.47, no.4, pp.381-386.

Scott, J. (1993). 'Homelessness and mental illness', *British Journal of Psychiatry* vol.162, pp.314-324.

Sullivan, G., Burnam, A. and Koegel, P. (2000). 'Pathways to homelessness among the mentally ill', *Social Psychiatry and Psychiatric Epidemiology*, vol.35, no.10, pp.444-450.

Supported Accommodation Assistance Act (1994). Section 4 *Definition of Homelessness,* Supported Accommodation Assistance Act, Canberra.

Susser, E. Struening, E. and Conover, S. (1987). 'Childhood experiences of homeless men', *American Journal of Psychiatry*, vol.144, pp.1599-1601.

Susser, E., Moore, B. and Link, B. (1993). 'Risk factors for homelessness', *American Journal of Epidemiology*, vol.15, pp.546-556.

Sutherland, Y., Carter, K. and Champion, V. (2004). *Housing Options Project for People with a Mental Illness,* TeamHealth and Department of Family and Community Services.

Swan, P. and Raphael, B. (1995). *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health,* Australian Government Publishing Service, Canberra.

Szirom, T., King, D. and Desmond, K. (2004). *Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems*, SuccessWorks.

Szirom, T., and King D (2004) *Review of SAAP IV Strategic Themes in Practice and SAAP Service Sector Capacity,* SuccessWorks, Component Evaluation Module of the National Evaluation of the Supported Accommodation Assistance Program (SAAP IV) -– Department of Family and Community Services*,* Canberra

Tacchi, M.J. and Scott, J. (1996). 'Characteristics of homeless women living in London hostels', *Psychiatric Services* vol.47, no.2, pp.196-198.

Tantam, D. (1991). 'High-risk groups: the homeless and ethnic minorities', *Current Opinion in Psychiatry*, vol.4, pp.295-303.

Teeson, M. and Burns, L. (eds.). (2001). *National Drug Strategy and National Mental Health Strategy: National Comorbidity Project*, Department of Health and Aged Care, Canberra.

Teesson, M. and Buhrich, N. (1993). 'Prevalence of cognitive impairment among homeless men in a shelter in Australia', *Hospital and Community Psychiatry*, vol.44, no.12, pp.1187-1189.

Teesson, M., Hodder, T. and Buhrich, N. (2004). 'Psychiatric disorders in homeless men and women in Sydney', *Australian and New Zealand Journal of Psychiatry* vol.38 pp.162-168.

Teeson, M. and Proudfoot, H. (eds.) (2003). *Comorbid Mental Health Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Department of Health and Ageing, Canberra.

Thornicroft, G. and Breakey, W.R. (1990). 'The Costar programme 1: Improving social networks of the long-term mentally ill with a mobile case management service', *British Journal of Psychiatry,* vol. 159, pp.245-249.

Timms, P. and Fry, A. (1989). 'Homelessness and mental illness', *Health Trends*, vol.21, pp.70-71.

Tolomiczenko, G.S. and Goering, P.N. (2000). 'The process and politics of community-based research with people currently homeless'. Psychiatric Rehabilitation Journal, vol.24, no. 1, pp.46-51.

Trevena, L., Nutbeam, D. and Simpson, J. (2001). 'Asking the right questions of disadvantaged and homeless communities: the role of housing, patterns of illness and

reporting behaviours in the measurement of health status', *Australian and New Zealand Journal of Public Health*, vol.25, no.4, pp.298-304.

Tsemberis, S. and Eisenberg, R.F. (2000). 'Pathways housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities', *Psychiatric Services*, vol. 51, no.4, pp.487-493.

World Health Organisation (1997). 'Intersectoral Action for Health' in *Australian Psychiatric Disability Coalition* (1999) Report of National Intersectoral Linkages Project, Australian Psychiatric Disability Coalition, Canberra.

Willis, M. (2004). *Ex-prisoner, SAAP, Housing and Homelessness in Australia: Final Report to the National SAAP Coordination and Development Committee,* Department of Family and Community services, CanberraWykes, T. and Carson, J. (1996). 'Psychosocial factors in schizophrenia: implications for rehabilitation and community care', *Current Opinion in Psychiatry* vol.9, pp.68-72.

Yano, P., Barrow, S. and Tsemberis, S. (2004). 'Community Integration in the early phase of housing among homeless persons diagnosed with severe mental illness: successes and challenges', *Community Mental Health Journal*, vol. 40, no. 2, pp.133-150.

Yates, J. and Wulff, M. (1999). *Housing markets and household income polarisation*, paper presented at the National Housing Conference 1999, Sydney.

Yates, J. and Wulff, M. (2000). 'Whither low cost private rental housing?' *Urban Policy and Research*, vol.10, no.1, pp.45-64.