Foundations for change: Homelessness in NSW

beyondblue Submission

NSW Government Public Consultation

Due 28 October 2016

beyondblue

PO Box 6100

HAWTHORN VIC 3122

Tel: (03) 9810 6100

Fax: (03) 9810 6111

www.beyondblue.org.au

Introduction

beyondblue welcomes the opportunity to make this submission to the New South Wales government strategy review *Foundations for change – Homelessness in NSW*.

beyondblue is committed to supporting all people in Australia to achieve their best possible mental health. As a national population mental health organisation, we have a range of integrated initiatives to prevent depression, anxiety and suicide and to support people who experience these conditions to get the right services and supports at the right time.

In 1993, the Human Rights and Equal Opportunity Commissioner Brian Burdekin wrote:

> *'One of the biggest obstacles in the lives of people with a 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.'*[1]

Over twenty years have passed and the issue of mental health and homelessness remains complex and intertwined.

beyondblue's focus in responding to the questions included in the Discussion Paper relate to how people with depression, anxiety and suicide affect people who are homeless, as well as the impact of homelessness on a person's mental health.

Discussion Points

How can government and non-government agencies build on previous NSW homelessness initiatives and plans to create a robust strategy to prevent and reduce homelessness in NSW?

The release of the *Framework for multi-agency client transition planning to reduce homelessness* a number of years ago provides an excellent base on which to strengthen action on homelessness. Coordinated, linked-up services that are person-centred and that address the fundamental individual and systemic drivers of homelessness is the most effective way to prevent and manage homelessness.

What are the key outcomes the homelessness system should deliver and what outcomes can it influence?

The key outcomes of the homelessness system are to:

- Prevent or minimise the experience of homelessness through a focus on the drivers of homelessness and through early, effective support for people at risk of homelessness, or experiencing homelessness
- Ensure that the immediate needs of people experiencing homelessness are met through access to safe and supportive crisis accommodation where their overall needs are assessed and addressed
- Reduce the duration of homelessness, and the re-experiencing of homelessness by supporting people through crisis and transitional housing into stable, sustainable long-term solutions
- Provide tailored responses for vulnerable or high needs individuals and groups.

Mental health conditions are a risk factor for homelessness.[2] Given the high proportion of people and families experiencing both homelessness and a mental health condition, a specific focus on this issue is an essential component of any homelessness strategy. This requires a 'mental health in all policies' approach that includes a focus on:

- Proactively providing information to potential clients and their carers or other support people about service and support options to enable good and informed decision making and choice
- Enhancing the mental health literacy of all health and human services staff to enable them to understand the experiences and identify the needs of clients with a mental health condition
- Creating open pathways between services in different sectors, whether through colocation, in-reach, and/or consultation-liaison services, so that clients can access supports and services from all relevant services, regardless of which point they enter the system.

Several years ago, *beyondblue* funded the establishment of a website called *'Tune in Now'*. The site was developed to help homelessness case workers discuss depression and anxiety with their clients they perceived to be at risk. Overall, it also gave case workers a greater awareness and understanding of mental health conditions and what some of the key issues were. The site was evaluated and found to be relevant, easy to use and simple, with case workers indicating that the information provided in the site's modules gave them confidence to talk about these conditions with clients.

What role can the corporate sector, philanthropists and other people in the community play to help reduce homelessness?

There is no single reason why people become homelessness however a number of risk factors have been identified which may contribute. In many cases, homelessness results from family breakdown. Young people may be escaping abuse or neglect and a parent and their children may be escaping family violence. Separation and divorce may lead to people having to leave or sell their home without an obvious alternative. Poverty, whether through under- or unemployment, low pay or job loss is another contributor. Research in Victoria indicates that 15 per cent of people who are homeless had a mental health condition prior to becoming homeless.[3] Substance use conditions may also contribute. Effective action to reduce any or all of these antecedents is likely to have flow on benefits in reducing homelessness.

The corporate sector and philanthropy can play a role in addressing these causes by providing financial support to organisations working on these issues. Governments can facilitate these arrangements by:

- creating databases to make it easier for businesses to find and support organisations working on these issues
- providing incentives, over and above donation tax deductions, which are targeted to those willing to address the key drivers of homelessness
- co-investing with corporate and philanthropic partners to pilot innovative approaches to these issues
- supporting the use of social impact bonds in funding, such as projects to address the number of children in foster care in NSW and in alcohol and drug programs in Victoria.

It is important that people who have experienced homelessness be engaged in the development of innovative programs and services to improve their applicability and suitableness.

The general community can also play a role. Like mental illness, homelessness is often misunderstood and stigmatised. Most people clearly identify sleeping rough as homelessness, but overlook people who are staying with friends and relatives, sleeping in hotels, short-term and crisis accommodation, in boarding houses, and even cars,[4] thereby underestimating the scale of the problem. Many people blame the homeless for their situation, rather than realising it happens through illness, job loss, relationship breakdown, or a range of other unexpected or unavoidable life events. Building a greater understanding in the community about what constitutes homelessness and how people find themselves in this situation may build awareness, acceptance and support for broader approaches to address the issue, as well as reduce stigma and the barriers this can create.

How can different housing options be better linked to other supports?

All too often health and human services operate from dichotomised positions – with health services taking a predominantly biomedical approach and human services taking a predominantly psychosocial approach. These dichotomies can be unhelpful as they can lead to a siloed approach. Addressing issues in isolation is unlikely to address people's needs or provide a sustainable solution. Efforts are therefore required to promote a holistic 'biopsychosocial' approach across all health and human services, which simultaneously addresses the individual, interpersonal, cultural and environmental factors that enhance wellbeing. In

addition to creating structural linkages between housing/homelessness services and other services through co-located services or coordinated care models, it is also important to promote a holistic approach to assessment and management to ensure a 'whole of person' approach is taken. The intersection between homelessness and mental health is particularly important with a recent study finding that 46 per cent of homelessness services clients said they required mental health support.[5]

Where are the opportunities to improve how employment, training and education services help prevent homelessness?

Loss of employment can be a cause of homelessness for some, or may be a consequence for others. Efforts to address unemployment are therefore an important element of any homelessness strategy. This should include a particular focus on those at higher risk of homelessness such as people with a mental health condition.

In some cases people with a mental health condition who want to work are not given the opportunity. Stigma and discrimination persists as a serious barrier for people with a mental health condition to gain and keep a job.[6,7,8,9] Recent Australian research shows that one in ten people with a mental health condition looking for work had experienced discrimination and one in seven people with a mental health condition reported being treated unfairly in keeping a job.[10] People with a mental health condition may miss out on work if an employer is aware of their condition. Much of this discrimination is the result of stigmatised views that exist about many mental illnesses.

On the job, people with a mental health condition may not be given the understanding, support and reasonable work adjustments that will enable them to work, particularly during times of increased psychological distress and other changes to their mental health. The symptoms of a mental health condition may be misconstrued as signs of laziness or incompetence, which can contribute to people feeling shameful about their experiences.[11] The person may be overlooked for career advancement or the career of their choice, or worse, they may lose their job if an extended leave of absence is not supported by their employer.

For people living with a mental health condition, being supported to remain or return to work is important. Yet many people with a mental health condition experience discrimination trying to return to work.[12] In some cases they may be required to take time off work when they would prefer to continue. In other cases they may not be given adequate time and support to return to work, after a period of unavoidable illness and personal leave. Where an individual who has had time off, early return to work, even on a part-time basis, can protect against them becoming unable to work and permanently exiting the labour market. Research from Sweden found that after 90 days of absence from work, 75 per cent of workers with a physical problem had returned to work, whereas just 50 per cent of workers who had taken mental health-related leave had returned. After 6 months of absence, the majority (90 per cent) of workers with a physical illness have returned to work; among people who have taken leave for mental health reasons, return to work falls to 70 per cent.[13] Work can be central to recovery for someone with a mental health condition, providing purpose and social connection. Further still, maintaining employment protects against the risk of homelessness.

Workplace mental health initiatives with a strong anti-stigma and discrimination component, could be included within a homelessness strategy as a preventive measure. *beyondblue's* Heads Up initiative provides guidance to workplaces on how to tackle stigma and consideration should be given to promoting this initiative throughout all workplaces.

How can employment initiatives be linked with other initiatives to support housing and homelessness outcomes?

Given the links between unemployment and homelessness, strong links between these two sectors are important, particularly for people who are vulnerable to the double disadvantage of unemployment and homelessness. As noted in the previous section, a proactive 'joined up' holistic approach is needed. Within this context, we would argue that all clients of crisis and transitional housing services should have a comprehensive needs assessment undertaken and those who are unemployed and wanting work should be given priority access to employment support services (and other necessary health and human services) to enable them to enter the workforce, as this has the potential to reduce the time spent homeless. Furthermore, consideration could be given to trialling the Individual Placement and Support (ISP) program support model within the homelessness sector. The ISP model has been used effectively to support people with a mental health condition to get into work in a sustainable way and could potentially be effective in supporting people experiencing homelessness to obtain work.

What are the barriers limiting services from working with people to get them the support they say they need?

Research suggest as many as 65 per cent of people experiencing a mental health condition do not receive treatment.[14] This figure is likely to be higher among people who are homeless. Research has identified a wide range of obstacles that can interfere with someone who is homeless from receiving adequate health care, including for a mental health condition:

- Financial barriers
- A lack of transportation to the place of treatment
- A lack of a Medicare card or health insurance
- A lack of a fixed address or permanent contact details
- A lack of insight into their illness
- A lack of awareness of available services
- A reluctance to access services due to past negative experiences.[15]

While some people who experience homelessness may be able to successfully navigate the health and human services system on their own; many are in crisis or feel confused and overwhelmed and cannot. A level of support and advocacy is required to assist people to make use of services to which they are entitled and could benefit from. Structural barriers also need to be removed through planning and coordination. What is easy to use will be used. Physical co-location of homeless services with other health and human services, particularly for mental health conditions, may reduce some of the obstacles identified above. In-reach and consultation-liaison models from other health and human services which focus on staff from one sector assisting staff from the homelessness sector to meet the diverse needs of their clients are other

potential solutions. Outreach services will be required for clients sleeping rough. A single mechanism to ensure the needs identified by the individual are holistically met is unlikely and a mix of service models tailored to the homelessness organisation's circumstances are required.

How can referrals between other sectors and systems, such as primary health networks, be improved?

Given the new role of Primary Health Networks (PHNs) in commissioning mental health services, it is important that human service organisations, such as homelessness agencies, have links to PHNs to support continuity of care. PHNs are also in a good position to establish and support local service networks that can promote cross service referral where a client may need both mental health and housing or employment services.

With the increased usage of electronic health records, consideration could be given to broadening access to housing and employment services to enable a central repository of client information, at the discretion of the individual. This may assist in reducing duplication of information and make for more seamless transition between services. In Canada, the At Home/Chez Soi trial showed significant improvements in quality of life and mental health outcomes when supported housing was coupled with treatment interventions, through cooperation of multiple service providers.[16]

In Western Australia, a central referral system has been established to improve the way health referrals are made. Rather than a referral from a primary care provider going straight to a particular specialist, the referral enters the centralised system that contains extensive information on services, locations, and specialist availability and expertise.[17] The hope is that the system will ensure referrals reach the right service at the right time, as well as allowing a centralised approach to health care.

A similar system could be considered to connect services for people at risk of, or experiencing, homelessness based on their needs.

Where are the opportunities to better identify and respond to the warning signs that young people are at risk of homelessness?

Given that experiencing a mental health condition and school dropout can both place young people at risk of homelessness, schools and health settings are ideal platforms to identify warning signs.

Mental health professionals working with young people should ensure their assessment is more holistic than just mental health specific needs. Establishing what supports a young person has available to them and whether housing is secure should form part of a person-centred management plan.

For schools, identifying students who may be at risk of homelessness may prove more difficult. Establishing a culture free of stigma with open and supportive communication may help students feel like they can ask for help when it's needed.

How can services better work together and engage young people at risk of homelessness to keep them in education, training or employment?

The transition from school to work can be tough for many young people, and in particular, those who may have a mental health condition. Young people with a mental health condition are more likely to drop out of school or further training/education and become inactive.[18] This can lead to homelessness if other supports are not available.

Models that are tailored to this transition period and consider factors particularly relevant for young people are vital for success. Young people identified as being at risk of homelessness or those with a mental health condition should be able to access these programs as well to prevent education drop out and homelessness.

The Individual Placement and Support (IPS) model described above, which supports people with a mental health condition to find and remain in employment, should be considered for wider rollout and for its potential application for young people at risk of unemployment for other reasons, including early school dropout.

Social enterprises are another way of reaching and engaging vulnerable young people to support them into training and work. Having such enterprises linked to youth housing and homelessness services could facilitate referral and access.

What needs to change to stop people living with a mental illness from becoming homeless because of the episodic nature of their illness?

Services should aim to consider the broader social determinants, as well as address clinical needs. Where a person is supported to stay connected to their social network, together with the care required for their mental health and social services, the chance of them staying well is much greater.

Navigating the complex health and social services system can be difficult, let alone when experiencing poor mental health. Establishing a 'No Wrong Door' approach for cross-sector referrals may improve access to housing services for people with a mental health condition who are at risk.

Particular consideration should be given to young people with mental health conditions. Given the early onset of many conditions and ensuing periods of hospitalisation that may interrupt education and training, they are often at greater risk of homelessness than their peers.

Aboriginal and Torres Strait Islander people are overrepresented among people who experience a mental health condition and those who experience homelessness.[19] Specific services, ideally Aboriginal community controlled, should be the focus of supporting this group of people to stay well and out of homelessness.

What is not assessed, is not addressed. Clinical services need to be attuned to asking about their client's broader social needs and facilitating links to appropriate psychosocial support services, which should in turn have their own mechanisms for supporting clients to avoid homelessness, or be able to link clients to organisations that can address this. Some housing options should be managed directly by the mental health sector to support people who may need a period of intensive support before they are able to move

onto other housing options. Residential rehabilitation services for people with a mental health condition who are at high risk of homelessness should also be readily available.

People with a mental health condition who have chronic and complex care needs as a result of psychosocial disability, should have access to wrap around supports, including housing support, as a matter of course.

In essence, all people with a mental health condition should be assessed for their risk of homelessness, and have their specific needs met through a stepped care approach. This may range from information about appropriate support services at one end of the spectrum, through to advocacy and warm referrals or access to co-located or in-reach services at the midpoint, and consumer driven selection of wrap around supports financed through care packages at the other end of the spectrum.

How can the mental health system better keep people at risk of homelessness engaged with their support?

A person-centred approach is vital. Assessment of people's housing situation should be considered a routine (and mandatory) component of mental health care. Based on the person's situation, a stepped care approach could be used to tailor assistance to the person's preferences and needs. Some people may be able to navigate the system independently, with the right information and advice, while others may need workers to advocate on their behalf or support them through the system. People with a mental health condition who have chronic and complex care needs as a result of psychosocial disability, should have access to wrap around supports, including housing support, as a matter of course. Some people, particularly those who are sleeping rough, will require an outreach approach, where supports are offered and brought directly to them.

Comprehensive (or joint assessment), information sharing (with client consent), coordinated care pathways as well as physical models of co-location, in-reach, or consultation-liaison are all ways of providing an integrated health and human services approach. Providing targeted care in a client's local community goes some way to addressing these barriers, and increasing the likelihood that clients will remain engaged in treatment. Governments, business and philanthropy can all play a role in supporting these models or providing funding to appropriate organisations to design, trial and evaluate innovative solutions.

It is essential to have a range of approaches and service models to cater for the diverse needs and circumstances of people with a mental health condition who are homeless or at risk of homelessness. These models should be clearly targeted to the known barriers that interfere with recovery or limit people's ability to exercise their rights and their options, such as lack of accessibility, affordability, acceptability and availability.

Summary

Homelessness can result from a range of factors, including as a result of mental health conditions and mental health conditions can be exacerbated by the experience of homelessness or unstable housing. It is therefore important to include a specific focus on the needs of people with a mental health condition within any new homelessness strategy. Improving awareness about other common causes of homelessness to reduce stigma and discrimination against people who are homeless is also important.

No single option can be identified as the solution to preventing and addressing homelessness – a multi-pronged approach is needed. A person-centred, holistic, integrated approach will have the greatest success at preventing homelessness and supporting people out of homelessness or unstable housing. Assessment needs to be thorough and multidisciplinary. People need access to information about their options and

should be given the opportunity to make choices about the supports and services they prefer and that are matched to their needs. Services need to work together from a shared practice orientation. Structural barriers to integration also need to be addressed by co-location, in-reach and consultation liaison or other models of coordinated care. Outreach services are needed for people sleeping rough.

Gaining and maintaining employment is often a crucial solution for people who have experienced homelessness, particularly those with a mental health condition, and supporting people who are homeless to access job opportunities should be considered a central pillar of any homelessness strategy and used as a key measure of success.

beyondblue makes the following recommendations for consideration:

1. That the proposed homelessness strategy should include a focus on preventing the key drivers of homelessness and well as supporting people who at risk of homelessness or are homeless
2. That the proposed homelessness strategy should include a focus on the specific needs of people with a mental health condition and their support people using a ‘mental health in all policies’ approach.
3. That a continued focus on upskilling case workers interacting with people who are homeless be included to help them better identify and respond to depression, anxiety and other mental health conditions among their clients.
4. That best practice models of service coordination should be included, including a ‘No Wrong Door’ approach supported by co-location, in-reach, consultation liaison and other initiatives that improve cross-sector referral and linking people to the services they need in a timely fashion.
5. That consideration be given to trialling an adapted version of the Individual Placement and Support (IPS) program within the homelessness sector, to assist people who are homeless to enter or stay in the workforce.
6. That governments support the corporate sector and philanthropy by brokering connections with organisations that aim to prevent or manage homelessness, by introducing additional incentives and by being prepared to co-invest with them to find innovative solutions.
7. That people who have experienced homelessness should be engaged in the development of programs and services to improve their applicability and suitableness.
8. That the NSW government works closely with Primary Health Networks to develop and support local service networks between primary health, mental health and social services in local communities.
9. That particular focus be given to programs that support young people and Aboriginal and Torres Strait Islander people who may be homeless or at risk of homelessness, particularly those with a mental health condition.
10. That governments commit to regular review of housing and homelessness programs and services to ensure they are meeting their objectives and the needs of people.

References

[1] Human Rights and Equal Opportunity Commission (HREOC) (1993). Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, HREOC, Canberra.
[2] Costello, L., Thomson, M., & Jones, K. (2013). Mental Health and Homelessness Final Report. Sydney: NSW Mental Health Commission.
[3] Johnson, G., Chamberlain, C. (2011) Are the homeless mentally ill? Australian Journal of Social Services, vol 46(1); 29-48.
[4] Mission Australia (n.d.) Homelessness and social housing, accessed on 26 September 2016 via https://www.missionaustralia.com.au/what-we-do/homelessness-social-housing
[5] New South Wales Government (2016). Foundations for change – Homelessness in NSW. Discussion Paper. Sydney: New South Wales Government.
[6] McAlpine D.D & Warner, L. (2002). Barriers to Employment among Persons with Mental Illness: A Review of the Literature. Accessed online 19 April 2011: http://www.dri.illinois.edu/research/p01-04c/final_technical_report_p01-04c.pdf
[7] The Sainsbury Centre for Mental Health (2007). Briefing 33: Mental health and employment. United Kingdom: The Sainsbury Centre for Mental Health.
[8] Mental Health Council of Australia (2007). Let's get to work: A National Mental Health Employment Strategy for Australia. Accessed online 12 August 2016: http://www.mhca.org.au/documents/publications/Let's%20Get%20To%20Work%20Employment%20Strategy.pdf
[9] Muir, K., Craig, L. & Sawrikar, P. (2011). Focus group research for beyondblue with consumers and carers. University of New South Wales.
[10] Reavley, N.J., Jorm, A.F. (2011). National Survey of Mental Health Literacy and Stigma. Department of Health and Ageing, Canberra.
[11] Muir, K., Craig, L. & Sawrikar, P. (2011). Focus group research for beyondblue with consumers and carers. University of New South Wales.
[12] Muir, K., Craig, L. & Sawrikar, P. (2011). Focus group research for beyondblue with consumers and carers. University of New South Wales.
[13] OECD (2015). Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work. Mental Health and Work, OECD Publishing, Paris.
[14] Mental Health Council of Australia (2009). Mental Health, Housing and Homelessness in Australia.
[15] Mental Health Council of Australia (2009). Mental Health, Housing and Homelessness in Australia.
[16] Mental Health Commission of Canada (2014). National at Home/Chez Soi. Accessed 27 October 2016 via http://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi-final-report
[17] WA Health System (n.d.) Central Referral Service – improving the patient referral system. Accessed 26 September 2016 via http://healthywa.wa.gov.au/Articles/A_E/Central-Referral-Service-improving-the-patient-referral-system
[18] OECD (2015). Mental Health and Work: Australia. Mental Health and Work, OECD Publishing, Paris.
[19] Mental Health Council of Australia (2009). Mental Health, Housing and Homelessness in Australia.