



Working For Mental Health

Homelessness and mental illness: mapping the way home

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1 Executive Summary

- The prevalence of mental illness in homeless people in Sydney has been estimated at 75% compared to 20% in the general population.
- Pathways to homelessness are varied, but all indicate the multifarious nature of its aetiology. Causes may be structural with biological, social and psychological implications; the failure of infrastructure to support the special needs of people at risk offers strong environmental cause; third, individual risk factors taking place within the former two arenas may further serve to disadvantage an individual.
- Such complex chains demand similarly multi-faceted treatment to address the many causes and symptoms of homelessness. Unfortunately this is at odds with the traditional delivery of services for the homeless, the mentally ill and the drug dependent. The issue demands a radical adaptation of conventional services, from a curative or palliative model to a new public health model, with an emphasis on prevention and health promotion. This will require a shift from a fundamental single focus on symptomatic circumstances, to a holistic approach to the structural, environmental and individual causes.
- Many innovative policies and programs are in place in Australia and overseas which reflect an awareness of the special needs of the homeless mentally ill and the importance of services that integrate them. However, the need for holistic and tightly integrated approaches is still largely unmet.
- To achieve change requires fundamental address of structural causes of health inequalities, and a major shift in the model and delivery of health services.

Prevention and early intervention

- The focus of our attention must firstly be on the upstream or macro factors that determine the issue. The health differential between the poor and the non-poor must be demolished. Homelessness is the evidence of multi-dimensional problems – structural, economic, systemic and clinical. There is a need for a structured framework to address issues for homeless people with mental health problems, which emphasise prevention over treatment, holistic address over symptomatic treatment, surpassing demand rather over failing it, and the drawing together of all these strategies in a united and comprehensive stance. Areas of urgent address include breaking the cycle of poverty, from educational and employment opportunities, to income differential to outcome in issues such as nutrition, environmental health and parenting factors. Required too is a major reorientation in formulation of bureaucratic policy and in the system and practices of public health. The identity of health services as a curative process in a competitive marketplace needs to change to encompass the principles of public health that are holism and integration, prevention and self-determination.

Recommendations

- Mobilise community sector and opinion leaders in electorate to develop and advocate more sophisticated economic models that clearly show the true cost of policies of disadvantage.
- Develop a coherent and defensible model which revises economic rationalist approach to economy by factoring in all those social, economic and health costs that are currently the externalised, or uncosted consequence, of dominant models.
- Demonstrate model is a more accurate measure of economic health, using current and alternative scenarios.
- Use the model to garner support, mobilise public opinion/voter behaviour in support of policies and programs to support goals.
- Mobilise political power. Address each stakeholder: unions, churches, welfare groups, small business, youth organisations.

- Inoculate strategy to prevent attack by those who it threatens – large business who stand to lose from redefinition; individuals who stand to lose from reorganisation.
- Identify and lobby champions.
- Hit panic button to get issues firmly on the agenda.
- Sow seeds of clear policy initiatives by working with political lobby groups and political parties.

Services

- The initiatives found to be reaching homeless people with mental health problems include: intensive outreach programs to engage disenfranchised people; dual diagnosis treatment teams to assist people with co-occurring mental illness and substance use disorders and supported housing programs to assist people with a severe mental illness obtain and retain permanent housing that is suitable to the individual.

Recommendations

- Provide a dedicated, central, integrated health care service for people at risk, providing consistent and long-term support throughout the lifecycle
- Formation of a cross-sectoral planning and advisory group that works in partnership to develop ways of addressing the complex needs of people with mental illness within a holistic framework.
- Identify specific departmental responsibilities for prevention and management of homelessness.
- Prioritise via research program areas of health differential for address eg parenting programs, development screening services, psychology and psychiatric services, housing referrals and legal advisory services.
- Development of a specific dual diagnosis program that can be adapted by individual states depending on community needs, including experts in dual disorders.
- Identify demographic regions of most need, according to income and health differentials. Survey may be required if current information is insufficient and to serve as a benchmark for later evaluation.
- Develop central computer system, linking files from other services (eg. GPs, accident and emergency services etc), ensuring consistency of care and prompt attention to problematic patterns and events.
- In each community, work with community to identify principal areas for address, prevention strategies and programs for individuals and groups.
- Develop and source funding avenues.
- Ensure adequate staffing through funding. Waiting periods must be minimised and referred services must always be staffed. Crisis staff must always be on hand for emergency and crisis situations. Opening hours must be geared to hours of most demand.
- Source staff from each jurisdiction – drug and alcohol workers, psychiatrists, community nurses, social and welfare workers, police and specialists.
- Increase available funding for extensive staff training and education regarding mental health issues and homelessness and the importance of partnerships between services in the same community.
- Develop communications program to encourage use of the service.
- Develop and undertake client surveys to determine areas most required for parenting and support programs.
- Develop mechanisms for informal support, including peer networks, and access to team members.

- Develop client referral and advocacy manual, helping individuals meet concrete needs such as food, housing and clothing, including referrals to complementary programs.
- Increased funding for a wider range of supported accommodation, respite and outreach case-management programs that incorporate *Continuous Relationship Models* and *Pre-treatment models* and/or *Mental Health Care Packages* into their services, to better target homeless people with mental disorders.

Evaluation

- A need for an evidence base to develop and deliver effective models should be balanced with the recognition that some of the most major efforts will take many years to take effect. Health promotion planning should take into account the longitudinal nature of projects to effect structural change and these should provide the framework within which services may be developed and implemented.

Recommendations

- Longitudinal research to track the pathways through and out of homelessness, over longer periods of time. This could also monitor the impact of policy initiatives over time. Comprehensive surveys to identify;
 - What groups are remaining homeless over the long-term;
 - To what extent do people move in and out of homelessness?
 - What factors are associated with moving in and out of homelessness?

Conclusion

- "Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions for the attainment of health by all its members" (WHO, 1986). This must be the goal, the means and the ends in preventing pathways to homelessness.

2 Introduction

The complex interrelationship between mental illness and homelessness has long been noted by service delivery agencies, public health workers and social justice bodies. Following changes in mental health service delivery in the latter part of last century, the observation was swiftly made that the homeless reflected higher rates of mental illness than the rest of the population. Documented rates of the prevalence of mental illness in homeless people range from 2 to 90% (Breakey, p385). *Down and Out in Sydney* (Hodder, Teeson & Burich, 1998) found that 75% of participants in the study of the Sydney inner-city homeless population had at least one mental illness compared to 20% in the general population. Indeed, in 1978, American researchers noted that people with mental illness had come to personify homelessness, referring to New York's Bowery as a "psychiatric dumping ground" (Reich and Siegel, 1978).

As psychiatric diagnosis became more discriminating, the diversity and origins of disorder became clearer (Drake et al in Breakey page 339) and the links between homelessness and illness discerned. Causal chains are many and varied. There is a well-established link between poverty and poor mental health (Shaw et al, 1999, p216); poverty may impact housing, education, employment, social support, family cohesion, and access to health services. Family dysfunction may be linked to individual dysfunction in childhood and poor kin support and coping mechanisms make the onset of mental illness more likely to result in homelessness (Fischer et al, 1996, p396). Unstable mental health may be linked to poor employment prospects, low income, and inability to sustain permanent and secure accommodation. Self-medication or other entries into substance abuse complicate psychiatric symptoms and make dually diagnosed individuals particularly prone to unstable living arrangements (Drake et al, 1996, p341).

These sequelae are of the utmost significance, not simply because each of them offer opportunities for preventative and interventive activity but because they demonstrate the many spheres in which homelessness and mental illness is active. The routes to homelessness are varied and services to assist the homeless mentally ill must stem them all in order for strategies to be at all effective.

As complex as the co-incidence of homelessness and mental illness is, the difficulty posed in its treatment is indicative of the limitations of conventional models of health and community service delivery. The issue demands a radical adaptation of conventional services, from a curative or palliative model to a new public health model, with an emphasis on prevention and health promotion. Many innovative policies and programs are in place in Australia, Britain, America and elsewhere which reflect an awareness of the special needs of the homeless mentally ill and the importance of services that integrate them. However, the need for holistic and tightly integrated approaches is still largely unmet. In *A Long Road to Recovery*, Robinson (2001) highlights the limited care and support services available in NSW to people with mental health problems and asks "Why are there so many people wandering our streets lost and confused, if our mental health system is truly working?" (p4).

A review of the pathways to homelessness is necessary to identify the risk profiles of the mentally ill homeless, however diverse their circumstances may be, and the points at which preventative strategies are feasible. Equally important is a broad exploration of new models of services and an assessment of their potential to provide effective treatment for this most disadvantaged group of our society. We must balance the practical lure of demonstrable intervention with the idealism of long-term prevention. Without activity at every level, strategies will have only limited effect. Our ultimate goal must be the non-existence of the situation we now describe.

3 Epidemiology

3.1 Definitions

3.1.1 Homelessness

Anyone who lives below what is the acceptable minimum standard of housing could be classified as “homeless”. This is an important point because it hints at the concept of relative deprivation – the degree of disadvantage of an individual, family or group relative to the society they live in (Shaw et al, 1999, p214). Relative deprivation suggests that there is no objective point of absolute disadvantage, rather that disadvantage starts with even subtle inequality, and continuing on to its extremes.

While an operational definition of homelessness is key to developing targeted policy, specificity may limit its scope to address only the extreme end of the spectrum. Many opportunities for intervention may occur in preceding, less extreme stages. The three-tiered definition of homelessness described by Chamberlain and MacKenzie (cited in Chamberlain, 1999) is appropriate.

- **Primary homelessness**

People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.

- **Secondary homelessness**

People who move frequently from one form of temporary shelter to another. It covers people using emergency accommodation (such as hostels for the homeless or night shelters), teenagers staying in youth refuges, women and children escaping domestic violence (staying in women's refuges), people residing temporarily with other families (because they have no accommodation of their own), and those using boarding houses on an occasional or intermittent basis.

- **Tertiary homelessness**

People who live in boarding houses on a medium to long-term basis. Residents of private boarding houses do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have security of tenure provided by a lease.

Other definitions alert us to predictive points on the route to homelessness. The Supported Accommodation Assistance Act (1994) addresses the need for Supported Accommodation Assistance Program (SAAP) services to include help for those persons who are at *risk* of becoming homeless.

These definitions illustrate that homelessness is neither static, nor linear. People shift between levels – up as they experience temporary intervention and down as their unstable housing arrangements collapse.

3.1.2 Psychiatric disorders

For the purposes of designing and delivering services to individuals in extreme conditions of adversity, practical definitions of mental illness, categorised according to symptom and treatment paths, is appropriate.

Fischer et al (1996, p387) offer broad but directly applicable categories of mental illness, defined not by diagnosis alone but by severity of affliction. This is useful because it has implications not just for the longevity and nature of the illness but for priority in treatment.

Major mental illnesses

As noted above, diagnosis alone cannot determine a person to be severely mentally ill. For example, a person suffering schizophrenia in a well-managed period may be fairly well able to cope with life and the navigation it demands. Conversely, bi-polarity can extend to psychosis and uni-polarity to suicide. Symptom severity combined

with diagnosis must be used to assess the degree of mental illness and thus the individuals who will comprise this group.

Alcohol use disorders

The correlation between homelessness and alcoholism extends beyond its stereotypical images of skid row residents. Alcoholism remains the most prevalent problem of homeless people, and those that suffer from it experience greater severity of illness in terms of duration, frequency, amount and affect.

Drug abuse disorders

Because drug abuse by homeless people has been commonly grouped with alcohol abuse in terms of "substance abuse", understanding of its patterns and prevalence is poor. Assessment of the frequency of drug use and the number of drugs used is also difficult. However, a literature review reveals that between 25 to 50% of the homeless population use drugs, compared to around 2% of the general population (Fischer et al, 1996, p388). Dual diagnosis of drug abuse disorders and mental illness is a contentious issue for health policy and services alike but with specific regard to homeless people, a more important point is that, like alcohol, drug use is a strong anchor to remaining homeless.

Other disorders

This category includes people with personality disorders, anxiety disorders and mood disorders, and typically, their incidence in the homeless population far exceeds that in other groups. While arguably less severe than major mental illnesses, the relevance of these disorders to homelessness is acute because they very often prevent functional relationships with family and friends, and hamper the individual's ability to cope and function.

3.2 Distribution of disease

Psychiatric disorders are not evenly distributed throughout the population. Since the 1930s studies have demonstrated a strong inverse relationship between social class and prevalence of mental disorder (Samuels and Nestadt, 1996, p78). Further, individuals with mental illness in lower socioeconomic groups tend to have more severe disorders, more extreme symptoms, of longer duration and are more likely to be hospitalised.

There may be geographic as well as demographic imbalance in the distribution of mental illness. American studies have investigated the different distribution of mental illness in rural and urban areas and concluded that depression and drug disorders were more prevalent in urban areas, while alcohol disorders had a higher rate in rural areas (Blazer et al, 1985).

Other variables affect the rate of mental illness in the community. Younger age is more strongly associated with schizophrenia, major depression and alcohol disorders. Males have a higher prevalence of alcohol disorder, but women exhibit almost twice as much major depression. Single or separated people are more likely to suffer alcohol disorders and separated people have higher rates of depression.

The high prevalence of psychiatric disorders in the homeless population is well-established although sample sizes and methodologies vary considerably and are reflected in widely ranging estimates (Fischer et al, 1996, p385). This itself is a call for urgent attention by epidemiologists but all of the reported estimates are sufficient to highlight gross inequality.

Down and Out in Sydney (Hodder, Teeson & Burich, 1998), in an effort to hurdle the endless debate as to the "real" extent of mental illness in the homeless community, undertook a comprehensive survey of 210 homeless people aged between 17-87 years from eight major hostels providing emergency accommodation in inner Sydney. Their findings demonstrated rates of mental illness matched only by those in psychiatric wards and hospitals.

- 75% have at least one mental illness compared to 20% in the general population;
- 23% of men and 46% of women have schizophrenia, compared to between 0.5% & 1% of the general population;
- 33% have depression compared to 6% of the Australian community;

- 93% were reported to have had at least one experience of extreme trauma in their lives;
- Over 36% of inner-city homeless persons have a drug-use mental disorder, compared to 2% in the general population; and
- 12% of people accessing homeless services are Aboriginal yet they represent less than 2% of the Australian population.

However, the study also found that 71% of people had consulted a GP or other health professional in the two weeks prior to survey and this compared to 28% in the general population. This conflicts with some academic and governmental claims that these groups simply do not access services thus making them difficult to assist.

4 Pathways to homelessness

Pathways through homelessness describes the “route of an individual or household into homelessness, their experience of homelessness and their route out of homelessness into secure housing” (Anderson, 2001, p2).

Several seminal research programs have been produced over the past five years, and the factors raised continue to be explored with a view to identifying tangible intervention opportunities. This paper offers a summary of the findings and observations to date.

There is growing consensus that many interrelated factors may contribute to homelessness (Susser et al, 1991). On a macro level, risk factors include low socioeconomic status, low education level, unemployment and poverty. Familial factors may include dysfunctional family relationships, family violence and sexual abuse, childhood institutionalisation, foster care, poor family and social support, and unemployment. Individual attributes, such as mental illness in its many forms, coping ability, socialisation, and emotional maturity also play a key role. On a practical level, causal factors may include poor availability of low cost housing, the complexity of the housing system, and the failure of government and community services to provide an adequate safety net for individuals sliding into homelessness. Understanding pathways to homelessness also means exploring the “housing careers” of individuals in relation to household formation and dissolution, and the variety and quality of housing situations experienced.

These streams of sequelae affect and are affected by each other, so it is impossible to identify a single cause or pathway to homelessness for any individual. Exploring how each of these individual, environmental and structural factors may work to increase the risk of homelessness will provide important clues as to strategies for effective change.

4.1 Structural factors

4.1.1 Disadvantage and health

Determining the health processes of poverty is not a straightforward process (Aber et al, 1997, p473), but the fact remains that poverty itself is a serious health risk for a range of diseases and deficiencies, as well as mortality. Low socioeconomic status is a risk factor for cognitive impairment, substance abuse, personality disorder and antisocial behaviour, schizophrenia and depression, while limited education – used by many as a proxy for socioeconomic status – is a risk factor for Alzheimer’s disease. How does this manifest?

From pre-birth, the effects of deprivation on physiology are massive. Wadsworth describes the process of biological programming in which malnutrition at specific phases of foetal development acts to limit the ability of organs to work optimally (1999, p46). These organs then carry a lifetime-raised risk, which may be triggered by later stressors. The results are not simply physical. While the direction of causality between poverty and schizophrenia is the source of ongoing debate, a series of studies has shown that insults to the fetus in pregnancy strongly correlate to development of schizophrenia.

Aber cites family income as the strongest correlate of IQ of any other measure (1997, p475). He explains that while income dictates the quality of nutrition, health care and living conditions experienced by the child, so too

does it affect the intellectual stimulation opportunities of the home environment. In this somewhat simplistic mechanism, books, toys and appropriate childcare are lacking, simply because of lack of money.

Aber et al further cite poor parenting as a correlate of family poverty and an important predictor of child development. The authors cite studies that posit the chronic stress of poverty in poor families as a factor in the corporal punishment and inadequate affection towards children. These, in turn, create developmental and mental health complications because: "receipt of long-term harsh treatment results in an insecure emotional attachment of children to their parents and subsequent behavioural problems, poor goal orientation, low levels of self-confidence and social competence and a greater tendency towards inconsistent conduct and behaviour" (p476). In the longer term, Kellam and Rebok have demonstrated that childhood behaviour patterns are strong predictors for antisocial behaviour in adulthood (1992, p326).

Acknowledging these, Wadsworth looks to broader social issues:

"Each of the factors that make up these family circumstances, and all aspects of the biological processes already described, are located in, and affected by a broader social context." (1999, p47-48)

These are summarised as:

- "Poverty, maldistribution of income, particularly for families
- High rates of unemployment of both parents
- High rates of family discord
- Gender biased and generally restricted opportunities for education, and low levels of literacy, especially in women
- Low levels of contraception and of breast-feeding
- Isolation of women from the mainstream of social participation, and from legal and social security." (p51)

Environmental hazards, too, pose a particular threat to disadvantaged children. First, there is an interaction between lead level and iron deficiency, thus creating worse outcomes for disadvantage children. Second, and perhaps as a result, even controlling for urbanity, children from poor families demonstrated lead levels 10 times those of their non-poor peers (Newacheck et al, 1994, p230).

This account illustrates the extent to which these factors operate in a cumulative and ecological process. They further do not end when the child becomes adult. Early pregnancy, crime, imprisonment, family dysfunction, unemployment and disenfranchisement are the social legacy of a poor childhood; in turn, they become the social causes of ensuing generational poverty.

4.1.2 Economic rationalism

Nowhere are the effects of economic rationalism and an emphasis on competition in industry, accelerated by the appointment of a neo-conservative government, more evident than in public health policy.

As Baum notes, "new style bureaucrats believed the doctrines of neo-classical economics could be applied to public services to make them more accountable and efficient, and their ideas found fertile ground in the policies of the Hawke-Keating Labor Government" (1998, p84). These principles were later appropriated by the Howard Government. Directed to pursue the competitive ideologies of industry, public policy in Australia has increasingly been shaped by the economic rationalist framework of the new right reform agenda (p83).

How is this manifest? In general terms, observe the premises of economic rationalism: "the free market should determine all economic transactions..." (p83). Associated policies have been included "roll-back of state activities, privatisation or contracting out of public services, the use of private sector management techniques within public service departments and the cutback of state funding for a range of activities including education, health, welfare, housing, arts and culture and transport" (p83).

The private sector management tools that have been employed to such effect are referred to as managerialism and include "strategic planning, results orientation, program budgeting and evaluation, contract or fixed term employment, cost-cutting, breaking down of bureaucracies, introducing quasi-market type mechanisms such as funder-provider splits and outsourcing, relying on generic rather than specialist managers, requiring staff to work to performance targets and emphasising service quality and customer responsiveness" (p83–84).

Health is seen in the context of input, process and output, with a focus on measurable outcomes. Improvement revolves around issues of efficiency and effectiveness. Planning becomes crucial, with budgetary and return issues paramount. Roles are allocated to all participants – even to the extent that the public become consumers. The efficiency of all units within the process are measured and reviewed.

Defined as a radical movement that "challenges the medicalization of health, stresses its social and economic aspects, and portrays health as having a central place in a flourishing life" (Downie et al, 1991, p1), how might public health be best served by market logic? How can an ideology based on competition appropriately conduct a program based on equality? Baum outlines the contradictions:

- Applying market logic to public health, which is an essentially non-market activity
- The privatisation of public services and the transformation of services delivered to "products"
- Transformation of bureaucracies to "funders" and "purchasers" of services through organisational forms based on the private sector.
- The emphasis on short term measurable outcomes
- The growing inequities evident under economic rationalist policies
- No commitment to broader social goals and the placing of activities such as public health below those with a direct economic improvement goal. (YEAR, p86)

We may add to this the observation by McClelland that "there is an increasing tendency to see the position and worth of individuals in market terms only... This is a limited and dangerous view of human worth and potential. It is likely to confine an increasing number, if not to the scrap heap, then to the very margins of our interest and concern." (McClelland, 2000, p54)

Like America before us, Australian public policy in all its manifestations is moving ever closer towards a total market mentality (Wiener and Strauss, 1997, p235). Education, transport, housing and health care all become prey to the predatory forces of competition. But, though competition may save money, its cost to the community in the medium and long term will be echoed in its cost to governments, as the failure to provide equitable and sustainable programs begins to show.

This is not intended as a damning indictment of current management and organisational practice in the public health policy realm. Peterson and Lupton reflect that in the absence of viable alternatives, current practices may remain worthwhile (p181). But investigation of the nature of the absence may sow the seeds of new thinking and new activity that may truly grow into a new public health.

Required is a major reorientation in formulation of bureaucratic policy and in the system and practices of public health. (Kerr, 1991, p157) Policy and political commitment are the first of four criteria imperative to effecting change in public health, followed by the nature of services and the environments in which they operate. (Baum, 1998, p463)

4.2 Environmental risk factors

4.2.1 Lack of affordable and appropriate housing

Along with people on low incomes, people with mental health problems can also find themselves without a secure home due to the lack of affordable and appropriate housing. In the USA, "when housing is affordable, it is unsafe, in disrepair or located far from services and public transportation" (Lezak and Edgar, 1996). The situation in

Australia is not dissimilar. Despite the fact that \$4 billion is given to the states and territories through the Commonwealth-State Housing Agreement to provide public and community housing of which homeless persons are included as a priority group, few tenants are moving out of public housing into the private market to make way for new moves into public housing. The rate of building and acquisition of new housing stock by no means parallels increasing demand, resulting in an escalating waiting list and a stabilising stockpile.

Private rental market prices are often unaffordable for people on benefits and these low rates of income support place restrictions on where a person chooses to live. Often people are forced to live away from their familiar social networks, in outer metropolitan suburbs not serviced well by public transport just to be able to afford a place in the private rental market. Requirements for securing private rentals as determined by landlords and real estate agents can also cause significant obstacles in accessing private housing. This is compounded for a person living with a mental illness who has had episodes of homelessness. These groups may have insufficient references to provide landlords and real estate agents, are compromised by their inability to compete with market prices, and are an unattractive prospect for landlords and agents who are reluctant to take a chance with high risk individuals.

4.2.2 Mental health system

While few would advocate a return to the pre-1960 practice of institutionalising people with severe mental illness, it must be said that governments have failed to adequately balance de-institutionalisation with a planned and coordinated system of community-based services and support.

Not only are community support services crucial in avoiding lapse and relapse into homelessness but adequate discharge planning is also a necessary prerequisite in terms of stabilising a person's life. Many people who experience an acute episode requiring hospitalisation or a high level of support are returned to the community without support plans in place or any stable and/or supported accommodation. The Australian Institute of Health and Welfare's SAAP National Data Collection Report showed that 5% of people seeking crisis accommodation had been in institutional care directly before their housing crisis and 4.6% resorted to institutional care after crisis accommodation (2001, p45-46). The symptoms of mental disorder very often compromise a person's ability to cope with the basic requirements of everyday life, creating difficulty in acquiring and maintaining stable housing. These problems may be increased by substance dependence, poverty and limited support from family or significant others (Kuno et al, 2000). While programs such as those provided by SAAP agencies, offering support and advocacy, transport and living assistance, are of enormous value in promoting adherence to tenancy, they tend to occur *in response to* homelessness, and are only of restricted longevity. Coordinated case management of discharged patients over the long-term, offering all the necessary support, is more likely to prevent crisis accommodation being sought in the first place, and to prevent the recurrence of symptoms and predictive behaviour.

Under-funded, incomplete, fragmented, and poorly monitored community-based services make community services inaccessible to many people. The homeless mentally ill arguably have suffered most as a result of these shortcomings, having multiple needs for intensive and ongoing support. Trials of coordinated care models are desperately needed, but even where pilot programs demonstrate significant results, funding is rarely provided for extension or enhancement of programs.

In *A Long Road to Recovery*, the authors note too that a shortage of hospital beds has led to shorter stays, and that discharge may take place before the patient has been adequately diagnosed or stabilised and the necessary supports identified and referred (Hodder et al, 1998, p4). Bed crises aside, a rationalist approach to health management in which health is seen as the processing of input to output has translated to set stay periods of bed days according to a DRG (Diagnostic Reference Group). Such prescriptions fail to acknowledge the particular needs of each patient.

To explain the breakdown of the community setting, Kuno et al (2000) point the finger at health systems which have failed to shift expenditures from hospitals to community programs, instead operating both systems under-resourced and under-planned. The result is a dichotomy between psychiatric care and community support, rather than a model that recognises the importance of both spheres in managing mental illness.

4.3 Individual risk factors

4.3.1 Mental illness

Mental illness increases a person's vulnerability to homelessness. Its various symptoms of paranoia, anxiety, depression, delusions, hallucinations and disordered thoughts may fundamentally affect a person's organisational skills, their relationships with family, flatmates and neighbours, employment opportunities and their ability to maintain tenancy.

Mental disorders may be cyclical in nature and occur and recur with only minimal warning. Not uncommonly, symptoms return during times of increased stress or trauma and can result in individuals facing difficulty managing day-to-day needs and responding to role responsibilities, such as worker, parent or tenant. People with mental health problems can also have difficulty in developing and maintaining social relationships and, without a strong and reliable support network, are at a greater risk of isolation, loneliness and conflict. If the appropriate networks of family and friends and support services within the community for such people are not in place and isolation and reduced ability to cope with life's challenges occurs, a person with mental health problems may drift into homelessness.

Once there, the stress of being homeless – exposure to violence, sexual abuse, concomitant substance abuse, and a range of physical health problems – promotes high rates of emotional distress. Depression and distress, two to eight times more likely to occur in homeless people, dramatically exacerbate the symptoms of original mental illness and hamper an individual's ability to exit from homelessness.

4.3.2 Co-occurring mental illness and substance use disorders

Dual diagnosis is a popular theme in public health practice, referring to the concomitant presentation of more than one mental disorder. While technically this terminology includes people who have simultaneous alcohol and drug disorders, it is most commonly used to refer to people who suffer mental illness and substance disorder concurrently. Estimates of prevalence vary widely, again due to methodological inconsistencies in this type of study, but research suggests that up to a quarter of homeless adults suffer alcohol and mental disorders, approximately 3% have both mental and drug disorder, and as much as 7% experience mental illness, drug abuse and alcohol abuse concurrently (Fischer et al, 1996, p385).

Common characteristics of people who have dual disorders include:

- Greater psychiatric symptomatology
- Denial of mental illness and substance abuse and refusal of treatment and medication
- Antisocial, aggressive and sometimes violent behaviour combined drug and alcohol abuse and poly-drug abuse
- High rates of suicidal behaviour and ideation.

(Lezak & Edgar, 1996)

Even where treatment services are accessed, diagnosis of dual disorders is extremely complicated and clinically difficult. Substance use may result in social or psychological problems. Psychoactive substances often exacerbate the symptoms of mental illness and, indeed, can "mimic almost any psychiatric symptom" (Drake et al, 1996, p344). Thus many of the symptoms of mental illness appearing in tandem with substance abuse may be temporary and will lessen or disappear with abstinence, suggesting that diagnosis in many cases should be deferred. However in clinical practice this presents a sizeable dilemma, when treatment appears urgent.

Without treatment, this consumer group is likely to be refused supported accommodation and/or permanent secure housing due to disruptive behaviours that could lead to future eviction, house bans, potential dangerous and violent situations, arrest, and incarceration in jail or admission into psychiatric facilities. Authors who have studied homeless and formerly homeless individuals have found that stable housing is rare among people with untreated substance use disorders (Dickey, 2000)

Multiply disabled, the dually diagnosed homeless present perhaps the greatest challenge to programs and services because of the implications of their illness for receptiveness to services and the segmented nature of treatment and practice. A 2001 study noted some of the issues (Welch and Mooney, 2001, p345):

- Both mental health services and alcohol and drug services present exclusive models of care, seeing themselves as operating independently
- Each service group knowing little about the role and practices of the other
- Mental health services and alcohol and drug services are designed to treat single disorders
- GPs and other clinicians had little understanding of, training or expertise in treating and managing dual disorders
- Information exchange mechanisms between services are extremely poor
- Assessment tools to fully explore physical, mental and substance use issues were inconsistent, incomprehensive and infrequent.

There is anecdotal evidence suggesting that individuals with a dual diagnosis are placed in the “too hard basket” because of limited services and inflexible eligibility criteria. For example, a service gap is created when mental health services will not see people who are drug and alcohol dependent as mental health workers do not have the skills or resources to deal effectively with drug and alcohol issues. The same occurs in reverse for drug and alcohol services: their staff do not have the skills nor resources to deal effectively with people with mental health issues (Robinson, 2001). While individuals with complex needs are being turned away from drug and alcohol and mental health services, such as community mental health services and drug and alcohol detoxification and rehabilitation programs, SAAP services have to fill this gap of service delivery. Already stretched to the limit and without additional funding or training, SAAP services becoming more and more crowded, waiting lists are increasing and people in need are being refused service due to lack of vacancies. In addition to lack of resources, the threat of violent and disruptive behaviour by people may cause them to be refused service.

4.3.3 Exposure to physical, psychological and/or sexual abuse

Homeless people share childhood histories of economic and social disadvantage, such as poverty, childhood family instability and violence (Fischer et al, 1996, p390). The salience of this observation refers as much to the intensity of those histories as to their incidence: “reported childhood violence... [is] pervasive enough to warrant diagnosis of post-traumatic stress disorder in substantial proportions of homeless populations” (Fischer et al, 1996, p390–391).

The findings of *Down and Out in Sydney* estimated that 93% of homeless people in the inner city had experienced at least one major trauma in their lives, including serious physical assault, sexual assault or exposure to extreme violence (Hodder et al, 1998). The proportion of traumas that took place in the family environment is not clear, but it is feasible to assume that these would include a significant number of domestic events.

This bleak assessment nonetheless holds promise for preventative strategies. Outreach and treatment programs for adults with an emphasis on interventions for children addressing these more pervasive causes of homelessness are important strategies: “the types of preventive programs that are likely to be effective depend on the causal pathways that link childhood experience to adult homelessness” (Fischer et al, 1996, p396). Similarly, domestic violence programs offer a rich arena for of primary and secondary prevention activities.

4.3.4 Aboriginality

It is a source of ongoing shame that in Australia, Aboriginality may be considered a proxy for poverty and disadvantage and the poor health outcomes that accompany these environments. A recent SAAP discussion paper noted that 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... include poverty, low self-esteem, a poor sense of emotional and social wellbeing, welfare dependency, high levels of family violence and substance abuse, poor physical health and low levels of

educational attainment" (Craze et al, 2000, p5). This discussion paper also describes the parallel weakening of the social, physical and psychological supports and structures essential to indigenous culture, resulting in devastating levels of homelessness for Aboriginal and Torres Strait Islanders.

5 Strategies for prevention and intervention

In May 1995, St Vincent de Paul released *Mental Health Crisis* which focuses on the multiple problems that face disadvantaged people living with a mental disorder. In 1998, *A Long Road to Recovery* noted that not a lot has improved since that point, citing instead an increase in the number of disadvantaged people requesting assistance. With this increased pressure, community-based services and crisis mental health teams are unable to provide adequate assistance and support to the growing numbers (Robinson, 1998).

To gauge the evidence of such a conclusion, we contacted a range of services to cover the various approaches to homelessness in metropolitan Sydney: crisis services (including drop-in centres), medium-term and long-term accommodation services for youth, women, men, women and children, families, and people from non-English speaking backgrounds. Many common themes were identified, including housing shortages, poor partnership models, problems of dual diagnosis, low funding levels, inappropriate training.

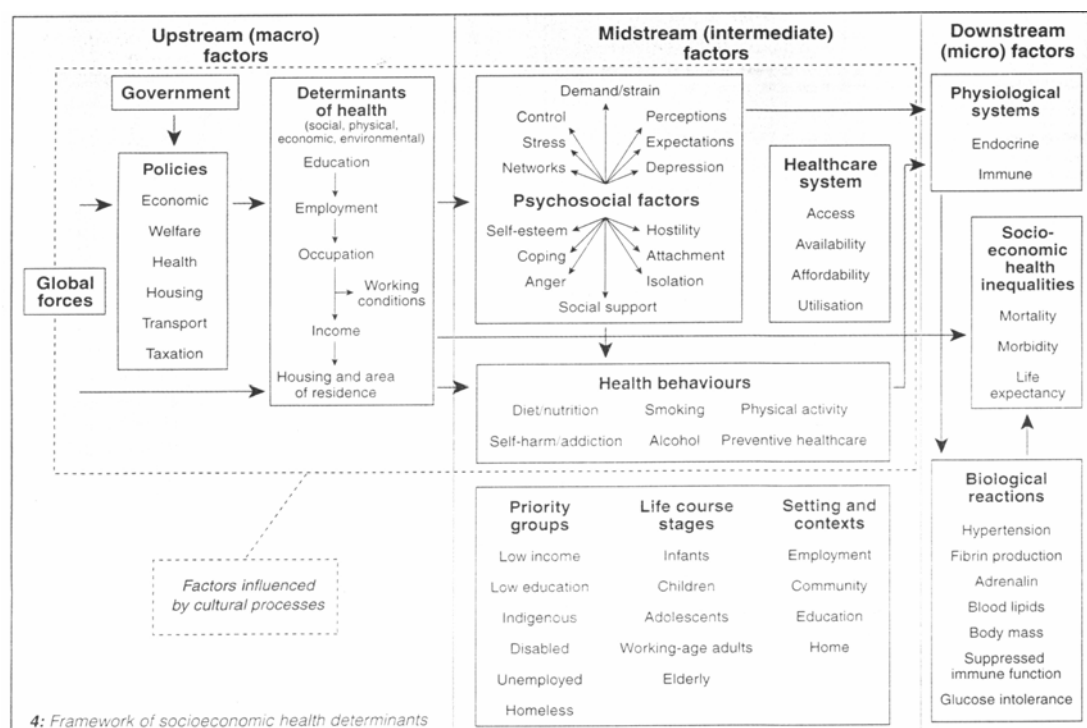
This input, together with the substantial body of research available in this area, reinforce that to be able to limit the complexities of pathways to homelessness for people with mental health problems, it is vital to implement a number of initiatives from policy development, to practice, to education. Initiatives such as the National Homelessness Strategy, SAAP, Rent Assistance, community-based housing schemes and outreach support services that have developed partnerships between agencies are all effective in addressing homelessness.

However, homelessness is the evidence of multi-dimensional problems – structural, economic, systemic and clinical. There is a need for a structured framework to address issues for homeless people with mental health problems, which emphasise prevention over treatment, holistic address over symptomatic treatment, surpassing demand rather over failing it, and the drawing together of all these strategies in a united and comprehensive stance.

From our identification of pathways above, we can present a holistic picture of the health environment, and target strategies accordingly. We can also see that the arena of health services – their access, availability, affordability and utilisation – is that which has remained the point of address of intervention studies and practice. We can observe that, almost entirely, efforts have been confined to this field.

While not diminishing the importance of these midstream programs, whose contribution is considerable, the focus of our attention must firstly be on the upstream or macro factors which determine the former issue (Wadsworth, 1999, p57).

Figure 1: Framework of socioeconomic health determinants (from Turrell and Mathers, 2000, p436)



5.1 Structural inequality

5.1.1 Goals and strategies

It is a mainstay of this paper that programs for the homeless mentally ill and the professional and research environment in which they operate exist without a solid framework to support them. The homeless mentally ill remain economically and socially marginalised and culturally disenfranchised. Thus, these preventative efforts operate within a vacuum, unendorsed by thorough and consistent governmental and public commitment.

Two predictions will eventuate should this status quo be perpetuated. First, such programs will continue to operate within a vacuum, limited by their own professional scope. Second, and most importantly, it follows that they can then only ever operate within the realm of secondary and tertiary intervention. A continuation of the current approach is therefore doomed to further failure.

The Ottawa Charter's inclusion of notions of "physical, mental and social well-being", and the ability to "realise aspirations, to satisfy needs and to change or cope with the environment" necessarily implies a multi-faceted approach to health and its determinants. Just as disadvantage cannot be encapsulated in a single measure, nor will a one dimensional approach act as more than a glancing blow to its progress.

Poverty acts in an ecological framework to create its health consequences, and it follows that approaches to prevention of health problems relating to poverty should be similarly ecological. We may take as our charter addressing the ultimate determinants of this health inequality. Ilona Kickbusch, in outlining five major principles guiding the development of the Ottawa Charter, states the second as: "Health promotion is directed towards action on the determinants or causes of health and the corresponding subject area: "Development of an environment conducive to health" (Kickbusch, 1986, p321).

To develop an environment conducive to health in this regard, we must look to massive and all encompassing programs of change.

Thus rather than focusing on the programs further downstream, for this task we have chosen to retrace our steps and outline how such a political, social and economic environment might come to be.

Using Hawe et al's process of program development (1990, p45), from identification of the principal risk factors, we may determine the types of strategic activities required (see Table 2).

Table 1: Addressing structural risk factors

Health problem	Health goal
Health differentials between poor and non-poor.	Reduce health differentials between poor and non-poor.
Risk factors	Objectives
Lack of affordable housing	Increase housing choices and access to housing.
Employment opportunities	Heighten employment opportunities for poor.
Education opportunities	Heighten educational opportunities for poor.
Family circumstances	Break cycle of poverty, from educational and employment opportunities, to income differential to outcome in issues such as nutrition, environmental health and parenting factors.
Contributing risk factors	Sub-objective
Commoditisation of labour, linked to global competitors (reinforcing)	Gain role in economic agenda.
Education system fails to address special needs of poor (enabling)	Address needs of poor within educational sphere.
Lack of income (predisposing)	Supplement area of highest differential.
Strategy objective	Strategy
Mobilise community sector and opinion leaders in electorate to develop and advocate more sophisticated economic models that clearly show the true cost of poverty	<p>Develop a coherent and defensible model which revises economic rationalist approach to economy by factoring in all those social, economic and health costs that are currently the externalised, or uncosted consequence, of dominant models.</p> <p>Demonstrate model is a more accurate measure of economic health, using current and alternative scenarios.</p> <p>Use the model to garner support, mobilise public opinion/voter behaviour in support of policies and programs to support goals.</p> <p>Mobilise political power. Address each stakeholder: unions, churches, welfare groups, small business, youth organisations.</p> <p>Identify and lobby champions.</p> <p>Hit panic button to get issues firmly on the agenda.</p> <p>Sow seeds of clear policy initiatives by working with political lobby groups and political parties.</p>

5.1.2 Current service models

The National Homelessness Strategy, a joint initiative of the Department of Family and Community Services and the Department of Health and Ageing, is currently developing models to best deliver partnership arrangements and multi-agency collaborations at a local level in an effort to address homelessness. While the government will continue to address homelessness at the crisis end, in responsive programs for homeless people, the Strategy has a strong emphasis on preventive, social strategies and actions (Commonwealth Department of Family and Community Services, 2000, p9).

The Strategy is aimed at reducing the pathways to homelessness, including:

- Interventions at youth;
- Prevention of domestic violence;
- Increased supported crisis accommodation through SAAP program (Australia's main response program to homelessness);
- Increase more appropriate housing options (community housing);
- Address family breakdown and isolation;
- Addressing mental health issues in areas of respite care, accommodation, effects of de-institutionalisation, decrease in boarding houses, appropriate accommodation options, increased substance abuse and illicit drug use;
- Changes to the structure and nature of the labour market which has dictated fewer jobs for low skilled people; and
- The connections between physical, psychological and sexual abuse, unemployment and mental disorders.

While the objectives of the strategy are to be applauded, it is critical that the avenues for action extend the causative and preventative, rather than solely curative attention to more endemic social symptoms.

5.2 Accessible and appropriate services

5.2.1 Goals and strategies

Issues of access and service provision may be limited in their effectiveness to address anything other than the consequences of poverty, but their role in a dedicated and integrated program that addresses all dimensions of the issue is a vital one.

Despite all efforts, there remains a fragmented and uncoordinated service system approach to homelessness in Australia. Complex funding processes mean that resources are spread over Commonwealth and State and Territory portfolios, non-government organisations and service providers, creating practical obstacles to agencies comprehensively addressing an individual's complex needs.

To assist individuals out of homelessness, services need to be more flexible and be able to provide long-term, tailored and intensive support, and on-going assistance when new problems arise. A "one size fits all" approach to service provision ignores the heterogeneity of people with mental health problems. A prime example is the ineffectual approach to care in dual diagnosis.

The initiatives found to be reaching homeless people with mental health problems include: intensive outreach programs to engage disenfranchised people; dual diagnosis treatment teams to assist people with co-occurring mental illness and substance use disorders and supported housing programs to assist people with a severe mental illness obtain and retain permanent housing that is suitable to the individual.

Again, we can make use of Hawe et al's process (1990, p46) in developing strategies that accurately target the problem.

Table 2: Accessible and appropriate services

Health problem	Health goal
Fragmented and inappropriate provision of health care services leads to inconsistency of care, poor monitoring ability and lack of emphasis on preventative care.	Provide a mechanism by which disadvantaged groups may more readily select primary care services and, through it, clear pathways to preventative services.
Risk factors	Objectives
Dual diagnosis presents problems of accurate clinical diagnosis and appropriate treatment.	Provide coordinated and appropriate health and other services and referral to support services.
Use of accident and emergency services as a form of primary care.	
Care sought is treatment-based, reacting to illness or injury, with little attention to long-term alternatives, such as primary, secondary or tertiary prevention.	
Longevity of illness creates new opportunities for destitution.	
Contributing risk factors	Sub-objective
Poor provision of dedicated services for low income and disadvantaged groups.	To facilitate the pathways to appropriate care and services.
Preventative care both less sought and provided as a coordinated health service.	To maintain a coordinated approach to long-term support and care
Information that is poor in either format or content given to homeless mentally ill may be an important contributor to low access of preventative care.	To overcome the barriers to accessing care.
Strategy objective	Strategy
Provide a central, integrated health care facility, providing consistent support, monitoring, respite, social opportunities and specialist referral for mentally ill.	<p>Prioritise via research program areas of health differential for address eg. immunisation, dental care, parenting programs, development screening services, psychology and psychiatric services, child protection referrals and legal advisory services.</p> <p>Identify jurisdictions in public, business and community sector for collective establishment of services.</p> <p>Identify demographic regions of most need, according to income and health differentials. Survey may be required if current information is insufficient and to serve as a benchmark for later evaluation.</p> <p>Develop central computer system, linking files from other services (eg. GPs, accident and emergency services etc), ensuring consistency of care and prompt attention to problematic patterns and events.</p>

	<p>Identify locale for placement of services eg. public spaces, hostels, refuges, adjacent to local council facility.</p> <p>In each community, work with community to identify principal areas for address, prevention strategies and programs for individuals and groups.</p> <p>Develop and source funding avenues: service is free to clients for all components.</p> <p>Investigate rewards for other preventative approaches.</p> <p>Ensure adequate staffing through funding. Waiting periods must be minimised and referred services must always be staffed. Crisis staff must always be on hand for emergency and crisis situations. Opening hours must be geared to hours of most demand.</p> <p>Source staff from each jurisdiction – drug and alcohol workers, psychiatrists, community nurses, social and welfare workers, police and specialists.</p> <p>Develop expert training program for client base.</p> <p>Develop communications program to encourage use of the service. Advantages include free service, ease of coordination on the part of individual, friendly environment, free childcare for parent-medico consultations. Executed through electronic media, as well as community networks.</p> <p>Develop and undertake client surveys to determine key areas for parenting and support programs.</p> <p>Develop mechanisms for informal support, including peer networks, and access to team members.</p> <p>Develop client referral and advocacy manual, helping individuals meet concrete needs such as food, housing and clothing, including referrals to programs embedded within bureaucracy.</p>
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The goals of such a program are clear: to deliver integrated health and community services for people that are easily accessed and relevant to their needs (Onyskiw et al,1999, p1070). Factors such as the community-based approach, absence of mandated authority (p1078), multidisciplinary approach, immediacy and responsiveness of services, and consistency of care are designed to be features of the program, developed in direct response to the contributing risk factors. The informal support systems provided by the service also play a valuable role in linking people with an informal social and support network, thus further serving a preventative function.

Similar strategies, though executed only at a community level, offer promising outcomes (Onyskiw et al,1999; Leventhal , 1996; Reppucci et al, 1999; Thompson, 1983). The City of Sydney's Homeless Strategy encompasses a raft of programs including homelessness services, communications programs, expert discussion, development of reporting and monitoring tools and community agency grants projects (City of Sydney, 1999). The Independent Community Living Association (ICLA) operates a Street Outreach program, of referral, counselling, material assistance and links with a brokerage system.

These strategies are easier to devise than massive structural change, and it is far easier to anticipate and measure the consequences. As stated though, their impact will be limited to specific effects rather than the causes of disadvantage.

5.2.2 Current service models

Outreach

Specialised outreach programs are often located within multi-service programs. Dickey (2000, p244) articulated the main characteristics of effective outreach programs: a non-threatening approach; flexibility in the type and delivery of services offered; repeated contact over extended periods of time; quick responses to basic needs such as food, accommodation and money; and patience while motivating “possible” clients to accept a variety of supports and treatment.

Levy (2000, p360) presents a “pre-treatment perspective” for outreach services to homeless rough sleepers who have a mental illness: “[pre-treatment] is an approach that enhances treatment readiness through supportive therapeutic intervention which facilitates problem recognition and increases client motivation for positive change”. (p361)

A further aspect of pre-treatment approaches concentrates on harm reduction (p361) and the need for a common language to be available between the outreach worker and the homeless person.

Levy’s model provides an integrated approach to be used by outreach workers, program managers and policy developers with five treatment principles:

1. Promote safety
2. Relationship formation
3. Develop common language
4. Promote and support change
5. Cultural and ecological effects (pp363–365).

Of paramount importance is evaluation to determine the effectiveness of programs, or lack thereof. A study of 13 federally funded homeless mental health programs reported that most of their outreach programs were ineffective due to their models. Under these models clients were provided with verbal referrals to treatments and support with little follow-up assistance. Under one project 2684 contacts with 683 homeless people (430 identified as mentally ill) were made, only 22 of these people received follow-up mental health treatment, five found accommodation and three received entitlements (Morse et al, 1996, p262).

Integrated treatment models

The theme of integration is scarcely new but its failed uptake reflects the structural and practical constraints to its implementation. Categorical funding models segregate services and treatment programs, and integration is limited to passing the baton to the next category of care. Specialised services have restrictions on the longevity of their care, so that the individual may be referred to a new stage of care, regardless of his or her own readiness. Ultimately, housing placement programs are finite and there are few avenues for referral to long-term community support.

Some promising programs exist that model service integration. Perhaps the best known of these is the Matthew Talbot Hostel that provides comprehensive, long-term, personalised care to homeless men through case management. Under this SAAP-designed initiative, a medical and nursing clinic within the hostel operates seven days a week and a psychiatrist and other specialist health practitioners provide in-situ services on a regular basis.

The Matthew Talbot Hostel’s Outreach program provides a range of medium to long term accommodation facilities. Assessment based options range from individual beds to supported housing throughout the city. Case-dedicated workers work in partnership with the client in developing a personal plan for treatment and management of their lives. Apart from clinical care of illness, components including literacy and other educational programs,

vocational training, living skills development, creative and recreational activities provide men with skills and confidence to reconnect with the community around them. A 65% success rate demonstrates the benefits of an integrated service.

A very recent offshoot of the program is Charles O'Neil House, providing supported housing to 40 men over a 12 month period. The program is broken up into three stages, with between 12 and 15 people entering each stage. The first three months has two strands: a focus on social and personal issues such as anger management and interpersonal skills, and a humanities curriculum, including philosophy and art history. This radical shift in conventional practice is based on work in the United States, and has proved to be extremely effective in helping people whose lives and thought processes have been chaotic to begin to think critically about themselves and the world around them. Practical training is balanced with visits from TAFE, continuing into the second stage in which participants go out to external courses and are assisted in job placement. The third stage is assistance and support for full-time employment and/or TAFE. Although only six months into its first cycle of participants, the program shows great promise in helping homeless people to engage in meaningful activity and participate in the community.

Models such as these mix the features of a home with those of a treatment facility. Some further enhancements may be the inclusion of three key features, as recommended by experts (Fischer et al, 1996 p396): first, a person is entitled to live there whether symptomatic or not, and whether in treatment or not; second, the person is entitled to live there episodically and indefinitely; and third, staff may provide treatment or referrals but their principal role is one of social support.

Dual diagnosis

Because of the prevalence of dually diagnosed people within the homeless population, services such as those just described often cater for people with both mental illness and substance abuse disorders. Indeed, there is increasing understanding that an effective model of treatment is to integrate both treatment programs into the one program providing a multi-disciplinary service team of both mental health and substance treatment professionals. This system is about integrating knowledge, skills, resources and experience resulting in better outcomes for consumers and leading to a reduction in people falling between the gap created by separating mental health services and drug and alcohol services.

Several successful programs now exist which rely on integrated treatment, long recovery timeframes, and a staged approach to treatment (Drake et al, 1996, p345). St Vincent de Paul has proposed a trial of a residential program for people with dual diagnosis, modelled on programs in the United States. These programs are focused not on the diagnosis but the individual and offer a transitional living setting for a period depending on the person's needs. A Mental Illness Substance Abuse program is designed for people with severe mental disorder and substance abuse problems. It offers stage-wise rehabilitation, management of illness, vocational and educational training and development of living skills over a recommended two year period. A Mental Disorder Substance Abuse program is designed for people with personality and anxious disorders and co-existing substance abuse problems. Again, the treatment is person-focused. Every resident completes an assessment and a personal recovery plan with staff, and these plans are monitored together routinely. Achievements and relapses are incorporated into the plan as they occur. Residential support skills are also provided, in money management, cooking, shopping, laundry, cleaning and socialising. The team supervises links to a full range of health services, and offers job training and access programs.

These programs are successful because they combine assertive, coordinated mental health and substance abuse treatment in the same setting, not in parallel nor sequential approaches, but as treatment for a disorder in its own right. The long-term emphasis is essential. Addictions may develop over many years and similarly require many years to overcome. A key precursor is the development of dual diagnosis experts in primary health care settings and community services.

Transition support

A variety of housing and accommodation options is essential to enable individuals to preference the type of housing or accommodation that suits their needs. Though independent housing is often voiced as a high priority,

attention needs to be drawn to choice and availability. Share accommodation, community housing and independent living, each with strong and integrated support mechanisms, should be nominated according to the coping ability and specific needs of the individual.

Boarding houses have proven to be a common choice for many people with mental disorder and other disabilities as either long-term accommodation options or as temporary exit points from psychiatric facilities. In Australia, a boarding house premise must be licensed if two or more people with a disability requiring "supervision and habitual support" reside on the premises (Youth & Community Services Act 1973).

There has been substantial criticism of this style of accommodation on a number of grounds. First, some suggest the boarding house serves only the function of housing, and ignores the many other supports necessary for full integration of people living with a mental illness back into the community. Rather than acting as a temporary halfway house, the boarding house style is little able to foster or encourage people to reach independence but rather settle in for the long-term. However, this ignores the fact that for some, boarding houses provide a balance of independent living, with the opportunity for supervised care of varying degrees. For many people with a mental disorder, independent living is and will remain unfeasible.

Other criticism stems from the difficulty in regulating quality of care, accommodation and tenancy in the boarding house sector. Where licensing laws are enforced, their requirements can cause massive shifts in the availability of accommodation.

The Central Sydney Area Health Service's Boarding House project grew from a recognition that boarding houses could work as an appropriate model of supported accommodation for people with mental illness and other disabilities, provided that sufficient monitoring and assistance was provided to boarding house residents and operators. The Boarding House project works to improve the health of residents, facilitate access to health and other community services, monitor the standard of accommodation and care in boarding houses, and provide support to boarding house operators. Staff provide primary and psychiatric care but with an emphasis on community development and collaborative care. Projects are continually evaluated and adapted to meet the needs voiced by residents and operators in a changing industry.

One such change was the massive reduction in the number of boarding houses in the late 1990s. Operators unable to meet the rising standards were closing their businesses, leaving more than 600 people homeless. For most of these displaced people, Boarding House project staff found new homes that matched their level of need, in other boarding houses, aged care facilities and supported accommodation and public housing.

This achievement and others of the Boarding House project demonstrate the essential role that cross-agency and cross-sectoral partnerships play in creating effective programs and services. Not only is the service multi-faceted in the types of programs it delivers, but its approach to *working with* rather than *working for* people with such special needs. Where autocratic licensing and regulation failed, collaboration and support between the service, the industry and its residents was able to achieve far more positive results.

Tenancy maintenance

One of the most significant gaps facing mental health service provision throughout NSW is the lack of adequate early intervention and preventative supports for a particular section of the mental health population living in the community. These are people who are not unwell enough to seek hospitalisation or high-needs supported accommodation but, provided they receive a small amount of in-home care, are capable of maintaining a high level of independence in their own homes. Similar to aged care packages, regular in-home services can deliver the basics in living skills needs, such as budgeting, home maintenance, or just regular company. These programs aim at prevention and early intervention to keep someone living with a mental illness from relapsing into a period of unwellness. Not only is this beneficial to the person's quality of life, but it frees up services and hospital beds.

The Community Support Scheme (CSS), originating in South Australia, was one of the first projects of its kind in Australia to offer in-home support to people with mental health problems through the brokerage of support services (Millington, 1991). CSS utilises the consumer's existing support networks and incorporates them into the in-home support package where possible. For example, free services such as those provided by extended family,

friends, neighbours and other community members can be retained by the consumer and financially reimbursed with CSI funds whereby the individual/s providing the service become "employees" of CSS by becoming Community Support Workers. That is, rather than replace an already existing and functional care system with new services, existing supports may be reimbursed by being brokered out as part of the in-house support given. This system can be of great benefit to someone living with a mental illness: strong and familiar relationships are a crucial factor in keeping someone living with a mental illness connected to the community. Discontinuity and unfamiliarity often are core reasons as to why a person living with a mental illness stops seeking support.

For those people who do experience an acute episode, hospitalisation is very often necessary. But just as familial, social, residential, financial and communal networks are effective preventative measures, their disruption during periods of hospitalisation and the stress of rebuilding them can hinder or prevent recovery. In ideal cases, a person re-entering the community would have retained their accommodation and well-structured support plans would be in place to see that their networks were rebuilt. Crisis outreach and emergency residential services would enable people to remain in their familiar surroundings, retain their networks and help in reducing anxiety or stress caused by the disruption of hospitalisation.

Family support also forms an important part of preventative activity. Misunderstanding, fear, frustration, exhaustion and feelings of helplessness are typical for families caring for people with mental illness. Respite care for carers of people with mental illness could divert situations of violence or crisis accommodation, which open the door to homelessness. The information and advocacy from family members is often vital for improved health outcomes. Individuals and their family members/carers need to be supported by a system of care, treatment and support that intervenes before the family relationships break down completely.

The Commonwealth Government funds the following programs:

- Reconnect program (\$60 million) providing a range of community-based early intervention services aimed at family reconciliation for young people and families who are at risk; (FaCS, 2000)
- Family Relationships Services Program (\$37 million) providing counselling and mediation support for families through eighty-three community organisations; and
- Partnerships Against Domestic Violence Strategy (\$15 million per annum) for projects aimed at preventing domestic violence, a key reason causing homelessness among women and children.

However, it is recognised that more outreach and respite support services need to be available to assist families whose lives are affected by a mental illness.

5.3 Evaluation

Global strategies for change, as in the strategies to affect underlying issues outlined above, present their own problems. The outcomes we have identified have travelled via a long and winding biological, personal, social and environmental road from the causal starting points we have proposed. It presents a double jeopardy: while modification of the personal, social and environmental characteristics that influence behaviour are the basis of health promotion itself, "the more remote from this starting point, the more difficult is the task of causal inference" (Nutbeam, 1989, p86). "Fragile and controversial" is the verdict for studies that have attempted to draw such conclusions (p86).

Further, the long time lag between the implementation of even the most direct strategies – free lunches and food vouchers for example – make evaluation difficult and unattractive prospects in the eyes of three year terms of governments and bureaucrats. More primary level programs may take a generation or more before the effects are realised. In the meantime, a host of other variables – changes in policies, government, national and global economies – may have all acted to affect change in one way or another.

Indeed, "...the causal chain in a community system is longer and harder to trace than in a clinical research study on volunteers" (Nutbeam, 1989, p85).

This difficulty presents the too hard basket to public health researchers and epidemiologists, as is evident from Green and Kreuter's comment in their guide to health promotion planning:

"Only the most ambitious, long-term, complex health promotion programs can be expected to produce significant impact on lifestyle and such programs are impractical for everyday health promotion planning." (1991, p4)

But such fatalism has no role to play in this agenda. For this reason, we must look to balance our own perspective on the various determinants of health and our approaches to them. Obviously measurement serves to validate our work but difficulty in its application should not prevent us from implementing the work itself.

Nutbeam (1997) urges health promotion and education practitioners to proceed with caution and pragmatism. It is, the authors write, unrealistic to expect a program to unequivocally demonstrate a causal path to subsequent long-term change (p355). Instead, interventions must be used and assessed for their ability to modify risk factors and the social environment in which they operate. "Achieving change at this level is the basic task of health promotion" (Nutbeam, 1989, p88).

6 Conclusion

Attention must, first and foremost, be paid to mobilising the support, interactivity and strategic dedication of all sectors of the community, from which point programs may be put into place.

While these goals, as part of creating supportive environments for health have been "a major focus of public health action for the past 150 years" (Nutbeam, 1997, p355), commentators note that little effort and few funds are actually dedicated to this end. In 2002 that is where we still stand (1986, p321).

It is helpful to return again to the definition of health proposed by the Ottawa Charter more than 15 years ago:

"Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions for the attainment of health by all its members." (WHO, 1986)

This is the social responsibility to which we must respond if we are to truly address health inequality in this context.

7 Recommendations

- **Mobilise community sector and opinion leaders in electorate to develop and advocate more sophisticated economic models that clearly show the true cost of policies of disadvantage.**
 - Develop a coherent and defensible model which revises economic rationalist approach to economy by factoring in all those social, economic and health costs that are currently the externalised, or uncosted consequence, of dominant models.
 - Demonstrate model is a more accurate measure of economic health, using current and alternative scenarios.
 - Use the model to garner support, mobilise public opinion/voter behaviour in support of policies and programs to support goals.
 - Mobilise political power. Address each stakeholder: unions, churches, welfare groups, small business, youth organisations.
 - Inoculate strategy to prevent attack by those who it threatens – large business who stand to lose from redefinition; individuals who stand to lose from reorganisation.
 - Identify and lobby champions.
 - Hit panic button to get issues firmly on the agenda.
 - Sow seeds of clear policy initiatives by working with political lobby groups and political parties.
- **Provide a dedicated, central, integrated health care service for people at risk, providing consistent and long-term support throughout the lifecycle**
 - Formation of a cross-sectoral planning and advisory group that works in partnership to develop ways of addressing the complex needs of people with mental illness within a holistic framework.
 - Identify specific departmental responsibilities for prevention and management of homelessness.
 - Prioritise via research program areas of health differential for address eg parenting programs, development screening services, psychology and psychiatric services, housing referrals and legal advisory services.
 - Development of a specific dual diagnosis program that can be adapted by individual states depending on community needs, including experts in dual disorders.
 - Identify demographic regions of most need, according to income and health differentials. Survey may be required if current information is insufficient and to serve as a benchmark for later evaluation.
 - Develop central computer system, linking files from other services (eg. GPs, accident and emergency services etc), ensuring consistency of care and prompt attention to problematic patterns and events.
 - In each community, work with community to identify principal areas for address, prevention strategies and programs for individuals and groups.
 - Develop and source funding avenues.
 - Ensure adequate staffing through funding. Waiting periods must be minimised and referred services must always be staffed. Crisis staff must always be on hand for emergency and crisis situations. Opening hours must be geared to hours of most demand.
 - Source staff from each jurisdiction – drug and alcohol workers, psychiatrists, community nurses, social and welfare workers, police and specialists.

- Increase available funding for extensive staff training and education regarding mental health issues and homelessness and the importance of partnerships between services in the same community.
 - Develop communications program to encourage use of the service.
 - Develop and undertake client surveys to determine areas most required for parenting and support programs.
 - Develop mechanisms for informal support, including peer networks, and access to team members.
 - Develop client referral and advocacy manual, helping individuals meet concrete needs such as food, housing and clothing, including referrals to complementary programs.
 - Increased funding for a wider range of supported accommodation, respite and outreach case-management programs that incorporate *Continuous Relationship Models* and *Pre-treatment models* and/or *Mental Health Care Packages* into their services, to better target homeless people with mental disorders.
- **Evaluation**
 - A need for longitudinal research to track the pathways through and out of homelessness, over longer periods of time. This could also monitor the impact of policy initiatives over time. Comprehensive surveys to identify;
 - What groups are remaining homeless over the long-term;
 - To what extent do people move in and out of homelessness?
 - What factors are associated with moving in and out of homelessness?

These unanswered questions have important implications for policy development. It will help identify those individuals/groups who are most at risk of sustaining poverty or social exclusion and long-term or cyclic homelessness.

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