



Council to Homeless Persons – Productivity Commission Issues Paper – The Social and Economic
Benefits of Improving Mental Health – April 2019



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Introduction

The Council to Homeless Persons

The Council to Homeless Persons (CHP) is the peak Victorian body representing organisations and individuals with a commitment to ending homelessness. CHP works to end homelessness through leadership in policy development, advocacy, capacity building and consumer participation.

The Council to Homeless Persons (CHP) welcomes the opportunity to provide feedback on the Productivity Commission's Issues Paper; The Social and Economic Benefits of Improving Mental Health. In this response we show that housing, homelessness, and mental health are intrinsically linked. For a mental health service system to work effectively, the housing needs of its consumers must be considered, as must the interaction of mental health and homelessness support services.

What we mean by 'ending homelessness'

Homelessness occurs at the intersection of personal vulnerabilities, and structural forces such as poverty, housing affordability and security of tenure. People who become homeless are often financially disadvantaged and some will have spent a lifetime in insecure housing.

Ending homelessness doesn't mean that people will never find themselves without shelter. It means that homelessness will be rare, the experience brief, and it will not recur in a cycle of repeated homelessness.

To achieve this vision requires action to reduce poverty, increase access to employment and critically, to improve the supply of housing that is affordable to people on low incomes, and the security of people's tenure within that housing. Simultaneously, Australia requires the services to help people manage the vulnerabilities that can lead to homelessness. Pathways into homelessness include eviction, job loss, family violence, physical or mental ill health, relationship breakdown, or indeed a combination of these factors. There is neither a single cause, nor a single solution. Some people may need relatively little assistance for a short period of time, while others may need support over a lifetime.

Reading this submission

In this response, CHP has sought to respond to questions asked by the Productivity Commission that had most relevance for housing and homelessness. We have sought to respond to these matters thematically, as well as specifically to questions posed in the Productivity Commission on which we have expertise.

In developing this response, CHP consulted with people with a lived experience of co-occurring homelessness and mental health treatment. Many of these consumers have also received mental health treatment while securely housed, and so are well placed to provide information on the differences between these two experiences. Information

from this consultation has helped to set the direction of our response, and excerpts are provided as evidence throughout this submission.

Housing, homelessness and mental health

'My life was a mess until I got housing. Just moving from room to room to room. Dealing with people with their own mental health issues, and drug and alcohol addiction and stuff like that is really, really hard. Getting housing helped me keep appointments, workers have helped me keep appointments. Sometimes that drops off, and a good worker keeps you on track and connected to your appointments and your networks and stuff like that.'

- Nigel Pernu, Consumer / Advocate

The interconnection between access to housing and mental wellbeing has been extensively evidenced;^{1 2} we know that housing supports mental health treatment, while homelessness leads to mental ill-health. The failure to properly respond to homelessness is exacerbating the demand pressures faced by Australia's mental health system, leads to worse outcomes for consumers, and decreasing the efficiency of the resources used for mental healthcare.

Research has emphasised the importance of secure housing to improve the mental health of people who have a diagnosed mental health issue. One example of this is the study of the mental health outcomes of residents at Elizabeth Street Common Ground (which operates the highly successful Housing First model). This evaluation reported that residents with psychosis required fewer days each year admitted to mental health units compared to the period before they were housed.³ Later in this submission we discuss similar findings from a transitional housing program for people discharged from psychiatric hospitals.

Remarkably, these improved outcomes for housed consumers were achieved without an increase in residents' use of community mental health care services. Improved outcomes instead reflected greater stability, improved consumer/clinician relationships, and resultant greater adherence to treatment plans.⁴

¹ Johnson, G., and Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 46, Issue 1, p.36.

² Brackertz, N., Wilkinson, A., and Davison, J., 2018, Housing, homelessness and mental health: towards systems change, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne

³ Holmes, A., Carlisle, T., Vale, Z., Hatvani, G., Heagney, C., & Jones, S., 2017, *Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness*, in Australian Psychiatry, Volume 25 Issue 1, pp. 56-59.

⁴ Ibid

The experience of Melbourne's Elizabeth Street Common Ground is mirrored by Brisbane Common Ground⁵ where significant savings were found not just in reduced mental health admissions, but across a range of domains.

'Having a home means you can actually start building up a good relationship with your GP and all of the services in your area, so that you finally get a good overall history going, and build a relationship with your professional.'

- Christine Thirkell, Consumer / Advocate

In 2017-18, at least 30 per cent of those aged ten and over who sought help from a specialist homelessness service in Australia had a diagnosed mental health issue.⁶ This incidence is far higher than the 18.2 per cent of Australians who have a mental health condition.⁷

Research has also demonstrated that housing insecurity both causes and prolongs mental ill health, with a major Victorian study finding that just 15 per cent of people accessing specialist homelessness services had mental health issues *prior* to experiencing homelessness, while another 16 per cent only developed mental ill-health *after* their experience of homelessness commenced.⁸

Lack of suitable housing options is also directly exacerbating demand pressure on acute mental health services. Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.⁹ The number of Australians who have been discharged from psychiatric hospitals into homelessness has grown by 49 per cent over the past five years.¹⁰ Overall, the number of people referred to homelessness services from mental health services has grown by 46 per cent over the past five years.¹¹

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

- John Kenney, Consumer / Advocate

⁵ Parsell C., Petersen, M., Moutou, O., Lucio, E., and Dick, A., 2016, *Brisbane Common Ground Evaluation*, University of Queensland.

⁶ Australian Institute of Health and Welfare, 2018, *Specialist Homelessness Services Collection 2016-17*

⁷ Australian Bureau of Statistics, 2015, *4159.0 – General Social Survey: Summary Results, Australia, 2014, Table 03. State and Territory*

⁸ Johnson, G., and Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 46, Issue 1, p.36.

⁹ Discussion in meetings between clinical mental health and homelessness services, 2018

¹⁰ Australian Institute of Health and Welfare, 2018, *Specialist Homelessness Services Collection*

¹¹ Australian Institute of Health and Welfare, 2018 and 2013, *Specialist Homelessness Services Collection*

The NSW Ombudsman found that a lack of appropriate accommodation options was a key factor preventing the discharge of mental health patients when ready. This led to both reduced availability of inpatient services for those who needed them, and to mental health staff referring inpatients to inappropriate housing options to promote earlier exits.¹²

Preventing and responding to homelessness and accommodation instability

'Housing means that people wouldn't be in and out of hospital'

- Helen Matthews, Consumer / Advocate

Prior to the 1980's people being treated for mental illhealth were effectively 'housed' in large congregate public mental healthcare facilities, now commonly referred to as 'institutions'. Housing was, in effect, provided as part of mental health treatment. These institutions have been characterised as "an unhealthy mixture of substandard care and human rights abuses".¹³ Changing psychiatric practice and improved psychoactive medications enabled the closure of these facilities from the 1980's and into the 2000's ('deinstitutionalisation').

In theory, mental health treatment now operates under principles seeking to strengthen rather than restrict a patient's full participation in the community. While the impact of deinstitutionalisation has been positive for those with access to both housing and support in the community, the reality is that the provision of in-community and supported residential mental healthcare has never achieved the scale required by Victorians living with mental ill-health. Further to this, governments have failed to fully recognise and fund the housing options needed to complement in-community mental health care.¹⁴

The consequence of this lack of funding is that many Australians have not benefitted from deinstitutionalisation, and instead fall through the cracks of a system that provides no guarantee that their needs will be met while living in-community, and no appropriate and affordable housing.

'At the moment in the mental health system, there are two treatments; one for the poor, and one for the wealthy'

- David Montgomery, Consumer / Advocate

¹² NSW Ombudsman, 2012, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability*, p.55

¹³ Mental Health Council of Australia, 2009, *Home Truths; Mental Health, Housing and Homelessness in Australia*, p.22

¹⁴ Green, D., 2003, *The End of Institutions: Housing and Homelessness*, in Parity Magazine April 2003, p.5

The Productivity Commission's issues paper asks "what approaches can governments at all levels and non-government organisations adopt to improve support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?". The first priority is to ensure that there are housing options that people can afford. This would require significant investment in public and community housing.

For the small number of people with complex needs this may mean supported housing with onsite support. Many others will require the improved security of tenure that we typically associate with public housing, in order to allow them to recover from an episode of mental ill-health and remedy any tenancy issues associated with such an episode. For yet others, those whose mild or risk mental ill-health would likely be meaningfully diminished by an experience of homelessness safe and *appropriate* affordable housing options, particularly for those on low incomes would likely be an effective population health measure.

'When I was living in supported accommodation, it really helped me. Even though it was only for a year. Just the kindness of the people there really worked for me. They understood that I was probably quite traumatised.'

- Nigel Pernu, Consumer / Advocate

Approximately half of all Australians experiencing mental ill-health have mild needs. Many in this cohort will not require the public, community, or supported housing that we have discussed above, yet may on occasion require support to resolve a crisis and maintain their tenancy. There is significant research to show that strong security of tenure provides greater ontological security, and as such, is better for a person's mental health.¹⁵ The Productivity Commission should consider ways to improve the security of tenure of Australians experiencing mental ill-health – particularly in the low-security private rental market.

Some in this cohort will have intermittent support needs. In order to reduce the number of people whose mental ill-health leads to homelessness, there should be an expansion of programs that offer time limited support for a person's mental ill-health or associated crisis, with access to brokerage funds that can support tenancy sustainment. Programs like Victoria's *Private Rental Access Program* and *Tenancy Plus* have proven both cost-effective and effective at achieving tenancy sustainment interventions.¹⁶

Recommendation: Governments to measure housing and housing support needs of people living with mental ill-health and develop plan to deliver it.

¹⁵ Rebecca J. Bentley, David Pevalin, Emma Baker, Kate Mason, Aaron Reeves & Andrew Beer (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, *Housing Studies*,

¹⁶ Council to Homeless Persons, 2019, *Council to Homeless Persons pre-budget submission 2019-2020*, p.5. Available at: chp.org.au/wp-content/uploads/2019/03/CHP-Pre-Budget-Submission-2019.pdf

Recommendation: Expand tenancy saving programs

Integrating services for housing, homelessness and mental health

‘With mental health and homelessness you need staff with specialist skills to deal with that. It’s not a disconnected mental health response and homelessness response.’

- Jason Russell, Consumer / Advocate

A lack of resourcing means that both the homelessness and mental health systems often use waiting lists for consumers who seek to engage their services. In resource constrained environments many services, particularly homelessness services, are required to implement case-periods, which typically end after 6-12 weeks. The combination of short case periods and long waiting lists means that for many consumers services are not integrated at all, but are consecutive, often with gaps where no support is available.

There is increasing recognition that many people, particularly those experiencing homelessness alongside complex mental ill-health, will require multidisciplinary supports,¹⁷ with flexible case period lengths as needed.

Rather than continuing to operate in ‘siloes’ and relying on referrals to other services and programs, a greater focus is required on integrated programs – programs which include professionals from a range of disciplines as part of a service delivery team. Studies have found that there is particular benefit to embedding primary and mental health, and drug and alcohol professionals within homelessness programs – an approach designed to stabilise housing and wellbeing first. Such stability then supports greater interaction with other services systems such as legal support or education and employment.¹⁸

Successful evidence-based overseas practices

‘There’s a study that shows that for every time you house a person you save money on mental health and prison. I think that’s an important point to make. If you want to address mental health and drugs in system, and improve outcomes for people living with a mental health system, then housing first is the best’

- Christine Thirkell, Consumer / Advocate

¹⁷ Phillips, R. and Parsell, C., 2012, The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No. 179, Australian Housing and Urban Research Institute Limited, Melbourne, p.1

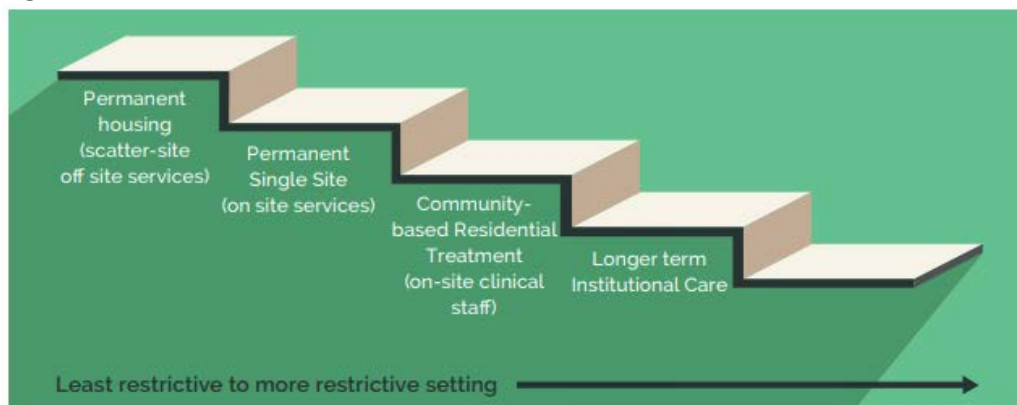
¹⁸ Phillips, R. and Parsell, C., 2012, The role of assertive outreach in ending 'rough sleeping', AHURI Final Report No. 179, Australian Housing and Urban Research Institute Limited, Melbourne, p.69

There has been considerable research and evaluation undertaken to demonstrate the effectiveness of Housing First as a response to people experiencing homelessness and who also have complex needs, including mental ill-health.

Housing First is not intended as a response to all forms of homelessness or all forms of mental ill-health. Housing First is a model of housing and support for people with severe mental ill-health who are experiencing or at risk of long-term homelessness. Housing First can successfully sustain housing for 80 per cent of this cohort,¹⁹ while recognising that there are those for whom residential clinical care is required on a short or long term basis.

In Figure 1 (below) the least restrictive option ‘Permanent housing (scatter-site off site services)’ is a Housing First approach that meets the needs of most people experiencing co-occurring homelessness and severe mental illness. ‘Permanent Single Site (on site services)’ would also represent a Housing First approach, akin to the Common Ground model discussed above. The remaining two settings are in-patient care. Common to all mental health service settings highlighted in Figure 1 is that they recognise housing as a precondition for mental healthcare, and indeed, a necessary component of that healthcare.

Figure 1.²⁰



While Housing First is often considered a “gold standard” approach to addressing a person’s co-occurring homelessness and mental ill-health needs, Tsemberis makes clear that it is not an approach that can successfully meet the needs of those who require clinical or institutional care. What all four stages approaches in Figure 1 do demonstrate is the need to consider housing as an important mental health support.

Pleace argues that while it is to be expected that programs should be contextually different when implemented in different jurisdictions, some incarnations of Housing

¹⁹ Pleace, N., 2016, *Housing First Guide Europe*, FEANTSA the European Federation of National Organisations working with the homeless, p.12

²⁰ Tsemberis, S., 2013, Presentation at the Final Conference of Housing First Europe in Amsterdam, as cited in Pleace, N., 2016, *Housing First Guide Europe*, FEANTSA the European Federation of National Organisations working with the homeless, p.76

First have failed due to low fidelity to the model's core principles.²¹ Similarly, Johnson has argued that Australian Housing First programs should not aim for total fidelity with the *Pathways to Housing* program from which Housing First derives, but that "having the capacity to access and manage permanent housing... are fundamental to the Pathways to Housing program achieving significant housing retention success".²²

Recommendation: The Productivity Commission should consider housing as a necessary component for mental health treatment for those experiencing or at risk of homelessness.

Recommendation: Housing First approaches must have meaningful access to housing.

Child safety, mental health, and housing

The causes and conditions of youth homelessness are often different from those of adults. Young people also experience mental ill-health differently from adults. We shouldn't assume that programs or models that are proven to be effective in supporting adults experiencing homelessness and/or mental ill-health are effective in supporting young people. Of particular concern is that Housing First supports a consumer's independence, whereas young people may not be fully independent and often require adult support and guidance.

'A Housing First approach for youth must not merely replicate an established approach that works for adults and simply create Housing First 'Junior' by changing the age mandate. If Housing First is to work for youth, it must be built upon our understanding of the developmental, social and legal needs of young persons'

- Gaetz, S., 2014²³

Gaetz provides a detailed consideration of the application of the Housing First model to young people in his literature review²⁴. CHP notes that many young people are more comfortable and achieve better outcomes in congregate care^{25 26}. Housing First then *can* work for young people experiencing homelessness and mental ill-health, but in a context where the support delivered is commensurate with their needs, which are likely to be both greater and different from that of the adult population.

²¹ Pleace, N., and Bretherton, J., 2013, *The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness*, European Journal of Homelessness, Volume 7. No. 2, December 2013

²² Johnson, G. et al., 2012, *Policy shift or program drift? Implementing Housing First in Australia*, AHURI Final Report No.184. Melbourne: Australian Housing and Urban Research Institute, p.14

²³ Gaetz, S., 2014, *Can Housing First Work for Youth*, European Journal of Homelessness, Volume 8. No. 2, December 2014, p.164

²⁴ Gaetz, S., 2014, *Can Housing First Work for Youth*, European Journal of Homelessness, Volume 8. No. 2, December 2014

²⁵ Ibid, p.167

²⁶ Gaetz, S, 2017, *THIS is Housing First for Youth: A Program Model Guide*. Toronto: Canadian Observatory on Homelessness Press, p.7

Baldry notes that in particular, those young people whose needs are among the highest in the country have no appropriate support service²⁷. The lifetime institutional cost of agency contacts with these individuals runs to millions of dollars per person. These young people are identifiable before they become entrenched users of institutions and services. This work shows that even supports which are more intensive than anything that is currently available for young people with multiple mental health, justice, and child protection interactions might be considered preventative when considered against a lifetime of high-cost service use.

Recommendation: Housing First approaches must recognise the different needs that young people have compared to adults. Each Housing First program for young people must be specifically tailored to ensure that it is delivering support commensurate to and appropriate for the needs of the young cohort it supports.

Homelessness, mental health, and justice interactions

'It's laughable that people think you get the same response if you're homeless... If you're not a threat, but you're behaving like a chicken on the street corner, I'll guarantee you that you're in the back of the wagon for the first 5-8 hours... Police processes need to be looked at.'

- Jason Russell, Consumer / Advocate

Many people who experience mental ill-health and have not had access to the full suite of services that they require to live safely and well in the community experience worsening mental health. Consequently, people experiencing mental ill-health are now cycling through acute mental health care and exiting into homelessness, only to return repeatedly to hospital based care, and/or are being accommodated in prisons.

The latest survey of prisoner health revealed that 49 per cent of Australian prison entrants report being diagnosed with a mental health disorder prior to imprisonment.²⁸ Those experiencing comorbid homelessness and mental ill-health are 40 times more likely to be arrested, and 20 times more likely to be imprisoned than those in stable accommodation.²⁹ In the absence of appropriate housing, prisons have effectively replaced the institutions that Australia so fulsomely rejected in the past.

²⁷ Baldry, E., Dowse, L., McCausland, R., and Clarence, M., 2012, Lifetime institutional costs of homelessness for vulnerable groups, School of Social Sciences University of New South Wales, Sydney, for Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

²⁸ Australian Institute of Health and Welfare, 2015, *The health of Australia's prisoners 2015, Data tables: Mental health s30-s55*

²⁹ NSW Department of Corrective Services, 2004, *Submission to Experiences of Injustice and Despair in Mental Health Care in Australia consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association*

This outcome is not inevitable, and while supporting people's housing as part of a comprehensive mental health system would greatly improve people's mental health and decrease incarceration, we should also look at how the justice system can respond.

Whether a person is experiencing street-based homelessness, or they are in accommodation that makes them feel unsafe, people experiencing homelessness spend a lot more time in public spaces than do those who are suitably housed. As such, people experiencing homelessness are highly visible to law enforcement officers, and have a disproportionate amount of contact with police and law enforcement.³⁰

Homelessness can lead to deteriorating mental health, as well as increased substance use; all three of which can lead to greater police interaction. Increased police interaction, particularly among those with histories of trauma, those experiencing mental ill-health, or those with past negative police interactions often results in more charges, more fines, and more penalties.³¹ This can lead to imprisonment.³²

'If I was at my own house and I flip out, I'd get a different response than if I was standing on the corner, homeless. It's laughable that people think you get the same response if you're homeless – not even fucking close.'

- Jason Russell, Consumer / Advocate

While there is some scope for improved practice among law enforcement officers (see Justice Connect Homeless Law 2013),³³ it is also important to recognise that law enforcement officers are being relied upon to respond in situations where specialist mental health supports are required.

Currently, if a person experiencing mental ill-health or a cognitive impairment is experiencing homelessness and is arrested, it is common for them to be placed in prison or police custody as a method of safe management and containment.³⁴ This is extremely disruptive to their life, and makes tenancy sustainment and treatment adherence extremely difficult. A law enforcement response to an episode of mental ill-

with the Human Rights and Equal Opportunity Commission, cited in Mental Health Council of Australia, 2014, Not for Service, p.220

³⁰ Povey, C., Adams, L., and Roberts, S., 2013, *Homelessness and Policing; Submission to the Consultation on the Victoria Police Field Contact Policy and Cross Cultural Training*, p.3. Available at: <https://justiceconnect.org.au/wp-content/uploads/2018/08/Homelessness-and-Policing-August-2013.pdf>

³¹ Ibid, p.10

³² Ibid, p.14

³³ Adams, L., 2014, *In the public eye; Addressing the negative impact os laws regulating public space on people experiencing homelessness*, p.3. Available at: <https://justiceconnect.org.au/wp-content/uploads/2018/08/Homelessness-and-Policing-August-2013.pdf>

³⁴ Baldry, E., 2014, *Complex needs and the justice system*, in *Homelessness in Australia*, Council to Homeless Persons, Sydney, p.201

health is a misplaced intervention for a person requiring healthcare. It can also be a traumatic experience for a person who is unwell.

'CAT (Crisis Assessment and Treatment) Teams need to be expanded. Now they don't turn up, and when they turn up they come with too many coppers. I understand that they need two, but they don't need ten. You feel threatened and it makes you more aggressive... You only need four to hold a person down, not ten.'

- John Kenney, Consumer / Advocate

Appropriate health-focused emergency responses must be made available at a sufficient scale to prevent the continued churn of people between acute mental healthcare settings, correctional facilities and homelessness. As we discuss in the next section, there also needs to be appropriate housing and support once a person leaves emergency care.

'Early and well-timed community and human service interventions to establish and maintain secure supported housing are likely to reduce if not eliminate years of high levels of police contacts, court appearances, associated legal processes, frequent custody and community corrections interventions and ambulance use.'

- Baldry, E., 2012³⁵

Recommendation: Improved police practices when interacting with people experiencing homelessness and/or mental ill-health.

Recommendation: Expand CAT Teams and other mental health-focused emergency response programs for people experiencing mental ill-health.

Prison and hospital exits, homelessness, and mental health

'I don't think people should be exited from either hospital or prison without a good tenure on a house. Not a rooming house. It's not a good enough.'

- Christine Thirkell, Consumer / Advocate

People exiting acute health or mental health in-patient services or correctional facilities experience high rates of homelessness. With low incomes, limited or negative rental histories, and often health issues or disabilities that present additional challenges, securing housing can be difficult.

Exiting acute care or correctional facilities into homelessness is self-defeating. Prisoners who exit prison into homelessness are more likely to reoffend than those

³⁵ Baldry, E., Dowse, L., McCausland, R., and Clarence, M., 2012, Lifetime institutional costs of homelessness for vulnerable groups, School of Social Sciences University of New South Wales, Sydney, for Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, p.107

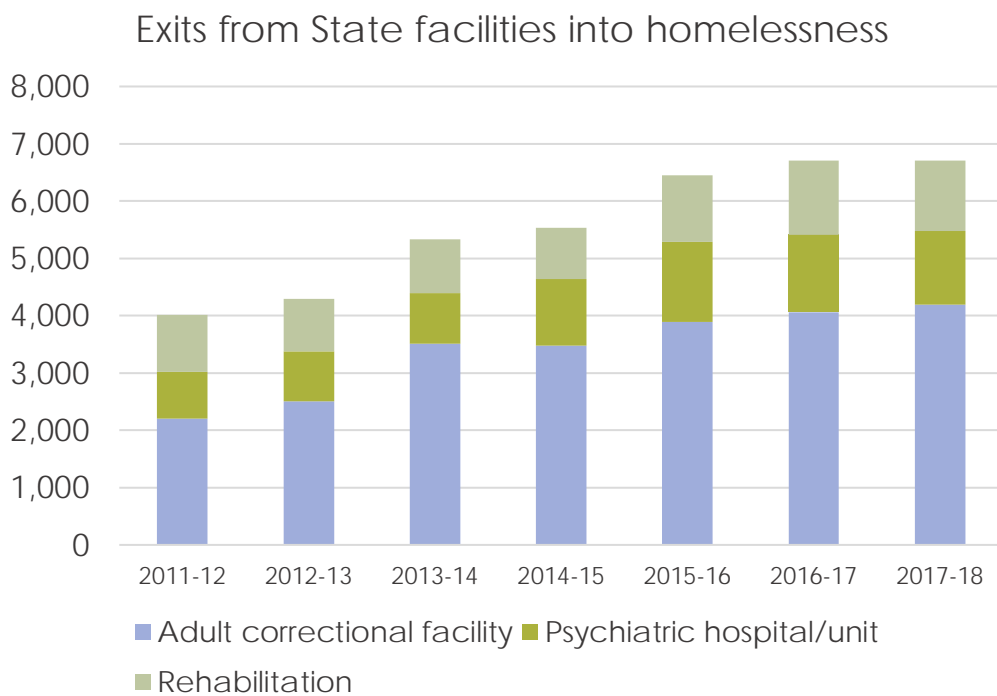
who don't³⁶. Homelessness is not only destructive to a person's mental health, but a lack of suitable accommodation undermines the provision of subacute and outpatient support required by hospital-leavers.

The number of Australians who have exited mental health, correctional, or rehabilitation facilities into homelessness has grown by 67 per cent since 2011-12. Thousands of Australians are being put at risk due to the lack of housing attached to follow up supports for those leaving state services.

'They need to have housing! It's no good putting them on the street where they're going to be problems for society. It's not society's fault. Instead of putting them on the street and saying you're on your own, they need to be put into a housing situation and get the support they need for the transition back into society.'

- John Kenney, Consumer / Advocate

Figure 2³⁷



The period of transition from a state facility (health or justice) into the community is marked by instability and stress. In particular, a lack of housing and poorly coordinated supports mean that many people exiting such facilities do not have their needs

³⁶ Willis, M., 2018, *Supported Housing for Prisoners Returning to the Community: a review of the literature*, Australian Institute of Criminology for State of Victoria, Corrections Victoria, p.11

³⁷ Australian Institute of Health and Welfare, 2018, *Specialist Homelessness Services Collection*

adequately met during this time.³⁸ One study that compared the outcomes of mental health hospital discharges who received transitional housing support against a control group who did not found that the program averted over 22 psychiatric in-patient bed days per participant – the financial savings of which eclipsed the cost of providing such support. Consumers' living conditions also improved.³⁹

'You get better after sale care on a laptop.'

- Jason Russell, Consumer / Advocate

Recommendation: Provide transitional housing support to people who do not have access to a suitable home who are exiting correctional facilities, hospitals, and psychiatric hospitals.

Other areas of the housing system to improve mental health outcomes

'I lived with someone with extreme schizophrenia, and he tried to set himself on fire, he was trying to kick my door down and kill me'

- David Montgomery, Consumer / Advocate

Rooming houses are a common form of housing for people experiencing disadvantage. This includes those who are unemployed, have a disability, are socially isolated, and who are not connected to services.^{40 41}

Rooming house residents across Australia overwhelmingly advise that they are dangerous and violent, dirty, and harmful to their mental health.⁴² Rooming houses are characterised by their density, a cohort comprised of people on low incomes and often high needs, and the use of shared facilities. A prominent cohort within rooming houses are those with psychiatric illnesses.⁴³ This environment can be volatile.

³⁸Brackertz, N., Wilkinson, A., and Davison, J., 2018, Housing, homelessness and mental health: towards systems change, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, p.43

³⁹ Siskind, D., et al, 2014, *A retrospective quasi-experimental study of transitional housing programs for patients with severe and persistent mental illness* cited in

³⁹Brackertz, N., Wilkinson, A., and Davison, J., 2018, Housing, homelessness and mental health: towards systems change, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, p.23

⁴⁰ Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p 36

⁴¹ The Salvation Army Adult Services, 2011, 'No room to move? Report of the Outer West Rooming House Project', p.16

⁴² Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p.25

⁴³ Ibid, pp.35 - 36

The provision of in-reach services to rooming houses are extremely poor. Despite the social isolation, service disconnection, and mental health needs of residents, very few services exist to provide services in the home of rooming house residents. There is some limited evidence that group based rooming house outreach programs can achieve dramatic improvements in residents' wellbeing.⁴⁴ However these pilot programs have typically lacked institutional funding, and as a result have been short-lived, with low-quality evaluations.

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

- Nigel Pernu, Consumer / Advocate

In the absence of a strategy to ensure that *appropriate* affordable housing is made available to all people experiencing mental ill-health, the mental health needs of rooming house residents cannot continue to be ignored.

Recommendation: Pilot and evaluate interdisciplinary rooming house outreach programs

⁴⁴ Council to Homeless Persons, 2019, *Council to Homeless Persons pre-budget submission 2019-2020*, p.6

Conclusion

CHP is pleased to have had the opportunity to provide feedback on the Productivity Commission's issues paper on the social and economic impacts of mental health. The relationship between housing and mental health is bi-directional, and for people receiving in-community mental healthcare any recovery is hampered by a lack of appropriate housing.

Considering housing as a mental health support will both improve the mental health outcomes of mental health consumers, as well as decrease episodes of homelessness by those living with mental ill-health, and improve the mental health of those experiencing homelessness. In all instances the Government's investments in mental health will be more effective – in many instances greater expenditure on housing and support will save money in other service systems while improving outcomes for consumers.

We look forward to continuing to engage with this inquiry in its later stages.