

Well and at home, 'It's like a big mental sigh': Pathways out of mental ill health and homelessness

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'My mental health wasn't too crash hot prior to getting my place, but it's pretty good these days. It's incredible how much it helps. It's like a big mental sigh . . .'



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Executive Summary:

This report arises from recognition of a knowledge gap in relation to mental ill health and homelessness in Tasmania. The ultimate aim of the project is to help prevent mental ill health and homelessness in this state.

When we are housed, ‘it’s like a big mental sigh’ – we can begin to relax and think beyond our survival needs. Appropriate affordable housing supports mental health. Yet for people who have experienced the ‘double whammy’ of mental ill health *and* homelessness, these difficulties are often part of a more complex life. These two difficulties are usually experienced alongside a range of additional experiences, including early life trauma, poverty, social isolation, physical ill health and a range of other difficulties. Mental health and social inclusion may require more than medical treatment and a house.

In order to build understanding of these complexities in Tasmania, this project sought advice from people with lived experience of these difficulties. Sometimes called consumers, clients, support recipients or service users, people with lived experience may be seen as the social casualties of structural and personal disadvantage. In the context of this report, people with lived expertise were consulted as experts.

This report is structured in four parts.

Part A: Project overview – offers an overview of the aims, frameworks and research methods utilised within this project.

Part B: Research, policy and service backdrop – provides a brief overview of mental health and homelessness research, along with a summary of Tasmania’s current policy context and an overview of Tasmania’s mental health and homelessness service sectors. This literature backdrop prepares readers for the central task of this research project.

Part C: What the experts say – a summary of twenty interviews is presented in the form of case examples. These span a breadth of age, gender, cultural heritage, family groups, and experiences. Each story is different. Early life experiences are critical, as are the key transition points in people’s lives. Social supports (or lack of) are central. People’s personal prevention and coping strategies play a role in maintaining mental health and housing, as do their personal hopes.

Part D: Conclusions and recommendations – based on wisdom arising from ‘lived experience’, these findings offer a critical bird’s-eye perspective and strong advice. A summary of targeted recommendations is offered, with relevance for policy, funding, service delivery and practice.

Key recommendations:

Recommendation 1

That the Tasmanian Government commit to providing public housing as a core government service, with appropriate investment to allow it to charge affordable rents, continue to offer security of tenure, operate sustainably, increase supply (of safe and appropriate houses), address the maintenance backlog and improve support services for tenants.

Recommendation 2

That the Tasmanian Minister for Corrections and Consumer Protection act to protect the rights of vulnerable tenants by expediting the passage of the amendments to the *Residential Tenancies Act 1997* to:

- incorporate a method to determine reasonable rent increases;
- protect tenants in the private rental market from unreasonable eviction processes; and
- introduce minimum standards for private rental properties.

Recommendation 3

That Housing Tasmania act to prevent people with mental illness from being evicted to homelessness by:

- developing policies that mandate that public housing tenants cannot be evicted to homelessness; and
- through its funding agreements with community housing providers, mandate that providers cannot evict tenants to homelessness.

Recommendation 4

That the Australian and Tasmanian Governments jointly fund community education programs about mental illness and homelessness (causes, risks, supports and treatments) and mental health promotion, via a range of mediums.

Recommendation 5

That the Department of Families, Housing, Community Services and Indigenous Affairs expand the 'Communities for Children Plus' program to specific Tasmanian locations, and roll out the 'Home Advice Program' to all Tasmanian regions.

Recommendation 6

That the Department of Families, Housing, Community Services and Indigenous Affairs fund homelessness prevention programs for Tasmanian parents and adolescents experiencing conflict (where escalation of the conflict may lead to young people becoming homeless).

Recommendation 7

That the Tasmanian Government invest in publicly subsidised transport services targeted to disadvantaged and regional areas, to improve both the frequency of services and the flexibility of service routes.

Recommendation 8

That the Tasmanian Government build on the mental health reform agenda established by the Australian Government and expand funding to its community based mental health services.

Recommendation 9

That the Department of Health and Human Services fund the mental health consumer organisation *Flourish*, to develop regionally-based consumer support and self-help groups to focus on wellbeing, support early identification of ill health, and play a role in assertive outreach.

Recommendation 10

That the Community Mental Health Services and Child and Adolescent Mental Health Services increase the availability of outreach services for service users.

Recommendation 11

That Housing Tasmania adequately resource specialist homeless services to provide ongoing case management for people who are homeless or at risk of homelessness with a mental illness.

Recommendation 12

That the Department of Education develop a strategic response to meet the needs of students who are at risk of developing mental illness and/or experiencing homelessness, including:

- funding professional development for teachers, social workers, guidance officers and aides, in mental health promotion and homelessness risks; and
- developing procedures to identify students at risk of homelessness, and appropriate referral pathways to support those students.

Recommendation 13

That Centrelink ensures staff are trained in mental health, homelessness, alcohol and drugs, and trauma issues, and issues around cultural diversity.

Recommendation 14

That the Australian Government ensures Centrelink and the Department of Education, Employment and Workplace Relations' workforce participation policies and compliance regime are consistent with the Principles of the National Mental Health Plan in relation to clients with a mental illness.

Recommendation 15

That the Australian Government funds Centrelink to work collaboratively with mental health and homelessness services, especially during episodic illness/in-patient care and experiences of homelessness, to ensure continuity of income for clients at these times.

Recommendation 16

That the Australian Minister for the Department of Education, Employment and Workplace Relations and the Australian Attorney General review the recommendations made by Anglicare Tasmania in relation to Centrelink debt recovery and prosecution (Hughes 2008) and pursue their implementation.

Recommendation 17

That the Tasmanian Government facilitate an interagency response to ensure effective discharge planning and coordination for people leaving juvenile detention, adult prisons and/or forensic settings and prevent 'exits' into homelessness.

Recommendation 18

That Statewide and Mental Health Services work with housing service providers to ensure clear procedures and support are established to prevent discharge from in-patient treatment facilities into homelessness, and specifically:

- that discharge accommodation planning is to commence at intake;
- that in instances where a patient is being discharged to another person's home, an assessment is made of that person's capacity to provide care/accommodation;
- that transport arrangements are in place at least one day before discharge;
- that at intake, Centrelink social workers and housing support workers are engaged to provide follow-up support upon discharge; and
- that this arrangement is activated one day before discharge.

Recommendation 19

That the Department of Health and Human Services fund community-based alcohol and drug services to engage General Practitioners as pharmacotherapy prescribers in order to improve access to pharmacotherapy medication and options for treatment.

Recommendation 20

That the Private Rental Tenancy Support Service and the Private Rental Support Service be provided with additional funding to support work with tenants who live in public housing and in all forms of community housing.

Recommendation 21

That Skills Tasmania use its 'Equity Support Program' to resource initiatives providing vocational training delivered one to one in safe settings for adult learners living with mental ill health.

Recommendation 22

That the Tasmanian Chamber of Commerce and Industry encourage its membership to offer work experience for people with a lived experience of mental ill health and/or a lived experience of homelessness.

Recommendation 23

That the Department of Health and Human Services revisit the 2003 SAAP/ MHS protocol and establish a strategy and appropriate resources for its redevelopment.

Recommendation 24

That workforce development and referral pathways be strengthened in both mental health and homelessness sectors via staff exchanges between services and agencies.

Recommendation 25

That Statewide and Mental Health Services, Housing Tasmania, and community service organisations working in mental health and homelessness sectors ensure that all staff receive appropriate professional development including in trauma, alcohol and drugs, mental health promotion, cultural competency in working with Aboriginal and CALD clients, and training in consumer participation and engagement.

Recommendation 26

That Statewide and Mental Health Services and Housing Tasmania are funded to adequately resource community service organisations to embed service user engagement within strategic planning, service development, service delivery and staff training.

Recommendation 27

That the Department of Health and Human Services adequately fund community service organisations to involve consumers in organisational processes, and employ consumer workers. This requirement needs to be built into contractual requirements for community service organisations providing mental health services, as is done by the Australian Government, and homelessness services.

Recommendation 28

That Housing Tasmania be funded to expand its current model of support for people who are homeless (the Integrated Continuum of Support Model) to ensure that they are housed as a first step, with supports offered (a Housing First approach).

Recommendation 29

That the Australian and Tasmanian Governments fund the Public Housing system as an important exit point for people leaving specialist homelessness services and entering into long term secure housing.

Recommendation 30

That the Tasmanian Government commit to a review of the need for homelessness and supported accommodation facilities prior to the development of the 2012/13 State Budget. Further, that if there is evidence of continuing unmet need, that the Government commit to funding additional accommodation facilities including funding for appropriate support.

Recommendation 31

That homelessness services, particularly those providing communal accommodation facilities, engage in rigorous monitoring of management practices, staff culture, resident safety, and resident feedback processes.

Recommendation 32

That the Tasmanian Government examine appropriate models for supporting homeless students aged 16–21 years and assess demand for service expansion in this area.

Recommendation 33

That the Australian Government urgently review all income support payments to ensure that all payment levels are adequate to allow for an acceptable minimum standard of living for all recipients and that they retain parity with increases in wages and living costs.

Glossary of key terms:

The following definitions are utilised throughout this report. In some cases, definitions include an explanation or implication related to the definition.

Mental ill health – Includes mental strain, impaired functioning, and diagnosable mental disorders, such as schizophrenia and depression (European Commission 2006). Mental ill health may be self-reported or psychiatrically (clinically) assessed.

Mental disorders – The term mental disorder implies that psychiatric assessment has taken place. The World Health Organisation has developed an International Classification of Disease (ICD-10) to differentiate mental disorders by listing sets of criteria necessary for a diagnosis to be made (Andrews 1999). The American Psychiatric Association has consolidated expertise around the assessment of mental disorders within a Diagnostic and Statistical Manual, now in its fourth edition (the DSM IV). Of note is that many mental disorders within both sets of classifications are defined in terms of lacking elements of mental health (Hosman 2007).

Mental health – A state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2009).

Mental health treatment – From a clinical perspective, effective treatments include medication, cognitive and behavioural psychological therapies, psycho-social support, psychiatric disability rehabilitation, avoidance of risk factors such as harmful alcohol and other drug use, and learning self-management skills. A host of alternative treatments are also in use, including herbal and nutritional supplements, meditation techniques, personal coaching, counselling, creative arts, social activities, contact with nature, and community participation (VicHealth 2009).

Mental health promotion – Aims to maximise wellbeing, quality of life, a sense of control over one's health, and the ability to bounce back (resilience) from the challenges of life (Pape & Galipeault 2002).

Mental health recovery – The intention of maximising wellbeing, within the constraints that might be imposed by symptoms of mental illness (Queensland Health 2006).

Homelessness – Chamberlain and MacKenzie (2003) describe three categories of homelessness:

Primary homelessness – includes all 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 – includes people who move frequently from one form of temporary shelter to another. On census night in 2006, this included all people staying in emergency or transitional accommodation provided under the Supported Accommodation Assistance Program (SAAP). Secondary homelessness also includes people residing temporarily with other households because they have no accommodation of their own, and people who are staying temporarily in boarding houses.

Tertiary homelessness – refers to people staying in boarding houses on a medium- to long-term basis, defined as 13 weeks or longer. Residents of private boarding houses are homeless because they do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; and their accommodation is not self-contained.

They are considered homeless because their accommodation does not have the characteristics identified in the minimum community standard.

Housed – Based on a contemporary cultural definition, the minimum accommodation for a single person or couple in the Australian context is a small rental flat with a bedroom, living room, kitchen and bathroom, and an element of security of tenure provided by a lease. Below this cultural standard, people are considered 'homeless', and above the minimum they are considered 'housed' (Chamberlain & MacKenzie 1992).

Homefulness – A phenomenological approach to housing and homelessness defines home as a physical space, a lived space, and an expression of social identity and meanings (Mallet 2004, cited in St Vincent's Mental Health Services and Craze Lateral Solutions [SVMHS & CLS] 2005, p.3). Homelessness refers to wider circumstances than merely an experience of 'rooflessness', therefore the notion of homefulness becomes useful in an exploration of homelessness prevention, which is closely aligned with aims of social inclusion.

Social inclusion – 'Social inclusion is the process by which efforts are made to ensure that everyone, regardless of their experiences and circumstances, can achieve their potential in life. To achieve inclusion, income and employment are necessary but not sufficient. An inclusive society is also characterised by a striving for reduced inequality, a balance between individual's rights and duties and increased social cohesion' (Jansen n.d).

For the Australian Government, social inclusion involves; reducing disadvantage, increasing social, civil and economic participation, and a greater voice to community members (combined with greater responsibility). Principles underpinning this approach include:

- building on individual and community strengths;
- building partnerships with key stakeholders;
- developing tailored services;
- giving a high priority to early intervention and prevention;
- building joined-up services and whole-of-government solutions;
- using evidence and integrated data to inform policy;
- using locational approaches; and
- planning for sustainability (Social Inclusion Board 2011a).

For the Tasmanian Social Inclusion Unit, 'Social inclusion means a fair go at having a decent education, skills, meaningful work, access to services, good relationships, and a say on what matters to us. It's about the relationships in life that make us healthy, happy and productive' (Adams 2009, p.8).

Introduction:

'It's like a big mental sigh'

This study focuses on the difficult combination of mental ill health and homelessness. Research demonstrates that people experiencing both mental ill health and homelessness are often suffering from more than poor mental health and a lack of housing. People struggling with both of these difficulties tend to not only lack appropriate shelter, but also lack other essentials, including social connection and opportunity for meaningful activity (SVMHS & CLS 2005, p.4). Lipton and Sabatini (1984) found that people experiencing mental ill health and homelessness are usually also jobless, penniless, without supports, and without a function or role. Many sources state homelessness accentuates a person's alienation and lack of social supports (MHCA, 2009; SVMHS & CLS 2005).

When we consider experiences of mental ill health and homelessness, we need to acknowledge experiences of social isolation (being 'familyless', 'partnerless', 'friendless'), income inadequacy (being 'jobless', 'resourceless'), and other forms of ill health (physical ill health, emotional ill health, family ill health, etc.). Early life trauma, grief and loss, substance abuse, and unsupported "exits" from intensive services may also form part the picture (SVMHS & CLS 2005; MHCA 2009).

Mental ill health and homelessness exist within a dynamic and dialectic relationship. Researchers and observers find it difficult to separate cause from effect, especially when viewed within the broader social and cultural contexts of a person's life. Based on a critical review of six studies and a study of 4,291 homeless people in Melbourne, Johnson and Chamberlain (2011) found:

There is little doubt that rates of mental illness among the homeless population are higher than in the general population, and it is clear that a significant minority of homeless people have mental health problems. However, it is inaccurate to claim that most of the homeless are mentally ill, or that mental illness is the primary cause of homelessness. This deflects attention away from the more pervasive structural causes of homelessness, such as family breakdown, insufficient income and a lack of affordable housing (p.44).

Proactive definitions of mental ill health and homelessness must acknowledge time and place, transience and transitions, episodes and stability, chronic conditions, social structural causes, and personal trajectories.

MacKenzie and Chamberlain (2008) argue that there are three predominant pathways into homelessness: youth homelessness (caused by a range of difficult life circumstances, sometimes leading to chronic adult homelessness); adult homelessness caused by a housing crisis (for example poverty or debts); and family breakdown (for example through violence or separation). This report examines these trajectories in light of a fourth possible pathway into homelessness: mental ill health, and attempts to unpack individual circumstances that lead to the 'double whammy' of both mental ill health and homelessness.

In a research project on mental illness and poverty, Cameron and Flanagan (2004) found that Tasmanians with serious mental illness lacked housing options. Their research found that people living with mental illness in a range of current housing options felt isolated, insecure, unsafe, and discriminated against. These stressors exacerbated their illness, sometimes resulting in hospitalisation (p.39). Several studies have found that once housed, with support, people with mental illness are better able to reach stable mental health (Padgett 2007; Tsemberis 1999; Tsemberis, Gulcur & Nakae 2004; Gronda 2009).

The Australian Department of Health and Aging (DoHA) has recognised the need for more studies to assess the needs of homeless people, to better inform policy and resource distribution (SVMHS & CLS 2005). Several authors have stated that services for homeless people with mental illness work best if they adapt service delivery and treatment approaches to reflect the experiences of service users (Goldfinger & Schutt 1999, cited in SVMHS & CLS 2005; MHCA 2009). In 2006, a report presented to the DoHA stated 'in any discussion of intersectoral linkages, an understanding of consumer views is essential if effective strategies are to be identified' (SVMHS & CLS 2005, p.26).

The aim of this project is to increase understanding about the experiences of people living with the difficult combination of mental ill health and homelessness in Tasmania. A key objective is to offer useful and achievable Tasmania-specific information to help prevent homelessness and mental ill health. Recommendations draw on literature evidence, and are grounded in direct experiences.

Service users (sometimes called consumers, clients, or support recipients) have gained an expertise that is hard won; their perspectives offer a bird's-eye and action-oriented view of services and service systems. If necessity is the mother of invention, perhaps lived experience is the mother of practical solutions. From this perspective, the decision to ask people with lived experience was a clear research decision. Anticipated was that personal stories would assist to illuminate authentic service gaps, bottlenecks and constraints, and potentially offer novel ideas, solutions and priorities for service delivery.

Twenty people from across Tasmania were invited to share their experiences and offer feedback for improving the current service system. Because the predominant voices within this report are based on lived experience, recommendations are from those with expertise that has emerged from necessity. Conclusions highlight useful supports, serious gaps, unhelpful barriers and novel solutions towards the prevention of homelessness for people living with mental ill health in Tasmania.

Throughout this exploration, it must be remembered that Tasmania lacks affordable, appropriate houses (including public housing). Almost without exception, Tasmanian housing and homelessness services are under great pressure, and have been since at least the early 1990s. Whilst it is useful to explore lived experiences, investigate explanations, and develop a strong list of recommendations to prevent homelessness, to ignore Tasmania's fundamental lack of affordable appropriate housing is to forget an essential part of the solution. Tasmania needs more housing stock (appropriate, affordable, supported housing); this need is central to this report.

Part A: Project overview

TIN ROOF

Rain pelting

Down hard

Thump thump

Thumping

Hard

Trickling

Down

The water spout

Into the

Gutter

Tin shed

Sea shanty

Drowning

In water

Rain

Pelting

On

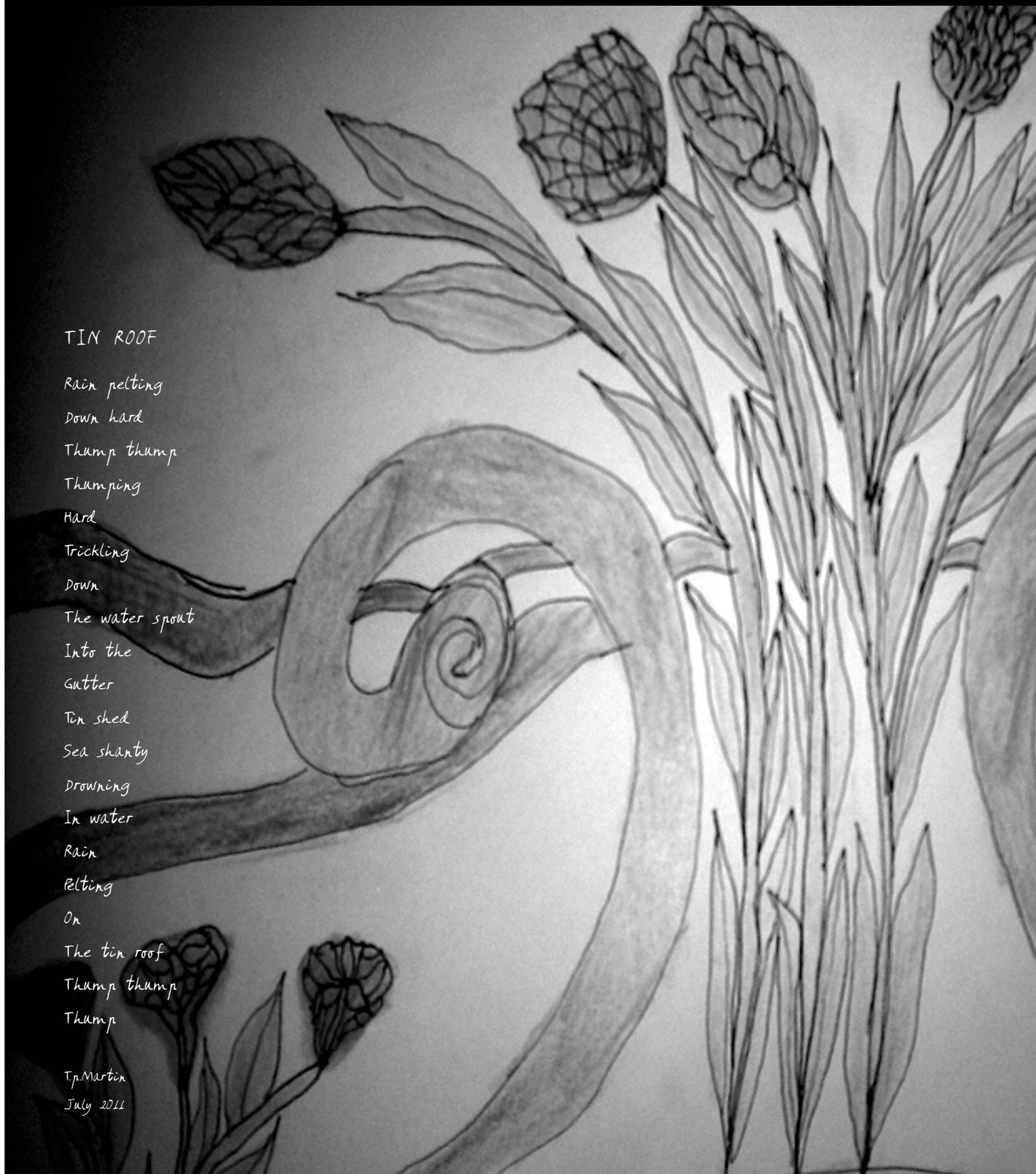
The tin roof

Thump thump

Thump

T.P. Martin

July 2011



History of the project

This project emerged from concerns that the needs of a specific group of people were being missed. Over time Anglicare staff, colleagues and clients had identified distinct and persistent service gaps and barriers relating to people living with the difficult combination of mental ill health and homelessness in Tasmania.

In June 2010 a state-wide mental health conference, 'Investing in Tasmania' was organised to highlight these issues. Hosted by Anglicare Tasmania and the Mental Health Council of Tasmania, the conference was attended by some 200 delegates. Findings from the conference became a catalyst for this project.

Research objectives

The overall aim of this project is to identify strategies for preventing homelessness for individuals living with mental ill health in Tasmania. The study was guided by the following research question: what supports are currently available, and what additional supports will help prevent homelessness for individuals living with mental ill health in Tasmania?

The following specific research objectives directed the course of the project:

1. To summarise the current policy backdrop (both federal and state) in relation to mental health and homelessness.
2. To map the support options available for individuals and families struggling with mental ill health and homelessness in Tasmania.
3. To identify service gaps, barriers and successes (including best practice examples) in relation to achieving stable housing and mental wellbeing for individuals and families in the Tasmanian context.
4. To explore the perspectives of people with lived experiences of mental ill health and homelessness in Tasmania through case examples.
5. To develop recommendations for policy and service delivery to better meet the needs of this target group in Tasmania.

Project Reference Group

A Project Reference Group (PRG) helped guide the direction of the study and develop recommendations. Made up of nine professionals engaged in areas of mental health, housing, homelessness, and consumer participation and one person with expertise based on lived experiences of mental ill health and homelessness, the PRG met three times during the course of the project. Specifically, the group assisted to refine the scope of the research; provide feedback on the literature review, research design and progress; identify and recruit research participants; review a final draft of the research report; and provide guidance on the development of recommendations.

Key concepts and useful frameworks

'Homefulness' and social inclusion

Some commentators argue that standard definitions of homelessness relate to 'houselessness' rather than 'homelessness'. Proponents of this perspective argue that more than a roof is required before we can say someone is not homeless. Based on the work of Ken Kraybill, Reynolds (2010) described the common human need for three homes:

The First Home: This is 'the self'. The characteristics of this home are physical, mental, emotional, social and spiritual in nature. This home needs to be nurtured, rested, nourished and emotionally supported.

The Second Home: This covers any of the descriptions within the primary, secondary and tertiary definitions of homelessness. It is the place where we live, and it refers not only to the physical structure but to the living environment within which it is located. This home is where we sleep, where we begin and end every day, where we store our belongings, and may be where we socialise and interact with others.

The Third Home: This is the larger community within which our first and second homes are located. It provides context to the lives that are lived within it and how that is connected at an individual level. Here the connectivity between individuals, multiple communities, the residential, business and visitors all meet in the same place. The quality of that home is defined by the relationships of all groups within it.

For Reynolds, addressing all three homes fosters social inclusion and creates 'homefulness'. This report follows conventional definitions of homelessness (Chamberlain & MacKenzie 2003), and uses homefulness to help reconceptualise service delivery in the area of homelessness.

Social inclusion includes aims of both mental health and homefulness. The Australian Government's vision of a socially inclusive society is one in which all Australians feel valued and have the opportunity to participate fully in the life of their society. According to this vision, Australians shall have the resources, opportunities and capability to: learn by participating in education and training; work by participating in employment, in voluntary work and in family and caring; engage by connecting with people and using their local community's resources; and have a voice so that they can influence decisions that affect them (Australian Government 2011b). Within this report, an aim of seeking homefulness is congruent with an aim of seeking social inclusion – for individuals, families and communities.

Mental health 'recovery'

According to the World Health Organisation (2001), mental health is interlinked with physical health, coping strategies, productive work, and meaningful contributions. Onken et al. (2002, cited in Patterson 2009, p.3) define 'recovery' as the product of a dynamic interaction among:

- individual characteristics (including hope and a sense of meaning and self);
- environmental factors (including opportunities for satisfying basic material needs, social relationships, meaningful activities and peer support); and
- features of the service delivery system (including choice and empowerment, independence and interdependence).

From this perspective, mental health recovery aims to maximise holistic wellbeing within the constraints of mental illness. Some people may recover from mental illness and may never have to deal with mental illness again; others may never reach a stage of being fully mentally well. In mental health promotion, recovery is not focused on cure (a desired ultimate outcome), but on philosophy, attitude, and process. The concept of recovery is closely aligned with health promotion (Patterson 2009). For Barry (2007) mental health promotion involves competence, resilience, supportive environments, and empowerment.

To embark on a recovery process is to choose to participate in a life-long process, with a focus on maximising day-to-day wellbeing for people living with mental health difficulties. Mental health recovery places high importance on both mental health promotion and the prevention of mental ill health, in the context of sometimes necessary medical treatments (Rickwood 2005). For many, mental health recovery does not end at the cessation of a mental health treatment – rather, it begins or continues with renewed vigour at that point.

The National Homelessness Strategy identified four aspects of service delivery in relation to homelessness: social coalition, prevention, early intervention, and crisis transition and support (SVMHS & CLS 2005, pp. 1-2). From this perspective, recovery becomes as relevant in housing/homelessness as in mental health. The term ‘homefulness’ assists us to envisage homelessness services as offering more than a roof. Ginsburg (1999) stated that ‘[o]ur residence is where we live, but our home is how we live’ (p.31). From a recovery perspective, homefulness, does not end when a person is housed – rather it begins or continues from that point. While homelessness services can’t be a ‘home’, they should be an important step towards having stable, appropriate and affordable housing –and social inclusion.

The ultimate aim in a recovery approach to both mental health and homelessness is to maximise wellbeing. A recovery approach invites consistent and continued efforts towards sustained wellbeing. This process involves simultaneously attempting to manage current constraints, prevent the worst, and maximise individual possibilities for physical health, coping strategies, and meaningful contributions. From a social inclusion perspective, mental health and homefulness become lifelong “recovery” processes for everyone, within the given constraints of our subjective lives.

A whole-of-population approach to mental health and homefulness

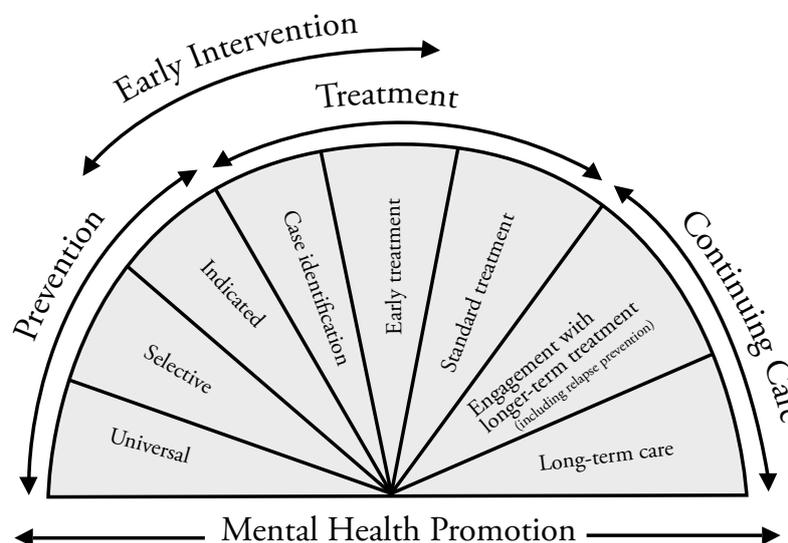
A whole-of-population approach recognises that health and illness (including mental ill health and homelessness) are influenced by the settings and events of everyday life, and result from a complex interplay of biological, psychological, social, environmental, economic and political factors (ANPPEIMH & Rickwood 2009).

Well-articulated within mental health policy reforms, the spectrum of interventions (Figure 1) has relevance for mental health and housing/homelessness services in both upstream (preventative) and downstream (treatment) service delivery. The Second National Mental Health Plan (2000) was the first time an Australian national policy adopted this framework, followed by the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000). No matter to which area of human service delivery it is applied, a whole-of-population (WOP) approach encourages that interventions be developed and delivered across the full spectrum of human need, from Prevention through Early Intervention to Treatment and Continuing Care.

To apply this model in both mental health and housing/homelessness sectors, the following terms are used:

- Prevention (to protect mental health and housing; to minimise risks associated with mental ill health and homelessness).
- Early intervention (to identify risks and intervene early in order to prevent the worst in relation to mental ill health and homelessness).
- Treatment & Transitional housing (the provision of mental health treatment and homelessness/housing services, usually at a time of crisis).
- Continuing care & Long-term housing (the ongoing protection of mental health and housing for people who have experienced difficulties in these areas; includes aims of maximising mental wellbeing and social inclusion).

Figure 1. Spectrum of Interventions for Mental Health Promotion (Mrazek & Haggerty 1994)



This spectrum provides a useful framework for examining what is required in order to deliver a WOP approach to mental health and homelessness. The spectrum has been used within this report to help organise data and present findings in a coherent way.

On the ground, Early Intervention services may appear very similar to Continuing Care services of the same sector – similar types of resources, approaches and service streams are necessary in order to intervene early and maintain the mental health and homelessness of individuals, families and communities.

A healthy and vibrant culture enhances both mental health and social inclusion. Ideally, at some point, Prevention services become barely noticeable – they are ‘part of things’.

Within this spectrum, the area of service delivery that stands alone is Treatment. Treatment services (specialist interventions) offer intense support at a crisis point, of a nature and quality that supports individuals towards recovery. In Tasmania, mental health treatment services and specialist homelessness services offer support in this area. Within mental health, these services include both clinical and community-based services. Within homelessness, this includes a range of initiatives and accommodation models delivered by specialist homelessness services (SHS).

Delivered well, Continuing Care services appear to ‘blend’ with Prevention services, offering a suite of concurrent and seamless strategies to maintain the mental health and social inclusion of individuals, families and communities. To whichever human service sector it is applied, a WOP approach aims to maximise individual, family and community wellbeing, in a cost-effective manner.

A WOP approach to mental health and social inclusion encourages governments and community-based organisations to consider service delivery needs across the spectrum of interventions, necessitating collaboration across sectors. A benefit

of applying such an approach to any question relating to human and social service delivery is that it highlights the need to ensure enough Prevention and Early Intervention services are delivered to limit the need for downstream services. Regardless which human service sector is being examined, the utopian vision of a WOP approach is to make Treatment services (including Transitional housing) redundant. Until that day, the idea is to get the balance right – focus on providing adequate and increasing amounts of resources to upstream services, whilst fully meeting the needs of those who require specialist intensive (downstream) support.

Based on research and feedback from key stakeholders (including reference group members), this report embeds philosophies of homelessness, mental health recovery, social inclusion and WOP approaches (sometimes called public health) throughout. Additional conceptual frameworks are introduced in Part B.

Research methods

In a review of national and international research on links between homelessness and mental health, authors noted the complex methodological and ethical problems associated with research into both homelessness and mental illness. They recommended a departure from standard quantitative research methodologies and a movement towards qualitative, including ethnographic, approaches to assist both the design and the evaluation of programs aimed at addressing the problem of homelessness and mental ill health (SVMHS & CLS 2005, p.43).

This study involves exploratory quantitative research methods. At the outset of this study, a literature review of recent research in mental health and homelessness was undertaken, and a series of face-to-face meetings with Tasmanian policy makers took place. A combination of these methods, along with guidance from the Project Reference Group, assisted in the development of research methods used within this study.

The following table identifies specific research methods and data sources utilised for each research objective in this study.

Table 1.

Research objective	Research methods	Data sources
1. To summarise the current policy context (federal and state) in relation to mental health and homelessness.	<ul style="list-style-type: none"> Literature review Interviews 	<ul style="list-style-type: none"> Federal and state policy documents relating to mental health and homelessness. Interviews with key policy-makers and peak body representatives in areas of mental health and homelessness.
2. To list the current support options available for individuals and families struggling with mental ill health and homelessness in Tasmania.	<ul style="list-style-type: none"> Literature review Interviews Symposium surveys 	<ul style="list-style-type: none"> Tasmanian Government and community agency documentation. Interviews with key policy-makers, peak body representatives, service providers, and consumers. 67 surveys received from Symposium delegates.
3. To identify service gaps, barriers and successes (including best practice examples) in relation to achieving stable housing and mental wellbeing for individuals families in the Tasmanian context.	<ul style="list-style-type: none"> Literature review Interviews Symposium surveys Qualitative analysis 	<ul style="list-style-type: none"> Tasmanian Government and community agency documentation. Interviews with consumers, key policy-makers, peak body representatives, and service providers. 67 surveys
4. To explore the perspectives of people with lived experience of mental illness and homelessness in Tasmania via case examples.	<ul style="list-style-type: none"> Interviews Symposium surveys Qualitative analysis 	<ul style="list-style-type: none"> 20 one-to-one interviews with consumers. 67 surveys
5. To develop recommendations for policy and service delivery in order to better meet the needs of this target group in Tasmania.	<ul style="list-style-type: none"> Qualitative analysis Development of recommendations based on a combination of data sources. 	<ul style="list-style-type: none"> All previously named data sources. Project Reference Group input.

Data collection

Interviews

At least six people from each Tasmanian region (South, North, and North West/West) were invited to share their experiences of mental illness and homelessness.

Interview questions invited participants to contribute their views relating to supports they have received and supports *not* currently available to them, including an invitation to provide feedback on aspects of the social service system. The emphasis was on identifying effective initiatives and gaps in support, in order to develop recommendations for policy directions and service delivery.

Eligibility

All research participants had direct experience of self-reported mental illness and homelessness, across a range of:

- genders (male and female);
- age groups (young people aged 15-24, adults aged 25-59, and older people aged 60+);
- cultural backgrounds (including participants from CALD and Aboriginal backgrounds);
- exit experiences (including recent release from hospital, foster care, and prison);
- family groups (including men with and without children, and women with and without children); and
- homelessness causes (for example due to illness, domestic violence, family breakdown, etc.).

Recruitment

Community and government agencies assisted in the recruitment of research participants. The following table outlines intended and actual participation for each region:

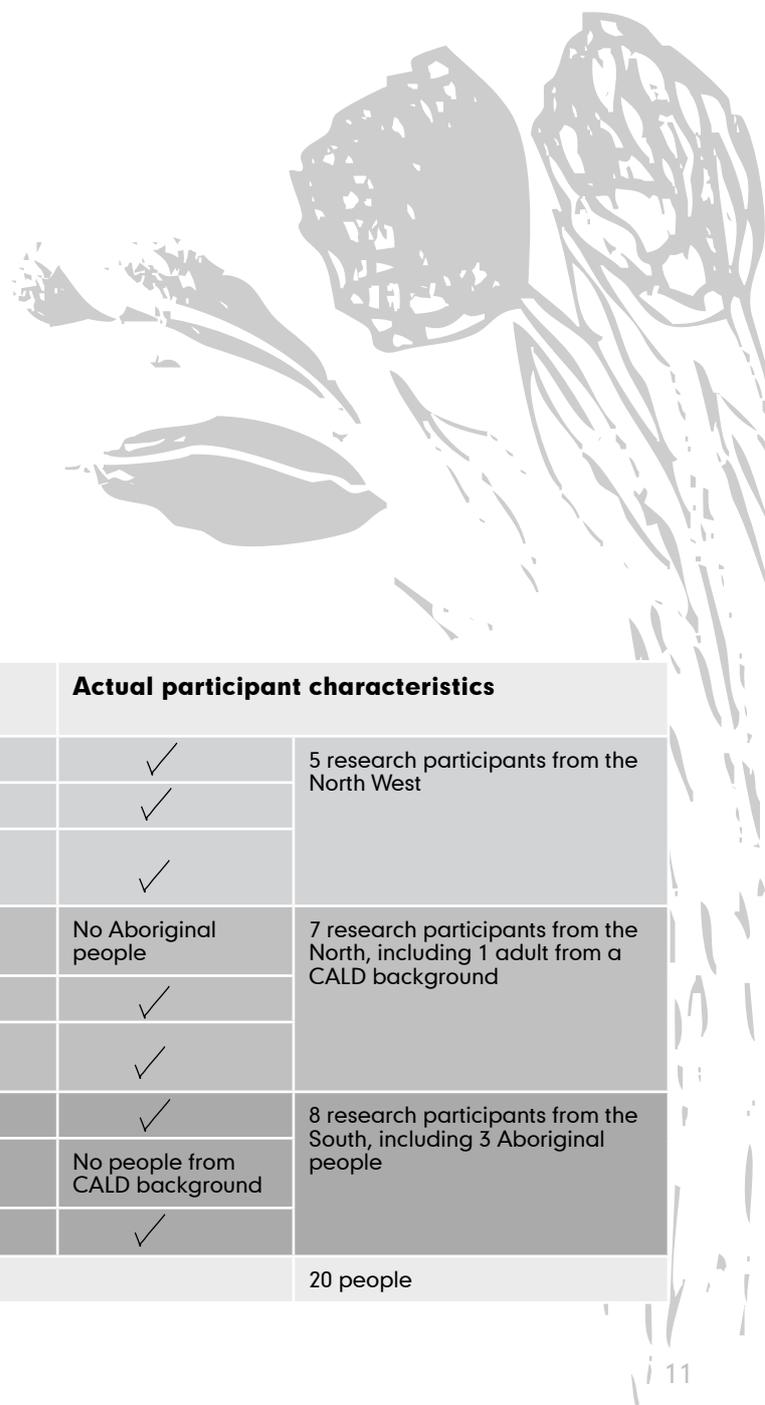


Table 2. Twenty research participants

Tasmanian Region	Proposed participant characteristics	Actual participant characteristics	
North West and West	2 young people aged 15-24	✓	5 research participants from the North West
	2 adult women with/without children	✓	
	2 people recently exited (from hospital, child protection or prison)	✓	
North	2 Aboriginal people	No Aboriginal people	7 research participants from the North, including 1 adult from a CALD background
	2 older people	✓	
	2 people recently exited (from hospital, child protection or prison)	✓	
South	2 Young people aged 15-24 years	✓	8 research participants from the South, including 3 Aboriginal people
	2 adults from CALD backgrounds	No people from CALD background	
	2 adult men with/without children	✓	
Total number of research participants			20 people

Ethics procedures

The following ethics protocols were implemented during the course of the study:

- An ethics advisory group was established to offer feedback on ethical processes including research methods and data collection tools. The ethics advisory group was made up of 2 researcher/academics and 2 manager/practitioners.
- Participation in the research was voluntary; individuals were free to cease participation at any point.
- No pre-existing relationship between the researcher and research participants (including all stakeholders) is known; no coercion was present.
- Participants were encouraged to provide information of a general nature rather than highly personal information, or information of an identifying nature.
- Face-to-face interviews took place on organisational premises, within normal business hours, at a mutually agreed time. Symposium surveys were completed anonymously.
- For young people (under 18 years of age), written consent was sought from parents or guardians. If signed consent was not possible, verbal consent was sought. No consent was required for Symposium surveys, as responses were anonymous.
- Follow-up conversations were offered to research participants at the conclusion of interviews; four participants took up the offer and used the opportunity to provide more information. Three participants were provided with additional information relating to services and supports available for mental health or housing, post-interview.
- Interviews were transcribed to gain accurate statements; all responses that included identifying data were de-identified to ensure the anonymity of individuals. Survey responses were collated on a spreadsheet; any identifying data was removed.
- Participants were invited to contact the Manager of SARC if they had any concerns or grievances about the conduct of the research project; none were reported.
- During the project, all data were secured within SARC premises. Upon completion of the project, SARC will store interview data in locked storage for a minimum of five years.

Limitations

This study explored the experience of mental ill health and homelessness in Tasmania via use of a literature review, interviews, case studies and surveys. It should be noted that whilst case studies sought the views of a wide range of individual experiences, gaps exist. For example:

- It was not possible to interview people with specific demographic characteristics across all three regions.
- No one from the west coast was interviewed.
- No one under the age of 16 or over the age of 71 was interviewed.
- Only one person from a CALD background was interviewed.
- Whilst three Aboriginal people were interviewed, the oldest person of known Aboriginal heritage was 34 years.

Due to the limited size of this project, it has not been possible to provide more than an overview of national and state policy reforms in both sectors (for example, this report does not include information on budgets, deliverables and implementation progress across government departments). Gaps exist, and it is recognised that the policy information presented within this report is a 'potted picture' rather than a comprehensive summary.

Nor was it possible to provide more complete details about services, service types, and referral pathways between the two sectors in Tasmania. In attempting to offer an overview of the service landscape for both mental health and homelessness sectors, it is recognised that much has been missed – and many good practice examples have not been included. To build a more complete understanding of these sectors in the Tasmanian context would be a worthy aim for future studies.

**Part B:
Research, policy and service backdrop**



CHILLY
Umbrella up
Raincoat on
Ground wet
Windows
Fogged up
Icy wind
Blowing
It is
A
chilly day

T.P. Martin
July 2011

Introduction

From anecdotal and empirical evidence, it is not just *one* disadvantage or difficulty that leads to homelessness. According to a Tasmanian homeless service manager, few people seek support from homelessness services with only homelessness as an issue (S Weinert, pers. comm.10 May 2011).

In a national survey of 2,974 homeless people in the USA, Mojtabai (2005) found that the most common reason for recent loss of housing related to financial and interpersonal problems. Asked reasons for their continued homelessness, people cited insufficient income and lack of employment as the most common reasons, regardless of their personal mental health status. These findings highlight the importance of asking clients about their priorities and concerns in relation to mental health and homelessness, and the importance of considering what supports are required in addition to a 'roof'. Tasmanian research has demonstrated the strong link between low income, unemployment and self-assessed levels of poor mental health (Cameron & Flanagan 2004).

According to the Australian Institute of Health and Welfare (AIHW), of people who used specialist homelessness services in Tasmania in 2008-2009:

- 50.5% required basic help (with meals, laundry, transport, etc.);
- 39.8% required financial and employment assistance;
- 57% of Tasmanian homeless service users also required personal support in relation to incest/sexual assault, domestic/family violence and relationship breakdowns; and
- 15.5% required health/medical services, specialist counselling, psychological/psychiatric services, drug/alcohol (AIHW, 2011).

For the Commonwealth Department of Health and Aging (DoHA), the interactions between economic and other systemic factors on rates of homelessness have not been fully explored, and there is need to better understand their impact on the problem of homelessness (SVMHS & CLS 2005, p.18).

According to wide-ranging research sources (SVMHS & CLS 2005; MHCA 2009), known risk factors for homelessness include:

- a) Structural characteristics – labour market, income levels, living costs, housing markets, housing policy, welfare policy, health care systems, mental health treatment systems, service provision, and models of service;
- b) Social characteristics – strength of social networks, level of social isolation, family support, family breakdown, family violence, and public attitudes towards mental health and homelessness (including mental health service providers, public housing providers, Centrelink staff, landlords, real estate agents etc.); and
- c) Individual characteristics – demographic factors (gender, age, education etc.), childhood experiences, physical health, cognitive capacity, social skills, and substance use experiences of trauma, family history of inadequate income levels and living in a poorly serviced or regional area.

These characteristics present multiple issues that may precipitate, cause, inhibit, exacerbate or lead to increased risks of mental ill health and homelessness. In order to set the scene for an investigation into lived experiences of mental ill health and homelessness in Tasmania, a research backdrop is provided,

along with an overview of the current policy context, and an overview of Tasmanian services in the areas of mental health and homelessness.

Research evidence

This section draws on international, national and state-based research authored by government agencies, peak bodies and community organisations. The research offers anecdotal, theoretical, and empirical perspectives relating to mental ill health and homelessness. Where possible, Tasmanian examples are provided.

What we know

The first National Survey on Mental Health and Wellbeing was conducted by the Australian Bureau of Statistics in 1997. This study demonstrated that around one in five Australian adults had experienced a depressive, anxiety or substance use disorder in the previous 12 months. Further, of people with a mental disorder, one in four people had one or more additional mental disorders (Robinson et al. 2008). Whereas physical disorders were found more prevalent in older people, mental disorders were more prevalent in younger people (Andrews et al. 1999). These rates make mental disorders the leading cause of non-fatal disease burden in Australia, with the expectation that prevalence rates will rise over time.

Mental disorders are known to impact on both the person experiencing the disorder and on people surrounding the person; interpersonal relationships may be both a cause and a consequence of mental health difficulties. Although most common mental disorders are amenable to treatment, the majority go undiagnosed and untreated. Many disorders are chronic or recurrent and call for long-term management, not just acute care. Whilst mental health issues affect people of all ages, gender and socio-economic status, known social determinants of health indicate that specific groups are more vulnerable to experiencing mental health problems (for example children whose parents have mental illness, families living on low incomes, and unemployed people). Much of the care provided for people with mental disorders (even very serious disorders) is informal care provided by family members (Robinson et al. 2008).

It is recognised that measuring homelessness is a difficult, if not impossible task. Some of the problems associated with estimating primary homelessness have been identified, and work is being done by the Australian Bureau of Statistics to collect more accurate Census data in 2011 (Homelessness Australia 2011). Current estimates of homelessness rely on data collected by service providers for the Australian Institute of Health and Welfare (AIHW). The AIHW reported that in 2008-2009, 219,000 people (1 in every 100 Australians) used government-funded specialist homelessness services. Of these, sixty-two percent were adults, and thirty-eight percent were children accompanying adults. Estimates suggest that one in every 51 young women in Australia aged 15-19 years utilised homelessness services. Services cited that interpersonal relationships, such as domestic or family violence were their clients' main cause of homelessness. According to services, single men over 25 utilised homelessness services for reasons of drug, alcohol or substance use or financial difficulties; and couples were reported to seek support from homelessness services due to accommodation-related issues, such as being evicted. Across all services, users were supported for an average of 64 days in 2008-2009 (AIHW 2011a).

In a report on mental ill health and substance use by homelessness service users in 2004-2005, the Australian Government identified that 12% of specialist homeless service

users reported a mental health problem, and 1 noted that these two groups overlapped (i.e. co-morbidity was prevalent). Service users who had a mental health or substance use problem were more likely to be alone (socially isolated) when seeking support. The majority of service users were Australian-born. Most service users were *not* Aboriginal or Torres Strait Islander. Service users with a mental health related issue were found more likely to request specialist services, but less likely to receive specialist support, and were more likely to close their support period with their needs unmet. At that time, specialist homeless services reported they were more equipped to deal with service users with substance use problems than with mental health problems (AIHW 2007).

In a ten-point plan to prevent homelessness for people with mental ill health, the Mental Health Council of Australia recommended that thirty percent of public housing stock in Australia must be set aside for people with mental illness (MHCA 2009).

Tasmania has a housing shortage, and many Tasmanians are experiencing a housing affordability crisis. Housing pressures are exacerbated by the low quantity of public housing stock available. There are 3239 people on the Tasmanian public housing waiting list (Tasmania, Legislative Council 2011). In 2008, Supply Council projections showed an overall gap in Tasmania of 7000 dwellings and predicted a further gap of 3000 dwellings, based on population projections to 2020 (Shelter Tasmania 2011).

Difficulties associated with measuring homelessness in Tasmania have been identified, and steps have been taken to develop more accurate figures (DPAC 2011). A working group was established in 2008 to develop a benchmark figure for the number of Tasmanians experiencing primary homelessness. Based on ABS 2006 Census data for Tasmania, two reports by Chamberlain and McKenzie (2008; 2009), and consultation with wide-ranging service providers, the working group estimated 385 Tasmanians experienced primary homelessness in 2006. The Tasmanian Government is working with other states and territories and the Australian Government towards producing more accurate homelessness data in the future, in order to better monitor their service targets.

According to data released by the AIHW (2011b), the number of people who received specialist homeless services in Tasmania in 2008-2009 was 4800. Homelessness service providers report the predominant reasons people sought assistance across all service user age categories was:

- relationship/ family breakdown (19.9%);
- ending of previous accommodation (including emergency accommodation) (13.2%);
- eviction (10.1%);
- financial difficulty (10%);
- recent arrivals with no means of support (7.6%); and
- domestic/ family violence (8.6%).

According to Tasmanian service providers:

- 4.9% of homelessness service users sought assistance due to sexual/physical/mental abuse;
- 4.9% sought assistance due to substance abuse;

- 2.3% of service users sought assistance for mental health issues;
- 9.4% of homelessness service users utilised specialist services during their support period, including psychological/ psychiatric services, and specialist counselling; and
- a further 5% gained help with health/medical services (AIHW 2011).

In 2008-2009, of 900 Tasmanian service users, eighteen point seven percent were young people aged 15-19 years. This was the highest number of clients for any age category, followed by those aged 20-24 years (fifteen point five percent). In both of these age categories, the number of female clients was almost double the number of male clients (AIHW 2011).

Authors who reviewed national and international literature on links between mental health and homelessness (SVMHS & CLS 2005) stated that a strong body of research evidence supports the following statements:

- The prevalence of mental illness among people who are homeless is substantially greater than that found in the general population.
- For some people the experience of homelessness may contribute to the development of mental illness, especially depression and anxiety.
- A psychotic disorder is a risk factor for homelessness, but effective treatment can prevent homelessness. Housing has proven to reduce the need for hospitalisation for people living with mental ill health.
- Residential stability for people who are homeless and living with a mental illness is possible if appropriate housing, effective treatment and flexible support is available.
- Stable and secure housing does produce positive benefits in terms of people's mental health and general wellbeing.
- Drug and alcohol services need to be integrated with clinical mental health services when responding to the needs of people who are homeless and living with a mental illness.
- Effective models of intersectoral collaboration incorporate consumer perspectives and preferences.
- Strategies need to be tailored particular at risk populations.

From simple mathematics, it is clear that most people living with mental illness are not homeless, and from wide-ranging sources we can assume that most homeless people are not mentally ill. Yet an Australian study found that almost half of those sleeping rough have at least one symptom of psychosis (SVMHS & CLS 2005, pp.9-10). Another study of homeless people in inner Sydney found that seventy-five percent of their sample had at least one mental disorder, and ninety-three percent reported having had at least one extreme trauma (MHCA 2009).

In a NSW study on homeless men by The Michael Project (a collaboration between Mission Australia, Murdoch University and NDARC), of 253 homeless men, around half indicated they had been diagnosed with a mental disorder other than a substance use disorder, ninety-five percent had experienced one or more traumatic events in their lives (the first traumatic event was typically experienced in early adolescence), and twenty percent screened positive for post traumatic stress

disorder. Ninety percent were not employed at the time of the survey, but half of those residing in short-term and medium-term accommodation facilities had been employed in the last 2 years. Thirty-five percent reported they did not have enough money to get by on, and seventeen percent were unable to afford medicines prescribed by a doctor. Seventy percent experienced social isolation, over twenty-five percent had experienced an overnight stay in a justice facility in the previous 12 months, and twenty two point seven percent from outreach and emergency accommodation services had been in contact with police because they were victims of assault (Mission Australia 2011). In a study on the nexus between homelessness and crime, findings revealed seventy five percent of people identified a direct causal link between their offending behaviour and their homelessness status (Rosenman 2006) (ie. homelessness can cause people to undertake offending behaviours).

We know that mental illness may raise the risk of housing instability and homelessness for individuals, couples and families. This is the case for both low prevalence disorders (such as schizo-affective disorders) and high prevalence disorders (such as depression) (Rosenman 2006). A study of 4291 homeless people in Victoria demonstrated that for those who had mental health issues prior to becoming homeless, it was the breakdown of family relationships that usually precipitated homelessness. And for those who developed mental health issues after becoming homeless, it was often their experiences in homelessness that brought on mental illness (Johnson & Chamberlain 2009). Mental illness may affect the onset and duration of homelessness, and it is likely that homelessness affects the strength and duration of mental illness (SVMHS & CLS 2005, p.9) unless hospitalisation becomes mandatory. It is likely that mental illness more often precedes homelessness than the other way around.

Whilst more research would be beneficial, we know that different kinds of mental illness place different pressures on individuals, couples and families. Mental illness clusters include:

- dementia, delirium and other organic mental disorders;
- schizophrenia, bipolar disorder and other related psychotic disorders (characterised by hallucinations, delusions, thought disorders, and behaviour disturbances);
- mood disorders (especially depression);
- anxiety disorders; and
- substance use disorders.

Whilst the cause-effect relationship between mental ill health and homelessness is complex, we know that they both raise risks across physical, mental, emotional and social domains. As well as physical risks associated with exposure to cold, heat and violence, homeless people experience specific emotional risks, including fear, danger, victimisation, emotional distress, grief and loss, and few social contacts. Social risks include lack of employment, lack of reliable communication mechanisms, stigma, and discrimination (SVMHS & CLS 2005).

According to the Australian Federation of Homeless Services, the homeless service system in Australia cannot meet the current demand for support; one in two people who request immediate assistance is turned away from homeless assistance services every day (Rosenman 2006). Census data and specialist homeless service data collected by the AIHW demonstrates that Tasmania has a 'known' homeless population (those already in contact with homeless services in one way or another and therefore able to be counted) (AIHW 2011b). As well as 'hidden' or invisible

(unknown) homeless population (DPAC 2011).

As already acknowledged, Tasmania has a housing shortage and a housing affordability crisis. According to an Anglicare Tasmania survey of the private rental market, ninety-eight percent of Tasmanian houses on the private rental market in April 2011 were unaffordable for a single person on the Disability Support Pension, and ninety-nine percent were unaffordable for a single person on Newstart or Youth Allowance (Anglicare 2011). There exists a shortage in public housing stock. There also exists a shortage in most forms of short-term and medium-term accommodation, including immediate emergency accommodation facilities (IEA). Shelters, refuges and crisis accommodation services of all kinds are under much pressure and have long waiting lists (SVMHS & CLS 2005, p.35). New initiatives are underway to address these issues, but most are not yet operational. To add to housing pressures, boarding/rooming houses are declining in number in Tasmania. This is due to a range of factors, including operational costs, inner city gentrification, and lack of funding, which means buildings are not always well maintained.

Research has demonstrated that stable housing can reduce drug use (Mares and Rosenheck 2004, cited in SVMHS & CLS 2005, p.25). Housing and mental health services are more effective for some individuals if they are integrated with alcohol and drug support services. Further outcomes of stable housing include: increased residential stability, decreased use of institutional settings (hospitals, detoxification units, prisons etc.), decreased cost of crisis/treatment services, and decreased dangerous substance misuse in public spaces (SVMHS & CLS 2005).

In addition, we can be relatively certain that links between income, mental illness and housing instability exist. For example, people with mental illness find it more difficult to find and sustain employment due to the effects of their illness (Jablensky et al. 1999). Several studies have found that living on a low income and being unemployed increases the risk of mental illness (Mathers & Schofield 1998; Cameron & Flanagan 2004). Income levels (including employment) and costs (including costs of basic essentials) have a direct influence on whether individuals, couples and families can afford housing and treatments to help them with their mental illness. Income and costs affect not just the quality of housing (e.g. where people might like to live and in what kind of house) but also affordability of housing at all within a given location.

Sub-groups most at risk of homelessness include Aboriginal Australians, young people leaving care (child protection), adults leaving prison (offenders), victims of violence, those misusing alcohol and drugs, and those with mental ill health (SVMHS & CLS 2005, pp. 33-42). According to wide-ranging sources, additional high needs groups include: those with co-morbid alcohol and drug misuse and schizophrenia; youth and children; older people; Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; women experiencing domestic violence; people involved in the criminal justice system; those with acquired brain injuries; and those with intellectual disabilities (SVMHS & CLS 2005; MHCA 2009).

We know that every individual's experience of mental ill health and homelessness is different. Research needs to examine sub-populations of age, gender, and cultural differences. We know that some gender differences occur in homelessness. For example, in SAAP data (2003-2004), the most common causes of homelessness for women included relationship breakdown and abuse or violence, with women over 25 years

most commonly citing domestic violence as the cause of their homelessness. The most common causes of homelessness for men included mental illness and alcohol misuse, with men over 25 years most commonly citing financial difficulty and unavailable accommodation as the cause of their homelessness (SVMHS & CLS 2005, p.18).

Carr et al. stated 'We appear to be spending disproportionate amounts on 'housing' people in hospitals and not investing sufficiently in supported community accommodation' (2002, p.35, cited in Cameron & Flanagan 2004, p.28). In a study of iterative homelessness, Robinson (2003) found that a number of community-based supported accommodation facilities were not appropriate for people with mental health difficulties because they were not able to address the specific vulnerabilities that living with a mental disorder may involve. For the Australian Federation of Homelessness Organisations, the failure of the mental health system to fund adequate community-based mental health services, combined with the shortage of acute care, means the homelessness service system is acting as an unacknowledged, unfunded arm of mental health services in Australia (Rosenman 2006).

The Senate Community Affairs Committee Report (2008) stated that housing for people with mental illness remains a major gap in community-based care, evident by the number of those with mental illness being held in hospitals, and the numbers who are surviving in accommodation settings that are less than therapeutic (cited in MHCA 2009). For Bleasdale, solving the problem of homelessness for people with complex needs (including mental ill health) requires: stronger strategic direction within policy; the development of specific housing-related support; and support that is individualised. 'The notion of choice and client-directedness in individual support arrangements is gradually becoming a hallmark of successful housing and support arrangements, and is an integral part of the inclusive disability services paradigm that is regulated by disability services legislation' (Bleasdale 2007, p.62).

In 2002, O'Brien et al. conducted a study on the experiences of 50 people with mental disorders aged between 25 and 50 who had successfully secured and maintained private rental housing, with support from a Psychiatric Disability Support Service (PDSS). The study sought to investigate what jeopardises peoples' ability to access and maintain housing, and what factors assist people to access and maintain housing. Results demonstrated four elements that in combination appear to contribute to people with mental illness accessing and maintaining housing: 1) they live in housing that they find acceptable (safe, accessible, manageable etc.); 2) they have support, medication and/or treatments that they trust, accept and find helpful; 3) they demonstrate a willingness and readiness to tackle, with support, the daily challenges and difficulties associated with independent living; and 4) major issues that may place their housing at risk have been identified and managed (O'Brien et al. 2002).

In relation to *preventing* homelessness and reducing risks of homelessness, we know the following:

- Early effective treatment for people with psychosis is likely to prevent homelessness.
- Enhancing families' and carers' ability to provide ongoing support for people with mental illness offers an important opportunity to prevent homelessness.
- Family reunification can prevent both mental ill health and homelessness.
- Protection of children, and childhood experiences is crucial.

- Strong social networks protect mental health and homefulness.
- Appropriate early treatment of alcohol and drug misuse/abuse may prevent mental ill health and homelessness.
- Early assessment of cognitive capacity (including screening for intellectual disability, acquired brain injury, autism spectrum etc.), and appropriate supports, may prevent homelessness.
- Early intervention must address poverty and debt, family breakdown and violence, and youth homelessness.
- Affordable housing is required – appropriate, long-term, and supported where necessary (SVMHS & CLS 2005, pp.2-13).

In relation to preventing mental ill health, Andrews et al. (1999) stated we need community education, training in self-help activities, and prevention strategies implemented within schools.

We know that in attempts to 'join up' service delivery, service users' perspectives become important. They help us to see across intersectoral gaps, and help us identify effective and practical policy and service delivery strategies (SVMHS & CLS 2005). According to the Mental Health Council of Australia (2009), '*Ten Home Truths*' should direct future action in relation to mental health and homelessness:

1. A national strategy on homelessness must recognise mental illness.
2. Access to mental health care must be increased.
3. There must be investment in innovative home-based programs.
4. Housing must remain a mental health priority for the Council of Australian Governments.
5. Treatment must be available in the community and at home.
6. Housing must be set aside for people with mental illness.
7. Community services must respond to mental illness and homelessness.
8. Properly resources and monitored discharge planning must be implemented.
9. Housing and mental health programs must be regularly evaluated.
10. Research must be a priority.

From a WOP approach to mental health and homefulness, from a recovery approach to service delivery, from a social inclusion approach to public health, and from a pragmatic view of cost-effectiveness, we know that housing and mental health interventions play a key role in keeping people mentally well and housed.

What we don't know

Whilst Tasmania's Statewide and Mental Health Services (SMHS) can account for the numbers of people using the range of clinical and community mental health treatment services delivered by the Department of Health and Human Services on a given day or year, it is impossible to quantify the amount of mental health support work that takes place across non-government

services, including via inter-agency collaborations, let alone informally within the (community including amongst families and between friends). Whilst much is known about the extent of informal caring, including alternative mental health supports and rehabilitation methods, much remains unknown.

In attempts to quantify homelessness, the Australian Bureau of Statistics (ABS) collects data on people using specialist homeless services on Census night. However much is unknown or remains hidden in attempts to quantify and qualify homelessness in Tasmania.

In relation to mental health and homelessness, we lack basic information about prevalence, both nationally and in Tasmania. Due to inconsistent reporting methods, there are gaps in current data collection methods across both sectors. Trends relating to both the number of homeless people who are mentally ill, and the number of mentally ill people who are homeless, are unknown.

In a national review of mental ill health and substance abuse by homelessness service users conducted by the AIHW in 2007, prevalence rates were based on information provided by service providers according to specific inclusion criteria. To be identified as having a mental health problem, service users had to either be referred to the homelessness service by a psychiatric unit, have self-reported psychiatric illness as their main reason for seeking assistance, or be referred on to psychological/psychiatric services by the homelessness service. Based on these inclusion criteria, 12% of Australians using homelessness services were cited as having mental disorders (AIHW 2007). These figures may miss a range of homelessness service users who live with mental ill health – for example those who cite domestic violence as their main reason for homelessness and request assistance with specialist counselling, but who choose not to mention mental ill health and/or previous contact with psychiatric services.

Whilst can access quantitative information about the utilisation of mental health treatment and specialist homelessness services, a mismatch of administrative interfaces between these sectors can multiply inaccuracies. Funding and reporting requirements for mental health and homelessness services remain discrete in Tasmania. Reforms are underway in this area, but a whole range of sub-groups are potentially missed in assessments of prevalence. Examples include:

- People who are not formally case managed within the mental health system may not be identified as homeless; and people who are yet to be formally engaged in homeless services may not be identified as experiencing mental ill health.
- People experiencing symptoms of mental ill health who are yet to be identified and/or are yet to receive adequate mental health support may be missed. This includes individuals whose symptoms are not severe enough or noticeable enough (pre-diagnosis), those individuals who are not case managed, those who are receiving inappropriate support (misdiagnosed individuals), and those choosing not to identify themselves and/or seek out support.
- Primary and secondary homelessness cohorts might be separated into two groups: socially isolated homeless individuals (those who have no choice but to 'sleep rough'), and socially connected primary homeless people (those with friends, family or acquaintances willing to host them for a limited time). In Tasmania, primary homelessness is relatively hidden due to a less obvious public presence of homeless people. This includes residents of lanes, parks, public spaces, cars, and sheds. To some extent, those staying temporarily

with friends or family ('couch surfing', a form of secondary homelessness) are also relatively hidden in Tasmania.

- Whilst all specialist homeless services collect data on service users, some personal details of residents of refuges, shelters, boarding houses, rooming houses, hostels, and supported accommodation services will be missed, for a range of reasons. One example is a lack of detailed data on the reason an individual, couple or family became homeless.
- Temporary residents of motels, hotels, caravan parks, backpacker lodges, and unregistered boarding houses or shared houses may also be missed. People living in short-term accommodation may be attempting to resolve housing instability and find their own way back into stable accommodation – usually at great personal and social cost. Often it is only when a crisis becomes personally 'unsolvable' that people will find their way to emergency housing services.
- Another hidden group is young people who are yet to engage in service systems. This sub-group tend to be transient, relying on friends or extended family members for support. They are yet to link into a service of any kind, including mental health services, housing services, or even Centrelink. They may carry experiences of early life trauma, and may or may not be using drugs and alcohol. It is possible that young people do not know what services exist, or where to find them. A homeless young person's first involvement with a service of any kind may be with the emergency services – such as involvement with the police or hospital.
- Another group at risk of mental ill health and homelessness is older people. With declining physical and mental health, and increasing social isolation, older people may suffer symptoms of depression and other mental health difficulties long before they are identified. In similar ways, an aging person's accommodation may slowly deteriorate or become unstable.
- Individuals being released from youth detention, adult prison, psychiatric hospitals and child protection services (therapeutic residential care) may be especially vulnerable to homelessness and mental ill health if they are not supported to develop a discharge plan that includes housing and ongoing support. The Tasmanian Government has recently identified a range of reforms and funded several new initiatives that seek to prevent 'exits' into homelessness for people exiting these intensive services.
- An additional unknown cohort is single homeless men supporting children (anecdotal evidence suggests that no Tasmanian services are specifically designed to assist fathers).
- In addition to those experiencing family violence, individuals and family members who experience family breakdown (including separation) are at higher risk of mental ill health and homelessness. For example, separated parents attempting to set up two new households with limited income, and children or young people whose parent/s have repartnered (sometimes with step-siblings) may feel alienated and decide to leave the family home prematurely, or be asked to leave home.
- Unemployed people have a specific range of vulnerabilities, both to mental ill health and homelessness, which may be missed in Centrelink data collection. Unemployment can have both short- and longer-term negative effects on mental health. The transition to unemployment can have severe effects on people's capacity to maintain rental properties and cover living expenses.

- The prevalence of mental ill health and homelessness is difficult to assess for specific cultural cohorts. For example, Aboriginal people and people from culturally and linguistically diverse (CALD) backgrounds are not always identified in mental health and homeless service records. Very few culture-specific mental health and homelessness services operate in Tasmania.
- A more recent and less apparent group at risk of mental ill health and homelessness is private home purchasers struggling with mortgage repayments. A recent survey of emergency relief clients found that home owners/home purchasers were a particularly vulnerable group among emergency relief clients, reporting problems with a much greater range of household expenses than other research participants (Flanagan 2009). Anecdotally, this group is presenting more frequently at emergency relief services requiring homeless support, but much is unknown regarding this group in Tasmania.
- In examining the relationship between mental illness and homelessness, some researchers choose to identify which kinds of mental illnesses are more prevalent in homeless populations. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DCM IV-TR, American Psychiatric Association 2000), mental illness clusters include psychotic, affective, non-psychotic, and alcohol and drug dependence (amongst others). The interrelationship between these various illnesses and the existence of co-morbidity is little known in relation to homelessness in Tasmania.
- Drug and alcohol misuse issues (including addiction) have been linked with both mental ill health and homelessness in various research studies. In a review of six studies, Johnson and Chamberlain (2011) found that the prevalence of mental illness amongst homeless populations was difficult to assess given the inconsistency of including substance misuse as a mental health issue or not. An examination of the links between alcohol and drug misuse, mental ill health and homelessness is worthy of further research in Tasmania.
- Another apparent gap in existing knowledge is the prevalence of acquired brain injury or intellectual disability co-occurring with mental ill health and homelessness in Tasmania. Anecdotal evidence suggests that for some people, assessment for these conditions is undertaken for the first time in youth detention, adult prison, or hospital psychiatric services (or not at all). The housing status of patients and first-time offenders is not necessarily recorded. Possible underreporting of intellectual disability and acquired brain injuries means this specific group may be missed.
- A significant number of homeless people experiencing symptoms of mental ill health first present at emergency services, including ambulance, police, and emergency departments in hospitals. Screening of people accessing emergency services for risk of homelessness or mental ill health is warranted.
- Whilst it is understood that good physical health benefits mental health, including reducing feelings of stress, anxiety and depression, and reducing duration and intensity of clinical depression (VicHealth 2011), the interrelationships between various forms of mental and physical ill health are not known. Furthermore, the links between physical ill health, mental ill health and homelessness are unclear.
- General practitioners are another possible entry point into services, yet little is known about their role in assessing or missing mental ill health and homelessness in patients.
- Due to social isolation and fewer services, Tasmanian's living in rural communities and remote locations may be at greater risk of falling into mental ill health and homelessness than those residing in urban areas or areas with higher populations (which tend to have a broader range of services). With fewer social contacts and formal supports, prevention and early intervention may be more difficult. Family fragmentation (such as when young people move to larger towns for study and work, or older people move into aged care facilities), as well as changing patterns in agricultural and natural resource industries, combined with declining numbers mean that rural and regional trends need to be examined in relation to mental ill health and homelessness.
- Transportation has been identified as a barrier to support for rural and regional residents, as well as in urban locations with high concentrations of disadvantage. A lack of transport may affect people's access to a range of support services. The prevalence and impact of transport issues in relation to mental ill health and homelessness in rural and remote Tasmania is unknown.
- Until recent policy reforms, the important role family members, friends and neighbours provide has been largely missed. It is likely that in Tasmania there exists a group of carers who carry on with a carer role they have fulfilled for a long time (as a friend or family member), not necessarily gaining the support they need to sustain their important role – particularly where the mentally ill person has not been formally diagnosed, and it may be difficult or impossible for their carer to persuade them to seek treatment. According to a range of sources, carers themselves (friends and family members) experience greater levels of social isolation, higher levels of financial stress, and a range of mental health issues related to their caring role. It is likely that Tasmanian carers are a vulnerable sub-group in relation to both mental ill health and homelessness, yet no research has specifically identified the risks posed to carers.
- Another phenomenon that complicates definitive statements is the level of mobility and internal migration that occurs in Tasmania – both within the state, and to and from the mainland. Mobility has been identified as a barrier to establishing effective place-based service systems. The lifestyles of people who have lived with mental ill health and homelessness long-term (sometimes identified as having 'homeless careers') may involve patterns of mobility – constantly moving, always transient – that make tracking difficult.

In short, prevalence rates are difficult to gauge due to definitional differences, lack of consistent data collection, and lack of assessment of data across the full range of services that people come into contact with. People experiencing the combination of mental health and homelessness difficulties fall through service cracks. It is hoped that this study will shed light on some of these unknowns, as well as provide some qualitative details surrounding individual experiences associated with this 'double whammy'.

What we need to know

From this literature backdrop, it appears that while much research has been undertaken, in the Tasmanian context much remains unknown. Questions emerge. What do we need to know, in order to better meet the needs of individuals, couples and families experiencing the double difficulty of mental ill

health and homelessness in Tasmania? What questions need to be asked in order to develop useful and achievable recommendations for policy, funding, service delivery, and service linkages?

These unknowns led to the development of research questions and methods, including interview and survey questions. It was decided to investigate people's early life experiences, key transitions points, existing social supports, personal prevention strategies, and recommendations for policy and funding via use of one hour interviews. In addition to interviews, attendees at Tasmania's 'Mental health and homelessness' Symposium (April 2011) were surveyed for their advice across the spectrum of mental health and homelessness interventions. The following table lists questions asked of 20 Tasmanians in an interview setting, in relation to their lived experiences of mental ill health and homelessness. Their responses, combined with the completed surveys of 67 delegates attending the symposium, offer a contribution to the body of evidence relating to mental health and homelessness in Tasmania.

Table 3: Interview questions

Interview Questions	
Introductory questions	
	<ul style="list-style-type: none"> • Please tell me about your current situation – for example what's going well for you, and what's difficult for you at the moment? • Prompts: What is your current housing situation? What are your current time priorities (commitments/activities/other)? What is your current financial situation (income/expenses/pressures)? What are your current closest relationships (family/kids/partner/friends/other)? How is your mental health currently?
Current supports	
	<ul style="list-style-type: none"> • What are the current mental health supports available to you? (Who offers these supports?) • What are the current housing or homelessness supports available to you? (Who offers these supports?) • Who (if anyone) is assisting you with long-term stabilisation of mental health and housing? • Is any one person or service going out of their way to help you in a special way currently? • What do you consider to be the best (most helpful) supports available to you currently? (Which initiatives, services, programs, people, etc.) • What helps you get the support you need?
Looking back	
	<ul style="list-style-type: none"> • What were the key things that lead to your mental health struggles? • What were the key things that lead to your housing instability/ homelessness struggles? • Looking back, could anything have prevented you from experiencing mental health struggles? • Looking back, could anything have prevented you from experiencing homelessness?
Gaps and barriers	
	<ul style="list-style-type: none"> • What's currently not available that would be a great help to you in relation to mental health and housing? • What gets in the way of services providing good support for people? • What's currently not working in the service system?
Dreaming	
	<ul style="list-style-type: none"> • If you could go back in time and be your own supporter, what would you do to help prevent the mental struggles and homelessness you've had to deal with? • What would it take for your mental health to never go as low as it's been in the past? • What would it take for you to be able to maintain stable housing into the future? • If you could make decisions and do things to help other people with their mental health and housing, what you would do as top priority today?

Current policy context

Introduction

Both mental illness and homelessness have received policy attention for many years. Since 2006, all levels of Australian Government have significantly increased their investment in mental health, with an aim of reducing the prevalence and impacts of mental ill health in the Australian community. Since 2007, the issue of homelessness has gained heightened attention, and a range of reforms are in place to reduce homelessness in Australia.

The Council of Australian Governments (COAG) has developed an action plan for each area, which attests to the identified importance of addressing both mental ill health and homelessness from whole-of-government perspectives. In Tasmania, significant reforms are currently underway in both mental health and homelessness sectors. In the last few years, both federal and state treasuries have allocated funds to a range of reviews, reforms, infrastructure, services and facilities. This section presents a policy overview of mental health and homelessness, from both Commonwealth and state perspectives.

Mental health

National mental health policy

1992 was a significant year, producing the First National Mental Health Strategy, the National Statement of Rights and Responsibilities of People with Mental Illness, and the first National Mental Health Plan. In July 2006, the Council of Australian Governments (COAG) endorsed a National Action Plan on Mental Health (NAMH) (2006-2011). This national whole-of-government agreement recognised the importance of addressing mental health promotion, prevention and early intervention, as well as mental health treatment. The original plan focused on four key outcome areas:

1. Reducing the prevalence and severity of mental illness in Australia.
2. Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery.
3. Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention.
4. Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

The agreement also identified a need to address issues in related areas, including in housing, employment, education and correctional services. Responsibility for implementing the Commonwealth component of the COAG plan spans a number of Commonwealth departments, including: the Department of Health and Aging (DoHA), responsible for implementing 11 of 17 measures; the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), focusing on community-based support; the Department of Education, Employment and Workplace Relations (DEEWR); and the Department of Veteran's Affairs (DVA).

Within the COAG NAMH agreement, DoHA holds key responsibility for administering clinical and medical mental health treatment targets, including in acute psychiatric illness (within the hospital system), primary mental healthcare (including Medicare

and access to general practitioners), and allied health services (including the provision of access to allied health professionals). Alongside DoHA, FaHCSIA carries responsibility for achieving COAG NAMH targets in the area of community-based mental health services, including personal helpers and mentors, mental health respite, and a range of community projects. FaHCSIA manages about one-fifth of the Australian Government budget, and according to the COAG agreement, has a key role in addressing mental health promotion, prevention and early intervention.

In 2003, the Third National Mental Health Plan (2003-2008) stated a key aim was to strengthen the capacity of the mental health sector to respond to people with mental illness who are homeless. In 2008, Australian Health Ministers endorsed a new National Mental Health Policy which formed the basis for development of the Fourth National Mental Health Plan (2009-2014). The Fourth National Mental Health Plan provides the current framework for mental health reform and service delivery in all states and territories, and includes action plans relating to five priority areas: social inclusion and recovery, prevention and early intervention; service access, coordination and continuing care; quality improvement and innovation; and accountability (measuring and reporting progress). The Plan is based on a population health framework, and promotes a whole-of-government approach. The following practice principles underlie the Plan:

- Respect for the rights and needs of consumers, carers and families.
- Services delivered with a commitment to a recovery approach.
- Social inclusion.
- Recognition of social, cultural and geographic diversity and experience.
- Recognition that the focus of care may be different across the lifespan.
- Services delivered to support continuity and coordination of care.
- Service equity across areas, communities and age groups.
- Consideration of the spectrum of mental health, mental health problems and mental illness.

Tasmanian mental health policy

The Tasmanian Government addresses their responsibilities to the National Mental Health Plan via involvement in the Australian Health Care Agreement, the National Preventative Health Taskforce, and the National Health and Hospitals Agreement. The Tasmanian Department of Health and Human Services (DHHS) administers reforms and service delivery relating to mental health in Tasmania via Statewide and Mental Health Services (SMHS).

Tasmania's commitment to the COAG NAMH (2006) includes targets in: promotion, prevention and early intervention, integrating the care system, alcohol and drug programs, secure mental health in-patient treatment, access to psychiatric care, youth health services, employment, accommodation for people with mental illness, and workforce development.

In 2004, three studies significantly influenced mental health policy reforms in Tasmania, leading to significant new investment in mental health by the state Government: *Bridging the Gap*:

a review of mental health services (DHHS 2004), *Thin Ice: The experiences of Tasmanians with serious mental illness* (Cameron & Flanagan 2004), and a review of Ward 1E. The development of Tasmania's Mental Health Services Strategic Plan (2006-2011) established a clear set of guidelines to inform state-based actions aimed at achieving better mental health outcomes for the Tasmanian community. This plan aligns with the Department of Health and Human Services Strategic Directions (2009-2011), and sits alongside an action plan for implementing mental health promotion, prevention and early intervention (PPEI) strategies in Tasmania (ANPPEIMH & Rickwood 2009; DHHS 2009a). These strategies intentionally complement national and state aims in relation to suicide prevention, social inclusion, and homelessness prevention.

Tasmania's Mental Health Services Strategic Plan (2006-2011) includes actions relating to social inclusion and recovery, the first priority within the Fourth National Mental Health Plan. Tasmania's Statewide and Mental Health Services (SMHS) seek to develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community and integrated approaches between housing, justice, community and aged care sectors (to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage).

In the area of coordination and innovation, current issues influencing mental health reforms in Tasmania include: dispersed population base; high service demand; coordination of service delivery and continuity of care; workforce development; national health and hospital reform; embedding promotion, prevention and early intervention in specialist mental health services; reorienting services towards a recovery focus; implementing effective consumer and carer participation; collaboration and coordination between services; and establishment of supported accommodation and housing options for people with mental ill health.

A critique of national and state mental health policy reforms highlights that contemporary conceptualisations of mental health include consideration of physical, social, environmental, and economic health, yet do not mention trauma – seen as causal to mental illness for many people (re-traumatisation exacerbates existing symptoms). In the mental health arena, the challenge is to find a working balance between identifying needs (risks, illness, etc.), focusing on solutions (protective factors, wellness, etc.), and allocating resources expediently. For some, getting this balance right means the difference between a mental health system that contributes to stigmatisation and further traumatisation, and one that promotes healing. Unless staff within the mental health service system are supported to enact recovery principles (including care for service users), the service system may work against its own aims. The conversation about trauma and re-traumatisation is missing within mental health policy documentation, both nationally, and in Tasmania.

Homelessness

National homelessness policy

Housing and homelessness services have undergone significant reform over the last decade. As early as 1944, the Commonwealth Housing Commission reported a national housing shortage – at that time recorded as a shortage of 300,000 dwellings (FaHCSIA 2011). On that basis, the first Commonwealth-State Housing Agreement (CSHA) was established, committing the Commonwealth Government to increase housing stock. Jump forward to 1985, and alongside the CSHA, the Australian

Government's primary response to preventing and reducing homelessness was the Supported Accommodation Assistance Program (SAAP) and the Crisis Accommodation Program (CAP), jointly funded by Commonwealth and state/territory Governments. A 1998 review and evaluation of SAAP (released in 1999) acknowledged both achievements and significant service gaps.

In 1999, a National Homelessness Strategy (NHS) was funded through the SAAP IV National Priorities. Since its inception, the NHS has provided a holistic and strategic approach, focusing on prevention, early intervention, working together, and crisis transition and support. The NHS appointed a Commonwealth Advisory Committee on Homelessness (CACH), and released a national strategy to address homelessness (*Working Towards a National Homelessness Strategy* 2001). The strategy identified key objectives relevant to the task of preventing and reducing homelessness including: a strategic framework that laid foundations for collaboration and linkages; identification of best practice models; strengthened capacity of community sector to improve linkages and networks; and awareness raising across all areas, levels of government, and in the community.

In 2004, CACH provided advice on mental health and substance abuse as causes of homelessness. Also in 2004, a National Evaluation of SAAP found that services needed to develop stronger connections with income security, employment, and educational agencies, while at the same time improving collaborative arrangements with mental health, drug and alcohol, housing, and child protection services.

In May 2008, the Australian Government released a Green Paper on homelessness, followed by a White Paper, *The Road Home: a national approach to reducing homelessness* (December 2008). The White Paper articulated the Government's goals to halve homelessness by 2010, and to offer supported accommodation to all rough sleepers who need it by 2010. In the White Paper, homelessness was presented as more than just a housing problem, demanding a whole-of-community response. An underlying premise in the Plan is that homelessness should be prevented, and that those who fall into homelessness should move quickly through the crisis system into long-term housing, whilst concurrently receiving support to participate in education, employment and the community. Along with a plan to increase the supply of affordable housing and specialist housing models, cornerstones of the Plan included aims to: 'Turn off the tap' (intervene early and prevent homelessness); improve and expand services; and 'Break the cycle' (ensure homelessness does not reoccur).

In January 2009, the Council of Australian Governments (COAG) set up the National Affordable Housing Agreement (NAHA) to replace the previous CSHA. The NAHA covers measures at all levels of government that impact on housing affordability. Alongside the NAHA, a National Partnership Agreement on Homelessness (NPAH) was established, in order to forward four NAHA outcomes:

- 1) Fewer people will become homeless, and fewer of these will sleep rough.
- 2) Fewer people will become homeless more than once.
- 3) People at risk of or experiencing homelessness will maintain or improve connections with their families and communities, and maintain or improve their education, training or employment participation.

- 4) People at risk of or experiencing homelessness will be supported by quality services, with improved access to sustainable housing.

Alongside these agreements, COAG established a National Partnership Agreement on Social Housing and a National Partnership Agreement on Remote Indigenous Housing. The Commonwealth Government's Nation Building and Jobs Economic Stimulus Plan (ESP) has provided additional investment in social housing. The National Rental Affordability Scheme (NRAS) provides another lever to assist national homelessness reduction targets. In 2011 SAAP became Specialist Homelessness services (SHS) (requiring transition to new reporting requirements). A review of SHS is currently underway.

Tasmanian homelessness policy

The Tasmanian Government addresses their responsibilities to the White Paper and the four COAG agreements via two key plans, the *Homelessness National Partnership Implementation Plan for Tasmania (2009-2013)* and the *Tasmanian Homelessness Plan (2010-2013): Coming in from the cold*. These documents present a whole-of-government and community approach to reduce and prevent homelessness in Tasmania. *Coming in from the cold* aims to prevent and reduce homelessness by building on improvements already achieved, and by better coordinating access to housing and support services so they are available where and when needed for the duration of need. Key themes in Tasmania's Plan include: increasing supply of affordable housing; new support services; engaging mainstream service system; improving service coordination; improving assessment referral and discharge planning; and improving inter-agency collaboration. Key priorities include targets relating to new supply, new services, and new ways of doing business (reform). Tasmania's Plan seeks to make sure homelessness is seen as 'everyone's responsibility', and ensure that homelessness clients get easy access through a streamlined service. Reforms involve creating an effective, efficient, integrated housing and homelessness service across policy, practice, protocols, funding, and co-location.

The Tasmanian Department of Health and Human Services (DHHS) administers reforms and service delivery in the area of housing and homelessness via Housing Tasmania (HT). HT is an operational unit within the Disability, Housing and Community Services Group. HT includes: housing services, housing strategy, strategic asset management, community housing, indigenous housing services, and homelessness services. HT manages contracts with Specialist Homelessness Services (previously SAAP), and is responsible for achieving national reform targets. To aid implementation of national policy reforms, and as a direct result of a Tasmanian homelessness report by Haggerty (2008), the Tasmanian Government established a Housing Innovations Unit (within DHHS) to specifically address housing supply issues in the Tasmanian context. Alongside national and state homelessness reform agendas, HT aligns with national and state Social Inclusion agendas and SMHS targets in relation to housing people with mental illness.

Tasmanian homelessness targets rely on ABS Census data and regular analysis of the national SHS data set (previously SAAP) by the Australian Institute of Health and Welfare. Attempts to develop new affordable housing supply are underway. Recent Tasmanian Government responses to homelessness include: Same House Different Landlord – KEYS to the Future; Five new Supported Accommodation Assistance Facilities; Specialist Intervention Tenancy Service – STAY service; Service Coordination and Improvement Program; and Workforce capacity audit and development plan.

Current priorities within HT's Service Coordination and Improvement Program include: projects focused on 'developing new ways of working'; a statewide roll-out of the NW Mental Health Pilot Program (to enable people with mental health issues to be given priority access to public housing with support); the development of housing and homelessness risk identifiers within mainstream services' admission/intake assessment and discharge planning processes (to ensure no one 'exits' a government institution into homelessness); and the development of whole-of-government protocols for discharge planning, referrals and sharing of information between services. Further improvements in service coordination will be supported by structural financial changes. In line with *Coming in from the cold* strategic objectives, HT has developed a discussion paper, and engaged Youth Development Australia to develop a consumer engagement strategy and a homeless charter (Youth Development Australia 2011). It is anticipated that a shared responsibility for homelessness will be promoted through cross-checked budgets measured against shared outcomes in the future.

A critique of national and state homelessness policy reforms illuminates that contemporary conceptualisations of 'homelessness' risk contributing to the marginalisation and stigmatisation of people experiencing homelessness. For those advocating a 'human rights' approach to homelessness, discourses about complex needs and social isolation are not as helpful as a dominant focus on the priority of ensuring every Australian has access to affordable safe appropriate housing. It is envisaged that a 'human rights' emphasis may assist to reconceptualise and de-stigmatise the difficult experience of homelessness in the Tasmanian context.

Current service landscape

Introduction

For Cameron and Flanagan (2004), it is difficult to measure the accommodation needs of people living with mental illness across Tasmania. In a study on people living with serious mental illness and poverty in Tasmania, findings demonstrated that people tend to live in a cycle of homelessness, with repeated movements through a range of accommodation types. When examining the range of services in place to support people experiencing both mental ill health and homelessness, findings demonstrate it is difficult to draw the line (define where the service system ends), and do justice to the complex interrelationships between all services (both specialist and mainstream services) (Cameron & Flanagan 2004).

This section presents an overview of 'Treatment' in the mental health service system, and emergency and transition services ('Transitional Housing') in the homelessness service system. It is recognised that support is offered in both sectors prior to a crisis (early intervention), and after a crisis, in order to help stabilise people (continuing care). It is also recognised that much support is offered via informal or unrecorded support networks (for example a friend or community groups). Unfortunately it is beyond the scope of this project to map the service interface between mental health and homelessness service sectors in detail.

Tasmanian mental health services

Tasmania has a high mental health budget per capita. According to the Australian Bureau of Statistics (2011), whilst mental and behavioural disorders decreased as the main disabling condition in Western Australia, Victoria, Queensland and South Australia between 2003 and 2009, prevalence rates in New South Wales and Tasmania increased by 0.5% and 0.4% respectively.

The Mental Health Council of Tasmania is the peak body for supporting the needs of Tasmanians with mental ill health. DoHA and FaHCSIA are central to the funding of mental health services in all states and territories. In Tasmania, SMHS has accountability for care of the 3% of Tasmania's population with a severe mental illness. Together, DoHA, FaHCSIA and SMHS provide support for an additional and essential range of community organisations (non-government organisations) delivering mental health services across three regions in Tasmania.

Both the Fourth National Mental Health Plan (2009-2014) and Tasmania's Mental Health Services Strategic Plan (2006-2011) identify a range of principles underlying service delivery and practice relating to the delivery of mental health treatment services. A key principle in both strategies is that services be delivered with a commitment to a 'recovery' approach – both as a process and an outcome, in order to promote hope, wellbeing and autonomy. This approach requires staff to work with service user's strengths, including coping skills and resilience, and capacity for self determination. Additional cornerstones of practice include commitments to social inclusion, involving addressing needs across age, gender and culture. From a recovery approach, Tasmania's Statewide and Mental Health Services (SMHS) highlight the following principles within their model of care: centred on consumers; promotes recovery; provides services equitably and efficiently; least restrictive care; increasingly skilled workforce; assertive and individual case management; partnership with consumers, carers, families and service providers across all levels of government and the community sector; and promotion, prevention and early intervention (PPEI).

SMHS comprises: mental health services (including the Mental Health Services Helpline), alcohol and drug services, forensic health services (incorporating correctional primary forensic mental health services), and other health and wellbeing services (oral health, etc.). In relation to mental health, SMHS responsibilities include delivery of inpatient and extended treatment services, older persons mental health services (acute inpatient services, day centre, community services, and a dementia support unit), adult community mental health services (includes in-patient/extended care and community services, plus a number of adult community centres), child and adolescent mental health services (delivered mostly as community-based services, but includes admission to paediatric ward if required), and recovery and rehabilitation programs (provided in the community sector).

In an attempt to provide an overview of mental health treatment services across commonwealth, state, and community-delivered services, mental health services are listed here under general service types, according to their role in:

- *Assessment and support*;
- *Intervention and support* (ie. Treatment – which usually means clinical treatment); and
- *Stabilisation and support* (ie. Continuing care).

All three of these 'stages' in mental health treatment rely on a recovery approach to service delivery. The lists are not seen as definitive, but attempt to offer a broad overview of a complex service sector.

Assessment and support includes all first-point-of-contact services for people experiencing mental illness, and acute services (for both voluntary and involuntary patients). These services are usually called primary (or clinical) mental health services. In Tasmania, these include: hospital emergency department, hospital inpatient and outpatient services (including case management),

forensic psychiatry, child and adolescent mental health (CAMHS), general practitioner referrals (to hospital, psychiatrist, psychologists), acute/crisis assessment teams (CAT), and carer and consumer consultants.

Community-based services meeting the needs of people at high points of need are delivered by government and non-government services and the private sector, including: crisis services (assess level of service required), outreach, counselling, disorder-specific programs, clinics and counselling (e.g. dual diagnosis services), case management, family support, community-based psychologists, psychiatrists, general practitioners, and mental health legal services.

Intervention and Support includes inpatient, transitional and outpatient services. In Tasmania these include: inpatient services (includes medical treatment and discharge planning, e.g. occupational therapy), outpatient services (step down transitional care/community residential units), and independent living outreach/outpatient services (case management, mobile support team, and outpatient psychiatry).

Community-based services that offer a form of intervention (sometimes called clinical services) delivered by government, non-government and the private sector include discharge support, outreach, counselling, disorder-specific programs, clinics and counselling (e.g. dual diagnosis services), case management, family support services (including respite), family reconnect services, parenting support services, community-based psychologists, psychiatrists, general practitioners, personal helpers and mentors (PHaMs) program, family mental health support, and psycho-social rehabilitation services. Housing services are also provided within this area of work.

Stabilisation and Support includes recovery, self management, relapse prevention and rehabilitation services. In Tasmania these include: case management discharge (disorder-specific), outpatient psychiatry (pharmacotherapy, etc.), and independent living outreach/outpatient services (case management, mobile support team).

Community-based services in this area of work are delivered by government, non-government and the private sector, and include: case management (discharge support), counselling, disorder-specific programs and clinics (e.g. dual diagnosis services), family support, family reconnect, parenting support services, respite, community-based psychologists and social workers, psychiatrists, general practitioners, personal helpers and mentors (PHaMs), family mental health support, and psycho-social rehabilitation services. In addition, community-based mental health treatment services have a role to play in supporting service users in areas of housing, economic participation (employment, education etc.), social connection (peer support), and encouragement towards community participation. Housing services are also provided.

The current legal framework for mental health rests on the Mental Health Act (1996). This Act has been undergoing a long period of review with community sector advocates calling for adequate safeguards to protect the rights of people with a mental illness. Of particular relevance to this research, is the need for legislation to be underpinned by a mental health system with well-functioning elements of prevention, early intervention, integrated community support and access to quality treatment, and to support for advocacy and representation (Anglicare, 2007).

Like elsewhere, current tensions in relation to the delivery of mental health services in Tasmania include problems associated with:

- A perceived cultural clash between medical and community services (a clinical approach versus a psychosocial approach). Increasingly this is an artificial divide with a range of services/interventions being provided across the service system.
- A tension between focusing on 'easily-addressed' issues versus addressing impossibly complex issues (and who is responsible). Across the entire mental health treatment sector resources are in short supply, so the question of which services are able to provide which supports is an ongoing debate.
- A dilemma that occurs across all human services is the sometimes tense interface between service user needs versus worker needs. An example of this is a worker's need for a service user's drug and alcohol use to be under control first, whereas a service user may express the need for stable accommodation before being able to address their substance misuse issues (Tsemberis, Gulcur & Nakae 2004).

In Tasmania, each of the three administrative regions has their own specific set of service delivery needs and challenges (not to mention sub-regional differences). It is acknowledged that the mental health service landscape is complex and multi-layered, and that much unrecorded treatment work is done by community organisations and informal community groups who offer healthy relationships and healing environments promoting mental wellbeing.

Tasmanian homelessness services

As a state, Tasmania has the fourth highest homelessness rate per capita. Tasmania's rate of homelessness (52.6 per 10,000 population) was equal to South Australia in 2006. The proportion of Tasmanian families who were homeless in 2006 and accommodated in SAAP was 52% (238 families). This was slightly higher than the Australian figure of 50%. (Chamberlain & MacKenzie 2008).

FaHCSIA is central to the funding of homelessness services in all states and territories. In Tasmania, Housing Tasmania (HT) has predominant accountability for homelessness services, including administering SHS services and establishing new services. HT also has responsibility for maintaining public housing stock. Shelter Tasmania is the peak body supporting the housing and homelessness needs of Tasmanians. Currently, there are 14 SHS in the South, 6 services in the North, and 7 services in the North West. In terms of client focus, 8 of these are for young people, 7 are for women and their children, 3 are for men, and 9 cater for a variety of people who are homeless or at risk of homelessness.

Both the Commonwealth Government's White Paper (*The Road Home*) and Tasmania's Homelessness Plan (*Coming in from the Cold*) identify a range of principles for service development and delivery, based on the central premise that 'homelessness is everyone's business'. This means that both specialist services and mainstream services have a responsibility to identify and respond to homelessness – a homeless person must never feel they've asked the wrong person or agency for assistance ('no wrong door'). *The Road Home* identifies that all services working with homeless people should focus on getting them into stable long-term housing, as well as into employment and training or other community participation. Tasmania's Homelessness Plan is based on a set of principles that align with Tasmania's Social Inclusion Strategy, including:

- Keeping the person at the centre of any intervention, offering hope and self-determination.
- Homelessness is a whole-of-government and community responsibility.
- A combination of political, business and community solutions are required.
- Practical and creative solutions are required (a 'one size fits all' approach does not work).
- Solutions must be evidence-based and underpinned by action learning.
- Social, economic and democratic inclusion are the key to responding to homelessness.

Previously called SAAP, Tasmania's Specialist Homelessness Services (SHS) have implemented an Integrated Continuum Of Support (ICOS) model to support homeless people through a process of assessment, referral and support towards self reliance. Services are funded according to their role within the continuum of care, and according to the kinds of support they provide.

Additional cornerstones of service delivery include a commitment to address needs across age, gender and culture, including Aboriginal people and people from culturally and linguistically diverse (CALD) backgrounds. True to a commitment of a whole-of-government and community approach to reducing homelessness, Tasmania's Homelessness Plan includes a set of five objectives, each with a clearly identified action and timeframe. Each action has an identified lead partner responsible for achieving the action and true to policy directions, lead partners reflect a breadth of government, non-government and private agencies to be held to account.

In an attempt to provide an overview of homelessness services delivered by Commonwealth- and state-funded services and community-delivered services, service types are listed here according to their role in:

- *Assessment and support* (which usually means case planning and support, and sometimes includes access to immediate emergency accommodation for up to six weeks duration).
- *Intervention and support* (Accommodation – which usually means access to immediate emergency accommodation for up to 6 weeks duration, and may mean access to special accommodation for up to 2 years duration).
- *Stabilisation and support* (Transition to independence – which usually means access to special accommodation for up to 2 years duration, but may include long-term and permanent housing).

Whilst this framework follows an Integrated Continuum of Support model (and a previous SAAP funding structure), all three levels of service delivery may be overlaid with a Housing First approach (i.e. ideally, long-term accommodation would be arranged for a person at any entry point to the service system). The lists by no means suggest all homelessness support follows a linear trajectory – real life is different to that. Neither do these lists convey the breadth of homelessness work being undertaken in Tasmania. Preventative work being undertaken is not included. The lists are used to portray general features within Tasmania's homelessness service landscape; in the case of housing, there is considerable overlap in service delivery across each level. From a

whole-of-population framework, these lists focus on Treatment (which in this sector means emergency and transitional housing).

Assessment and support includes early intervention and crisis services. In Tasmania, these include: use of brokerage funds to maintain accommodation, crisis assessment and support, information and referral services, immediate emergency accommodation (IEA), crisis services, outreach, case planning and support, and advocacy. The STAY program (previously Specialist Intervention Tenancy Service) offers intensive support and access to KEYS program properties (previously *Same House Different Landlord* program).

Additional services for people with immediate housing needs include: renters legal services, support to secure/stabilise current tenancy (Private Rental Tenancy Support Service), private rental support (Private Rental Support Services), provision of direct tenancy partnerships with community organisations and Housing Tasmania, community-based housing, and Homeshare (support for home owners).

Intervention and Support includes transitional accommodation services. In Tasmania these include: overnight emergency beds, immediate emergency accommodation (IEA), use of brokerage funds to purchase IEA in the private sector, supervised supported accommodation for young people, transitional housing for adults and for women with children, crisis services, outreach, case planning and support, and advocacy.

Additional supports for people with some degree of housing stability (i.e. short-term/medium-term accommodation in place) include: exit planning, access to primary health practitioners, provision of financial assistance, financial counselling, general counselling, disorder-specific clinics and programs (e.g. dual diagnosis services), family reconnection services, family support, parenting support and psychosocial rehabilitation.

Stabilisation and Support includes services supporting transition to independence. In Tasmania these include: long-term case planning and support (including discharge/exit support), STAY (previously the Specialist Intervention Tenancy Service), advocacy on a systems level, access to brokerage funds, private rental assistance (Private Rental Tenancy Support Service), provision of direct tenancy partnerships, KEYS properties, supported accommodation facilities (SAF), community-based housing, and public housing. More initiatives will be operational in the coming months, including five more supported accommodation facilities, and the Supported Tenancy Service for Parolees, Prisoners and Remandees (STSPPR) to assist people exiting institutional settings.

Additional supports for people with relatively stable housing (i.e. medium-term/long-term accommodation in place) are similar to the supports available to those still in transitional housing, including: access to primary health practitioners, mental health treatment services, provision of financial assistance, financial counselling, general counselling, disorder-specific clinics and programs (e.g. dual diagnosis services), family reconnection services, family support, parenting support, psychosocial rehabilitation, and opportunities for social, recreational, economic and community participation. The Tenants Union of Tasmania also has a role to play at this level.

The legal framework for current homelessness initiatives rests on the SAAP Act (1994), which has been criticised for holding SHS services to a linear (ICOS) framework, requiring service users to progress towards stable housing in a staged way.

Current policy issues in relation to the delivery of homeless services in Tasmania include problems associated with:

- A need to increase the supply of affordable housing. In general housing and homelessness services are not able to meet current demand, and workers have difficulty finding housing for people moving out of homelessness services. There is a lack of affordable, appropriate housing stock. Current government policy directions favour a reduction in the supply of public housing and the utilisation of the private market to address affordability and supply issues. This has resulted in increasing unmet demand.
- An Integrated Continuum of Support model versus a Housing First approach. This includes the challenge of finding a balance between resourcing a safety net versus investing in a strong housing strategy. This dilemma also relates to investment in prevention (preventive) measures versus treatment (reactive/transitional) measures. Without adequate housing stock, workers are forced to work within ICOS model.
- Mainstream services versus SHS services. This includes the question of where the role of SHS services stop and mainstream services start (i.e. which sector is up-skilled and resourced to do what).
- Service user needs versus support worker needs. For example, service users typically identify the need for long-term housing, mental health services, and dental services before medical services and financial assistance. In contrast, workers typically identify the need for mental health services, long-term housing, and financial support, as well as substance abuse treatment services (SVMHS & CLS 2005, p.30).
- In Tasmania, regional and sub-regional issues need to be taken into account. The provision of housing and homelessness services must include consideration of remoteness, provision of additional support services, access to public transport, access to employment, and population density.
- Addressing the housing needs of people exiting care, hospital and detention (youth and adult prison settings) can be problematic as this task may be considered the role of another worker or agency.

Individual housing service providers have described the application of recovery-based practice within the delivery of housing and homelessness services as a value-adding strategy across the spectrum of services (Anglicare 2010) yet such strategies are yet to be implemented on a systemic level.

Service gaps and barriers

Based on research evidence, policy documents and an overview of Tasmania's mental health and homelessness services, a sample of service gaps, barriers and successes (including good practice examples) are provided. This section helps to 'set the scene' for a critical review of services provided via twenty case examples (Part C).

Key service gaps:

- There exists a lack of housing stock in general. This includes a lack of affordable private rental, a shortage of crisis accommodation (Immediate Emergency Accommodation), a shortage of medium-term and long-term supported accommodation facilities, and a shortage of public/social housing. In addition to these shortages, there exists a lack of

appropriate affordable accessible housing for people living with mental ill health in particular.

- There exists a shortage of preventative initiatives and early intervention services in relation to mental health, meaning that crisis and acute mental health services are under huge pressure and unable to meet existing demand.
- There exists a lack of consistent assessment, referral and support pathways for people moving between mental health and homelessness services.
- For a range of reasons, people are 'exiting' into homelessness upon discharge from institutional care settings, including youth detention, adult prisons, and psychiatric inpatient units.

Key service barriers:

- People with mental illness are at high risk in a competitive housing environment, and like other sub-groups, may be disproportionately affected by housing policies.
- The private rental market is expensive and limited, and discrimination exists in relation to obtaining private rental properties.
- There is a shortage and insufficiency in appropriate accommodation for people living with mental illness.
- Public housing waiting lists are long, and much unmet need exists.
- There exists a lack of information about services and specific supports available (what is available and where/how to find them) in both mental health and homelessness service sectors.
- There exists a lack of service flexibility and capacity to adapt to the needs of individual service users (due to rigid legal and funding structures) in both mental health and homelessness service sectors.
- Obtaining accommodation (a roof) is essential, but may not be enough. For some people living with mental health difficulties, tailored and flexible support may be required in order to maintain housing.
- Stigma associated with mental ill health and homelessness exists, and can be a barrier to both service uptake and service provision.



Potential service solutions

A relative dearth of literature evidence exists in relation to the effects and effectiveness of Tasmanian mental health and homelessness services (including a lack of formal evaluations and published information). Whilst a review of Tasmanian community sector organisations funded by SMHS was undertaken in 2009, and a review of Tasmanian Specialist Homelessness Services is imminent, an assessment of contemporary service successes is difficult to make, other than via out-dated published information, in-house program material, or anecdote. A full review of Tasmanian services is beyond the scope of this study, however on the basis of an initial literature investigation, a brief discussion is provided.

In 2003, a review of three mental health/housing supported accommodation projects was undertaken, including TAMOSCH (in the North West, a collaboration between Anglicare, the Home and Community Care program, SMHS, and Housing Tasmania), Barton Lodge (in the North, a collaboration between Housing Tasmania, Richmond Fellowship, and SMHS), and Lutana (in the South, a collaboration between SMHS Mobile Intensive Support Team and Housing Tasmania) (Quinn 2003). The report demonstrated successes had been achieved in each program. Anecdotally, many changes have since taken place in each program. Due to lack of published information since 2003, these services can not necessarily be held up as best practice examples of Tasmanian mental health housing services at this time.

Also in 2003, the Tasmanian Department of Health and Human services supported the development of service protocol between SMHS and SAAP, including information, referral processes, client information management processes, contact details, case conferencing, grievance procedures, and management (Tasmanian Government 2003). This set of protocol was established on the basis of a previous set of protocols set up in 1994-5 that had fallen into disuse. Anecdotally, it appears the 2003 SMHS-SAAP protocols may have also fallen into disuse. Further investigation into why and how these protocols fell into disuse is warranted.

Now in operation for several years, the Northwest 'Pilot Project' is a collaborative initiative between SMHS and HT services in the North West. The initiative included the development of inter-agency protocol and the establishment of working relationships between services to ensure the provision of priority housing for people living with mental ill health. The pilot program was reviewed and an unpublished report was completed. Anecdotally this model has been heralded as a successful housing initiative for people living with mental health in that region.

A review of Tasmanian community sector organisations funded by SMHS was undertaken by Tohl (2009). At that time, twelve programs were reviewed, including: Anglicare Tasmania's recovery programs (in the South, North and North West); Aspire's recovery programs (Aspire: A Pathway to Mental Health Inc, in the South, North and North West); and five Richmond Fellowship residential rehabilitation services (Richmond Fellowship of Tasmania Inc., Glenorchy, Rokeby, Mowbray, Ulverstone, Lindisfarne and Northwest). Findings demonstrated a number of successful mental health housing models:

It is the Evaluator's view that the community service organisation programs are providing significant benefits for people with a mental illness and they play a valuable role as a part of the Tasmanian Government's investment in the mental health system (Tohl 2009, p.6).

The report demonstrated a number of areas for improvement. Key recommendations included: service agreements, community recovery program models, residential recovery program models, participant data analysis, evidence base and quality focus, outcome measures, service outcomes and perception of care, participant feedback, family/friend feedback, extent of integration, reporting, value for money, and other issues. In relation to ensuring best practice, the evaluator noted: more education and training was needed for staff to better understand the recovery approach; both Mental Health Services and community organisation staff needed to develop a higher appreciation of the important roles of each sector in assisting people in their recovery journey; that the tension between Mental Health Services and programs needed to be addressed strategically and promptly (p.16); and that DHHS need to explore the possibility of increasing affordable housing options and supported housing with security of tenure for participants. In relation to housing people with mental illness, the evaluator noted:

During the review, stakeholders raised the issue of a severe lack of affordable housing options and supported housing, with security of tenure across Tasmania. It is considered that this creates delays in participants exiting the residential recovery programs. Participants also reported this issue in the Focus Group. The lack of affordable housing options and supported housing needs to be further explored (Tohl 2009, p.13).

Based on the literature review that informed this section, it is acknowledged that a mapping project to identify and describe government and community service organisations delivering services in mental health and homelessness may be highly useful to both sectors. Outcomes from such a project would include useful information about the interface between these two service sectors, along with a description of referral pathways. A comprehensive review of the effects and effectiveness of existing Tasmanian services is also warranted, including identification of best practice examples.

The next section provides information about Tasmanian mental health and homelessness service sectors from a birds-eye action-oriented perspective. Tasmanians with lived experience of mental health and homelessness offer their perspectives.

Part C: What the experts say

A JOLLY SWAGMAN

Give me a swag
where the air is fresh and clean
where the banjo is being played and
the song chiming to the tune of Waltzing Matilda.

Give me a swag
where the smell of the barbie
lingers for days and where we had a barmy of a time.

Give me a swag
where there is plenty of juice
alongside with the mosies and the flies
we will play two ups and see how we go with it mate.

Give me a swag any day
where the bushman lay to rest
under the stars and the moon
in the open land
that is ours

T.P. Martin
July 2010

Introduction

This chapter provides stories and advice from twenty people with lived experience of the difficult combination of mental ill health and homelessness in Tasmania. The twenty case examples are based on a one to two hour interview with each person and comprise:

- Seven young people (aged 15-24);
- Nine adults (aged 25-59) with and without children; and
- Four older people (aged 60+).

Following the case examples, summaries of common 'early life experiences' and 'transitions into homelessness' are provided, along with a discussion of various themes that emerged. Key quotes are provided under each of the following topic areas: accommodation, income, employment, Centrelink, alcohol and other drugs, and mental health. A concluding section presents a summary of recommendations and requests, arising directly from the advice of the research participants.

Overview of research participant demographics

Regions

In Tasmania mental health and housing/homelessness services are administered across three regions. Research participants were relatively evenly spread with seven from the North, eight from the South and five from the North West. Unfortunately no interviews took place on the West Coast.

Cultural heritage

In order to include people from different cultural backgrounds, interviews were sought with people from Aboriginal and culturally and linguistically diverse (CALD) backgrounds. Without specific targeting, it is likely these cultural groups would not have been included. All but one of the research participants was born in Australia. Use of the term 'cultural heritage' was intentional, in the hope that the question might be answered in a way that had relevance to the respondent; for example, personal perceptions of ancestry, race, place, language, traditions or identity. Fourteen research participants claiming European heritage were Anglo-Celtic, and one person had southern European heritage. Three people identified as Aboriginal. Three participants were unsure what their cultural heritage was. Two of these three were young people disconnected from family and had no knowledge of their family's cultural heritage. They believed they may have been Aboriginal. One person came from an African community.

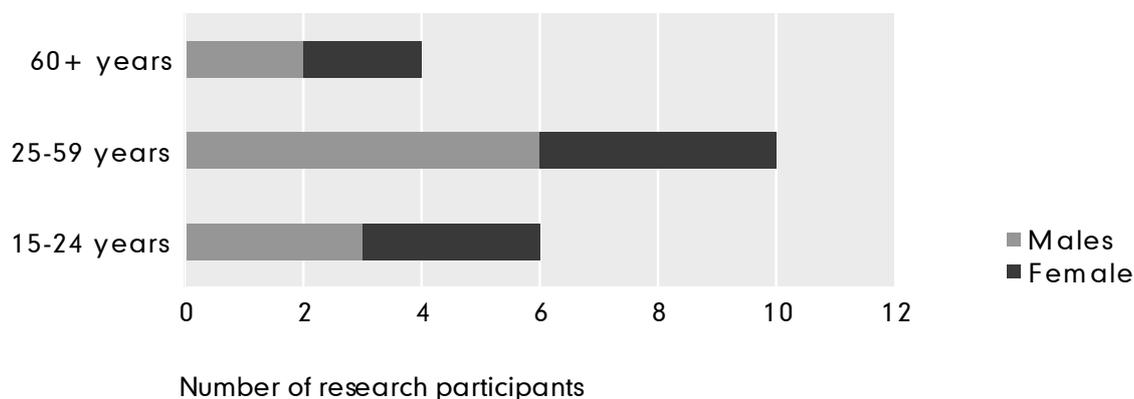
Ages and genders

A decision was made to include a breadth of ages in this study, including young people and older people. Without this as a specific intention, these groups may not have been included. Participation was relatively even across males and females. No research participant identified as transgendered. Interviewees were not asked about their sexuality.

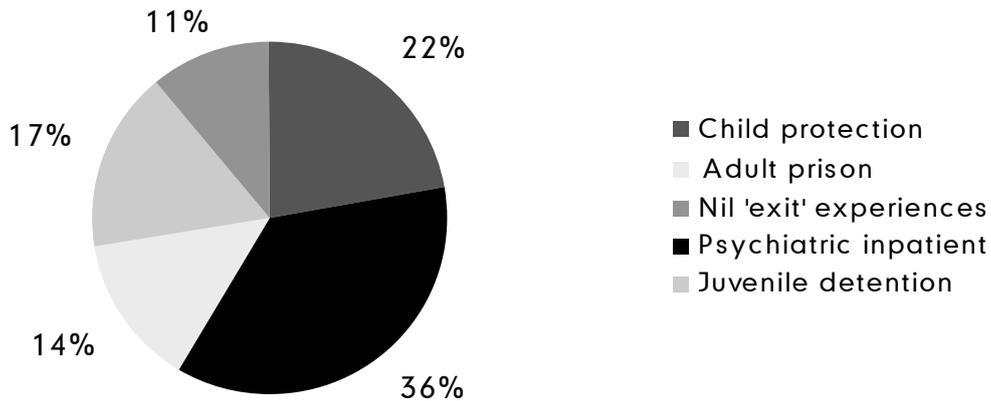
'Exit' experiences

Based on research demonstrating that 'exiting' from intensive services raises risks for homelessness, all research participants were asked if they had previous involvement in: a) child protection (either as child or parent); b) hospitalisation for mental ill health; and c) detention (either as a juvenile or adult). The majority of interviewees had experienced involvement in at least one of these intensive services in their lifetime. Six research participants had experienced at least three forms of intensive services. Four research participants had not been involved in these services at all.

Age and Gender of research participants



'Exit' experiences of research participants



Family groups

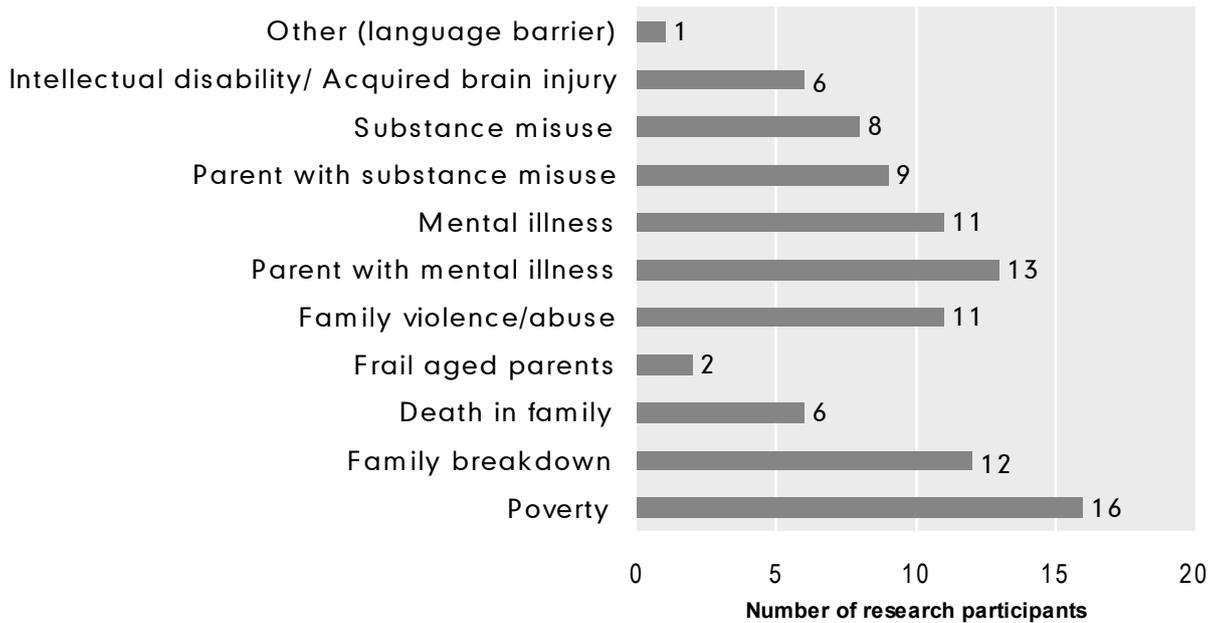
In terms of child and parent relationships, the largest sub-group in the research sample included adult males aged 25-59 without children (five of six men in this age group did not have children). Two of these men regretted not having children, stating they had not met the right partner. Only three of nine women did not have children (two of the three were seventeen years old). No research participant spoke about other family groups, such as families without children, or gay and lesbian families.

Ten participants had children, of whom four had no contact with their children. Of seven young people aged 15-24, only one reported having good relationships with their parents. Four young people stated their relationships with their parents had improved since they had left home. Of twenty research participants, seven mentioned involvement with child protection; five of these had experienced child protection both as a child and as a parent.

Causes of homelessness

When asked what had led to them becoming homeless, responses ranged from 'unable to pay rent' to 'language barrier' through to 'being exited from juvenile detention'. This question is explored within case examples.

Causes of homelessness for research participants



Research participants gave their permission to be quoted within this report. All personal names have been removed (including names of workers, friends and family), along with the names of specific services. Upon request, certain additional details have been removed. The names of some service types and policy initiatives are included in order to assist with understanding targeted recommendations. It should be noted that each of the twenty stories is unique; no two stories are similar. The only consistent experiences across all twenty participants are those of mental ill health and homelessness. The mental ill health is self-reported and does not necessarily refer to 'diagnosed' illness.

For each case study, a sample of reflections relating to their life, key transition points and current supports are provided. A list of 'personal prevention advice' is provided (i.e. personal strategies to protect mental health and housing) along with a sample of personal hopes for the future. In addition, each research participant took time to provide thoughtful advice, recommendations and requests in relation to funding, policy decisions and service delivery in areas of mental health, homelessness and beyond.

Summaries of case examples, including recommendations arising from the experiences of the twenty research participants, is provided in the last section of this chapter.

1. Mack

(#1 of 7 young people interviewed)

'My family was there, I was over here...'

Mack is 16 and is Aboriginal. He has no contact with his parents. He had involvement with child protection before he became homeless. After one and a half years in juvenile detention, Mack walked out the door into homelessness. Mack has no income and little formal support. He is couch surfing at another interviewee's public housing flat.

Early life:

Mack is young; his life has been a mixture of violence, neglect, and finding people he can trust. When he was a child, his mother sought shelter for herself and her children in a women's refuge. When asked what might have stopped him leaving home, Mack said:

If my family give a fuck about me... No one cared about me. There was violence every day. That's why I went on the streets.

Mac found 'family' on the streets, in gangs. This made things worse at home:

They just didn't want me there because of my past and what I was doing. They didn't want me there 'cause I was part of gangs and stuff. That's the reason why my family moved away from me. But the only reason I got into gangs is because they pushed me away – you know, I had nothing and these people were me mates, me family.

Involvement in gangs led to involvement in crime, and Mack was sentenced to detention in Ashley for two years. He was homeless before going into Ashley, and when he was released, he came out with nothing:

I was a juvie... I got out for good behaviour. When I got out I went to a mate's and they helped me out, got me clothes and fed me and all that, but then he, my best friend he died about a month back, he got stabbed. He'd got me out of heaps of trouble, if it wasn't for him I'd be dead or in juvie or something like that. [My mate's place] was a place I felt safe.

Transitions:

Mack depends on friends, but has no one to rely on. He has no income – he's not yet registered with Centrelink. He's not been diagnosed with a mental illness. Mack currently spends his days sleeping and drinking. He has no idea how to get linked in with social services; he says he doesn't need much. He says he'd like a job. He's feeling about five out of ten at the moment.

Current supports:

Mack currently sleeps on friends' couches, sometimes with an aunt, sometimes outside, and sometimes at a youth crisis centre. He gets food from his aunt, or from the women's refuge who helped his mother in earlier days:

The Hobart Women's Shelter down there. They helped me. Me and Mum. They got to know Mum but then they got to know me better.

When asked what's stopping him from getting the help he needs, Mack said:

Not needing or trusting adults – I haven't had one for long enough.

Personal prevention advice:

It's been a while since Mack went to school apart from his time at Ashley. He's visited a youth program a couple of times, but isn't

regular. When asked what's missing in his life, he said 'an adult to trust'. He said he would have benefited from a safe home and a family that cared – a 'real' family:

Sometimes I reckon I need help, sometimes I want to do it myself.

When asked what's going to help him in the future, he spoke about needing to get some goals. He recognised he was yet to:

Start wanting to do whatever you need to do.

Future hopes:

If Mack could choose to live anywhere, it would either be with his aunt or at a place for young people – in a house. He'd like a base, but freedom too. He'd prefer to share, as he'd need a bit of help with food, and an income. Mack described the kind of place he'd like to live in:

A big building – really big, so all the homeless people could have their own little place. Downstairs, a cooking area maybe. Furnished. We'd always have something to eat, something to do. You'd have to ask the people – it depends what they want to do.

Mack also listed some things he'd like to be doing if he had a choice – boxing, get a job, do a building apprenticeship. He says the building course is over the river, so he couldn't get there.

Recommendations and requests:

- *A house is missing. Probably to share.*
- *Make a building with lots of rooms, and make it really big so all the homeless people have their own little place like this really. A big place. Downstairs a cooking area. Definitely make it furnished. Always have something to eat.*

From the researcher's perspective, Mack is also requesting:

- Income
- A safe and social home environment
- Access and transport to vocational training of interest

Physical and social recreational activities of interest

2. Phoebe

(#2 of 7 young people interviewed)

'I try not to look ahead; I just take one day at a time...'

Phoebe is 19, is of Anglo-Celtic heritage and in contact with her parents and seven siblings. Phoebe has been diagnosed with depression, and medicated briefly for post-natal depression. She lives in temporary housing with her partner and baby. They need to move in three months.

Early life:

Phoebe grew up in a large family. She ran away from home during her last year of college because she was sick of fighting with her father. She moved in with her sister for a while, and then gained temporary accommodation. While there, she had a baby. It was a counsellor who helped her find her current accommodation:

I was seeing a counsellor in college and she set me up because I'd run away from Mum and Dad and I was really depressed.

Phoebe's been 'Category 2' on the public housing waiting list for nearly two years. Meanwhile, she rents a furnished two-bedroom unit managed by a community service organisation. They've been helpful from the start:

Don't know what I would have done if [that service] weren't there.

Transitions:

Phoebe's 19 year old partner is supportive, and her friends and family have helped to prevent the worst – they were good people to talk to. It was her friends and sister who told her she needed to get help after the birth of her baby five months ago:

Straight after the birth I felt like crying all the time... Friends and family, they gave me more support to figure out where to go next. Everyone kept telling me I needed to get help... The doctor put me on antidepressants... but they got addictive – I'd go off at my partner if I didn't have them so I took myself off them. I like to have control over myself.

Phoebe's unit is furnished and is in a good, quiet location, although the stairs are a problem. Rent and electricity (for heater, dryer, fridge etc.) are directly debited from her bank account. Her income is a fortnightly parenting payment from Centrelink. Food is the biggest expense, 'especially with the baby stuff'. After rent and food, there's nothing left. Her partner is looking for work. Private rental is too dear, 'it's about \$250/week, and rental assistance is only \$100 a week'. Phoebe's coming to the end of her two-year rental arrangement:

This is not permanent. I've got to be out in July so it's pretty scary, but they said they're not going to kick me out. They're going to get on Housing's back to try to get me a place.

Current supports:

Phoebe says people need other people in their life to tell them when they need help. Phoebe's partner lives with her and provides good support, along with both of their parents. The community service organisation helped her access TILA (Transition to Independent Living Allowance) which provided a one-off payment for furniture. Phoebe also gains support from a program for young mothers called 'CU@Home'; she was referred to this program by Housing Tasmania.

Personal prevention advice:

Phoebe and her partner are planning to move to another town to be closer to family support and employment prospects. Ideally she'd like to work in retail, two to three days a week. If she doesn't get public housing, she'll have to spend all her money on private rental. She thinks she could afford around \$200 a week if she's working and if family members can provide childcare.

Future hopes:

Phoebe thinks owning her own house one day would be great.

I'd love to own my own house. We'll get there one day... Prices would have to come down. We'd have to save a lot of money.

Recommendations and requests:

- *I think they need more places for people. More houses to help the young people out.*

- *Maybe more information about supports – I didn't even know about it until the counsellor set me up – on posters and things.*

From the researcher's perspective, Phoebe is also requesting:

- Affordable private rental accommodation
- Lower cost of living for essentials (electricity, food, transport, communication, and domestic items)
- More easy access to information about services

3. Kayla

(#3 of 7 young people interviewed)

I got too violent, saying I was going to slice me step-dad's throat on him...'

Kayla is 17 and is Aboriginal. She is in contact with some family members (her mother, aunt, sister and nephew). Kayla has been involved with the child protection system, hospitalised for mental ill health, and has spent time in youth detention. Kayla gained public housing five days ago.

Early life:

Kayla's home-life was tumultuous; she was abused by her father, who was sent to prison. She said home was too violent and she had no one to talk to. When she got old enough, she threatened violence in order to protect herself. Asked how she came to be homeless, Kayla said:

People taking away your safety and that.

Asked what might have stopped her from becoming homeless, Kayla said:

If they'd not interfered with me. I got reasonably good support from Mum but Mum couldn't really deal with it either. She still hasn't dealt with it. She had her own mental stuff.

Transitions:

Since leaving home, Kayla has moved around a lot, staying in her mother's shed, her auntie's house, friends' couches, and a couple of flats. She's been attending a course at the Polytechnic fairly regularly. She was on the public housing waiting list for a long time, and has recently moved into her own one-bedroom flat, surrounded by other public housing flats. She likes her neighbours, and feels lucky to have a place, but due to her transient past, Kayla wonders if she'll be able to stay in one place:

Hope I don't get sick of it. I can't stay in this place for so long.

Current supports:

Kayla named two staff at the Polytechnic, a sexual assault counsellor and workers at two youth services. Sometimes her mother helps out, but at the moment Kayla sees herself as her main support – friends, family and counsellors have let her down:

I don't really go anywhere, I learnt to deal with it myself because everyone talks about your problems.

For Kayla, it would be helpful if counsellors could assertively follow-up on missed appointments. After all, those who miss appointments might be the people most in need of help:

Aren't counsellors meant to keep in contact with you? If you don't make an appointment, aren't they supposed to call you to see why? Make an arrangement to make another appointment?

Kayla spoke about the barriers that get in the way of her gaining the support she needs. She said that hospital doesn't help:

If you tell them counsellors (about your problems), then if it's bad and they believe you, they're either going to put you in hospital and if they don't, they'll sit there, and they might judge you and not believe you.

Now that she has a flat, Kayla is being asked by other homeless young people if they can sleep on her couch.

Personal prevention advice:

Kayla thinks it would be good to have a worker who tracked you down if you didn't attend an appointment – someone who followed up, someone you could trust, someone who won't judge you, someone who believes in you. Meanwhile, Kayla will look after herself:

I'll be keeping to myself. I do everything for myself, always have always will.

Future hopes:

Kayla is aware that one of her 'homelessness risks' is the possibility that she'll get sick of being in one place – she thinks it's hard to stay in one place for long. She expects she'll be able to keep her flat, but that she might get moved to a bigger one if she has kids. In relation to planning goals for the future, Kayla says:

I done all mine because I'm turning 18. I don't want to be a person that's got no life when I turn 18.

Recommendations and requests:

- *A worker on your case, a worker that pops in every week, just make sure you're doing good and make sure you're doing the stuff you've got to do, getting to your appointments and all that.*
- *They need more shelters for young people. And more for them to do – activities – like things to keep them off the streets – community stuff.*

From the researcher's perspective, Kayla is also requesting:

- Safety for children – no child abuse
- Safe home environments
- Assertive outreach for children and young people
- 'Parent' type care for children and young people (more than just a counsellor)
- Alternative options to in-patient psychiatric care
- More youth housing – appropriate, safe
- Access to healthy recreational activities for young people

4. Cade

(#4 of 7 young people interviewed)

'I think every kid needs a mum and a dad. I think it's pretty unfair to have to go without. I guess if you don't have a dad, then you don't have a choice, you deal with it – but I think in all fairness every kid needs a mum and a dad...'

Cade is 18 and is of Anglo-Celtic heritage. He is in distant contact with his mother and sister and has closer contact with an aunt. Cade hasn't had involvement with child protection, hospital, or youth detention. Currently Cade is housed and engaged in pre-employment training three days a week. He's decided not to spend time with people he can't trust, so is very socially isolated at the moment. His bike riding keeps his mind calm.

Early life:

When asked what led to his homelessness, Cade said:

It probably started when my Dad moved out... I would have been 11, I think. ... Mum was distraught over that... She just sort of well – she just lost her nerve I guess, as a parent.

Yeah, out on my bike all hours of the morning I drunk a fair bit. Just didn't really care much at all. Stopped going to school. And then came up here, and I don't know, I guess I just got my stuff sorted out. Just a different environment.

Cade said that there had been a lot of sexual abuse in the family. Cade said he hates sexual abuse, he can't stand men hurting women. In relation to his mother, Cade said:

She's very messed up... physically and mentally she had a very messed up childhood.

Transitions:

After moving away from his home, Cade was staying temporarily at his aunt's, then with a girlfriend, then back at his aunt's. He was keen to have his own place:

I just wanted to be grown up... I guess I think that by the age of 18 you should be in your own place and be able to cook and clean for yourself. I don't ever want to be, I don't like being dependent on other people...

Cade heard about an accommodation support program through a friend who had recently gained a unit in the same way:

You know the idea is to help people, young adults, gain a sense of living on their own.

Cade is attending a pre-employment course three days a week. He says that financially, he's better off studying rather than working. Rather than go on to an apprenticeship, he'll study something else after this course.

Cade drinks alcohol, but doesn't smoke or take drugs, and says he never will. He says his mental health is not too bad; it goes up and down. He hasn't been diagnosed with a mental illness; he says he gets run down with his responsibilities and people asking things of him.

Current supports:

Cade receives Youth Allowance and Commonwealth Rent Assistance. Rent and electricity are directly debited from his payment. If he needs something, he goes to Centrelink – because they know stuff – 'but it depends who you get on the day'. Cade says he tends to manage his money OK – he's only come up short twice:

Obviously, if I ran out of money or something like that then my auntie, she'd be there to help me; she always is, which is really handy to have someone like that.

He doesn't have a support worker. His father is not a big support. In terms of social supports, Cade says:

My Mum and my aunty would be about it. I didn't have a good relationship with Mum before I moved out, but since I've been up here I have a great relationship with her. We get along a lot better, which apparently seems to be the case with a lot of people.

Cade says he's not having much contact with friends at the moment:

I've been let down by so-called friends... I just got very hurt and upset, and I'd knock that one off the list and then that one... I think I'll always be very cautious about who I actually trust...

Personal prevention advice:

When asked what's important to him, Cade answered:

I guess there are little rules like that I sort of go by. Dad always taught us to be very polite when we were out... I always use my manners and I'm very polite.

I definitely like to be clean, I feel it says something about me.

When asked what he does to prevent himself from becoming low, Cade said:

Staying active... And having my own space is definitely a big part of it, having my own place.

Future hopes:

Cade hopes to have his own house one day:

I expect I'll be a mechanic at that point. I'd love to live out in the bush, have a big shed with all my project cars, or whatever.

I would love to be a father... You know, have an excellent job, got job security for life sort of thing, be completely set up. But I kind of have to wonder, I mean I don't remember a couple that have been together and stayed together indefinitely. And if they have, my Nan and Pop were like that, but I think my Nan was just scared shitless her whole life and I don't see the point in that...so I kind of got to wonder if it's even worth it at all.



Recommendations and requests:

- *I'll definitely be out on my own... This was definitely a big stepping stone for me. For some of us being out is best.*
- *If I was prime minister I'd definitely stop giving out baby bonuses because I think that was probably the stupidest thing that anyone ever came up with. That means the people who can't get jobs will have babies...*
- *I think it would be kind of better if Centrelink or whoever it was that organised these things actually enforced it a little more. There are so many people that I know that just don't give a rat's arse, they don't care, they just do whatever they want.*
- *Transport to school is a barrier.*

From the researcher's perspective, Cade is also requesting:

- Support for parents who are not coping
- Support for children whose parents are not coping
- Supported 'independent' youth accommodation
- Better public transport

5. Katie

(#5 of 7 young people interviewed)

'If you don't have at least one parent who is able to support you and knows what's going on, then you don't have a guarantor and you're not able to move out at all – unless you just get lucky...'

Katie is 17 and is of Anglo-Celtic heritage. She has loose contact with her mother, father, brother and sister. She hasn't been involved in child protection, hospital or detention. Katie recently moved into a house with a landlord, in a boarding arrangement.

Early life:

Katie grew up in a household with family members who had diagnosed mental illness. Katie was having to deal with her mother's mental health symptoms on a daily basis:

She slept a lot, you know, for most of my childhood. A change of medication sent her into a manic high ... She started like abusing me because of it. And if she came down, she wouldn't even remember it, and if you said anything, she called me schizophrenic.

When asked about what led her to moving out, Katie said:

In the end, it reached a point where I decided it was the best thing for me. When my parents were out, I just packed my bags and got to a friend's house, and from there I found a place to stay boarding.

Transitions:

When things got to crisis point Katie saw the school counsellor. It was here that she learned she had a lot to deal with:

Last year I was seeing a counsellor at school, and that was a big help because until that point I thought that all my stress and all my anxiety was coming from me. I thought everyone was dysfunctional and that I didn't have it bad at all. And then the counsellor told me that I have it really bad, and it was even worse considering I've had some things happen when my Mum was manic that I assumed were just normal.

Katie hadn't known moving out was an option:

I didn't know that under 18 year olds could move out before then... It's not like they [services] go to the schools or anything, so you don't hear about any of the things that are available.

Katie learned about services that could support her, including Centrelink payments for young people who must leave home (Unreasonable to Live At Home Allowance, UTLAH). But along the way, she discovered barriers for young people trying to access homeless services

The thing is you can't get UTLAH until you've moved out, and so I had to stay at a friend's house for an amount of time. And if you don't have a friend who's able to keep you that long, you usually end up stuffed.

I inquired about a place and the secretary called me up and was asking my details and being very friendly and then just before the phone call ended I said "oh one thing I'm under 18 but I can try and get a guarantor" ... and then the other end went silent and then I heard the dial tone.

Katie moved into a women's refuge, and met many dead ends trying to find private rental accommodation. Staff helped her find a landlord who gave her a chance.

Current supports:

Katie is attending Year 12, and coping with her studies. She's on medication which gives her a good emotional balance:

I don't get frustrated, which was my main issue. I got frustrated which led to anger, and then all my friends would get scared of me, and I couldn't really have a friendship with anyone.

When asked what helps her to get the support she needs, Katie said:

Opening up and admitting there is a problem. Because if people know what's going on, they can help you.

Katie knows she can get a one-off payment for furniture through Centrelink's Transition to Independent Living Allowance (TILA) and can get help with budgeting and living skills. She knows which services can get her food coupons and help her with private rental assistance.

Personal prevention advice:

In order to never be as low as she's been again, Katie says she needs connections with other people:

If you're alone, you just end up getting worse. Even if you think you can deal with the problems, no one's that strong. And unless you realise that, you're stuffed.

Future hopes:

Katie believes more housing options will open up to her when she's eighteen:

I'm just taking advantage of this until I turn 18, which is when people actually take you seriously and you can go anywhere. You can actually apply and be taken seriously by a real estate.

Recommendations and requests:

- *Right now we need a quick fix, because we need cheap accommodation that can be built within a short period of time for young people. Making cheap apartments, build as much accommodation with as little space.*
- *There's a lot of accommodation going to kids that could stay at home. Despite Centrelink trying to change that by UTLAH only being eligible for people that are legitimately unreasonable to live at home.*
- *You can expect if you're applying for UTLAH to be waiting for quite a while. Well for me I waited over a month. It would be helpful if [Centrelink] had more people on staff. But as well as that I'm not sure if this is the correct term but maybe like a half way house which is what [the shelter] was for me. And because the UTLAH you can't apply for it until you've already left home.*
- *Definitely get information. Maybe start having some people going*

around to the schools maybe around grade 8, grade 9 when people are sensible enough to actually stop and listen.

- *Maybe even have the counsellors assess children who have the anti-social behaviour. Have teachers watching out for kids and when they see someone struggling, asking why.*

From the researcher's perspective, Katie is also requesting:

- Support for parents with mental illness
- Support for children whose parents have mental illness
- Assertive outreach within schools – teachers and counsellors actively seeking to be aware of who is struggling, and initiating the provision of support
- More easy access to information about services at schools
- More affordable housing
- Greater flexibility from real estate agents and landlords in relation to tenant characteristics
- Speedier access to UTLAH



6. Chris

(#6 of 7 young people interviewed)

If I could live at Ashley and be allowed to leave during the day, I'd live there for the rest of me life. Go out and hang out with girls during the day. Come back at night. I'd be there forever...'

Chris is 16 and of Anglo-Celtic heritage. He has contact with his mother and stepfather. Chris left youth detention into homelessness.

Early life:

Chris said his problems started when he lost his father to suicide:

My Dad had schizophrenia and stuff, and very bad drug problems and alcohol problems. And he committed suicide when I was about 12. At the same, I was starting to have the bipolar... So I get in trouble at school and stuff, hanging out with the wrong people, and I just wanted to get away from the family if you know what I mean. Like, I didn't want to be thinking about Dad. And I've got a step-Dad, and he's trying to be my Dad, but he's not my Dad.

Chris has spent a lot of time sleeping rough:

When I was cruising around, you know, I had a tent the Salvos gave me, a two man tent. There was three of us staying in it and we would get a pack of sausages, and we'd go and find a park – mainly a council park, because they had the barbecues and they also have a power point to plug your phone into. You know, because it's just bullshit sleeping in toilets and stuff.

When you're homeless things that you worry about is where you're going to go that night, where you're going shower, during the day where are you going to keep your stuff, and where are you going to charge your phone.

When asked how he came to get in trouble with the police, Chris said:

You know, it got to the point where like me and some mates, it'd be 10 o'clock and we'd say "we'll steal a car and we'll sleep in that tonight".

I had a NYAC unit¹ – but they're only for 12 months. So... I just sort of cruised around again. And I didn't have anywhere for my mail to be sent and then I got locked up so my housing application apparently ... just disappeared.

Chris enjoyed his time at Ashley Youth Detention Centre and didn't want to leave. For Chris, Ashley provided a clear structure, a place where he could learn, be fed, and have time out from having to deal with other pressures. He liked the discipline:

You have your time out room and punishment room and you deal with it.

Transitions:

For Chris, being released early was inconvenient. He told the staff he didn't have anywhere to go and that he didn't want to go. To Chris, a discharge plan was pointless because he didn't have anywhere to live:

Oh, well, they do an exit plan right? They said you got to go to youth justice every week and we want you to go to TAFE and do your ... class but we're going to drop you off at youth justice and you've got

nowhere to go ... So they expected me to be dropped off with all my furniture on my own ... and then walk into town with a table and a cabinet ...

In Ashley, Chris was in the middle of making things, studying and doing good activities. He knew what was expected from him, he knew what was going on, and he fitted in. He left with two pieces of furniture he'd made, an armful of clothes, and a list of requirements to meet, which included counselling. He decided to go and stay at his mother's for one or two nights, but then move on:

Thank god a guy ... said that in two weeks I can go up to a place. And I can have some accommodation there.

Until then? I'll just cruise around with mates and stuff.

Current supports:

One day out of Ashley, and Chris doesn't feel very trusting or supported:

People are your friends one day, they're not your friends the next. I don't trust anybody.

I've been trying to build as many contacts as I can to support me through because I don't really want to go to Risdon in a hurry.

Chris found staff from a community based support service helpful whilst he was in detention, and plans to go and find them for involvement in camps and other activities. In the next few days, he also plans to go and find another worker he grew to trust:

He's pretty good, you know. He's the sort of person who actually cares and will actually try to help you. He's not one of those yeah yeah yeah and nothing ever happens. He actually will, you know if he says he's going to help you, he actually will help you. He's the one that got me the NYAC unit.

Personal prevention advice:

Chris knows that if he were to steal another car, he'd get two years detention straight away. He plans to keep his nose clean, stay out of Risdon, but he doesn't really know how he's going to do what's required – without accommodation, he doesn't feel that he'll be able to keep his appointments.

Future hopes:

Chris dreams of a youth shelter that is set up a bit like Ashley – with lots of clear structures, a timetable, a program of classes, spaces for outdoor activities, indoor activities, games and learning. He'd want strict rules: 10 warnings, and then you have to go to another youth shelter. He'd want records kept of wrong-doings, and punishments dealt out. There'd be meals, and the

¹ The Northern Youth Accommodation Coalition (NYAC) is an accommodation option for homeless young people aged under 16-21 years (with a focus on those under 18 years).

youth would help out. There'd be schooling, horticulture courses, woodwork, metalwork, and training for work. He'd like to live at a place like that.

Recommendations and requests:

- *I didn't want remission from Ashley – I'm better off in there where I know what I'm doing... And I know I'm going to bed that night and I'm watching the TV, getting my canteen every Friday. You've got a shower in your bedroom, can have a shower whenever you want. You're not walking around trying to find somewhere to shower, somewhere to hide your clothes and stuff. It's just easier.*
- *I'd set up like drop in centres. More of them. Have a shower. Wash your clothes. Charge your phone. And go. Because they're the most important things when you're homeless... There is no food van. Melbourne food van – it is the best thing ever... Food's the most important thing.*
- *And they need storage lockers so you can keep your stuff there throughout the day because you know if you've got to go to town and stuff you don't want to be lugging around all your clothes, your tent, all that sort of stuff.*
- *I'd build a youth shelter. And houses for everybody. I know 76 year olds that live on the street. And they're just as much needed to be helped as your 14 year olds walking around at night time.*
- *If I wasn't going to build the youth shelter that I want I would buy compartment complexes. I'd make sure they were on a Centrelink payment and I'd have them out for rent for people in crisis. Cheap, you know your \$80 a fortnight sort of thing. Small, but still something you know. Once they're in there they have to see mental health psychologists and drug and alcohol counselling and you have to engage in that weekly.*
- *Just have more doctors and psychologists available. And just have more people that want to help.*

From the researcher's perspective, Chris is also requesting:

- Grief and loss counselling for young people (e.g. for those who lose a parent)
- Support for family members transitioning to become stepfamilies
- More accommodation options for young people – appropriate, with rules and boundaries, affordable
- No 'exits' from youth detention into homelessness
- Greater provision of support to people experiencing primary homelessness (e.g. access to emergency accommodation, showers, lockers, power points, food, etc.)
- More support for young people (e.g. more adults for young people to talk to)



7. Michelle

(#7 of 7 young people interviewed)

'Having my son stopped me from killing myself...'

Michelle is 23 and of Anglo-Celtic heritage. She has never known her father and has no contact with her mother or with her three year old son. Michelle has had involvement with child protection both as a child and as a parent. She has been hospitalised for mental ill health, and spent time in youth detention. Michelle is awaiting more secure housing; she's hoping it'll be closer to where her son is living.

Early life:

Michelle's mother was in and out of jail for heroin use. Michelle has been in foster care and has also lived with several different family members in Sydney, Melbourne and Adelaide. .

Michelle has a complex history of drug use and mental ill health. When she was 14 she 'lost her mind a bit':

Was put into a hospital psych ward for three months – a psychotic episode from trauma.

It was pretty bad for a few years. I ended up stopping smoking marijuana as much because it made me paranoid. It made it worse. I moved onto heroin because it didn't make me paranoid. My life was pretty scary. I was looking for things to calm me down.

I've had four stays in hospital, the longest for three months. Was in intensive care before that, for anorexia, a bit crazy. Hospital stays have mostly been for psychosis, but once I cut myself.

Michelle spent time in a youth detention centre:

Someone died because of the crime I did, but it was indirect. I got so scared, but I got a lot of support in there. I even dropped in and thanked them for what they did.

For Michelle, family support would have been helpful:

As it's turned out, people that have helped me have also really hurt me – done bad stuff.

Her most stable time began about six months before she was pregnant, and lasted for a year or two after her son was born. She lived in private rental with her partner who had a job. That was probably the happiest time of her life.

Transitions:

Michelle moved to Tasmania about two months ago, and was going to stay with her boyfriend, but that didn't work out. She asked her boyfriend's mother to look after her son, because she was worried about her own mental health. At some point, child protection services become involved.

In relation to changes she'd like to make, Michelle said:

It seems like my life's been the same for a long time – I'd like to try and work on changes, feeling different – without medication or drugs.

Current supports:

Churches have helped a bit sometimes, and hospital has helped a lot:

I liked them a lot – my psychiatrist and psychologist helped a lot – if it wasn't for them, I might not have got my mind back. Medication and talking to them helped.

Looking back, child protection services were a very good support for Michelle:

I wish I'd behaved more with them. I wish I had their support now.

All through Michelle's life, key support workers have been helpful – but they seem to come and go very quickly:

I moved a lot, but I probably didn't get the help I needed from them because I was waiting for them to leave.

Michelle feels it is mostly herself that has kept her alive. She says she's just survived – somehow got through each day; she doesn't really know how she's survived.

When Michelle moved to Tasmania she made contact with a community service organisation she had heard of on the mainland. They paid for her to stay in a motel with a shared kitchen. Michelle is now staying in a house owned by a women's shelter. She can stay there for six weeks while she waits for more permanent housing.

Personal prevention advice:

When she lived with her partner, he helped get her out of the house and feel more confident. Now that she's alone, Michelle struggles with isolation and loneliness. She knows she needs to call people and get closer support. She'd like someone nice, encouraging her. But she wouldn't know where to ask for it.

The fact is, a lot of services just focus on certain things – so they have to focus on that – and then move on to the next person.

For Michelle it's hard to deal with a lot of different people who never get to know her. She'd like to have more contact with people, including a psychiatrist or a psychologist:

I probably need a lot of different support, but have been without it for so long, it'll be hard to know. I trust psychiatrists and psychologists because they know what they're doing.

She wishes she had responsibilities. She knows she needs to have a stable home before she can have her son back; she also knows she needs to learn to deal with her anxiety.

Future hopes:

Michelle would love her own home:

Until I get there, I probably won't be able to have my son.



Recommendations and requests:

- *Mental health issues are really bad. They need help. Link a support worker to the person, and get the worker to link in with the services. Make sure it's a good fit, person to person. Like a friend to talk to, to encourage them. That would make the world feel smaller.*
- *It's hard to afford rent on my own. I should have been on the public housing list, but a worker lost the forms.*
- *I would have told myself to stay in school – I would have told myself that all the time – and try and stay a bit more stable. So that I could've got to know people around me and felt a bit more comfortable.*
- *Talking to someone would've helped. I've spoken with people about it, but talking more to one person, more often, for longer, and see what their professional opinion is – see how they can help without medicine. That's the only thing I haven't tried yet – is things different to medicine and drugs – the drugs have got me into trouble.*

From the researcher's perspective, Michelle is also requesting:

- A safe home environment for children
- Assertive outreach and support services that 'wrap around' the person rather than individuals having to navigate their way around a complex service system
- Affordable private rental
- No 'exits' from child protection into homelessness
- More adults to talk to (counsellors, someone they can trust)
- Alternative mental health treatments in addition to pharmacotherapy

8. David

(#1 of 9 adults interviewed)

I was moving from place to place. Sort of running from something or trying to find something. Trying to find peace and a nice place to live, somewhere comfortable. And looking for a partner. Travelling made me feel a lot healthier and comfortable. All over Australia...'

David is 35 and of Anglo-Celtic heritage. He has contact with his parents. David has been hospitalised for mental ill health and is currently living in a residential rehabilitation setting, where he can stay for two to three years.

Early life:

David says he got mixed up with the wrong people and began a life he should never have lived:

When I was young, I was only 17... I got kicked out of a backpackers one day and ended up on the streets and met up with this fella... and then he introduced me to all this homeless stuff, all this soup kitchens, youth hostels, and all this sort of stuff, Salvation Army and all that.

I then became all reliant on those people and those places... it was always so easy for me to dump everything that was going on because I knew i could make a new start anywhere I wanted to go. I kept moving. Change of community, change of people. Change from where everyone knew me to where no one knew me, made it easier for me.

David wasn't working; he was using drugs and alcohol. He stayed with the lifestyle partly for the sense of belonging:

There's all sorts of reasons why I ended up relying on those sorts of people... Made it look better than it was, I thought I was part of something. But it just wasn't like that...

Transitions:

David moved and moved, and started realising his life wasn't good:

From the different drugs and stuff my life was unmanageable. I went over to Perth to rehabilitate myself and give up the alcohol and ended up getting bashed and I've been pretty crook since then.

I stayed at Mum's place for three years not long ago. That was good, done well actually. I was happy, I got used to staying in just one place.

Last time I really struggled was leading up to come here. I was paranoid, lots of troubles from things from the past, a lot of bad memories bottling up, just really troubled.

Current supports:

Alcoholics Anonymous has been helpful for David. His sisters and his mother are supportive. He currently has his own two-bedroom unit in a residential rehabilitation service in a nice setting. He's been there five months and can stay for two to three years on the condition that he keeps up the program – no alcohol or drugs, no violence, keep paying rent. David's on the list for public housing.

Day programs at the rehabilitation service include gardening, cooking, community meetings, individual plans involving budgeting, health, natural therapies and paying off debts. Staff are helpful and supportive; he has a case manager.

David assesses his mental health at around seven to eight out of ten currently. He has a psychiatrist. He receives a disability support pension. After rent, food and electricity are taken out, he has enough, but it's tight – there's no money for extras like the aquatic centre, or for back care.

Personal prevention advice:

When David looks back, he wishes someone had stepped in:

At the time if there had been somewhere for me to go and stay or if someone had tried to convince me I was starting to walk down the wrong path.

David knows he could be drawn into the life of alcohol and drugs again, but he knows he'd lose his accommodation. He says he knew that at 20 too, but it took him 12 years to stop.

To never go as low as he's been in the area of mental health, David wants to:

Stay clean, stay accommodated with a bed and roof and shower; behave as best I can; stay home at night and things like that. Eat healthy, exercise.

To stay housed, David plans to:

Stay straight, stay out of trouble, and keep taking medication, pay my bills, stay on top of my business.

Future hopes:

David would like a hang-out place where people can be educated, learn skills and gain employment. David has worked previously, in apples, landscaping, strawberries and tiling, and he'd like to work again. He also has a dream:

My long term plan is to just save as much as I possibly can and get my own campervan.

Recommendations and requests:

- *People in crisis aren't all bad people. It's just that they've got no cheap accommodation anymore anywhere.*
- *Some affordable supported accommodation with good management. I wouldn't make it crisis because I think there's enough crisis care here. Somewhere for these people to go to after they leave that. But I s'pose people don't want these sorts of places around the community do they? It's hard to find somewhere to put one...*
- *Keep the old and the hurt and that away from the young ones that want to party would be a lot better... Their lives are misery having to put up with the young yahoos but they have to stay there, they shouldn't have to stay there, there should be somewhere for them to go to, a different age group.*
- *The police should organise their own place for people to go to instead of sending them to crisis because people in the community in crisis aren't all bad people and don't want to hang around bad people.*
- *When people leave hospital, make a plan that on pay day they leave the hospital and move in.*
- *I think what's missing is a hang out place where people can be educated and learn skills, employment, whatever. Something like*



Colony 47 Community Central, but with yards and gardens and things like that.

From the researcher's perspective, David is also requesting:

- Affordable rental accommodation
- Access to permanent supported residential accommodation
- More medium-term accommodation options rather than crisis accommodation
- Selective medium and long-term accommodation options (e.g. places for 'peaceful' and older people, and different places for people who are still using drugs/alcohol or are prone to violence)
- No 'exits' into homelessness from hospital
- Interesting places and activities for adults to participate in (including recreational opportunities, vocational training, opportunities for volunteering, pathways to flexible employment)
- Respect for homeless people – homelessness is more to do with poverty than personal character

9. Tammy

(#2 of 9 adults interviewed)

'Writing, drawing, poetry, being in the artists and writers group has kept me going. I enjoy those things...'

Tammy is 46. She is of Southern European heritage and thinks that 'maybe' she is Aboriginal. She has no contact with her three adult children. Tammy has been involved with child protection as both child and parent, and has been hospitalised for mental health several times.

Early life:

Tammy's early life was very difficult; she was abandoned and neglected as a child. Being with her ex-husband triggered all of those memories. She left him because he wanted to kill her:

I still have fears if I hear wood snapping. A lot of fear. It took me a lot of years to get used to living by myself.

I had my first episode of mental ill health in 1996... I couldn't believe I had mental illness ... In the 1980s, I worked in the area of de-institutionalisation and 'breaking down the barriers'. It took some years to accept that I have a mental issue. Being treated in the community is much better – we are all human beings.

I first became homeless in 2005. I fled my place because of fear and threats. I was homeless for two years before I came to Tassie. ... I first stayed at a bed and breakfast, then fell ill and was taken to a clinic, then to a women's shelter, then to a lodge. I was there on and off (for around two years), until I became homeless again – my room at the lodge was given to someone else. I had to move out because my room had prematurely been given to someone else.

After that, for four months, I stayed in hotels and in a women's shelter, then a private rental property for \$250 a week.

Transitions:

Tammy initially came to Tasmania because she wanted to escape from everyone – 'the whole kit and caboodle' – she wanted to press the 'start' button. She then met a wonderful partner who has since passed away.

A significant change in Tammy's life has been becoming an artist:

In 2008, [a community mental health service organisation] staff person recognised me as an artist – they discovered me ... I enjoy writing, I enjoy drawing, I enjoy being in exhibitions. Seeing my work going into a calendar ... was wonderful. Even though I was homeless, my work I had entered into the exhibition went into a calendar.

Current supports:

Tammy has gained public housing; she lives in a 'wonderful unit', a comfortable one-bedroom surrounded by other units. She can stay as long as she wants:

I don't intend to leave; I'm settled in my property. I love Tassie.

She receives the Disability Support Pension, and after all rent and electricity have been taken out, has \$200 left for food, smokes and art materials. She thinks that gets her by – *everything is covered.*

Her main social supports are artist friends. Tammy is in the process of applying for and seeking an artist mentor, via a grant application. She is also talking with staff at two services about the possibility of them supporting a new artists group. Tammy

socializes with friends on weekends and has support of numerous workers:

They're all special – each one plays their own role – each one helps me with my health, my wellbeing.

Personal prevention advice:

In order to never go as low as she's been in the past, Tammy says:

You know, with all that's happened in the past, it's made me who I am today. If it happens [being low], at least I know that I can jump the hurdle. But I hope it doesn't happen again, or me being homeless.

For Tammy, all the people around her and the services have played (and are playing) an important role.

Future hopes:

In relation to all the projects and artwork Tammy has on the go, she says:

I've pressured myself; it's not anyone pressuring me, I've pressured myself. I'm my best friend, my worst enemy. It's a dream of mine, to have an artist mentor and to have an artists group. To make it come true is always, anyone's dream, is always a wish to come true. Poetry and the story of my life, my manuscripts. My artwork. Keeps me going.

Recommendations and requests:

- Well, information, it would be nice if I was informed of it or asked when I was leaving. I put in several complaints about the management. The management once [was aggressive and rude to another tenant] so I put in a complaint. It's my duty to do that. Not long after, I lost my room.*
- Even in the mental health profession, some people, because they haven't suffered from mental illness, do not understand someone who has suffered from mental illness. And the anguish and pain and suffering, it's not understood as clearly as it should be understood. And so the help and resources and support is not there for the ones that need it the most.*
- We need better education, better understanding, better empathy – these three criteria – amongst the mental health staff.*
- Failing to meet stigma is a problem, failing to eliminate stigma. People are so scared of people with mental disorder.*
- We need more workers in mental health, social workers as well as clinical nurses into mental health and psychiatry.*
- I don't think anyone should be homeless in Australia. I think we should all be housed even with our growing population... All the policy makers – housing, education and health – they're the three major ones and where the projects should be looked at.*



- *Housing... more houses, more accommodation places to be built. Not so much blocks of units or flats but indiscriminately housed people. In different places. In among the private sector.*

From the researcher's perspective, Tammy is also requesting:

- Safety for children – no child abuse
- Safety for women – no domestic violence
- More opportunities for healing; more services that help people heal from early life trauma
- More information about homeless services
- No 'exits' from homeless services (short-term accommodation facilities) into homelessness
- Respectful management practices and staff attitudes within homelessness services
- More respect from mental health staff for people with mental illness
- More empathy and understanding from staff – more training for mental health and housing staff by people with lived experience
- The elimination of stigma in relation to mental ill health and those experiencing homelessness
- Enough houses for all people – affordable, public housing placed within mainstream communities to prevent public housing 'ghettos'
- More government funding focused on linking health, education and housing – that's our 'core infrastructure'

10. Jimmy

(#3 of 9 adults interviewed)

My mental health wasn't too crash hot prior to getting my accommodation, but it's pretty good these days. It's incredible how much it helps. It's like a big mental sigh...'

Jimmy is 40 and of Anglo-Celtic heritage. He has an eight year old daughter. He has been in prison many times; each time exited into homelessness. Jimmy recently moved to Tasmania from the mainland; he's here to 'paint a new picture', living near his family.

Early life:

Jimmy grew up without a mother, and was brought up by a father who was violent:

My Mum died when I was an infant and my father had no idea. Look, I don't want to try to justify my years and years of being antisocial. I'm not trying to justify it, but look, Mum – Mum not being there, I used to crave for me Mum, just crave for her. And Dad, he didn't show love the way people should show love – he showed love by discipline and putting food on the table – you know, old school love. Well he was a pretty violent man, so when he wanted to make sure something was happening he'd use violence – you know, control the situation with a heavy hand. I didn't really want to stick around.

Looking back on his early life, Jimmy wishes he'd had an adult to talk to – someone who told him: 'Don't touch the drugs, mate'.

Transitions:

One of the biggest changes in Jimmy's life was the birth of his daughter:

... whilst in prison I had a little baby girl come into my life and brought some sunlight into my somewhat dark world.

Jimmy is feeling like he's doing well. Having a house does help:

I pat myself on the back every day. I've done well. The best thing I've ever done was come over here and see my family.

Current supports:

Jimmy tried to live with his half brother and his family when he first came here, but it didn't last long. His brother put him onto a community service organisation. Jimmy is very respectful of a worker who helps with advice, guidance, direction, and food:

I consider him someone I can talk to for a long, long time to come.

Jimmy applied for public housing when he first exited youth detention, back when he was 18. After 22 years and moving states, he finally has a place provided through a housing program.

Jimmy has made a couple of friends and has a dog. In terms of additional support, Jimmy says:

I have a lady from a service that comes visit me every fortnight for an hour visit, see how I'm going. ... I think her job description is counselling but doesn't feel like I'm getting counselled, I just have a good old yak.

Personal prevention advice:

Jimmy knows that he needs to stay away from drugs and crime:

Don't touch heroin, keep away from the drugs, mate. They should just decriminalise it and give it out for free.

Jimmy's been looking for work:

It's hard to get, but I'll keep trying... I've driven trucks, been in

transport before... I'm thinking about studying... An employment place have found me a couple of jobs, but they haven't worked out. It's who you know... I was told it takes about four years to get a job after you get here.

Future hopes:

Jimmy's personal advice to himself for the future is to stay healthy and housed:

What I need is... food and cash. Stability, a bit of security, which I have with my house. Stability with income, which is finding something where I fit in and I enjoy doing.

Recommendations and requests:

- I'd put it 50/50 into mental health and accommodation. Maybe units but don't turn it into a concrete jungle, do they work? With all those people living on top of each other? Maybe units aren't a good idea, so maybe houses. If you put a heap of athletic children together they'll just do their athletics but if you put boozers together, then look what you'll get. So maybe units is not a good idea.*
- If they haven't been taught, they might need help. If they don't have that gene, you know that gene where you clean up after yourself, like some people don't have it and they live in squalor. ... Some people might need guidance and direction regards with paying their bills, and general looking after themselves. Some people don't know how to cook, mate*
- I'd create more places for these 12 year olds so they feel safe – and somewhere they could just come in, like drop in centres, where you could just talk to someone who cared – someone who really cared. I think kids just need people to talk to who understand – maybe people who've been on that path and know the outcome to it all.*

From the researcher's perspective, Jimmy is also requesting:

- Support for children who lose a parent; support for adults who lose a partner
- Safe drop-in centres for young people experiencing troubled home lives
- Safe adult role-models for children (someone to talk to who offers sound advice)
- More effective drug/alcohol services for young people
- No 'exits' from youth detention or adult prisons into homelessness
- More houses for families, and more independent apartments for individuals
- Tailored support for people who need it, connected with housing – for example teaching people living skills, personal management, coping strategies, etc.
- Employment

11. Bob

(#4 of 9 adults interviewed)

'She helped me get a fridge and stuff, she probably wasn't meant to, but she bent the rules she did. And new clothes and stuff. She used to help you go and do your shopping, make sure you bought all the right stuff, didn't waste your money...'

Bob is 45 and of Anglo-Celtic heritage. His parents have both died. Bob has contact with sisters. He hasn't been involved in child protection, hospital or prison. Bob may have been assessed for intellectual disability.

Early life:

It seems that Bob had a relatively peaceful early life. He got on well with his father and left his family home only after his father died. He was diagnosed with depression, and his mother had become too old to look after him. She died 12 months ago:

It was a decision made because about six years ago Dad died. Mum, she wasn't too good either, she had diabetes and that and she ended up in a nursing home before she died. I moved in with my sister.

Transitions:

After leaving his sister's place, Bob lived in a boarding house for a while, but got caught having a drink outside. He found staff at another boarding house helpful at the start, but he 'got in trouble with them when I told them what I thought'. He had to leave both because of disagreements about drinking in public. He was living in a caravan park, paying \$60 a week, 'enjoying a few social drinks here and there with friends', when a worker from the Salvation Army helped him apply for public housing:

I had one lady help me from the Salvation Army. I was at the caravan park and she just said it's not the right place for you, too many riff-raffs there, as there always is in caravan parks. And she went and talked to one of the top bosses and I had an interview with a psychiatrist and that and asked a few questions... She sorted out the interviews and anywhere you wanted to go. Make sure you're getting on alright. Take care of the doctor's appointments and everything I had to go to. Most of the time we got on pretty good... After the interviews, ...just a three to four days wait for a house.

Current supports:

Bob now lives in a one-bedroom apartment in a block of 20. He's been there two and a half years. His rent and \$50 electricity are directly debited. After bills, he's left with enough to manage with:

After food and smokes for one person, I go short for a day or two. It's not enough if you want to buy a CD or two or stuff for your house. I have to learn to budget. A friend helps me. She holds me money for me til I need it. She's trustworthy.

Bob has good neighbours. Once a month a housing worker comes by for maintenance. He sees his doctor once a month for medication. He attends a day program four days a week, all day, and gets on well with the staff and participants. In the afternoons they go on a trip.

Bob gets on well with his family. He's the waterboy at a footy club every Saturday in winter. At nights he watches TV. He says he eats well: *'cook up something in the frying pan'*.

Personal prevention advice:

Bob thinks there's help around if you need it:

Doesn't matter who it is, if you use your noggin, there's a thousand people out there that are willing to help people, between backpackers and caravan parks and whatever else...

Future hopes:

Bob plans to keep being waterboy in winter, and plans to keep attending the day program:

I can keep coming here forever. Well, it beats watching some crap on the TV.

Recommendations and requests:

- *Build more places like [where Bob lives] and all them sort of places for all these homeless ones that need it. They always put workers and everything in there and if you've got any problems you just go and talk to them and they'll take you to the doctors and whatever else.*

From the researcher's perspective, Bob is also requesting:

- Supports for parents supporting young people with disabilities
- Respite for aging parents supporting adult children with disabilities
- No 'exits' into homelessness from family homes for people with disabilities
- Assertive outreach (including into caravan parks)
- Affordable housing, with regular support (including with budgeting, cleaning, cooking etc.)
- Opportunities for participation in social and recreation activities
- Access to supportive workers
- Access to primary health services

12. Michael

(#5 of 9 adults interviewed)

'If I can find no friend to help me out I may be ending up in the car in the next few days...'

Michael is 25 and of African heritage. He only has one relative in Australia. He was detained in a police station briefly. Michael is sleeping at friends' houses and in his car.

Early life:

Michael grew up in an African country experiencing significant political upheaval. He left his home and family as a child and was sent to a neighbouring country. From there he came to Australia, to Sydney. He came to Tasmania seven years ago. He has also spent time in Melbourne. He grew up in a very different culture with different traditions around looking after people and an emphasis on families and communities looking after each other.

I grow up in very natural way where I grow up with my sisters and brothers, share everything together with them and I don't have to eat by myself. And if any of them in trouble I always give them a hand.

Michael was not intending to come to Australia, but people encouraged him to come.

If things work out here, I might stay. I miss home. Big time. I can talk on the phone, they say if it doesn't work out here they can sell some cattle and pay for me to come back. A step-mother of mine causes bad luck for me – she's why I got sick.

Michael has worked whilst in Australia, but has sometimes been charged too much for things including work equipment and transport. He has bought a car for too much money, and has accrued thousands of dollars worth of fines relating to the car. His current employer has not paid him, and Centrelink has not been paying him because he's been working:

But I learn a lot of consequences of being with other people. Some people are really good positive friends, some are not a good friend, that's what I learned so far about people.

Transitions:

Though he's had some hard experiences, being homeless is the most difficult:

The hardest time of my life is having nowhere to stay. Being in a car is OK, it's the same as being in the bush, but it's too cold here. Very uncomfortable. ... Therefore I have to find a roof on my own.

Michael was well paid in Melbourne, and in private rent, but he let someone stay who fought with his girlfriend, so they left. He says he drinks, but doesn't cause trouble – doesn't fight with anyone. He says some people cause him trouble. In Tasmania Michael stayed in a hotel and was catching cabs to his work, which was in the country. Accommodation and transport cost him more than he earned. He has a substantial debt and says government people are not really trying to understand him:

If they are going to have us here, they should try to understand us... They don't listen. They don't understand my situation. I need to see a social worker – that would help. I don't really mind, because I've been in bad situations before, I know I can work it out.

He does not really know where to go for help, or what help to ask for. He has debts to pay, and a car on the street:

I haven't chosen this. It's a combination of losing license, working out of town, not getting help I need. That's OK, I'll keep trying... Well to get a house for me, I try to work it out myself but I have no regular job to do and I have no income money to get to save up to get a house, it's hard.

Current supports:

Michael is relying on sleeping at friends' houses at the moment, and has made contact with a service that may help him. If none of his friends help him, he'll be sleeping in the car again. His only idea for where to go for help with housing is a worker he's seen once before.

Personal prevention advice:

Michael says he will try to work it out himself:

But without a job, without no money in hand, it will not be solved.

Future hopes:

Michael has some ideas that help him make sense of things:

Corruption is caused by lack of basic need. I can't get this, so what am I going to do, sell drugs in ways not meant to be. There are some good, some bad people here. Some people still have problems from a convict past. A lot of people become homeless, and it causes a lot of stress, it can lead them to want to kill themselves or into crime. The whole nation should do what this service does – listen to people's situation – they never say they're not going to help. To men, women, everyone.

Recommendations and requests:

- *They're not paying me right. Not paying me the correct amount. They are charging me extra costs and doubling costs [for a work knife].*
- *The job is too far away without a car. There's not transport, it's too expensive without a car. No public transport. Others are experiencing the same.*
- *I can see people discriminate against me because of my colour. I didn't choose my colour. They don't take the time to listen to me.*

From the researcher's perspective, Michael is also requesting:

- Respect for people from CALD backgrounds and attempt to understand their circumstances (using interpreters if required)
- Greater support from Centrelink
- Equal pay, fair pay, fair employment conditions
- Greater access to public transport
- Transport support for attending rural workplaces
- Opportunities to negotiate fines and debts
- Access to affordable housing

13. Karen

(#6 of 9 adults interviewed)

First off Housing Tas said I didn't have a good enough reason to move house, and when I told my worker, he flipped out and he said "I think death is a really good reason"...'

Karen is 43 and of Anglo-Celtic heritage. She has two adult children, one of whom is in close contact with her. She has been involved in child protection, hospitalised for mental ill health, and has spent time in prison. Karen lives in a public housing flat, but has drug dealers living on both sides.

Early life:

Karen had a very difficult early life:

My Dad, he got killed when I was six ... that's when all of our lives just spiralled down, we were put in homes, just shoved everywhere because Mum was an alcoholic and then she turned to prostitution and I hated her. My elder brother sexually abused me, same with Mum's blokes. If I'd told Mum he said he'd flog me, which he would have and I never ever told Mum, I never told anyone until about four years ago.

In her late teens, Karen 'got into the wrong group' and started using drugs. She was spending up to \$900 a day on drugs – getting into it heavier and heavier. Bashings were part of the scene:

I've never ever felt loved, never. And my last relationship was 14 years. I was with him and yeah, just never felt like that I belonged, that I mattered.

Well I was homeless nearly three years, I was living in me car because my ex physically abused me and mentally. I got homeless when I left my ex, just the beltings, he was a drinker and every time he got drunk he'd bash me. I'd rather he hit me than the mental abuse, the mental abuse I could not cope with because I'm a thinker and I just used to dwell on the abuse.

Transitions:

Karen applied for public housing while she was still living with her partner. She had to go back to him because she had nowhere else to go. Along the way, she was jailed for three months:

They wouldn't bail me unless I had an address to move to, and I couldn't get no address so this worker helped with crisis accommodation so I could be bailed. He's known me a long time, since before I was sleeping in my car.

Her relationship with her kids was strained:

I put on a front in front of my kids, I put on a front that everything's OK and I'm OK and it's not. And I'm sick of pretending I'm happy and everything's OK. I feel like I'm lying all over again, like I was when I was on the drugs and now I'm lying about how I'm feeling.

After four years of waiting, Karen got a public housing unit. She got caught for drink driving five years ago, and had to tell her kids – that was the hardest part of it:

Kids are the reason I don't do drugs no more. And a grandkid soon.

Sadly, Karen's best friend died in her current apartment, on her couch. His death haunts her house.

Current supports:

When asked about her current supports, Karen lists her brother who is living with her as a carer, and her son who drops in a lot. An uncle also sees her once a week. Still, she feels she'd really like

someone to talk to:

Really I don't feel anyone's helping me, I feel like I'm still stuck in that rut. And I feel I can't get out of it and nothing's going to happen. I'm just very negative.

She says there are not enough counsellors and that the help she's getting with mental health isn't helping. She says her GP is available, but has no one to refer her to. She's still waiting for an appointment with a psychologist – 'that should happen soon'. She says she needs friends – new friends that aren't drug addicts:

I just feel I don't fit in nowhere. I hate it.

Personal prevention advice:

Karen says she just wants to be happy – she would like to think positively. She says her son makes her smile. And concentrating on grandkids helps her stay positive – she's looking forward to shopping for a cradle cot:

My son's girlfriend is having a baby and my daughter's got a little girl so my motto is I'm living for my grandchildren.

In relation to her future happiness, Karen says:

My biggest problem is I've got to get out of that unit, it's dragging me down, it's really dragging me down. I started a flower garden out the front and all the customers that go to the dealer's house just trod on them so I gave up on the flower garden.

For Karen, her public housing is stable and secure – she'll have no problem keeping the place if she keeps going like she's going – but the location is not good for her:

I want to move to a new area and not mix with my neighbours, I don't want to know 'em.

Future hopes:

When asked what future advice she would give herself, Karen says:

I think friends, I've got no friends, because they're drug addicts the ones I used to associate with and the ones I had before that want nothing to do with me because I was on the drugs and they still treat me like I'm on them.

I'm just very negative, very negative. I think the only time people get smiles out of me when my son turns up.

Recommendations and requests:

- *I'd actually spend it on both mental health and homeless. I'd build more houses. Where I live there's paddocks galore, so much room to build heaps more but they don't.*
- *Someone to talk to. There's just not enough counsellors, not enough help out there.*

From the researcher's perspective, Karen is also requesting:

- Safety for children – no child abuse
- Drug and alcohol services for young people
- Access to supports for young people who have experienced trauma
- No domestic violence
- More affordable housing options
- No 'exits' from juvenile detention or adult prisons into homelessness
- Appropriate safe public housing, with flexibility in relation to location
- More counsellors and mental health workers – more people to talk to
- Alternatives to psychiatric in-patient mental health treatments
- More opportunities for social connection, and healthy recreation options

14. Kaylene

(#7 of 9 adults interviewed)

'I'm doing a course, a half hour walk from town, haven't got anywhere to live. I'm waiting and calling the shelter every day...'

Kaylene is 34 and is Aboriginal. She has no contact with her 12 year old son. She has been involved with child protection. Kaylene is experiencing primary homelessness – she sleeps in her car or at friends' places.

Early life:

Kaylene grew up in Tasmania and left home at 15. She's been homeless on and off since then. Kaylene has a 12-year old son who has lived with other family since he was a baby. He doesn't want to see Kaylene.

Kaylene had public housing for 10 months, an attached unit, in a court. But one neighbour caused a lot of trouble – partied every night, was using drugs. She couldn't sleep because her bedroom was attached to the neighbour's house. One day the neighbour 'snapped' and smacked her in the face:

Started asking for a transfer, they didn't have anything. Two months later I walked away – couch surfed at friends' places for 12 months. Then moved into private rental for 2 months, paying \$200 a week. I was struggling financially, so abandoned the property, [community service organisation] lost the bond, I moved out and down to Hobart to do this course a few days later.

Transitions:

Kaylene has been sleeping on the streets, couch surfing, and sleeping in her car for two and a half years.

She's on medication for depression. Some mornings she doesn't feel like doing the course, but she's managing. Kaylene says if she had a good place to live and a job she'd stay.

Current supports:

A worker in Launceston will transfer Kaylene's Aboriginal public housing application to Hobart.

Kaylene had a financial counsellor in Launceston, and will need one in Hobart. She bought her car from a friend, and is paying them back bit by bit. Her car is very important for independence, but means she needs money for fuel. Kaylene receives the Disability Support Pension, and has a number of debts deducted from her account directly:

Fines, power bills which I gotta cancel, two NILS loans, dental, a \$77 loan from Centrelink, parking fines.

Kaylene is doing a full time Aged Care course. To get there, she walks half an hour from town then gets a bus, meaning an hour of travel each way. A Job Network Agency in Launceston paid for the course.

Kaylene makes use of food vouchers. She has a doctor in Launceston and in Hobart. She has two friends in Launceston.

Kaylene is calling the women's shelter every day, but they have no beds. There are 30-40 people on the waiting list. People are coming and going all the time, but she never gets a place. When she gets in, she can stay for six weeks.

Personal prevention advice:

Kaylene says she's pretty independent – she'll ask for it when she needs it. She tries not to ask all the time, but says she's struggling financially at the moment. For Kaylene to not go as low as she's been in the past, it will take networks and friends:

A public house, and support networks, and financial counselling – sticking to a budget. I've got fines to pay.

Future hopes:

Just getting a place. Public housing is the hope. If I got a job in Hobart I'd stay here. Otherwise, I'd go anywhere if there was a job going.

Recommendations and requests:

- Private rent is too expensive.
- Emergency shelters for women don't have enough beds.
- Provide more mental health services – psychiatrists, gynaecologists, medical services in general.
- Get more funding for homeless people. Build more units.
- A "good place" means no bad neighbours, in a good area, affordable (\$60 a week, which means public housing), 1-2 bedrooms, close to shops, close to public transport, close to medical facilities, a yard, a carport for the car.

From the researcher's perspective, Kaylene is also requesting:

- Safety for children – no child abuse
- Safe accommodation options for homeless young people
- Affordable private rental
- Safe public housing (safe neighbours, in suitable locations)
- More vocational training opportunities in regional centres
- More crisis accommodation facilities, more medium-term accommodation facilities

15. Dazza

(#8 of 9 adults interviewed)

'Straight after school I went hunting. I did catch a lot of rabbits for pocket money and that, went out and made a quid...'

Dazza is 46 and of Anglo-Celtic heritage. He has contact from family on the mainland occasionally. He has not been involved in child protection, hospital for mental health or prison. Dazza has a hearing disability.

Early life:

Dazza grew up in rural Victoria, and wasn't doing too well:

School? It was just another day to me, the sooner it was over the better you know? Back [there] it wasn't good. Mainly to do with the motorcycle clubs.

Early on, Dazza couldn't get a place to live – he was couch surfing, smoking and drinking. Dazza has been in Tassie for 20 years. He came here because people told him it was a good place – they said it would be easier here. When he got here he moved into a private boarding house for a while:

It wasn't a bad place, but it didn't leave you much of your pension. They were closing some accommodation down, so they let Mission Australia know, who told us. I had daytime rehabilitation – woodwork, art, outings, I made a bookshelf, coffee table, CD rack.

Dazza gets on OK with his mother and father and they still send him some money every Christmas.

Transitions:

The lease expired at a private boarding house, and Dazza had to leave. Dazza registered for public housing:

I got introduced through NILS, next thing you know I had nice new washing machine, no interest loan they call that, NILS, and it just led on all the way down the grapevine. Everything just started turning around.

You only get 18 months with Mission Australia you see. That runs out, they said "oh you've recovered" but you haven't really have you? Sometimes they come out, meet you, have a coffee, but it's mainly what you want to do in the future, what your plans are, they help you with that. You know, push you in the back – you know what I mean, push you in the right direction.

Dazza lives in a one bedroom unit – he got the area he wanted, but not the place:

It's a bit small. I can't have furniture in there.

For Dazza, it's difficult that everything has to be done by phone – he can't hear.

Now, I've got no communications at home you know because of my hearing and that, I can't use telephones and there is TV but it's not set up. I have to have extended speakers for my hearing.

Current supports:

Dazza talks to his parents a couple of times a year, and a brother 'sometimes picks up the phone'. Dazza receives the disability pension:

I was on it originally for alcohol and drug problems, but is now for other reasons.

After rent and paying back his NILS loan, Dazza has about \$480 left for power bills, lay-bys, food, and buses. The 'Add Up' program helps him with his budgets. He sees someone from the Salvation Army every month, and a doctor every six months. He used to see an occupational therapist. Dazza takes medication, but he's not sure what for:

I flipped out; I was under a lot of pressure, even the cops, about four years ago.

Dazza attends [a mental health support program] most mornings, has a coffee, sometimes goes to the cinemas, and goes home after that. He has contact with workers at the program and at NILS. Dazza talks to people at the mental health centre, depending on who's in, and with people around the streets. He thinks it's useful to have support workers:

Oh and I go to church, my mate comes over and we have a bible reading every Friday night.

Personal prevention advice:

Dazza fills in his day:

You fill in your day quite well. Sometimes you stroll in here, grab a cup of coffee and usually I go down to the op shop and see some of me Christian mates and that. By the time you've done that it's lunch time. And they're usually on an outing in the afternoon and so you're better off to go home. Sometimes you stop off have a hot chocolate and talk to some of the women in the café.

I don't drink, I don't smoke dope, I have a go at the pokies every now and then and probably Lotto syndicate. So the money doesn't get spent.

In thinking about housing, and how he will stay housed, Dazza said:

Luck. The right place at the right time. Well, the Housing Department you can stay as long as you like, that's one good thing about it you know. If I had my way I'd be in the private sector, but I'd have a one on one relationship with the landlord and tenant, I could have my rent deducted, and turn around and I'd be sitting pretty. A garden, bit of room to move. It's probably better accommodation you know? And you'd finish up with a better area because the housing department places are usually pretty rough. And yet you only get a certain amount of rent assistance don't you? It's a set amount so you've got to pick a place pretty carefully. It could possibly balance out a bit if you get the right place.

Future hopes:

Dazza has plans for owning his own house one day:

I'm putting together money to go in the shared home program. I'll share-buy it with the government, ex-housing department houses. I've got about 12 grand saved up as it is now, or invested. It's earning me a hundred bucks every two months, but better than a kick in the pants you know what I mean? Plus I deposit once a year, usually works out by the time I save my loose change and 50 bucks a



fortnight usually finish up with about 3 grand, 4 grand to put into it each year.

Recommendations and requests:

- *If I was PM, there'd be gifts all round. Heh look, houses. Houses.*
- *I'd develop the red centre – we could make a farm there.*
- *The hearing, yeah, something for that. Because everything is done by the phone.*
- *Everyone's equal.*

From the researcher's perspective, Dazza is also requesting:

- More housing options for young people
- Safe recreational options for young people
- Earlier assessment of mental health, intellectual disability, acquired brain injury, etc.
- Affordable private rental
- Options/pathways to own your own home
- Opportunities for social connection, recreation and participation in the community

16. Ryan

(#9 of 9 adults interviewed)

I like battered fish. I go and buy it from the take away shop. It's delicious isn't it? Especially if you get a good piece...'

Ryan is 45 and of Anglo-Celtic heritage. He has no family living. Ryan was involved in child protection, was admitted to a psychiatric institution when he was young, and again when older, and has been in prison. Ryan has diabetes and doesn't see very well.

Early life:

Ryan's early life involved a series of foster homes and youth detention:

I had a good family and due to circumstances... they were all killed for one reason or another, murdered that is. A lot of killings to do with my family, jealousies. My father was actually rich but I've never seen any of it. His will was made out to the government. I lost my real family when I was about six years old and I was just adopted out. Adoptive care for 18 months-2 years; a children's home from seven onwards; Ashley boys home from 14 years onwards – I don't know the reasons for that.

His adoptive parents are now dead. There were seven children altogether; Ryan tries to keep contact with one of them.

According to Ryan, 'drugs in the system' caused mental and physical illnesses:

I just tried a bit of marijuana like everyone else. But people did things to me behind my back that I had no control over. I was diagnosed with paranoid schizophrenic – mostly because of my trouble with the police.

At some stage in his childhood, Ryan was put into the New Norfolk psychiatric ward. At 16 or 17 Ryan was knocked unconscious in a motorbike accident. As a 20 year old, Ryan experienced burns to 40% of his body:

Face, head. I was in hospital, my head swelled up bigger than a football. Pressure on the brain. There were mental repercussions.

When asked what kept him going, Ryan said:

Love kept me going. Love of life. I wanted to be able to see birds chirping when I get up in the morning...

Ryan wishes he'd had children:

I missed out on that one because of not the right girlfriend. Never met the right girl.

Transitions:

Ryan is currently housed in a residential rehabilitation supported accommodation setting. His furniture is provided, and rent is paid out of his account directly. There are 10 units, one for staff, one for the community, and eight for residents – seven men and one woman. 'Just a good wife is missing'. He can stay for three years, and has been there for two years.

Ryan's mental health is pretty good currently:

Better than average... going out all the time and looking after myself properly... showering every day, wearing clean clothes, or trying to, and keeping my unit tidy, nice and clean, eating me vegetables every night.

But his physical health is a concern:

Because I'm 45 years old, you never know when you're going to have a heart attack, that's my worry because of the medication.

Due to recently diagnosed diabetes, Ryan lost some of his vision:

I've stopped going to the clubhouse. I couldn't see, so I couldn't drive. And I was having trouble seeing people – keeping the correct eye contact with people.

Current supports:

Ryan is supported by staff at his residential accommodation setting. He gets on with all staff OK, and has one friend amongst the residents – an older mental health patient:

The service refers to everyone as clients but it's not really the truth... The patients really refer to each other as people. My key worker's actually putting a bit of pressure on for me to go to Housing.

Ryan receives the Disability Support Pension. Rent and electricity and food are directly debited from his account. He says that leaves him with money to save:

I believe in saving as much as I can. I believe everyone should save a little bit so they can buy their own house when they're old and retired. I'm working towards that by saving \$20 a fortnight. Smoking and eating out takes that down.

Ryan has a case manager in mental health services and has his injection at the community forensic mental health service. It was they who discovered his diabetes. He did have a 'great' mental health worker there who left:

It was very hard – very disappointing – we got on very well. It was an injustice to me that she left, that I lost her as a worker. We became friends. It was hard to lose a friendship when she left.

For Ryan, the mental health system has kept him alive:

There's a lot of good in a lot of ways – but you've got to be prepared to talk to them. I've got more out of them than I could get out of others anywhere else. Overall, I wouldn't be here without them.

Personal prevention advice:

Asked what will stop him from going as low as he's been, Ryan said:

Making sure I've got a roof over my head, and making sure I got money in the bank and making sure I don't do anything illegal... Jail would be low.

Asked what will stop him from losing his housing, Ryan said:

I got to stay on medication, I got to stay under the mental health to stay here. If the mental health kicks me out, then I'm gonna get kicked out of here aren't I? If you're violent, you're not allowed here.



Ryan would stay in his current accommodation service if he could:

Under mental health, people should be able to stay in places like this – they're perfect. But there's only one of them. And I have to move after 2-3 years. And I've been here 2 years.

Future hopes:

In terms of his future, Ryan said:

I'm really taking one day at a time... Day by day I try to keep myself busy every day but time to relax too.

He plans to follow the rules of his current accommodation service:

Stay involved in mental health and medication.

Recommendations and requests:

- *Having my own parents would have helped – I was sharing rooms and not knowing if I was going to have a roof over my head.*
- *I'd just put more of the taxpayers' money into housing for poor people – but it wouldn't only be for the mental health. It would be for poor people. It might be a program where anyone on Centrelink benefits is entitled to a Centrelink house... That's what I'd do if I was Prime Minister so as all the poor have a place to stay.*
- *If I had money for housing, I'd buy my own place.*

From the researcher's perspective, Ryan is also requesting:

- Safety for children – no child abuse
- No 'exits' from child protection, youth detention, adult prison or psychiatric inpatient services into homelessness
- Effective drug and alcohol services for young people
- No 'exits' from short-term and medium-term accommodation facilities into homelessness
- More supported residential facilities for adults with mental illness, including support with budgeting, food, personal goals (drug and alcohol-free environments)
- More opportunities for social connection, recreation, training, volunteering and employment for adults with mental illness
- Intergradation between primary health and mental health services

17. Leo

(#1 of 4 older adults interviewed)

'I've tried to kill myself a few ways. It's caused a lot of trouble for me...'

Leo is 71 and of Anglo-Celtic heritage. He has two adult sons, one of whom is also homeless. Leo has been involved in child protection as both child and parent, he's been hospitalised for mental ill health, including as a child, and has been in adult prison and forensic mental health services. Leo is living in a private boarding house, with meals provided and shared facilities.

Early life:

Leo had a very difficult childhood:

When I started off at school well I just couldn't learn... It would have made a hell of a difference if I wasn't been so retarded, not really retarded but slow learner... I suffer from lack of confidence.

Leo's family life was violent:

I'm wondering what Dad's life was like himself. I only seen him, visited him at the gaol in Launceston when I was a little fellow with Mum. He was behind bars. Lucky for me I didn't go with my father. He didn't want me anyhow. I don't blame him anyhow because I don't like myself. I'd like to get me nose altered ... and something else done.

I was sexually troubled I should have had education on sexual problems.

He's had a lot of involvement with mental health services, including time in New Norfolk Asylum when he was young:

I've had so much shock treatments. I've had 15 or 16 ECTs or whatever they call them. I had all me teeth pulled out. I hated them.

At about 19 I finished up down in New Norfolk as well ... I said "I want to go to the asylum, doctor" and so he said "alright", and he give me a note. And Nanna took me down on the bus and they put me in down at New Norfolk. And I was there a while.

I did time because I was violent at home. I was frightened at Risdon. I used to ask them to shoot me. The psychiatrist told me things that upset me.

Leo worked, and was married:

I was a good lawn cutter I've gone down and down and made all the wrong decisions really.

Leo describes that he was violent towards his wife at times and teased and threatened his children, breaking their confidence. He has tried to commit suicide a few times:

My uncle reckons only cowards do it but it takes a bit of doing to knock yourself off.

Transitions:

Leo had a breakdown. He was diagnosed with bi-polar disorder and hospitalised. He was brought to this boarding house by a psychiatric nurse, straight from hospital. Before that, he was at an aged care facility.

Current supports:

Leo has been living in this private boarding house for four and a half years. He has a friend down the road:

Got my own room, with kitchen. Food's provided. Shared toilet and shower. 21-22 residents. Ladies and men. Everyone's been homeless here; most have come off the street, most are on medication for illness.

Leo's been back in hospital twice since being here – once when he tried to physically injure himself. Leo receives the age pension; his food and board are directly debited. All of his money from his earlier life is managed by the Public Trustee. He gets \$105 a fortnight:

That seems to be enough at the moment. Can get little extras.

Personal prevention advice:

Leo is on medication:

It's all to do with keeping me reasonably quiet, I'm a pretty excitable sort of a fella.

Future hopes:

Leo would like to live in private rental again:

I'd like to handle my own money again one day. The doctor says if I can do it they'll support me. I have to prove I can do it.

When asked what he needs to do to stay well and safe, including keeping others safe, Leo said:

Read my Bible, drink plenty of water, and medication – extra strong.

Recommendations and requests:

- *Make sure people are comfortable, I'd make sure I was comfortable.*
- *I'd like to set my two boys up properly.*

From the researcher's perspective, Leo is also identifying the need for:

- Safety for children – no abuse
- Appropriate mental health treatment for victims and perpetrators of sexual offences
- Appropriate housing options for victims and perpetrators of sexual offences (incorporating safety for all residents, and preventative supports for offenders)
- More support for parents with mental illnesses
- More support for children whose parents have a mental illness
- More effective rehabilitation services within adult prisons
- More effective mental health treatment services within child, adolescent and adult forensic services
- Access to supported accommodation that includes provision of meals
- Opportunities for social connection, recreation, and mental stimulation for residents of long-term supported accommodation facilities

18. Lenah

(#2 of 4 older adults interviewed)

I'm a determined little cuss. I've got Yorkshire blood on both sides of me...'

Lenah is 67 and has no family. She thinks she may be Aboriginal. She has been hospitalised many times for mental ill health. Lenah lives in a private boarding house, with two meals a day, and has to climb stairs to reach the bathroom.

Early life:

As an infant, Lenah had meningitis:

The doctors reckoned I wouldn't make my first night.

If there's not anything up here [brain], then you're a nutcase. And I'm not one... Practically all my life people treated me like a dimwit – and that's bad enough when you are – but when you're not, it's ten times worse.

Lenah didn't feel cared for, except by her grandparents:

Mum was bad to me – belted me with wire coat hangers and blocks of wood. Nan and Pop only people that really loved me, really cared about me, and only one of four people I've trusted in me life were Nan and Pop, and [two current workers]. It was, oh, just barely seven years the only time when I really had what makes life – like family, love, home, you know? The rest of the time I battled for somewhere to live, even for the food.

When Nan died when I was seven, Mum said Pop didn't want me anymore. Pop didn't die until 1966 so I could have had all that time that's another 15 years that I could have had a life, could have had love, could have had family, could have had it all. I found out later Pop did want us. Mum had said he didn't.

Lenah was married for six weeks, but her husband 'nearly killed her': *His Dad offered us a property, a farm, but he threw an iron at his Dad.*

She was employed:

You could only get the real jobs if you had the high school leaving certificate. I never went past grade 5. But you can have knowledge without education. Worked at [a government] department just over 10 years. Then I fell up the stairs at work, and fell and hurt my back... I said could go in there and just do the busy times but they didn't want me back.

Lenah has had to look after herself since she was a child. When she left home, she lived in her mother's shed. When asked how she looked after herself, Lenah said:

As far as safe, I could take care of myself, I've had to since I was just over seven.

Transitions:

Lenah was in private rental for some time, but it was very expensive 'and then some'. She was in public housing for a few years, but lost it due to a run in with a worker who swore at her:

Don't worry I told her what I thought of her. She put me out... She stole my things. Things that you can't buy. Things from Nan and Pop.

When asked how people come to lose public housing, Lenah said:

People lose public housing because 1) they don't pay rent; 2) they demolish it in some way; 3) due to personality; or 4) someone comes along in greater need.

Current supports:

Lenah currently lives in a private boarding house. Her worker says she's provided with two meals a day:

Two 'part' meals to be totally accurate.

She is provided with support from a community service organisation. One worker helps her with washing and keeps her 'on the level'; the other provides personal care. Lenah has to shower in a building separate from her room – not suitable for her disabilities. Her workers are currently looking at other options, including an aged care facility. Private rental is too expensive; she doesn't fit in to places that are 'too choosy'; the hope is that she'll get assessed for the level of physical care she needs.

Personal prevention advice:

In relation to her physical and mental health, Lenah said:

In everything, including health, I'm black and white, I've got no grey whatsoever. I say what I mean and I mean it...

She has three health issues currently: problems with one leg; side-effects from meningitis include some paralysis; hearing loss and poor sight and 'my forthrightness'. She says she needs to look after these things.

Future hopes:

Lenah's worker says:

It will be good to have find another place – her own room, bigger than now, with an ensuite. She'd prefer a bath, she grew up with baths. She could have three meals a day, good meals. And mental stimulation, people to talk to. Her mental health would improve.

Recommendations and requests:

- *Fixing up the Royal – I don't mean building more things like that stupid blooming cafeteria out the front. I mean getting the equipment and the staff to open up the three quarters of it that is shut up.*
- *More ramps too. Except for two places, all the ramps around town are vertical... I have trouble getting up, and I'm a lot more mobile than a lot of people that's got to go up them things. But they don't take ask the people that's got to use them...*
- *If I was PM for the day I'd improve hospitals.*
- *I don't think it's right they should be paying for people to have kids.*
- *Support kids better ... it should not just be the physical things – they should give the mind things... In some ways that's the more*

important of the two. Feed the mind and the mouth.

- *Not only just build more houses or more, you know, get them helps - things for people who can't cope and need more help.*
- *It should be more to the individual. Housing's not the major thing; it's more to making the thing good than housing. But it's good, it's nice to have somewhere to live. But the main thing is having something that's worth living.*
- *Put more thought into the way it's given and the things it's given for. A better society.*

From the researcher's perspective, Lenah is also requesting:

- Safety for children – no child abuse, more support for children growing up in unsafe homes
- Good education for all children – mental stimulation
- More accommodation options for young people
- No 'exits' from in-patient psychiatric services into homelessness
- No 'exits' from public housing into homelessness
- Respect for people who are 'different'
- Review of income and conditions for politicians
- More access to buildings and spaces for people with limited mobility
- More accountability for spending relating to Centrelink allowances (i.e. not permitted to spend allowances on drugs/ alcohol)
- Remove financial incentives for couples to have children (baby bonuses)
- Upgrade hospitals, ensure adequate access to primary health care for all (including in rural and remote areas)
- Affordable private rental
- More supported accommodation facilities (with tailored support for people who need it)
- More respect and closer listening to people with 'lived experiences' in relation to services and policy decisions

19. Brian

(#3 of 4 older adults interviewed)

'But if you give somebody TLC all the time from the day that they're born the mental health issues will eradicate...'

Brian is 62 and of Anglo-Celtic heritage. He has two adult children and his mother is still alive. Brian has been hospitalised for mental ill health. He lives in a flat owned by his daughter, but a relationship breakdown is putting that housing at risk.

Early life:

Brian says:

I'm not a baby boomer, I'm a production line increase. Because men came home from war.

In relation to his family, Brian says:

My father was an alcoholic and a gambler. He obviously had bipolar... He was the worst father and the worst husband in history.

Brian worked from the age of 15, and married, and has two children. It was when he was working in a remote town in South Australia that he was at his lowest. He tried to end his life, and was hospitalised, then returned home with little support. His sister and brother in law invited him to Sydney for a break. All was going well, until they left for an extended family visit:

They were gone for eight weeks, and at the end of that eight week period I become a drug addict. A total drug addict... I was history... I ended up living on the streets of Kings Cross. I had no where to live, I had no money... for over 12 months.

Well, obviously I tried to commit suicide while I was on the streets and all that sort of stuff. You had days where you're totally full on and well, and within the week you've got no money again, so you're back down there again. And so what's the first thing you do, you take [marijuana]. Peace of mind, it helps me relax, made me sleep. But it's like everything else, anything in moderation's OK. My son used to ring every morning and every night to make sure I was alive.

Transitions:

For Brian, a big change happened when he realised he might have bi-polar disorder:

I didn't find out I was bipolar until I was 52. I mean I always thought I had a pretty happy life as a teenager... Because I read the story in the Herald Sun. That's when my life changed, dramatically, changed a lot. That told me then that's the reason why I couldn't control money. That told me the reasons why ... all that stuff.

It's still taken me from that time until ... I started to get really better to where I am now. But you know, it's the power of the mind that's the most important, productive, dominant...

Brian still has debts to family and friends because of drug addiction:

I believe 'why should I go out when I owe people money'... When I pay my debts and I can walk around the streets again in Hobart is when I'll start rebuilding my life.

Current supports:

Brian's son helped him get back to Tasmania, and his daughter's husband got him a job in retail. His daughter bought a flat for him to rent but things have gone bad lately. Brian followed the advice of his doctor and raised the issue of pay with his workplace.

He was working a lot of hours for not much pay. Brian didn't want to be paid more, but wanted to work less, for his health. He's ended up being sacked, and has no income:

Right at the moment I don't have any income because I resigned... My doctor said I was working too hard... I had no intention of resigning. I went and asked if I could speak with [the general manager] and said "my doctor wants me to reduce my hours - is it possible?. If I resign, can you re-employ me on a 20 hour basis or whatever it is on the amount I can earn of a comparable size so I don't lose my benefits?" And he told me to go ... for five minutes he was shouting at me, it was an embarrassment. He doesn't believe that anyone can have bi-polar, he thinks you catch it by a bee sting; he spells it bi-pola.

Since then his relationship with his son-in-law has been difficult and Brian is feeling uncomfortable continuing to stay at his daughter's place. He's starting to think about moving on:

And the people who live [nextdoor] ... are drug addicts.. And I've reported them to the police on 17 occasions since I moved in because they have parties on their welfare payment nights... I can handle it, but it's not good.

Brian wants another job, he has always worked, but he can't physically work full time. A mate might employ him as a bottle shop salesman. He wonders if there are any housing options for someone like him.

Personal prevention advice:

Brian thinks his mental health issue is the major issue of his life, which includes gambling. He thinks his mother also has it, but just doesn't know it:

What people don't realise is that people with bipolar have all sorts of addictions.

Gamblers Anonymous has been very helpful for Brian:

It was very useful; it gave me the opportunity to speak and get it off my chest even though I was totally depressed and I was petrified... People with addictions - the worst thing you can do is take everything away from you. So I thought to myself maybe if I give up the worst part of my addictions such as the drugs, the illicit drugs, and the alcohol, when I can give the alcohol up, that's what I can do...

Brian still smokes cigarettes, and finds ways to give himself a treat:

Once a week I like to have takeaway chicken with the best chips that they make... I haven't had it for weeks because I haven't afford it.

He thinks he needs to find a job and move into a different house. He's not doing anything drastic, but just starting to look.

Future hopes:

Brian says he'll stay away from people whose names start with 'psy', and stay away from anti-depressant medication:

I say that 999 out of 1000 'psy' people are dumb. Psychologists, psychiatrists, psychiatricians. They ask you the same questions in the same tone of voice in the same sequence, whether you go to them in Sydney, Mt Gambier or Hobart.

Brian thinks it's pretty simple:

You've got to be honest. You've got to pay your bills on time, no matter what circumstances. If you actually pay your rent, you'll be OK.

Recommendations and requests:

- *Top priority? It's all to do with TLC I think. But, from when you're born... I also believe a female should not have a child unless they can prove they're in a stable relationship.*
- *Spell out to the individual people what your entitlements are.*
- *Fair pay, part time. So I can still get my pension. I can't work full time. It wasn't my choice to take him to the fair workers trader. My doctor said... it's not fair they've been underpaying you. So I lost my job.*
- *Stop the baby bonus – that's beautiful but, the people that cannot prove they're in a stable relationship for 3, 5, 7 years aren't entitled to the \$7000.*
- *I think the most important thing is what everybody in the mental health industry has got to understand is this: it's up to the individual themselves that they want to quit the life that they're doing at present. If they don't want to quit the life that they're doing at present, the help that they give them if they don't want to do it - well it won't happen.*
- *Maybe that individuals need time out.*
- *They 'psy' people have got to be more human, the same as GPs*
- *People have to stop judging people. I had old clothes on, and a beanie on, and went into a shop and wasn't served. People judge people.*
- *You know this Wilkie fella, this Wilkie... He's going to close down all the pokie machines. He is that far off, I'll challenge him... to a debate. He's miles off track. There's people that play poker machines that enjoy their life. There is an elderly lady or an elderly man that's lost their partner; it gives them an opportunity of a social outlet.*

From the researcher's perspective, Brian is also requesting:

- Safe adult role models for children
- Better mental health treatment and support in rural areas
- More education about mental ill health

- More effective services for people who struggle with a range of addictions
- Affordable accommodation
- Flexible employment options for people receiving disability payments
- Flexible employment options for people living with mental ill health

20. Veronica

(#4 of 4 older adults interviewed)

'It would be best if public housing came with help – just someone popping in from time to time...'

Veronica is 61. She has some contact with her ex-husband, adult son and granddaughter. She thinks she may be Aboriginal. Veronica's son has child protection involvement with his daughter. Veronica has been hospitalised 10 times for mental ill health. She has lived in public housing for eight years.

Early life:

I was living in a big house when I first had a homeless experience – the owner sold the house, and I didn't have anywhere to go. I went to a shelter first, but that's not long-term. Then a community hostel – it's closed down now. I was there for two years. After that, I went back to my ex-husband. We were renting privately there until they sold it from under us.

Transitions:

Asked about her homelessness, Veronica said:

It wasn't any good for my mental health. In those days I was hearing voices – that's a hell I don't want to go into again. My husband begged the doctors to cure me. I've been on lithium since; it keeps the voices away. Within two weeks it helped; it's not bad, but it's affecting my kidneys, and it's an awful thing to taste. I get injections every fortnight. Antipsychotic. I can get very anxious – it hurts, in the backside.

I've been in housing for eight years. People are complaining about my garden – it's only a few weeds. I've got to hoe my garden. Rent is taken out, I pay as I go for electricity. If you don't see it, you don't have the nuisance of having to go down and pay for it. I've been out of electricity before – there's not many places you can buy power.

Current supports:

Veronica has no parents or siblings; she has a sister-in-law who lives on the east coast; her ex-husband keeps an eye on her:

He promised my Dad he'd look after me.

Veronica receives the Disability Support Pension and believes it's 'just enough'. Her public housing unit is one bedroom:

A little box, but I like it.

Veronica says her mental health is not the best at the moment – she's been trying to get help from the mental health team, but they think she's going all right. She's been diagnosed with bi-polar disorder, schizophrenia and depression. She gets moody. She says she went down and thought about losing her flat, but hopes she'll get on top of it. She'd like more support from mental health services – she was 'with them for years, had a case manager and all', and now nothing. Her medication helps:

Medication and housing have helped me be stable for a while.

Veronica has learned some strategies she can use herself:

I did a recovery course for nearly 12 months. It was very helpful and useful, I learned a lot from the mentally ill people...

I can psych myself into being calm. A relaxation tape helps. I find I have energy at the end of it. A beautiful energy – a proper relaxation. ARAFMI put me onto it – one of the ladies there. Candles help too, plus a Carer's CD with exercises.

Veronica is supported by a social worker from a health centre who goes to her house sometimes. She sometimes goes to a mental health support program, but has stayed inside by the fire lately due to the cold:

I can talk to social workers here at [program], about health issues or other things that come up. That's useful. I'm doing an assessment for them at the moment, as I haven't been here for a while.

Personal prevention advice:

Veronica knows she needs to think positively:

Because I've been very negative – people pointed it out, but I didn't believe that I was. I just have to strive for goals to better myself.

I'd like to go to the Grief and Loss classes at the Mental Health Centre, but they start at 9:30. Maybe I'll get there.

Future hopes:

If I get fitter, I'd like to go to the PCYC [Police and Citizens Youth Club] to get fit and tackle fitness a little bit. Would like to get my partner to go too.

Recommendations and requests:

- *The thing is, it's in the papers, it looks like there are empty houses – and people are waiting for houses. I don't understand it.*
- *They put you into these houses, and you could rot for all they care. You've just got to battle on, the best you know how, with no help at all. It would be best if public housing came with help – just someone popping in from time to time – like at the start (they were there all the time). For morale – seeing you're happy in that particular place or not. Once a week.*
- *A big mental health hospital – especially for the mentally ill.*
- *Just let people know that there's support out there – that they're not on their own – there's strategies they can put in place – encourage them. Give them books and pamphlets.*

From the researcher's perspective, Veronica is also requesting:

- No 'exits' from private rental into homelessness
- Grief and loss services, including individual and group work relating to grief and loss
- Mental health support services, including peer-led programs that incorporate training in personal strategies to maintain wellness
- More treatment services for mental illness
- More information about services for mental ill health; more information about how to connect with mental health services and 'someone to talk to'
- Affordable accommodation options
- Support services connected with public housing – including someone who checks up on you for morale
- More opportunities for social connection and recreation

Common experiences and perceptions

The following tables list common experiences and perceptions. The number in the right hand column refers to the number of research participants who stated they have experienced those issues or perceptions.

Early life trauma

Parental mental ill health/not coping	13/20
Poverty	10/20
Neglect	9/20
Traumatic event	9/20
Physical violence/ Emotional abuse/ Sexual abuse	8/20
One absent parent (due to family breakdown)	8/20
Intellectual disability or Acquired brain injury	8/20
No family support/ child protection involvement	7/20
Parental alcohol or drug misuse	7/20
Childhood mental illness diagnosis	6/20
Parental crime	5/20
'The wrong crowd' (crime, alcohol or drug misuse)	5/20
Poor relationship with one parent only (both are present)	5/20
Premature loss of parent/s (1-parent suicide, 1-parent death, 1 –parent frail aged, 1 –both parents dead)	4/20
Large family	3/20
Finding 'alternative' families (streets/ alcohol or drug users)	3/20
Parental prostitution	2/20
Significant physical injury	1/20
Childhood offending behaviours	1/20

Transitions – perceived causes of homelessness

Lack of affordable housing	11/20
Lack of parental support	9/20
Inhibited cognitive capacity (Intellectual disability or Acquired brain injury)	8/20
Personal alcohol or drug misuse	7/20
Personal mental illness (including problem gambling)	7/20
Personal social skills (not fitting in/'different'/anti-social etc.)	6/20
Relationship breakdown (family/partner)	6/20
Clash with parent/s	6/20
Personal crime (5 - juvenile detention, 1 – petty involvement)	6/20
Extended family problems	6/20
'The wrong crowd'	6/20
Service gap/Service not responding (3 – exited into homelessness from detention, 2 – exited into homelessness from hospital)	5/20
Loss of private rental (2 – accumulated bills, 1 – damage to property, 1 – housemate relationship breakdowns)	4/20
Sale of private rental property (all were evicted more than once)	4/20
One absent parent	3/20
Two absent parents	3/20
Lack of youth housing	3/20
Loss of public housing (1 – personal AOD, 1 - neighbour AOD/unsafe, 1 – clash with management)	3/20
Not understanding the system (1 – no income, 1 – language barrier)	2/20
Personal debts/budgeting issues	2/20
Partner alcohol or drug misuse	2/20
Partner violence	2/20
Personal violence	1/20
Personal offending behaviours	1/20

Key social supports

Informal supports	
Friends/peers/acquaintances	11/20
Parents or children	10/20
Partner of close family members	4/20
Extended family	4/20
Formal supports (essential services)	
Centrelink allowance (4-newstart/job seeker, 2-student, 10-disability pension, 2-age pension)	17/20
Psychiatrist and clinical mental health team	9/20
Community-based housing (and support)	8/20
General counsellors/outreach workers/specialist counsellors	8/20
Public housing and support	5/20
General practitioner	4/20
Case manager	4/20
Crisis accommodation	4/20
Churches	3/20
Supported residential rehabilitation recovery accommodation	2/20
Community connections	
Day programs	5/20
Education/training	3/20
Employment	1/20

Personal prevention advice

Social connection	19/20
Stay away from alcohol and drug misuse	17/20
Maintain house and bill payments	16/20
Staying active	15/20
Accept extra support (finances, budgeting, health, etc.)	15/20
Someone to talk to/trust	14/20
Set personal goals	14/20
Get public housing (currently waiting)	13/20
Maintain mental health treatment/medication	13/20
Have manners, stay out of trouble, etc.	13/20
Employment	9/20
Recreation	7/20
Good counsellor	6/20
Education	5/20
Treatment for physical health	5/20
Accept support from family	4/20
Seek opportunities to contribute (including volunteering)	3/20
Find a mentor/friend	2/20
Undertake art/creative expression	2/20
Change public housing location	1/20

Personal hopes

To think positively and be happy	19/20
To be socially connected	19/20
To have people I can trust	17/20
To maintain stable accommodation (either current, or once achieved)	17/20
To stay out of debts, pay bills, etc.	17/20
To get a job	10/20
To engage in interesting recreational experiences	8/20
To talk to someone about previous trauma, emotions and mental health	5/20
To undertake training or education	5/20
To participate in meaningful activity (including volunteering)	5/20
To find a partner	5/20
To own a house	5/20
To be able to afford private rental accommodation	3/20
To finish school	3/20
To have a family and kids	3/20
To stay out of trouble	2/20
To start an artists group for people with mental health difficulties	1/20
To save up for a campervan	1/20
To have contact with my child	1/20

Summary:

Prevention, Early intervention, Treatment and Continuing care

Early life – Prevention

The majority of interviewees had experienced some form of trauma in early life, including a specific event, neglect, abuse, or grief and loss associated with the absence of one or more parents. More than half had struggled with parents who had mental ill health or did not cope during their early childhood. Half cited poverty as a key component of their early life experience.

You know I just didn't want to have to be there around that shit. I just couldn't deal with it. So it was easiest just be off your face you're not thinking about what's going on.

That was the hardest thing I've ever had to do in my life is tell my kids I was a drug addict.

In order to prevent mental ill health and homelessness, seven young research participants (aged 16-24) recommended the following strategies: more safety for children (no child abuse), a safe home environment, support for parents who are not coping, support for children whose parents are not coping, a safe adult for children to talk to, access to healthy recreational activities for young people, access to adequate income, access to transportation, affordable housing, and a fair rental market.

Nine adult research participants (aged 25-59) recommended the following prevention strategies: no domestic violence, support for children who lose a parent, support for adults who lose a partner, support for parents who have a child with disability, respite for aging parents supporting adult children with disabilities, early assessment of mental health and disability, safe recreational options for young people, safe drop in centres for young people, safe adult role models for children, more housing options for young people, respect for people from different backgrounds, enough houses for all people, more houses for families, vocational training opportunities in regional centres, employment, fair pay, fair employment conditions, greater access to public transport, public transport to rural workplaces, and more government funding that links health, education and housing ('our core social infrastructure').

Four older research participants (aged 60+) had the following prevention recommendations: no child abuse, better mental health treatments for parents in urban and rural areas, more education about mental illness, more support for children growing up in unsafe homes, remove financial incentives for babies (baby bonus), appropriate treatment or exclusion of potential perpetrators of violence against family members, good education for all children, respect for people who are different, and upgraded primary health hospitals in urban and rural areas.

Transitions – Early intervention

Most interviewees were disadvantaged by the high cost of private rental accommodation, and lack of housing options in general. Mental illness, alcohol and drug misuse, and co-morbid disability (intellectual disability or acquired brain injury) were relatively common causes of homelessness, along with lack of parental support (which in most cases was due to family breakdown or parental absence).

You imagine what it would be like for people living on the streets in Hobart last night. How cold it would be. The coldness is the worst thing when you're on the streets.

There's a lot more young people looking for private rental than you

think. It's either a NYAC unit which is a wait of at least 3 months to 9 months, with public housing it can be like 4 years, and College accommodation is too pricey. We can't get places that want adult guarantors.

Can't really keep control of your life when you're on alcohol and drugs. You'll end up in trouble, life's too hard to manage.

In order to intervene early and prevent full-blown mental ill health and homelessness, young research participants (aged 16-24) recommended: more information about services, assertive outreach to children and young people in schools (teachers and counsellors actively looking for students who are struggling), 'parent' type care offered to young people who need it (a listening adult), grief and loss counselling for young people, support for children transitioning into stepfamilies, speedier access to UTLAH allowances (or earlier application –before being homeless), no 'exits' from youth detention into homelessness, no 'exits' from child protection into homelessness, and more youth housing (appropriate, affordable, supported).

Adult research participants (aged 25-59) added the following early intervention strategies: support for children who have experienced trauma, more opportunities for early healing, more effective drug and alcohol services for young people, more counsellors, more information about homeless services, no 'exits' from family homes into homelessness for people with disabilities, no 'exits' from hospital into homelessness, no 'exits' from adult prison into homelessness, assertive outreach by homelessness services (into caravan parks, car parks, etc.), support to maintain housing, more affordable access to health care (including back care, dentistry, etc.), more affordable access to physical activity (including swimming, parks, etc.), more supports linked with Centrelink, flexible payment options for debts and fines, direct access to permanent supported residential accommodation for people with mental illness, easier access to public housing, closer integration between primary health, mental health and housing services.

Older research participants (aged 60+) had the following early intervention recommendations: more people to talk to, more information about who to talk to, more access to counselling (for trauma, grief and loss etc.), opportunities for social connection, more effective mental health treatments for children and adolescents, more effective rehabilitation services within youth detention and adult prisons, no 'exits' from private rental into homelessness, no 'exits' from public housing into homelessness, more accountability in relation to spending of Centrelink allowances (e.g. on drugs/alcohol etc.), more support attached to transitional housing facilities, and more access to buildings and spaces for people with limited mobility.

Social supports – Treatment and Housing

Discussion of social supports includes informal supports (family and friends), formal supports (services), and community connections. Seven of twenty people stated they had no friends; another seven had no family supports at all. One person's dog was their main support. In terms of formal supports, four people urgently needed specialist support, three people had no housing at all, and three people were not linked in to basic income support at the time of the interview. Three people were engaged in education, and one was employed at the time of their interview, but facing termination.

Well I got my housing unit so could finally leave the violence, after 4 years waiting.

I came to this place, a psychiatric nurse brought me, and I thought I don't think I like it here, I was a bit frightened. I came here, and now it's like a home away from home as far as I'm concerned.

It's a wonderful unit, comfortable to be in, and I like it there. It is a one bedroom unit... and I've got great neighbours. I've been there two months. It is home.

My doctor couldn't get me into any counselling because everywhere was booked out, they weren't taking on new clients so I've just had to deal with it and talk to my doctor.

Especially the mental health workers, they don't do jack shit. They put you in hospital but they just sign you out a day later.

The mental health staff will help you in a lot of different ways. You've got to be prepared to talk to them and find out what you can and can't do. Like I wouldn't be here if weren't for the mental health. I've got more out of the mental health than I could have got anywhere else.

I guess it would be good if was a bit more personal, have someone like a social worker get to know them a little more, get to know them as a person but sort of evaluate what sort of things they might be interested in, you know, organise the courses for them, sort of, but not to a stupid extent where they just get things handed to them, sort of help them organise something to actually to do with their lives.

I suppose it's just like what everyone says, there's just not that many housing units available.

In the treatment of mental ill health and provision of housing for homelessness people, young research participants (aged 16-24) stated we need: alternative options to psychiatric inpatient care for young people, alternative options to pharmacotherapy treatment for young people, greater practical support for people experiencing primary homelessness (access to showers, lockers, power points, food, etc.), and more long-term youth accommodation facilities (affordable, supported, semi-independent, with rules, consequences and boundaries).

Adult research participants (aged 25-59) added the following treatment and housing strategies: the elimination of stigma in relation to mental ill health and homelessness, greater respect and empathy for people experiencing mental ill health and homelessness (it is more to do with poverty than character), respectful attitudes from workers towards service-users, more people to talk to (counsellors), more options for recovery in mental health (in addition to pharmacotherapy), more 'step down' facilities (after in-patient care, before community living), more crisis accommodation facilities for women and children escaping domestic violence, reformed standards for crisis accommodation (independent sleeping spaces, empathetic but clear management practices, safe 'selection' of clients within shared accommodation settings), more medium-term accommodation options for a range of target groups (old, young, substance-using etc.), no 'exits' from homeless services into homelessness, and more long-term supported residential facilities for adults with mental ill health (drug/alcohol-free environments).

Older research participants (aged 60+) made the following recommendations: more mental health treatment services, more respect and closer listening to people's lived experiences in treatment situations, direct access to permanent supported accommodation (including provision of meals etc.), peer-led support networks, tailored support to address individual wellbeing needs (physical, mental, social), assertive outreach ('someone checking up on you').

Prevention and hopes – Continuing care

In order to 'never go as low again', people cited various strategies and goals they knew would personally assist them. Four people without accommodation stated they were currently 'at their lowest' –their first need was housing. One person stated she needed to move location, because her current public housing flat was not safe (due to neighbourhood bullying). Staying away from alcohol and drugs was important for the majority of participants. For all but one person, social connection was their best and most important personal strategy for staying well and housed into the future.

Research participant's personal hopes for the future varied, but some strong themes emerged, including people's wish for social connection, to think positively, and to feel happy. For many, if they had someone in their life they could trust, their life would be a lot better. Stable accommodation was cited as a key personal hope, along with a wish to maintain their housing (which meant managing bills and not falling behind in rent). Many would like to get a job, engage in recreational experiences, and participate in meaningful activity. Five wish to undertake counselling to address a traumatic specific event or series of events in their life.

By the time we pay rent, food, it's pretty much all gone.

I've got no income.

... manageable but tight. Don't have money to do things like go to the aquatic centre and I don't have the money to get my back fixed. My back gives me a lot of grief. It would be good to have some extra money to get that fixed.

You can't keep control of your life when you're on drugs and alcohol, cos you don't know what you're doing on it. It's too hard to manage your life – you end up homeless, broke, in bad relationships, you end up with nothing.

And unless the individual their self wants to say to their self 'that's it I'm never going back there' it won't happen.

I'm not real good at looking after myself. I don't think I'm capable of looking after myself.

Well that's the initial name of the game isn't it? Own your own place. That way no one can say anything to you can they? You only have to front up with your rates, insure it if you like, but they highly recommend it.

It's sort of your life entitlement to have your own house when you're older. I'm working me way towards that and save money every fortnight you know to make sure I've got my own house when I'm a bit older at the retirement age anyway.

In order to protect people's mental health and social inclusion (including homelessness), young research participants (aged 16-24) recommended: assertive outreach and supports that 'wrap around' a person rather than people having to navigate their own way back or through the system, access to vocational training of interest, access to physical and social recreational activities, affordable long-term supported accommodation facilities for young people, rent assistance and a 'substitute guarantor' to enable young people access to the private rental market, a trustworthy adult to talk to, and assistance with living skills if needed (cooking, cleaning, budgeting, paying bills, etc.).

Adult research participants (aged 25-59) added the following continuing care strategies: more respect for service users, more skills and empathy from staff in relation people they're working

with (more people with lived experience employed in worker roles, more training of staff by people with lived experience), tailored support for those who need it (e.g. living skills, personal management, coping strategies, etc.), more opportunities for healthy recreation and meaningful social connection, interesting activities for adults with mental illness to participate in, opportunities for vocational training, volunteering and flexible employment, more respect between all people.

Older research participants (aged 60+) had the following continuing care recommendations: opportunities for social connection, recreation and mental stimulation, more opportunities for service-users to help guide service development, peer-networks and support, flexible employment options for people receiving disability allowances, flexible employment options for people living with mental ill health, someone checking up on you to make sure you're OK.

The next section examines findings in the light of literature evidence, and presents a range of recommendations across the spectrum of interventions.

Part D: Conclusions and recommendations

HOME IS . . .

Home is where I'll be
with every breath and
every care of this great
land of ours.

Home is where I'll be
land that provide us
with nourishment
land that quenches
our thirst.

AND

A land that feeds us
with food for our souls
For this is my home

A home of richness

A home of opulence

A home of colours

AND

A home of sweetness

Home is where I'll be

AUSTRALIA

TASMANIA

T. J. Martin

July 2010



Introduction

Findings arising from this study have implications for public awareness and education, children, schools and families, community-based services and programs, mental health services, housing and homelessness services, funding and administration, workforce development, economic participation and community involvement.

Causal links between mental ill health and homelessness vary and remain unclear. Not all people who are homeless have mental ill health, yet the pressures of homelessness take their toll on peoples' mental health. It is fair to assume that in comparison to the rest of the population, subsections of the mental health population are at greater risk of homelessness, and subsections of the homeless population are at greater risk of mental ill health as a result of the pressures of homelessness.

Homelessness is preventable; yet until more houses are available, in-patient mental health treatment services and immediate emergency accommodation facilities will bear the burden of attempting to meet Tasmania's accommodation requirements for people with mental ill health. Whilst evidence exists that housing can prevent hospitalisation for people with mental illness, the lack of supported accommodation facilities means services attempt to 'hold' service users within inadequate short- and medium-term accommodation facilities. In addition, some people won't or can't use the existing homelessness services. The imminent review of Specialist Homelessness Services in Tasmania will shed more light on these barriers, particularly for people with mental ill health.

According to homelessness research, the most vulnerable homeless people are those in shelters or on the streets, and with severe mental health symptoms. In such cases, outreach services are essential. The findings of this research suggest that more assertive outreach needs to be undertaken in Tasmania. Findings also suggest that access to drug and alcohol services for people with mental ill-health who are experiencing homelessness is also difficult. There appears to be a lack of accessible, flexible, engaging options for people experiencing alcohol and drug misuse, meaning treatment options may centre around mental health facilities.

Previous Tasmanian research found that a chronic lack of affordable housing, an under resourced homelessness sector, and a shortage of public housing are having a severe impact (Flanagan K 2007, Cameron P 2004). Tasmanian housing sector advocates argued in 2007:

The single biggest issue facing all Tasmanian SAAP services and other services that support people affected by the housing crisis is the lack of exit points from crisis and transitional housing. In other words, there are very, very few places for clients in this kind of accommodation to go, even once they have addressed the issues that led them to be in crisis in the first place... The obvious way to address this issue is to increase supply (Flanagan 2007).

In the Tasmanian context, a lack of formalised links and cross-trained staff means service sectors still operate largely separately from each other. In the context of a shrinking state budget with subsequent cuts to community services, it is important to identify cost effective solutions for improving cross-service linkages. Certainly, a relatively cost effective solution to enhancing the effectiveness of existing services is to equip existing staff with skills in areas outside of, but connected with their core expertise – this includes equipping both specialist staff and mainstream staff (including in education, vocational training, employment, housing, and income support) with a wider skill base in relation to mental health and housing difficulties.

The evidence is clear that neither mental health nor housing solutions are formulaic – each individual requires different supports. Creative and innovative solutions will be required to better tailor supports to individual needs. In line with what is known about the importance of consumer engagement, one approach might be to develop greater involvement by service users who are willing (and skilled) to offer a role in assertive engagement – peer support. Certainly, continued coordinated efforts by policy makers, service providers and researchers are required to ensure service users are part of the discourse on homelessness and mental illness, and that their views are actively informing both inter-sectoral collaboration and service development.

Social connection and participation in the community (including economic participation) are known protective factors for mental health and social inclusion. The establishment of services and programs that encourage active social involvement in meaningful activity offer a cost-effective strategy and will take the pressure off treatment and transitional housing facilities. More opportunities to 'work when well' will assist people with mental health difficulties to feel connected to a community. Flexible employment solutions will require contributions by and partnerships with business and industry. Equally important, government agencies and community services will be required to shift their thinking in relation to consumer involvement.

From a population approach to mental health and social inclusion, we need to cater for all needs, but get the balance right. According to the World Health Organisation, inter-sectoral collaboration (including collaboration between upstream and downstream services) is vital (WHO 1997). An added challenge associated with this task in relation to mental health and housing are the relatively rigid legal frameworks and funding/administrative structures that oblige services to meet targeted outcomes. In times of high service demand, services are reluctant (and possibly unable) to step outside of their core business. It is the task of Commonwealth and Tasmanian law-makers, policy-makers and administrators to understand more about their role in prevention and early intervention, and establish structures that mean these sectors can better work together ('break down the silos'). Tasmania is yet to find a balance between investment in upstream services in order to decrease demand on downstream services.

Cohen (1994) identified that government policy and socio-economic variables play a dominant role in the creation and mitigation of homelessness, including pressures such as high living costs, competitive demands for housing by the middle class, unstable and low-paying employment, and tight housing markets (cited in SVMHS & CLS 2005). This study of twenty people's lived experiences also sheds light on structural, social and personal circumstances that transition people towards homelessness and mental ill health.

Along the way, this study has attempted to understand the following questions: What are the experiences of those living with the combined difficulties of mental ill health and housing stability (including homelessness) in Tasmania? How are the pressures of mental ill health and housing instability experienced by those who are living it, and what do they recommend is needed? What can be done in the near future (by government, community services and the private sector) to make a big difference for this group of people in Tasmania? Questions remain.

Specific opportunities relating to future research projects, include the possibility of learning more about Tasmania's 'hidden'

homeless, structural conditions that influence prevalence rates, contrasts between consumer (service user) views and views of policy-makers/service providers, and practical recommendations relating to cross-sectoral collaboration. It is recommended that future research projects seek to identify innovative programs and services already operating in Tasmania, evaluate positive processes and impacts to guide future reforms and service development.

Well and at home

This research project sought advice from people with lived experience of mental ill health and homelessness in order to better prevent these difficulties in Tasmania. Literature evidence and twenty case examples demonstrate that a range of early life experiences increase the risk of mental ill health and homelessness for people, including: parental mental ill health (and/or not coping), poverty, neglect, a traumatic event/s, physical violence, emotional abuse/sexual abuse, one absent parent, undiagnosed intellectual disability (ID) and/or acquired brain injury (ABI) (often undiagnosed until later in life), lack of family support, involvement with Child Protection services, and parental alcohol or drug misuse.

From the same body of evidence, it is clear that a common set of events and circumstances increase the risk of mental ill health and homelessness for individuals. Key risks include: lack of affordable housing, lack of parental support, inhibited cognitive capacity (ID/ABI) (often undiagnosed), personal alcohol or drug misuse, personal mental illness, and relationship breakdowns (family/partner).

For twenty Tasmanians who have experienced mental ill health and homelessness, key current social supports include: informal supports, formal supports, and community connections. In each of these areas, the quantity and quality of support desired by people is not matched by the actual availability of social supports. A clear message is that people living with mental ill health and homelessness would benefit from more social support. Currently, formal support is offered by Centrelink, psychiatrists and clinical mental health teams, community-based housing and support workers, and a range of additional human service staff including general counsellors, outreach workers and specialist counsellors. For half of the interviewees important informal social support was provided via friends, peers and acquaintances (rather than family members). A number of interviewees reported they received no support from family or friends. Currently, the main social support people gain from the wider community is the opportunity to attend a range of day programs, followed by opportunities for education and training.

All interviewees could identify a range of personal prevention strategies – strategies that help protect their health, maintain their housing, and stay well (sometimes called mental health promotion strategies). All but one cited social connection was their most important prevention strategy. From experience, if people have social connection, they are more likely to stay mentally well and housed. Another key prevention strategy – something that was not readily available for many interviewees – was someone to talk to and trust. Additional personal prevention strategies included: staying away from alcohol and drug misuse, maintaining their housing (cleaning, paying bills, etc.), staying physically active, and accepting extra support if available (for example with finances, budgeting, health, etc.). Many people found setting personal goals was useful – it kept them motivated and moving towards greater recovery. Several cited that achieving public housing was a personal goal – they are currently waiting for housing. Many identified that they needed to maintain their mental health pharmacotherapy treatment (medication) to stay well.

The common personal hopes of interviewees tell a story of the importance of mental health and social inclusion: to think positively and be happy, to be socially connected, to have trustworthy people, to maintain stable accommodation (either current, or once achieved), to stay out of debt (pay bills, etc.), to get a job, to engage in interesting recreational experiences, and to talk to someone about things that concern them (including previous trauma, emotions and mental health, etc.).

These stories from twenty people offer critical advice based on hard won expertise and offer rich advice for targeted recommendations. Their experiences assist us in a whole-of-population approach to preventing and reducing the severity of mental ill health and homelessness in Tasmania.

A key theme that emerged from research participants was the need to ensure a recovery approach was implemented within government, non-government and private organisations providing services in the area of mental health and housing/homelessness. Embedding ‘recovery’ approaches within organisations requires cultural change, comprehensive user-led education and training, increased service user choice, and a transformation of the workforce (Shepherd et al. 2008)

Recommendations arising from this study are presented across whole-of-population and life course aims, which embed principles of recovery. By structuring recommendations across whole-of-population aims (prevention, early intervention, treatment/housing and continuing care), and across age groups (young people, adults, and older people), it is hoped that measures to assist good health, good housing, good support and good practice will be clearer. Due to their importance, two additional areas of recommendation included: Workforce development and Housing supply. These areas are given separate attention, as they are considered to underpin whole-of-population and life course approaches. Appendix 1. Provides a research participant’s advice to service providers; Appendix 2. Provides an example of one young man’s “Ideal youth shelter”; Appendix 3. Offers a potential list of recovery principles for both mental health and homelessness services.

Recommendations:

responding across the spectrum of needs

1. Prevention

Young people stated that in order to prevent mental ill health and homelessness, there must be safer home environments, support for parents and children who are struggling, a safe adult for children to talk to, access to vocational learning and healthy recreational activities, access to transportation, and affordable appropriate housing for young people who can’t live at home.

Adults stated that to prevent mental ill health and homelessness, there needs to be prevention of domestic violence, support for children and parents who lose a key family member, support for parents (including aging parents) who have a child with disability, early assessment of mental health and disability, vocational training and employment opportunities, greater access to public transport, government funding that links health, education and housing (‘our core social infrastructure’), and more housing - enough houses for all people.

Older people stated that to prevent mental ill health and homelessness, there needs to be more support for children growing up in unsafe homes, better mental health treatments

for parents (and exclusion of potential perpetrators of violence against family members), more education about mental illness, good education for all children, upgraded primary health hospitals in urban and rural areas, and more respect for people who are different.

1a. Housing

Housing supply and housing services have a role to play in preventing and reducing the effects of mental ill health in the Tasmanian community. Although there is a need for increased supply across the housing system, public housing plays a critical role in providing affordable, appropriate and secure housing for low income and disadvantaged tenants.

Recommendation 1

That the Tasmanian Government commit to providing public housing as a core government service, with appropriate investment to allow it to charge affordable rents, continue to offer security of tenure, operate sustainably, increase supply (of safe and appropriate houses), address the maintenance backlog and improve support services for tenants.

In the context of inflated residential and investment housing markets, landlords, real estate agents and housing services share a key role in preventing and reducing homelessness, with spin off effects for mental health in the Tasmanian community.

Recommendation 2

That the Tasmanian Minister for Corrections and Consumer Protection act to protect the rights of vulnerable tenants by expediting the passage of the amendments to the *Residential Tenancies Act 1997* to:

- incorporate a method to determine reasonable rent increases;
- protect tenants in the private rental market from unreasonable eviction processes; and
- introduce minimum standards for private rental properties.

Recommendation 3

That Housing Tasmania act to prevent people with mental illness from being evicted to homelessness by:

- developing policies that mandate that public housing tenants cannot be evicted to homelessness; and
- through its funding agreements with community housing providers, mandate that providers cannot evict tenants to homelessness.

1b. Mental health services

The mental health service system plays a key role in mental health promotion and the enhancement of mental wellbeing for all Tasmanians.

In 2010 the Mental Health Council of Tasmania received \$115,000 to conduct a social marketing project. In the first instance this will benchmark the mental health literacy and map the experiences of stigma and discrimination experienced by those living with a mental illness. A social marketing campaign to increase the mental health literacy of the Tasmanian community, and to reduce stigma will then be developed. Research findings support the critical importance of this strategy,

and highlight that further work is needed to address stigma about homelessness (in addition to mental health).

Recommendation 4

That the Australian and Tasmanian Governments jointly fund community education program about mental illness and homelessness (causes, risks, supports and treatments) and mental health promotion, via a range of mediums.

A healthy funding balance needs to be struck between the provision of mental health treatment, services and the provision of community-based prevention and early intervention services.

1c. Family support services

Greater investment needs to be made in family support services, in order to prevent traumatic experiences in early childhood. This includes support for families from pre-pregnancy onwards and for families with an incarcerated parent.

Several examples of family-focused prevention services exist in Tasmania. For example, the Communities for Children Plus program (CfC+) offers an example of 'joined up' service delivery, aiming to promote service linkages and enhanced referral pathways by providing resources promoting collaboration between local, state and Commonwealth Government services and the community service sector. The Pregnant and Young Parent Support group (PYPS) supports young people during pregnancy and early family life. The COMPASS, KIS and NEST programs support the development of resilience in families. The Household Organisational management Expense Advice Program (HOME) helps households manage practical tasks, and the Australian Government's Personal Mentors and Helpers Service (PHaMs) (greater Hobart) offers another example of an initiative providing services to family target groups, including people who are homeless or at risk of homelessness.

Recommendation 5

That the Department of Families, Housing, Community Services and Indigenous Affairs expand the 'Communities for Children Plus' program to specific Tasmanian locations, and roll out the 'Home Advice Program' to all Tasmanian regions.

Like the Options program in the South, the Hassles program in the North was providing conflict and mediation support for children, young people and their parents where there was a risk that escalation of conflict might lead young people to become homeless. (therefore, a preventative program for adolescent homelessness). A shift towards a reunification model in the North (and subsequent servicing of a different cohort) has left a gap in this area of preventative service delivery in the North and North West.

Recommendation 6

That the Department of Families, Housing, Community Services and Indigenous Affairs fund homelessness prevention programs for Tasmanian parents and adolescents experiencing conflict (where escalation of the conflict may lead to young people becoming homeless).

1d. Public transport

Recommendation 7

That the Tasmanian Government invest in publicly subsidised transport services targeted to disadvantaged and regional areas, to improve both the frequency of services and the flexibility of service routes.

2. Early intervention

In order to intervene early and prevent mental ill health and homelessness, young people recommended: more information about services, assertive outreach to children and young people in schools (teachers and counsellors actively looking for students who are struggling), 'parent' type care offered to young people who need it (a listening adult), grief and loss counselling for young people, support for children transitioning into stepfamilies, speedier access to UTLAH allowances (or earlier application – before being homeless), no 'exits' from youth detention into homelessness, no 'exits' from child protection into homelessness, and more youth housing (appropriate, affordable, supported).

Adults added the following early intervention strategies: support for children who have experienced trauma, more opportunities for early healing, more effective drug and alcohol services for young people, more counsellors, more information about homeless services, no 'exits' from family homes into homelessness for people with disabilities, no 'exits' from hospital into homelessness, no 'exits' from adult prison into homelessness, assertive outreach by homelessness services (into caravan parks, car parks, etc.), support to maintain housing, more affordable access to health care (including back care, dentistry, etc.), more affordable access to physical activity (including swimming, parks, etc.), more supports linked with Centrelink, flexible payment options for debts and fines, direct access to permanent supported residential accommodation for people with mental illness, easier access to public housing, closer integration between primary health, mental health and housing services.

Older people made the following early intervention recommendations: people need more people to talk to - and more information about who to talk to, more access to counselling (for trauma, grief and loss etc.), more effective mental health treatments for children and adolescents, more effective rehabilitation services within youth detention and adult prisons, no 'exits' from private rental into homelessness, no 'exits' from public housing into homelessness, more opportunities for social connection, and more access to buildings and spaces for people with limited mobility.

2a. Mental health services

The National Standards for Mental Health Services are the key mechanism for assuring quality in mental health services, and include a requirement for services to have policies and procedures around consumer and carer participation (to maximise their roles and involvement). These are reviewed by external accreditation bodies but there is a lack of guidance about how processes or mechanisms should be facilitated. This means there is local interpretation of standards, and the potential for ad hoc and unsystematic responses. Some of this has been addressed by a Tasmanian statewide review of consumer and carer participation to identify an optimum model for participation in the state, and inform the implementation

of a consumer and carer participation framework. This also emphasised the importance of consumers as employees. A key outcome of this review was the establishment of a new consumer organisation, Flourish.

Community-based mental health care is a decentralised model of mental health care and other services, to support people with mental illness. Delivered in a range of community settings these services can be more accessible, and more responsive to local and consumer needs than expensive inpatient services. The literature in this area supports strong resourcing of the community mental health sector to enhance positive outcomes for people with mental illness. In its 2011-12 Budget the Australian Government announced a \$2.2 billion expansion of funding for community mental health services, including funding for accommodation support, presentation, admission and discharge planning from hospital emergency departments, funding for headspace and Early Psychosis Prevention and Intervention Centres (EPPIC), additional Family Mental Health Support Services, Personal Helpers and Mentors Programs and Support for Day to Day Living in the Community programs (CMHA 2011). Findings suggest that the Tasmanian Government should invest in highly successful models that have been rolled out by the Australian Government.

Recommendation 8

That the Tasmanian Government build on the mental health reform agenda established by the Australian Government and expand funding to its community based mental health services.

Previous research by Anglicare into models for strengthening the mental health consumer voice in Tasmania recommended that funding be made available to develop and nurture mental health consumer support and self-help groups across Tasmania (Hinton 2009 p.71). Since then, a mental health consumer peak body has been established. The following recommendation acknowledges this step, and requests that the peak body be adequately resourced to facilitate the development of consumer networks across the state.

Recommendation 9

That the Department of Health and Human Services fund the mental health consumer organisation *Flourish*, to develop regionally-based consumer support and self-help groups to focus on wellbeing, support early identification of ill health, and play a role in assertive outreach.

Recommendation 10

That the Community Mental Health Services and Child and Adolescent Mental Health Services increase the availability of outreach services for service users.

Recommendation 11

That Housing Tasmania adequately resource specialist homeless services to provide ongoing case management for people who are homeless or at risk of homelessness with a mental illness.

2b. Education

Recommendation 12

That the Department of Education develop a strategic response to meet the needs of students who are at risk of developing mental illness and/or experiencing homelessness, including:

- funding professional development for teachers, social workers, guidance officers and aides, in mental health promotion and homelessness risks; and
- developing procedures to identify students at risk of homelessness, and appropriate referral pathways to support those students.

2c. Centrelink

Recommendation 13

That Centrelink ensures staff are trained in mental health, homelessness, alcohol and drugs, and trauma issues, and issues around cultural diversity.

Recommendation 14

That the Australian Government ensures Centrelink and the Department of Education, Employment and Workplace Relations' workforce participation policies and compliance regime are consistent with the Principles of the National Mental Health Plan in relation to clients with a mental illness.

Recommendation 15

That the Australian Government fund Centrelink to work collaboratively with mental health and homelessness services, especially during episodic illness/in-patient care and experiences of homelessness, to ensure continuity of income for clients at these times.

In 2008 Anglicare Tasmania published research into the patterns of Centrelink debt recovery and prosecution, and the experiences of people who had debts raised against them by Centrelink. The report made a series of recommendations for improved practice in this area, including that Centrelink simplify its rules and practices about customers notifying income; that it employ more social workers to work with customers identified as being at risk of overpayments; that it ensure that its staff are trained in appropriate and sustainable repayment options for customers; and that, in recognition of the fact that many participants in that research indicated that they did not know about Centrelink support services or how to get advice on welfare rights issues, all relevant information with Centrelink customers contain information about Centrelink support services (such as social workers and where to get independent sources of advice on social security matters). Since the publication of that report, the Australian Government has raised the level of repayments which may be ordered from individuals, and announced further measures to get 'tougher' on people with debts.

Recommendation 16

That the Minister for Education, Employment and Workplace Relations and the Australian Attorney General review the recommendations made by Anglicare Tasmania in relation to Centrelink debt recovery and prosecution (Hughes 2008) and pursue their implementation.

2d. The Department of Justice and the Department of Health and Human Services

This report raises serious concerns about the discharge of people from adult and youth detention into homelessness. An interagency response is required to address this problem, involving the Department of Justice, the Department of Health and Human Services' Child and Family Services, Housing Tasmania and Statewide and Mental Health Services.

Recommendation 17

That the Tasmanian Government facilitate an interagency response to ensure effective discharge planning and coordination for people leaving juvenile detention, adult prisons and/or forensic settings and prevent 'exits' into homelessness.

3. Treatment and Transitional housing

In the treatment of mental ill health and provision of housing for homelessness people, young people stated we need: alternative treatment options (in addition to pharmacotherapy), a broader range of settings for mental health treatment (in addition to psychiatric inpatient care), greater practical support for people experiencing primary homelessness (access to showers, lockers, powerpoints, food, etc.), and more long-term youth accommodation facilities (affordable, supported, semi-independent but supervised).

Adults added the following treatment and housing strategies: greater respect and empathy for people experiencing mental ill health and homelessness, caring attitudes from workers towards service-users, more counsellors, more options for recovery in mental health (and other treatment options that are not centred on pharmacotherapy), more 'step down' facilities (as an alternative to in-patient care), more prompt access to pharmacotherapy treatment, more crisis accommodation facilities for women and children escaping domestic violence, higher management standards for crisis accommodation facilities, more medium-term accommodation options for a range of target groups (old, young, substance-using etc.), no 'exits' from homelessness services into homelessness, and more long-term supported residential facilities for adults with mental ill health (drug/alcohol-free environments).

Older research participants made the following recommendations: more mental health treatment services, more respect and closer listening to people's lived experiences in treatment situations, the development of peer-led support networks, tailored support to address individual wellbeing needs (physical, mental, social), assertive outreach in the home - 'someone checking up on you', and direct access to permanent supported accommodation (including provision of meals etc.).

3a. Mental health

In 2004 Anglicare's research into the experiences of people with serious mental illness in Tasmania urgently recommended the development of effective discharge planning protocols specifically relevant to people experiencing socio-economic disadvantage (Cameron and Flanagan 2004). The report recommended that discharge accommodation planning commence at intake; that in instances where a patient is being discharged to another person's home, an assessment is made of that person's capacity to provide care/accommodation; that transport arrangements are in place at least one day before discharge; and that at intake, Centrelink social workers and housing support workers are engaged to provide follow-up support upon discharge, and this arrangement is activated one day before discharge. This research revealed that seven years later, the absence of effective discharge planning is still a pressing problem and that these recommendations remain unaddressed.

Recommendation 18

That Statewide and Mental Health Services work with housing service providers to ensure clear procedures and

support are established to prevent discharge from in-patient treatment facilities into homelessness, and specifically:

- that discharge accommodation planning is to commence at intake;
- that in instances where a patient is being discharged to another person's home, an assessment is made of that person's capacity to provide care/accommodation;
- that transport arrangements are in place at least one day before discharge;
- that at intake, Centrelink social workers and housing support workers are engaged to provide follow-up support upon discharge; and
- that this arrangement is activated one day before discharge.

3b. Alcohol and Other Drug Services

Tasmania needs a more accessible and effective suite of alcohol and drug treatment services. Service providers report that people wishing to access pharmacotherapy treatment face long waiting times and have few options for treatment.

Recommendation 19

That the Department of Health and Human Services fund community-based alcohol and drug services to engage General Practitioners as pharmacotherapy prescribers in order to improve access to pharmacotherapy medication and options for treatment.

4. Continuing care

Young people offered their suggestions for protecting people's mental health and promoting social inclusion into the future, including: assertive outreach and supports (one worker rather than many allocated to each young person), access to vocational training of interest, access to physical and social recreational activities, a trustworthy adult to talk to, assistance with living skills if needed (cooking, cleaning, budgeting, paying bills, etc.), affordable long-term supported accommodation facilities for young people, and for some, rent assistance and a 'substitute guarantor' to enable young people access to the private rental market.

Adults added the following continuing care strategies: more respect for service users, tailored support for those who need it (e.g. living skills, personal management, coping strategies, etc.), more opportunities for healthy recreation and meaningful social connection, opportunities for vocational training, volunteering and flexible employment, people with lived experience employed in worker roles, training of human service staff delivered by people with lived experience, permanent housing options – and more respect between all people.

Older people made the following continuing care recommendations: opportunities for social connection, recreation and mental stimulation, peer-networks and support, more opportunities for service-users to help guide service development, flexible employment options for people receiving disability allowances, flexible employment options for people living with mental ill health, someone checking up on you to make sure you're OK.

This advice constitutes a very strong and detailed set of recommendations for policy, funding and service delivery across a range of sectors – not just within mental health and housing/homelessness sectors. Implications exist for all public arenas engaged in human wellbeing, including government, community organisations and the private sector. Findings have relevance for individuals, couples, families and specific geographical communities.

A common underlying difficulty for people facing mental health and housing difficulties is the need to address previous and (sometimes ongoing) trauma. In general, interviewees with lived experience of mental ill health and homelessness stated that the establishment of trusting relationships, combined with a recovery approach to service development and delivery assists personal healing. Clearly, mental ill health and homelessness exacerbate feelings of loneliness and social isolation. A "whole of population" approach to mental health and homelessness requires the embedding of a set of attitudes that cut across sectors, service types and service roles. This information requires policy-makers and service providers to consider how they can offer healing environments and healing relationships – within the context of their core business. All services and human service staff are invited to relate with service users as a whole person – to take on a position of listening, and actively consider the service users' physical, emotional and social needs. This requires understanding, empathy and respect. These implications invite us as a community to offer medical treatment and housing in the context of caring relationships and healing environments – these steps will not alleviate immediate required costs associated with the delivery of mental health treatment and housing, but will assist to prevent further harm, and protect people's mental health and social inclusion into the future – a potentially cost-saving exercise with as yet unmeasured benefits.

Recommendation 12 stated the importance of increased funding to non-government organisations to deliver a range of community-based support, respite and recovery-focussed services for people with mental illness. Funding for recovery programs was also strongly identified by participants as an important part of continuing care. Additional recommendations from the research participants relating to continuing care include:

4a. Mental health and housing/ homelessness services

Gaps in the current service system cause difficulties for people who find they cannot access the help they need because they live in the wrong type of tenancy. The Private Rental Tenancy Support Service provides important support to people who are renting in the private market (in the development of skills in relation to maintaining housing, maintenance, cleaning, bill payments, budgeting, and communication). People who live in public housing and some forms of community housing cannot use this service. The Private Rental Support Service provides financial assistance and support to people who live in the private rental market and some community housing tenants. This means that someone who has difficulty meeting the terms of their tenancy in public housing cannot gain the assistance they may need, and may risk eviction.

Recommendation 20

That the Private Rental Tenancy Support Service and the Private Rental Support Service be provided with additional funding to support work with tenants who live in public housing and in all forms of community housing.

4b. Skills Tasmania

Participants in this research identified barriers to participation in education and training, and highlighted the need for opportunities for one to one training in safe settings. Skills Tasmania offers a small grants program (the Equity Support Program) which provides grants for projects that increase opportunities for people who may be experiencing barriers to participation in post-compulsory vocational education and training (VET) and employment. Because the program is designed to assist in the overcoming of barriers to VET participation, funds are available to support projects which do not have to include accredited training.

Recommendation 21

That Skills Tasmania use its 'Equity Support Program' to resource initiatives providing vocational training delivered one to one in safe settings for adult learners living with mental ill health.

4c. The Tasmanian Chamber of Commerce and Industry

Recommendation 22

That the Tasmanian Chamber of Commerce and Industry encourage its membership to offer work experience for people with a lived experience of mental ill health and/or a lived experience of homelessness.

Two additional areas of need emerged so strongly from this research that they have been extracted for specific comment outside the whole-of-population/life course structure adopted above. These recommendations relate to workforce development and housing supply.

5. Workforce development and consumer engagement

Participants in the research had specific recommendations about the professional development of staff in key statutory agencies and staff in the private sector who work in the delivery of essential services. Specifically, it was recommended that the Department of Education fund professional development for teachers, social workers, guidance officers and aides in mental health promotion and mental health protection (Recommendation 7). It was also recommended that Centrelink ensure its staff are well trained to react more supportively and appropriately to people experiencing mental ill health, trauma and/or homelessness (Recommendation 8). There was also discussion of the need to give real estate agents more information in order to address discriminatory attitudes in the private rental market. The recommendation drew on a successful pilot program delivered in Victoria to address stigma in the private rental market by providing real estate agents with information about the client group and relevant support services (Recommendation 5). Recommendations were also aimed at developing the skills of staff in mental health services, and a greater use of service user expertise within staff training processes.

5a. Mental health

Mental health staff need to be held to account in relation to their provision of caring practices and healing environments. Mental health managers and staff need to embed respectful relationships and the provision of healing environments across the service system. In 2003 protocols were developed between the then Supported Accommodation Assistance Program and Mental Health Services. This research identified a need to reinvigorate

this protocol. To do so will require the provision of adequate resources and appropriate workforce development strategies, with a detailed plan for sustaining these cross-sectoral protocols into the future.

Recommendation 23

That the Department of Health and Human Services revisit the 2003 SAAP/ MHS protocol and establish a strategy and appropriate resources for its redevelopment.

Additional recommendations in relation to workforce development include a proposed strategy to provide professional development, skill diversification, increased knowledge of the service system and the prevention of burnout through staff workplace exchanges.

Recommendation 24

That workforce development and referral pathways be strengthened in both mental health and homelessness sectors via staff exchanges between services and agencies.

This research identified the critical importance of having a skilled workforce in both government and non-government services. Training is required for staff in the following critical areas: working with survivors of trauma, including prevention of re-traumatisation; cultural competency training and the application of culturally-sensitive practice in working with Aboriginal clients; cultural competency training and the application of culturally-sensitive practice in working with clients from non-English speaking backgrounds, including the use of interpreters; and comprehensive training and awareness raising about consumer participation and engagement.

Recommendation 25

That Statewide and Mental Health Services, Housing Tasmania, and community service organisations working in mental health and homelessness sectors ensure that all staff receive appropriate professional development including in trauma, alcohol and drugs, mental health promotion, cultural competency in working with Aboriginal and CALD clients, and training in consumer participation and engagement.

5b. Consumer engagement and leadership in workforce development

Opportunities for service user engagement and employment in the mental health and homelessness sectors will assist workforce development. The following recommendations promote a use of consumer engagement, participation and leadership within strategic workforce development aims.

Recommendation 26

That Statewide and Mental Health Services and Housing Tasmania be funded to adequately resource community service organisations to embed service user engagement within strategic planning, service development, service delivery and staff training.

Recommendation 27

That the Department of Health and Human Services adequately fund community service organisations to involve consumers and employ consumer workers in organisational processes. This requirement needs to be built into contractual requirements for community service organisations providing mental health services, as is done by the Australian Government, and homelessness services.

6. Housing supply and support

Adequate housing supply is considered essential to both prevent homelessness and support mental health. Both housing supply and the housing/homelessness service system play a key role in the achievement of social inclusion for all Tasmanians. To support Tasmanians at risk of homelessness, a healthy funding balance needs to be struck between the provision of homelessness services and the provision of houses (with support where required). Recommendations to prevent homelessness via an increase in housing stock have been made in relation to public housing (Recommendation 1) and Private rental properties (Recommendations 2 and 3). Recommendations to intervene early and protect housing for people with mental ill health have been made within Recommendations 8, 11, 14 and 15. A number of recommendations have been made in relation to workforce development for housing/homelessness staff (see Recommendations 23, 24, 25, 26, and 27). This section provides recommendations for housing supply and support to prevent and reduce the severity of homelessness. The focus is on specialist homelessness services (to provide benefits in the area of Treatment/Transitional housing).

Tasmania's Specialist Homelessness Services (SHS), previously SAAP, have implemented an Integrated Continuum Of Support (ICOS) model (Department of Health and Human Services 2000). The ICOS model is a way of describing the range of services (preventative, early intervention, information and referral, crisis and support services) which are necessary to provide an overall response to meeting the needs of those who are homeless or who are at risk of becoming homeless. The model supports homeless people through a process of assessment, referral and support towards self reliance; the aim is to ensure that tailored support follows people wherever they live. This research supports previous research suggesting that being housed is a critical first step. Support, which might include mental health treatment, is then offered. As a service model, this is called a 'Housing First' or 'Street to House' approach. A current limitation in applying this approach within the Tasmanian context is the lack of housing stock, reinforcing the importance of increasing the supply of secure, appropriate and affordable housing (see Recommendation 1).

Recommendation 28

That Housing Tasmania be funded to expand its current model of support for people who are homeless (the Integrated Continuum of Support Model) to ensure that they are housed as a first step, with supports offered (a Housing First approach).

Recommendation 29

That the Australian and Tasmanian Governments fund the Public Housing system as an important exit point for people leaving specialist homelessness services and entering into long term secure housing.

At the time of writing there are a number of Government-funded initiatives underway to address homelessness in Tasmania. However, services and people who are, or have recently experienced homelessness are reporting worrying levels of unmet need. Regular monitoring of the level of need and commitment of funds to provide the level of crisis, medium-term and supported accommodation facilities needed in the community is required. Funding for these accommodation options also requires adequate support costs to ensure the services are well managed, safe, supportive accommodation options with the opportunity to move on into long-term housing

Recommendation 30

That the Tasmanian Government commit to a review of the need for homelessness and supported accommodation facilities prior to the development of the 2012/13 State Budget. Further, that if there is evidence of continuing unmet need, that the Government commit to funding additional accommodation facilities, including funding for appropriate support.

Participants in this research highlighted the importance of a sense of safety for all residents in communal accommodation services. They recommended that consideration be given to the mix of residents in terms of age, gender, physical capacity and emotional vulnerability. Further, that residents' sense of personal safety be part of ongoing monitoring of homelessness services.

Recommendation 31

That homelessness services, particularly those providing communal accommodation facilities, engage in rigorous monitoring of management practices, staff culture, resident safety, and resident feedback processes.

This research highlighted gaps in accommodation provision for young people who are homeless, or at risk of homelessness. A particularly striking gap was the lack of provision of accommodation to support young people to stay in education and/or training. Some models do exist. Staying Put is a program delivered by Anglicare in conjunction with Claremont College and Housing Tasmania, providing support and independent housing to six regionally disadvantaged students. The Northern Youth Accommodation Coalition (NYAC) is an accommodation option for homeless young people aged under 16-21 years (with a focus on those under 18 years). This service has proven a useful homeless service for young people in the North. Long waiting lists attest to the demand for this service type.

Recommendation 32

That the Tasmanian Government examine appropriate models for supporting homeless students aged 16–21 years, and assess demand for service expansion in this area.

7. Income

A significant issue faced by most interviewees was the low level of income on which they had to live. This research supports previous research and calls from the community sector urging the Australian Government to review income support payments to make sure they are keeping pace with increases in cost of living. It is important that people who depend on support payments can afford an acceptable minimum standard of living.

Recommendation 33

That the Australian Government urgently review all income support payments to ensure that all payment levels are adequate to allow for an acceptable minimum standard of living for all recipients and that they retain parity with increases in wages and living costs.

Reference list

- ABS – see Australian Bureau of Statistics.
- Adams, D 2009, *A social inclusion strategy for Tasmania*, Social Inclusion Unit, Department of Premier and Cabinet, Hobart.
- AHURI – see Australian Housing and Urban Research Institute.
- AIHW – see Australian Institute of Health and Welfare.
- American Psychiatric Association 1994, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, American Psychiatric Association, VA, USA.
- Andrews, G, Hall, W, Teesson, M & Henderson, S 1999, *The mental health of Australians*, Mental Health Branch, Department of Health and Aged Care, Canberra.
- Anglicare Tasmania 2003, *TAMOSCH: towards a model of supported community housing*, report to Department of Health and Human Services, Hobart.
- Anglicare Tasmania 2007, *Strengthening Safeguards and Support: Review of the Mental Health Act 1996*, Submission to the Review, May 2007, Hobart.
- Anglicare Tasmania 2010, 'Strengths/ recovery based practice: value adding to delivery of housing and homeless services', Housing & Homeless Services, unpublished.
- ANPPEIMH – see Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).
- Australian Bureau of Statistics 2011, *Main Disabling Condition*, Disability Australia 2009, viewed 16 June 2011, <<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4446.0Main%20Features42009?opendocument&tabname=Summary&prodno=4446.0&issue=2009&num=&view=>>>.
- Australian Institute of Health and Welfare 2007a, *Mental health services in Australia 2004-05*, cat. no. HSE 47, AIHW, Canberra.
- 2007b, *Homeless SAAP clients with mental health and substance use problems 2004-05: a report from the SAAP national data collection*, Bulletin 51, cat. no. AUS 89, AIHW, Canberra.
- 2007c, *Drug use and psychiatric illness send vulnerable segments of homeless to seek support*, media release, AIHW, Canberra, 15 March, viewed 4 June 2011, <<http://www.aihw.gov.au/media-release-detail/?id=6442464682>>.
- 2011a, *Government-funded specialist homelessness services: SAAP national data collection annual report 2008-09: Australia*, cat. no. HOU 246, AIHW, Canberra.
- 2011b, *Government-funded specialist homelessness services: SAAP national data collection annual report 2008-09: Tasmania supplementary tables*, cat. no. HOU 227, AIHW, Canberra.
- Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) & Rickwood, D 2009, *Building the foundations for mental health and wellbeing: a strategic framework and action plan for implementing promotion, prevention and early intervention (PPEI) approaches in Tasmania*, Department of Health and Human Services, Hobart.
- Barry, M 2007, *Implementing mental health promotion*, Department of Health Promotion, National University of Ireland, Galway, viewed 20 April 2011, <<http://info.stakes.fi/NR/rdonlyres/41B2096D-DA6D-4584-B77F-ABEE79DEB6C3/0/Barry.pdf>>.
- Bleasdale, M 2007, *Supporting the housing of people with complex needs: AHURI final report*, Australian Housing and Urban Research Institute, Melbourne.
- Bullen, J 2008, *From transitional housing models to permanent housing models for homeless people: a paradigm shift*, University of Technology, Sydney, viewed 4 April 2011, <http://www.chp.org.au/parity/articles/results.shtml?filename_num=00410>.
- CMHA – see Community Mental Health Australia.
- COAG – see Council of Australian Governments.
- Community Mental Health Australia 2011, *National call for \$3.5b for mental health program*, media release 3 April, viewed 29 June 2011, <[http://www.mhccact.org.au/cms/media/user_uploads/cmha/CMHA%20National%20Call%20for%20\\$3.5B%20For%20Mental%20Health%20Program.pdf](http://www.mhccact.org.au/cms/media/user_uploads/cmha/CMHA%20National%20Call%20for%20$3.5B%20For%20Mental%20Health%20Program.pdf)>.
- Council of Australian Governments 2006, *National action plan on mental health (2006-2011)*, Australian Government, Canberra.
- 2008a, *National affordable housing agreement*, Australian Government, Canberra.
- 2008b, *National partnership agreement on homelessness*, Australian Government, Canberra.
- 2008c, *National partnership agreement on social housing*, Australian Government, Canberra.
- Cameron, P 2004, *Condition Report: Low income earners in the Tasmanian private rental market*, Anglicare Tasmania, Hobart.
- Cameron, P & Flanagan, J 2004, *Thin ice: living with serious mental illness and poverty in Tasmania*, Anglicare Tasmania, Hobart.
- Chamberlain, C 1999, *Counting the Homeless: Implications for Policy Development*, cat. no. 2041.0, ABS, Canberra.

Chamberlain, C & MacKenzie, D 1992, 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues*, 27(4), pp274-297.

----- 2003, *Counting the Homeless 2001*, cat. no. 2050.0, ABS, Canberra.

----- 2008, *Counting the homeless 2006*, , cat. no. 2050.0, ABS, Canberra.

----- 2009, *Counting the homeless 2006: Tasmania*, cat. no. HOU 208, AIHW, Canberra.

Department of Families, Housing, Community Services and Indigenous Affairs 2008, *The road home: a national approach to reducing homelessness*, FaHCSIA, Canberra.

----- 2009a, *Fourth national mental health plan: an agenda for collaborative government action in mental health (2009-2014)*, FaHCSIA, Canberra.

----- 2009b, *National Housing Supply Council state of supply report*, FaHCSIA, Canberra.

Department of Health and Ageing 2011, *What is mental illness?* viewed 4 June 2011, <[http://www.health.gov.au/internet/main/publishing.nsf/content/B7B7F4865637BF8ECA2572ED001C4CB4/\\$File/whatmen.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B7B7F4865637BF8ECA2572ED001C4CB4/$File/whatmen.pdf)>.

Department of Health and Human Services 2000, *Integrated continuum of support model for homeless people and those at risk of homelessness*, Child, Youth and Family Support, DHHS, Hobart.

----- 2003, *Supported Accommodation Assistance Program (SAAP) and Mental Health Services protocol: a partnership between mental health Services and the Supported Accommodation Assistance Program (SAAP)*, Division of Community, Population and Rural Health and Division of Children and Families, DHHS, Hobart.

----- 2006a, *Mental Health Services strategic plan (2006-2011): partners... towards recovery*, Mental Health Services, DHHS, Hobart.

----- 2006b, *Consumer and carer participation framework*, Mental Health Services, DHHS, Hobart.

----- 2008, *Mental Health Services Strategic Plan (2006-2011): 'taking stock and moving forward' progress report*, Mental Health Services, DHHS, Hobart.

----- 2009a, *Building the foundations for mental health and wellbeing: a strategic framework and action plan for implementing promotion, prevention and early intervention (PPEI) approaches in Tasmania*, Statewide and Mental Health Services, DHHS, Hobart.

----- 2009b, *Homelessness national partnership: implementation plan for Tasmania (July 2009-June 2013)*, DHHS, Hobart.

----- 2010a, *Coming in from the cold: Tasmanian homelessness plan (2010-2013)*, DHHS, Hobart.

----- 2010b, *Tasmania's suicide prevention strategy (2010-2014): a summary and government response*, Statewide and Mental Health Services, DHHS, Hobart.

Department of Premier and Cabinet 2010, *Estimating primary homelessness in Tasmania*, Social Inclusion Reports, viewed 4 April 2011, <http://www.dpac.tas.gov.au/division/siu/reports_research_and_data/benchmarking>.

DHHS – see Department of Health and Human Services.

DoHA – see Department of Health and Ageing.

DPAC – see Department of Premier and Cabinet.

European Commission 2011, *Green Paper improving the mental health of the population: towards a strategy on mental health for the European Union*, viewed 5 June 2011, <http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf>.

FaHCSIA – see Department of Families, Housing, Community Services and Indigenous Affairs.

Flanagan, J 2007, *Dropped from the moon: the settlement experiences of refugee communities in Tasmania*, Anglicare Tasmania, Hobart

Flanagan, K 2007, *Housing: building a better Tasmania – the bigger picture*, Anglicare Tasmania, Shelter Tasmania & Tasmanian Council of Social Service, Hobart.

----- 2009, *Hard times: Tasmanians in financial crisis*, Anglicare Tasmania, Hobart.

Ginsberg, R 1999, 'Meditations on homelessness and being at home: in the form of a dialogue', in GJM Abbarno, (ed.), *The Ethics of Homelessness*, vol. 86, Rodopi, Amsterdam.

Gronda, H 2009, *What makes case management work for people experiencing homelessness? Evidence for practice*, Australian Housing and Urban Research Institute, Melbourne.

Haggerty, R 2008, *Ending homelessness in Tasmania: report to the Tasmanian Government*, Department of Premier and Cabinet, Hobart.

Hinton, T 2004, *The housing and support needs of ex-prisoners: the role of the supported accommodation assistance program*, SAAP Coordination and Development Committee, Department of Family and Community Services, Canberra.

- Homelessness Australia 2011, *Methodological review of counting the homeless 2006: sector briefing*, viewed 10 May 2011, <http://www.chp.org.au/public_library/items/2011/04/00289-upload-00001.pdf>.
- Hosman, C 2007, *The mental health promotion debate: a contribution from Europe*, Institute of Medicine, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Adolescents and Young Adults, Maastricht, viewed 3 April 2011, <http://www.bocycf.org/hosman_presentation.pdf>.
- Jablensky, A, McGrath, J, Herman, H, Castle, D, Gureje, O, Morgan, V & Korten, A 1999, *People living with psychotic illness: an Australian study (1997-98)*, National Survey of Mental Health and Wellbeing Report 4, AGPS, Canberra.
- Jansen, M [n.d.], *Social inclusion in Australia*, Soroptimist International South West Pacific, viewed 16 June 2011, <http://www.siswp.org/index2.php?option=com_content&do_pdf=1&id=612>.
- Johnson, G & Chamberlain, C 2009, *Are the homeless mentally ill?*, paper presented to 6th National Housing Conference, 24-27 November, Melbourne.
- Johnson, G & Chamberlain, C 2011, 'Are the homeless mentally ill?' *Australian Journal of Social Issues*, vol. 46, no.1, pp. 29-48.
- Lipton, FR and Sabatini, A 1984, *Constructing support systems for homeless chronic patients: the homeless mentally ill*, American Psychiatric Association, Washington, USA.
- MacKenzie, D & Chamberlain, C 2003, *Homeless careers: pathways in and out of homelessness*, Swinburne University/ RMIT, Melbourne.
- Mathers, CD & Schofield, DJ 1998, 'The health of unemployment: the evidence', *Medical Journal of Australia*, vol. 168 (4), pp. 178-182.
- Mental Health Council of Australia 2009, *Home truths: mental health, housing and homelessness in Australia*, Mental Health Council of Australia, Canberra.
- 2011, *Mental Health Commission will lead to better outcomes in mental health care*, media release 10 May 2011, viewed 29 June 2011, <<http://www.mhca.org.au/MediaReleases/2011/MHCA%20welcomes%20Mental%20Health%20Commission.pdf>>.
- McDermott, S, Bruce, J, Muir, K, & Johansson, K 2010, *Evaluation of the mental health, housing and accommodation support initiative (HASI): first report*, SPRC Report 6/10, Social Policy Research Centre, University of New South Wales, Sydney.
- MHCA – see Mental Health Council of Australia.
- Mission Australia 2010, *Increasing our understanding of homeless men: The Michael Project*, Snapshot 2010, Mission Australia, Sydney.
- Mojtabai, R 2005, *Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness*, viewed 14 June 2011, <<http://ps.psychiatryonline.org/cgi/content/abstract/56/2/1172>>.
- Mrazek, P & Haggerty, R (1994), *Reducing the risks for mental disorders: frontiers for preventive intervention research*. National Academy Press, Washington DC, USA.
- O'Brien, A, Inglis, S, Herbert, T, & Reynolds, A 2002, *Linkages between housing and support – what is important from the perspective of people living with a mental illness: AHURI final report*, AHURI, Melbourne.
- Padgett, D 2007, 'There's no place like (a) home: ontological security among persons with a serious mental illness in the United States', *Social Science and Medicine*, vol. 64, pp. 1925-36.
- Pape, B & Galipeault, JP 2002, *Mental health promotion for people with mental illness: a discussion paper*, Public Health Agency of Canada, Ottawa.
- Parliament of Australia 2001, *The Commonwealth-State Housing Agreement*, E-Brief: Online Only issued 29 November 2001, Parliamentary Library, ACT, viewed 14 June 2011, <<http://www.aph.gov.au/library/intguide/sp/statehouseagree.htm>>.
- Patterson, A 2009, *Building the foundations for mental health and wellbeing: review of Australian and international mental health promotion, prevention and early intervention policy*, Statewide and Mental health Services, Department of Health and Human Services, Hobart.
- Queensland Health 2006, *Queensland Plan for Mental Health (2007-2017)*, viewed 1 June 2011, <http://www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/qpfmhfsheet1.pdf>.
- Quinn, W 2003, *Mental health/housing supported accommodation project: discussion paper*, Department of Health and Human Services, Hobart.
- Reynolds, F 2010, 'Homefullness: our 3 homes', blog, 3 January 2010, *Homelessnessends: a blog about ending homelessness*, viewed 11 July 2011, <<http://homelessnessends.wordpress.com/2011/01/03/how-do-you-think-about-homelessness/>>.
- Rickwood, D 2005, *Pathways of recovery: 4As framework for preventing further episodes of mental illness*, prepared for the National Mental Health Promotion and Prevention Working Party, Department of Health and Aging, Australian Government, Canberra.
- Robinson, C 2003, *Understanding iterative homelessness: the case of people with mental disorders*, *AHURI final report*, AHURI, Melbourne.
- Robinson, E, Rodgers, B & Butterworth, P 2008, 'Family relationships and mental illness: impacts and service responses', *AFRC Issues*, no.4 March 2008, Australian Family Relationships Clearinghouse, Australian Institute of Family Studies, Melbourne.
- Rosenman, E 2006, 'Homelessness and mental health', *AFHO News*, April-May 2006, Australian Federation of Homelessness Organisations, ACT.

- St Vincent's Mental Health Service & Craze Lateral Solutions 2005, *Homelessness and mental health linkages: review of national and international literature*, DoHA, Canberra.
- Seaborn, L 2003, *Eureka Clubhouse housing research project April-May 2003*, DHHS, Hobart.
- Shelter Tasmania 2011, *Submission to the Tasmanian State Government's Budget Process (2011-2012)*, Tasmania, viewed 18 June 2011, <http://www.shelbertas.org.au/about/pdf/2010%20Folder/ShelterTas-Bud_Sub_2011-12.pdf>.
- Shepherd, G, Boardman, J & Slade, M 2008, *Implementing recovery: a new framework for organisational change: Position paper*, Salisbury Centre for Mental Health, London.
- Social Inclusion Board 2011a, *Social inclusion principles*, Department of Education, Employment and Workplace Relations, Canberra, viewed 4 May, <<http://www.socialinclusion.gov.au/SIAGenda/Principles/Pages/default.aspx>>.
- 2011b, *Social inclusion vision*, Department of Education, Employment and Workplace Relations, Canberra, viewed 4 May 2011, <<http://www.socialinclusion.gov.au/Pages/default.aspx>>.
- Stronger Communities Taskforce 2008, *The state of our community report 2007: starting the conversation*, report to the Department of Premier and Cabinet, Hobart.
- SVMHS & CLS – see St Vincent's Mental Health Service & Craze Lateral Solutions.
- Department of Health and Human Services 2000, *Integrated continuum of support model for homeless people and those at risk of homelessness*, Child, Youth and Family Support, Tasmanian Government, Hobart.
- Tasmania, Legislative Council, Estimates Committee B 2011, *Hansard, part 1: Wednesday 29 June 2011*, viewed 11 July 2011, <<http://www.parliament.tas.gov.au/HansardCouncil/isysquery/e934de2a-8307-4860-b1e2-1e2dcb4be60a/2/doc/>>.
- Tasmania Together Progress Board 2010, *Tasmania Together 2020: progress report 2010*, Tasmania Together Progress Board, Hobart.
- Tohl, M 2009, *Evaluation: Community Sector Organisations funded by Mental Health Services*, report for the Department of Health and Human Services, Hobart.
- Tsemberis, S 1999, 'From streets to homes: an innovative approach to supported housing for homeless adults with psychiatric disabilities', *Journal of Community Psychology*, vol. 27, no. 2, pp. 225-41.
- Tsemberis, S, Gulcur, L, & Nakae, M 2004, 'Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis', *American Journal of Public Health*, vol. 94, no. 4, pp. 651-56.
- VicHealth 2009, *Strategic Priorities 2009–2013*, Victorian Health Promotion Foundation, Melbourne, viewed 4 June 2011, <<http://www.vichealth.vic.gov.au/en/Publications/VicHealth-General-Publications/Strategic-Priorities-2009-to-2013.aspx>>.
- 2011, *Promoting physical activity*, Victorian Health Promotion Foundation, Melbourne, viewed 4 June 2011, <[http://www.vichealth.vic.gov.au/Programs-and-Projects/Physical-Activity/Promoting-Physical-Activity.aspx#Physical activity is essential to health](http://www.vichealth.vic.gov.au/Programs-and-Projects/Physical-Activity/Promoting-Physical-Activity.aspx#Physical%20activity%20is%20essential%20to%20health)>.
- WHO – see World Health Organisation.
- World Health Organisation 2001, *The world health report: Mental health: new understanding, new hope*, WHO, Geneva.
- 2009, *Mental health: a state of well-being*, WHO, Geneva, viewed 14 June 2011, <http://www.who.int/features/factfiles/mental_health/en/index.html>.
- Youth Development Australia 2011, *Homelessness charter and consumer engagement strategy: discussion paper*, DHHS, Hobart.

Appendix 1. Letter to service providers

Obligations of the Service Providers:

Contacting a service provider is difficult. Making an appointment with the service provider is also difficult, and keeping to the appointment is hard.

[a] The person may not have any funds to travel to and from the service provider appointment. This person might be on foot and distance to travel may be long and hard.

[b] The person health may be in question and travelling from and to the service provider may prove to be of difficulty.

[c] Weather may play a role in the person travelling to and from the service provider.

Suggestions:

Maybe IF the service provider would travel to this person. This would be of great assistance to this person. An arrangement can be made between the service provider and the person to be picked up and dropped off at a particular time and destination. Preferably from where the person may be residing temporarily. This person/s may not have slept, showered or eaten.

The engaging service provider Must be tolerant, Must be patient and Must have empathy towards this person/s.

Perhaps offer some food and drink; a couch to rest their weary heads with blankets and pillows wouldn't go astray.

IF there is accommodation on offer to this person/s, the news would be welcomed.

Treat them with Respect

Treat them with Dignity

Show Empathy towards them and Keep all of their records confidential.

Do Not laugh or Joke at this person/s. Take them seriously.

IF they cry, Cry with them. Provide as much assistance as you can for this person/s.

Do Not let this be a waste of Time, Do not come up Empty. This will only exasperate their current situations.

Provide something, anything. You could even offer to take them to the hospital for a check up.

It is Important to Help them in anyway possible. Give them feedback and as many options as possible.

Thank You.

Theresa.P Martin

May 2011

Appendix 3. 'Recovery' in mental health and homelessness

Recovery principle	What can recovery mean in mental health practice?	What can recovery mean in housing practice?
<p>Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms and problems.</p>	<p>A move away from a focus on the removal of symptoms as the prime purpose of mental health services. (E.g. Learning to live with voices may be the focus rather than eradication). A focus on the positive aspects of each person's life. The role of mental health workers becomes 'recovery guide' to help the individual reach their goals in a way of their choosing. Social inclusion becomes increasingly important.</p>	<p>A move away from a focus on homelessness, towards offering stable supported long-term housing as the prime purpose of homelessness services. A focus on the positive aspects of each person's life. The role of housing workers becomes 'recovery guide' to help the individual reach their goals in a way of their choosing. Social inclusion becomes increasingly important.</p>
<p>Recovery represents a movement away from pathology, illness and symptoms to health strengths and wellness.</p>	<p>The past emphasis on illness has led to a neglect of what it is that keeps people well and gives their life value and meaning. Staying well and building support structures become important. Contingency plans, joint crisis plans, negotiated safety plan and advanced directives which honour people's preferences become increasingly important.</p>	<p>The past emphasis on homelessness has led to a neglect of 'homefulness', including long-term aims of social inclusion and meaning. Staying housed and building support structures become important. Financial/budget plans, joint crisis plans, negotiated maintenance plans, and advanced directives which honour people's preferences become increasingly important.</p>
<p>Hope is central to recovery and can be enhanced by seeing how we can have more active control over our lives and by seeing how others have found a way through.</p>	<p>Having people with lived experience of mental health problems as workers and trainers makes training more real and can lead to culture change. Some stories are heroic examples of people who have refused to accept dire predictions of outcome. Training service users in self management and setting their own agendas when working with professionals becomes important in achieving a partnership way of working.</p>	<p>Having people with lived experience of housing instability and homelessness as workers and trainers makes training more real and can lead to culture change. Training service users in self management and setting their own agendas when working with housing workers becomes important in achieving a partnership way of working.</p>
<p>Self management is encouraged and facilitated. The processes of self management are very similar though what works may be very different for all of us. There is no 'one size fits all'.</p>	<p>Individuals define their own goals and agenda. The role of workers is to help them achieve it in ways and settings which are meaningful and acceptable. A move away from providing 'group solutions' which are defined by professionals without reference to actual service user need. Empowering approaches such as the Wellness Recovery Action Plan (WRAP) are offered in conjunction with housing workers.</p>	<p>Individuals define their own goals and agenda. The role of workers is to help them achieve it in ways and settings which are meaningful and acceptable. A move away from providing transitional solutions which are defined by existing housing stock and homelessness services, without reference to actual service user need.</p>
<p>The helping relationship between clinicians and patients moves away from being expert - patient to being closer to peer support; as coaches or partners on a journey of discovery. Clinicians are 'on tap, not on top'.</p>	<p>Therapies and treatments are evaluated via the recovery framework according to whether they give or take away power from people. Working in partnership as equals replaces 'service user involvement' as an ideal. The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.</p>	<p>Housing and supports are evaluated via the recovery framework according to whether they give or take away power from people. Working in partnership as equals places 'service user involvement' as an ideal. The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.</p>

(Adapted from original table developed by Laurie Davidson, Recovery Devon Group: www.recoverydevon.co.uk)