

HOME-IN-QUEANBEYAN

PUTTING THE CASE

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December 2006

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FOREWORD

As President of the Mental Health Association NSW Inc., I am pleased to provide the Foreword to this important report. The aim of 'Home-In-Queanbeyan' reflects well one of the key goals of the Mental Health Association, namely to raise community awareness of mental health and mental illness in ways which promote the status and rights of people living with mental health problems, and which create opportunities for public involvement. Home-in-Queanbeyan when established will provide a model for communities throughout Australia and indeed in other countries for creating a safe, supportive home environment for those with serious mental illness who are frequently forgotten and left to live in poverty and isolation. Home-In-Queanbeyan proposes a new model which will help people whose mental illness does not currently enable them to live independently to live in high quality individual, self contained apartment style accommodation. The accommodation will afford both independent and private living in a communal and supported environment for as long as it is required. With support and assistance, many residents will make new friends, participate in community activities, resume education or training, become employed and with time, move into their own housing.

Home-In-Queanbeyan is also important as it provides an example of how members of a community can become involved in helping people with mental illness to recover and enjoy a better quality of life. Home-In-Queanbeyan provides a crucial element which is often missing in mental health service deliver, widespread community support and involvement in making sure that gaps in services are plugged. By doing so, the community plays its role in helping to address problems that are too big for governments to address on their own.

This report is well researched and its conclusions are sound and evidence-based. I commend this report to governments, administrators and members of the community. May it encourage many more communities to stop and consider what they can do to promote mental health and prevent mental illness.



Dr Meg Smith OAM
President
Mental Health Association NSW

EXECUTIVE SUMMARY

Introduction

During 2006, Home-In-Queanbeyan's research team comprising Dr Leanne Craze, Glenn Jarvis and Anne Pratt, examined Australian and international literature to see if there was a case for the vision of Home-in-Queanbeyan. The team as well as drawing on local research, professional experience and anecdotal evidence also collected information from people who are or have experienced mental illness and homelessness. The findings are presented in this report.

What Home-In-Queanbeyan Proposes

The foundation for the vision for Home-in-Queanbeyan is to create a safe, supportive home environment for those who have been forgotten and abandoned by the community at large; a place where the homeless, mentally ill - and those for whom living independently is extremely difficult or not possible at this point - can live with the dignity and love they deserve. Individual, self contained apartment style accommodation affording both independent and private living in a communal and supported environment is proposed for as long as it is required. It is envisaged that with support and with time many residents will move into their own accommodation in the community.

Homelessness and Mental Illness in the Queanbeyan District

Research evidence indicates that on any given day in the Queanbeyan area there are at least fifty to one hundred plus people with severe and long-term mental illness who are homeless. Mental illness compounds the daily struggle to acquire, prepare and consume enough food needed to maintain health. As a result of both their mental illness and declining physical health, increased and frequent periods of hospitalisation are occurring. When alcohol and drug dependency and brain injury is added to the equation, hospitalisation increases as might periods of incarceration in police cells and gaols.

How Many People Would Be Immediately Assisted By Home-In-Queanbeyan?

The picture emerging is that at the very least 25 people with roots in the Queanbeyan community and who are well known to service providers and community groups would be helped significantly by Home-in-Queanbeyan. It is thought that there would also be another 20-30 people who across the course of year would be assisted by the availability of respite care and intensive outreach support. If Home-in-Queanbeyan is built and developed, it will be making an important contribution but there will still be people whose needs remain unmet, simply by reason of the size of the problem in our community.

The Cost of Homelessness and Mental Illness for Society

Research indicates that the total annual average costs to society per person with severe mental illness are estimated to be \$46,180.37. The total annual costs to society are estimated to be \$2.25 billion or 0.36% of GDP. The average annual cost per person of providing a supported accommodation program for homeless people and for people with mental illness is around \$34,000 whilst the average annual cost of keeping a person in prison in NSW is \$57,500.

What Drives These Costs to Society

The research indicates the following:

- The average costs of psychosis are extremely high, even on the basis of conservative assumptions;
- The main driver of these costs are inpatient care and reduced productivity;
- The per person costs will increase as duration of homelessness increases; and
- It seems that disproportionate amounts are being spent on ‘housing’ people in hospitals and other institutions rather than on investing sufficiently in supported community accommodation and rehabilitation.

How Might These Costs Be Reduced

Ground breaking research indicates that investing more in supported accommodation and evidence-based psychosocial interventions in the community could achieve better outcomes and save money.

What Contribution Might Home-In-Queanbeyan Make To Reducing These Costs

Based on Professor Vaughan Carr’s authoritative study, even if one out of every 10 clients of Home-in-Queanbeyan is assisted to be able to participate in meaningful activity, there will be reduced costs to government and to society as a whole (Carr et al 2002:34).

The Research-Based Evidence for Home-In-Queanbeyan

Home-In-Queanbeyan is consistent with research-based evidence about the requirements for effective interventions with people with severe mental illness who are homeless or at risk of homelessness.

- Home-In-Queanbeyan will promote and increase community awareness and ownership of the problems experienced by homeless people with severe mental illness.
- Home-In-Queanbeyan will provide permanent, independent housing.
- Home-In-Queanbeyan will provide housing and support suited to the individual needs of a group of people with severe mental illness who have high and complex mental health care and support needs.
- Home-In-Queanbeyan will provide housing and support which addresses the social and psychological needs of residents as well as practical needs.
- Home-In-Queanbeyan will provide housing and support which helps residents to feel a part of the local community and to feel like they belong and have a home.

Importantly, Home-In-Queanbeyan will address the well-documented barriers to homeless people with severe mental illness maintaining stable housing. It will also provide a means by which community awareness and acceptance of people with mental illness continues to be raised. Home-In-Queanbeyan will also have an outreach capacity and will work in tandem with other existing and new programs including the NSW Health Housing and Accommodation Support Program (HASI) and Commonwealth Government based programs providing counselling, personal helpers and mentors, support workers and employment and training assistance and support.

What Potential Residents of Home-In-Queanbeyan Told the Research Team

Overall, the participants who spoke with the research team stressed the need for Home-In-Queanbeyan to:

- Provide a high quality home that a person could call 'home';
- Provide a home for as long as it is needed;
- Ensure intensive onsite support;
- Provide a home-base for independent living; and
- Support residents to become active members of the community and to achieve their goals and dreams.

Conclusion

The report concludes that Home-In-Queanbeyan is based on sound evidence and is consistent with research findings about the preferences of homeless people with mental illness. The uniqueness of the Home-In-Queanbeyan model lies in the high and complex needs of the target group as well as proposing a permanent home affording independent and private living in a communal and supported environment. Home-In-Queanbeyan, by providing personalised support to help residents participate in meaningful activity and to build new relationships and networks, will prevent the situation of 'institutions of one', whereby people with mental illness live in isolation and neglect, trapped within their own four walls.

Importantly, Home-In-Queanbeyan provides a replicable and transferable model to other Australian communities for harnessing the concern, care, goodwill and resources of the community to assist people with mental illness whose problems are currently too big for government and other services.

INTRODUCTION

An *'outmoded concept'*. Or, a *'much needed local initiative that will work'*. These are some of the reactions that emerged when the concept of Home-In-Queanbeyan was initially being discussed. Given the different reactions and views, the Home-In-Queanbeyan team undertook an extensive research process to investigate the need for a local response to homelessness among people with severe mental illness and an appropriate model for any such local response.

Drawing on local research and professional experience, Australian and international literature was reviewed to see if there was a case for the vision of Home-in-Queanbeyan. Anecdotal evidence and information was also collected from people who are or have experienced mental illness and homelessness as well as from professionals and community members with relevant experience. The findings are presented in this report which is divided into the following sections.

- The vision and objectives of Home-In-Queanbeyan;
- Research findings;
- The nature of the problem in Queanbeyan;
- What are the lives of those requiring a solution to their homelessness like now;
- What are the costs to society of homelessness among people with severe mental illness;
- How is homelessness among people with severe mental illness addressed – what works and helps;
- What people with mental illness told the research team;
- The specific contribution of Home-In-Queanbeyan; and
- The Benefits of Home-In-Queanbeyan.

The report concludes that Home-In-Queanbeyan is based on sound evidence and is consistent with research findings about the preferences of homeless people with mental illness. The uniqueness of the Home-In-Queanbeyan model lies in the high and complex needs of the target group as well as proposing a permanent home affording independent and private living in a communal and supported environment. Home-In-Queanbeyan, by providing personalised support to help residents participate in meaningful activity and to build new relationships and networks, will prevent the situation of 'institutions of one', whereby people with mental illness live in isolation and neglect, trapped within their own four walls.

The Vision and Objectives of Home-In-Queanbeyan

Tragically, due to the lack of adequate and appropriate levels of care, there are too many people affected by severe mental illness who are homeless or left to fend for themselves in refuges, boarding houses, gaols, and public housing estates throughout Australia. 'Home-in-Queanbeyan' will create a place where they can live with the dignity and the support of the community. People, who are unable to live independently, will be cared for and valued in a safe and supportive community environment.

The foundation for the vision for Home-in-Queanbeyan is to create a safe, supportive home for those who have been forgotten and abandoned by the community at large; a place where the homeless, mentally ill - and those for whom living independently is extremely difficult or not possible at this point - can live with the dignity and love they deserve.

The objectives for 'Home-in-Queanbeyan' are:

- To recognise the dignity of all people, by striving to restore a sense of self-worth and belonging to people with mental illness who are homeless or at risk of becoming homeless.
- To generate broad community awareness and in doing so to obtain the involvement and support of local people, churches, community agencies, business and government.
- To create a purpose built, long term 'Home-in-Queanbeyan' for up to 20 people (including five respite places), with 24 hour care and support.
- To provide outreach support to people who by reason of severe mental illness are living in precarious circumstances and to help them find and maintain a place they can call home where they feel secure and are supported by the community.

Harnessing community awareness into action will include the training of members of the community to help people with severe mental illness with their interests, goals and needs including:

- Education and training;
- Preparation for work and employment;
- Finding and starting work;
- Budgeting;
- Health care;
- Self care and homemaking;
- Recreation, leisure and hobbies,
- Physical fitness and exercise,
- Getting mobile by obtaining a driver's license and getting one's own transport and/or using public and community transport; and
- Restoring or establishing important relationships.

Harnessing community action to provide emotional and practical support to people with mental illness who are homeless or at risk of homelessness aims to help people have a sense of belonging and of fitting into their community.

Research Findings - Homelessness And Mental Illness



Australian and international research from countries including Britain, Canada and America demonstrates that the homeless population compared to the general population have higher prevalence rates of severe mental illness, particular schizophrenia, other psychotic disorders and accompanying problematic drug and alcohol conditions. The research evidence supports the on the ground view that severe and prolonged mental illness increases the risk of long term homelessness. People who also have drug and alcohol problems are at an increased

risk as they are less likely to remain in stable living circumstances for sufficiently long enough periods.

How strong is this link between mental illness and homelessness in our communities?

.... It is possible to conclude from studies that between one quarter and one half of adult homeless persons across western cities are experiencing severe and perhaps chronic mental illness. (St Vincent's Mental Health Services Melbourne and Craze Lateral Solutions, 2005:8-9)

Why People With Severe Mental Illness Are At Risk Of Homelessness

Though the research enables us to understand the interaction between mental illness and homelessness, there is still much to learn about the nature of the causal relationship. It is possible that mental disorders, social isolation and drug abuse are both causes and consequences of mental illness (Herrman & Neil 1996). For example, it is thought that key symptoms of severe mental illness including hallucinations, disordered thinking, paranoia, anxiety, depression, lack of motivation and interest and difficulty in relating to others may contribute to the risk of homeless, whilst also being a consequence of being homeless (St Vincent's Mental Health Services Melbourne & Craze Lateral Solutions 2005:11-16). Contributing to this increased vulnerability is a range of experiences with which people with a severe, long-term mental illness may be familiar:

- Disrupted education;
- Lack of employment opportunities;
- Limited income;
- Limited affordable housing options, stigma and discrimination;
- Broken relationships and very little emotional support;
- Abuse; and
- Poor physical health including digestive system diseases, respiratory illnesses, diabetes, skin conditions and a backlog of dental problems.

As a result of both their mental illness and their poor physical health, increased and frequent periods of hospitalisation occur. Australian evidence shows clearly that people experiencing homelessness are sick and die of preventable and treatable conditions and illnesses (Campbell 2006). This evidence also reveals that homeless Australians are subject to ongoing hunger, weight loss and energy starvation related to malnutrition. Mental illness compounds the daily struggle to acquire, prepare and consume enough food needed to maintain health. Because of the precarious and chaotic nature of living on the streets or in night shelters, this group of people are often the victims of abuse and assault. Maintaining a place to call home in these circumstances becomes extremely difficult if not impossible unless there is significant support coming from somewhere. When alcohol and drug dependency and brain injury is added to the equation, hospitalisation increases as might periods of incarceration in police cells and gaols.

Researchers including Craig and Tims (1995) and Tacchi and Scott (1996) suggest that over the past 30-40 years there have been changes in the demographic profiles of homeless people. How has this profile changed?

More young people, women, families and ethnic minorities are using shelters and are more likely to be homeless (St Vincent's Mental Health Services Melbourne & Craze Lateral Solutions 2005:12).

Additionally, Australian commentators (Lipmann 2006) have noted increased homelessness among older men and women with severe mental illness. It is important that government and community tailor responses to meet the needs of all people with mental illness who are now at risk of homelessness.

What Are The Issues In Queanbeyan And Surrounding Districts?

At the time of the last Census in 2001, there were at least 206 members of the Queanbeyan community who were homeless (Chamberlain & MacKenzie 2002:62).

Where were these 206 people living? As far as we can tell this was the picture in Queanbeyan:

- 31 people were in boarding houses;
- 6 in SAAP (Supported Accommodation Assistance Program) shelters and crisis accommodation;
- 114 were intermittently with friends or acquaintances; and
- 15 were in 'improvised' circumstances ie on the streets or in parks etc.

What does this mean?

Based on our best research knowledge, between 52-103 of these homeless people would have severe and long-term mental illness or a related disorder.



Homelessness tends to be under reported in Census statistics for many reasons. We do know that the rate of homelessness in the Queanbeyan district of 50 per 10,000 was higher than for metropolitan Sydney areas (around 39 per 10,000). The rate of homelessness in Queanbeyan is actually thought to be higher than statistically indicated. One reason for this is the migration of homeless people including people with serious and long term mental conditions from other country towns. For example, in the nearby Snowy Mountains area where there are few homeless services and where mental health services are stretched, the rate of homelessness is 197 per 10,000 persons. The picture is similar down the coast where some areas have higher homelessness rates than Queanbeyan. With Queanbeyan relatively close, it is likely that some of these people are moving to Queanbeyan in search of better circumstances. There is also significant cross border movement between the ACT and nearby NSW towns as homeless people seek out options.

What Do Local Professionals And Community Workers Tell Us About Who Would Be Helped By Home-In-Queanbeyan?

In preparing this report, discussions were held with a range of local service providers and community workers. In the time available, though services were only able to provide rough numbers, there was a core group of people with complex needs who were consistently identified by professionals as being people who could be assisted by Home-In-Queanbeyan.

Mental Health Services

We know from informal discussions with staff of mental health services that at any time there are 6-9 people from Queanbeyan in extended inpatient-based care because appropriate supported housing options do not exist. The needs of this group exceed available support. In the absence of intensive support and a permanent place to call home, they soon end up in trouble or back in in-patient or extended hospital-based care. Others who do not come from Queanbeyan but who come from the coast or the Snowy Mountains would be assisted by Home-In-Queanbeyan's proposed respite care capacity.

Housing Services

Informal discussion with professionals working with the Department of Housing, community housing and crisis services suggest that at any one time there are at least 12-16 people with severe and long term mental conditions whose housing placements keep failing. Over the course of a year, the number would be greater. Some of these people's needs will be met through a new mental health support program known as HASI (discussed below) but it is estimated that at 6-8 of these people have needs too great for existing programs to address in the short term.

Ambulance Services

The picture concerning people with mental illness transported by Queanbeyan Ambulance is complex. This group present to Ambulance services in a couple of ways:

- At crisis point;
- With manageable symptoms; and
- With a presenting illness not associated with their underlying mental condition e.g. chest pain, diabetes etc.

The crisis point refers and includes people who are threatening self harm or harm to others, or have self harmed. The latter are primarily managed medically. Crisis point intervention usually also involve the police which, although there for the protection of the patient, can exacerbate the problem in the patient's mind. Occasionally the patient requires restraint and/or sedation. This is a stressful and traumatic time for the patient, family, police and paramedics. Drugs and alcohol use further complicate the assessment, management and diagnosis of mental health patients at the point of crisis.

Patients with manageable symptoms from a NSW Ambulance perspective are those with depression for example who are agreeing to assistance, or those who have other mental health problems and are easily convinced to accept this help. The final category refers to those with an underlying mental health issue which is usually only realised when the Paramedic, as a part of medical history taking, notes specific mental health medication in the patient's tablets list.



Informal discussions with the NSW Ambulance Service suggests that approximately 2 patients per month on average present in the crisis stage, 5 to 10 per month in the

manageable symptoms category, and dozens of others per month in the category of an underlying mental health issue with other presenting medical problem.

Police And Magistrates

Police officers and magistrates report similar numbers to those observed by ambulance officers and staff of housing services. There is a group of people with severe long-term mental disorders who are well known to the police and who bounce back before the courts because their housing circumstances are inappropriate and because they lack the level of support which they require.

Community Support Programs

Community support programs including St Benedict's Day Program, Mary's Place, St Vincent de Paul, Salvation Army and Nurturing Womanhood report that the number of people with severe long-term mental conditions who are homeless may even be as high as the numbers indicated by the Census statistical extrapolation based on research findings. Of this group of people, it is thought by community workers that over the course of a year somewhere between 15-25 need the type of housing and intensive support proposed by the Home-in-Queanbeyan concept.

The picture emerging is that at the very least 25 people with roots in the Queanbeyan community and who are well known to service providers and community groups would be helped significantly by Home-in-Queanbeyan. It is thought that there would also be another 20-30 people who across the course of year would be assisted by the availability of respite care and intensive outreach support.

What Are The Lives Of Those Needing Home-In-Queanbeyan Like Now?

The circumstances of people with severe or chronic mental disorders who either experience homelessness or are at risk of doing are well known to service providers and to many of our volunteer-based services. They are people of all age groups and from all walks of life. There at least four major groups who would benefit from Home-In-Queanbeyan and its intensive support:

- Young people and young adults whose lives unravelled before they could live independently;
- People aged later twenties and mid thirties whose lives are characterised by chaos and isolation;
- Middle aged people whose circumstances have come unstuck;
- Older people – left out and left behind.

All are experiencing severe and disabling mental illness and because of their high and complex needs have either no where to go or are running out of appropriate options. These circumstances and needs of each group are discussed in turn.

Young People Experiencing Severe And Disabling Mental Illness

Twenty years old and unable to live at home due to the impact of his mental illness on other members of the family, Zac began to change in his early teens and by 16, schizophrenia was evident and diagnosed. But there is something else as well that as yet has not been diagnosed. Turning to drugs or abusing alcohol only made the situation worse as more frequent and deeper episodes of psychosis occurred. Zac is too unstable to leave hospital care but at this stage needs a twenty-four hour a day supported environment. If Home-in-Queanbeyan was available Zac's prognosis and life opportunities would improve significantly. It is likely that he would be able to at some stage leave Home-in-Queanbeyan and move into independent accommodation in the community. It is also likely that in the future, Zac would be able resume education and training and go on to gain employment.

At the moment, young people like Zac have nowhere to go as the level of support and supervision required exceeds what can currently be provided by existing programs. Life currently comprises stints in Chisholm Ross, the Extended Care Unit, Ainslie Village, Matthew Talbot or somewhere similar and brief periods of staying at home or with other family or friends. Some are beginning to be at risk of imprisonment.

People Aged Late Twenties And Mid Thirties

Joy, who is now 29 years old, began to experience problems in her first year at university. Her thoughts began to race and she began to experience delusions that caused her to place herself in situations of risk. Joy was diagnosed with bi-polar and began to experience frequent hospitalisation due to mania. Though Joy's family are supportive she cannot live at home because there are younger children who Joy turns on when she is unwell. Joy also refuses to live with her family. As yet she has not remained well enough for long enough to secure accommodation and to take the first steps toward independent living.

Though the mental condition of people in this group might be beginning to stabilise, they are struggling with the disabling affects of severe mental illness. As a result of cognitive impairment, the chaos and level of disorganisation this group is experiencing seems to be increasing rather than decreasing. Up until this point, their experiences have often been characterised by lengthy periods of hospital-based care, periods of homelessness and semi-homelessness and periods of living in unstable and abusive relationships. Now that they aren't kept in hospital for as long, they are becoming increasingly isolated and alone as they struggle to stay in one place for long enough.

Many have experienced trauma and abuse and still carry the effects of such. The physical affects of the abuse or injury might not be known and may have been not diagnosed by health services. Many also have poor physical health. Some may have frequently committed minor criminal and property offences or engaged in risk-taking activities to get by. The disabling affects of their mental illness combined with alcohol and/or drug abuse and their experiences have left them with little confidence and insufficient living skills. They often live in a state of fear and vulnerability and strike out when feeling threatened. Their threatening behaviour draws unwanted and often adverse



attention to themselves. Quite often this group will turn to hospital emergency wards for help or will draw themselves to the attention of police in an attempt to find protection.

Because of the chaotic and disturbed nature of their lives, this group may have few friends and may have burnt the bridges between family members far too often. With the intensive support and the constancy that Home-in-Queanbeyan could offer, this group like many of the younger group might go on to live independently in the community.

Middle-Aged People Whose Situations Have Come Unstuck

Stephan is 48 and for twenty years since becoming unwell and diagnosed with schizophrenia, he has lived with his mother. His mother took care of all of life's daily necessities for him including cooking, shopping, banking, washing etc. Stephan has a high level of dependency and few social skills. Following the death of Stephan's mother two years ago, Stephan has moved between his siblings. Unfortunately, all 'placements' failed and all of his relatives have said they cannot have him any longer. Stephan currently stays for brief periods at Ainslie Village, local caravan parks and parks around Queanbeyan. Due to significant funds, Stephan is being 'befriended' by people who are abusing him and taking his money.

This group have struggled with the effects of severe mental illness for many years. Their lives have often been characterised by frequent periods of hospitalisation, broken relationships and periods of going from being virtually homeless to living in unsuitable accommodation. Some have remained engaged in mental health treatment, some haven't. Some have children who have struggled to maintain contact over the years. Some might have returned to live with their parents who are now ageing. Some may have lived with family members whose circumstances have now changed. Others might have rented privately or been public housing tenants. Some might have remained housed only through the support and determination of family or friends, volunteers or community workers. Some might have lived quietly but in recent years their level of dependency has grown rather than reduced. The full extent of the poverty and disorganisation in which this group lived for many years may have come to light only recently. Others may frequently have come to the attention of the criminal justice system.

Now and for a number of different reasons, this group finds themselves without a stable base in the community, without a place they can call home and without the living skills and without sufficient stability in their mental condition to care for themselves.

Older People

Sue is 69 years old and has been diagnosed with a major mental illness since the age of 18. Until she was in her forties she lived with her parents who are now both deceased. After this time she lived in private rental accommodation and was intensively supported by her sister. Since her sister moved to far North Queensland three years ago, Sue's situation has unravelled. Since being evicted from her unit, Sue has been in and out of hospital-based care. An old friend of the family provides Sue with accommodation on an on-and-off basis. Sue will be there for two weeks and then without notice will not return home at night. The next thing the friend knows is that Sue is staying in a homeless shelter in Sydney or has been admitted to hospital either in Sydney or locally.

Like the middle-aged group, this older group have experienced severe mental illness for many years and now find they are facing a precarious future. Too young, too robust or too 'with it' for aged care services, the unremitting and disabling effects of their mental illness

has resulted in this group falling between the gaps in services. They have few friends and little or no family support. Their support needs remain too high for outreach-based services and there are no permanent mental health residential programs. They are often experiencing high levels of ill health and have a backlog of health complaints requiring specialist intervention.

There is literally no suitable accommodation option for this group given the level and complexity of their care and support needs and their age.

Where Does This Leave Us?

If Home-in-Queanbeyan is built and developed, it will be making an important contribution but there will still be people whose needs remain unmet, simply by reason of the size of the problem in our community.

It is thought that the proposed outreach support component of Home-in-Queanbeyan together with new mental health housing and support programs including HASI, and Broughton Place and new Commonwealth-based support initiatives will make headway into addressing unmet need.

What Are The Costs To Society Of Homelessness Among People With Mental Disorder?

Significant progress has been made in Australia in estimating the monetary costs of both severe mental illness and homelessness. Though this is a complex and difficult area of research, we have attempted to provide an overview of what is known in as simple as possible terms.

Based on statistics analysed during the late 1990s and early this century the costs of psychotic mental disorders eg schizophrenia include the following.

- *Cost to Governments* including administration, Centrelink payments, legal costs, health and mental health care, tax forgone, housing etc:
 - Total annual average costs per patient of \$29,629.84
 - Total annual costs of \$1.45 billion
 - 0.23% of the GDP
- *Cost to society* includes all of the above plus Carers' earnings foregone and individual's earnings foregone:
 - Total annual average costs per patient of \$46,180.37
 - Total annual costs of \$2.25 billion
 - 0.36% of GDP. (Carr et al 2002)

The average annual cost per person of providing a supported accommodation program for homeless people and for people with mental illness is around \$34,000 whilst the average annual cost of keeping a person in prison in NSW is \$57,500. Professor Vaughan Carr and his Newcastle-based mental health research team concluded:

The high costs of psychosis are largely associated with inpatient care and the reduced productivity of persons with psychosis and their carers..... The burden associated with inpatient care in Australia appears to be high relative to other countries, while the costs associated with supported accommodation are lower. This situation is worthy of further investigation, not least because

inpatient care may not be cost-effective, and improved patient outcomes and reduced costs may potentially be achieved by providing psychotic persons with adequate supported housing. (2002:35)

It is accepted that even the best estimates are conservative as they do not take into account 'time-lost' costs due to death and a range of other factors. We know that premature death by suicide is 10% higher for people experiencing schizophrenia than for the general population. There are also significant costs that are not included because they are difficult to quantify, evaluate or calculate. These are intangible or psychological costs which include the impact of:

- Reduced quality of life (eg pain and suffering);
- Undesired changes in life plans;
- Impact on family members that can be generational;
- Impact on other carers;
- Social isolation;
- Unwanted educational and job changes;
- Loss of opportunity for promotion and education;
- Loss of housing and having to relocate etc.

Our communities are also the poorer as they lose the opportunity of being enriched by experiences and talents not only of people with severe mental illness themselves but frequently their children and other family members as well.

- *The average costs of psychosis are extremely high, even on the basis of conservative assumptions.*
- *The main driver of these costs are inpatient care and reduced productivity.*
- *The per person costs will increase as duration of homelessness increases.*
- *It seems that disproportionate amounts are being spent on 'housing' people in hospitals and other institutions rather than on investing sufficiently in supported community accommodation and rehabilitation.*
- *Investing more in supported accommodation and evidence-based psychosocial interventions in the community could achieve better outcomes and save money.*

The analysis of Carr et al also indicated that the costs are increased by the level of disability and unemployment amongst people with serious mental illnesses like schizophrenia. The researchers argued that there are many potential cost-benefits of providing rehabilitation and supported accommodation programs that enable people to have a home and to resume employment or other meaningful activity and participation. The researchers concluded that even if providing supported housing and rehabilitation programs were to result in a modest 10% improvement in meaningful participation rates, significant cost savings would be attained in less than three years. (Carr et al 2002:34)

Based on Professor Carr's authoritative study, even if one out of every 10 clients of Home-in-Queanbeyan is able to participate meaningfully or engage in meaningful activity, there will be reduced costs to government and to society as a whole (Carr et al 2002:34).

Then they are the gains that society values and considers worthwhile that cannot be measured in monetary terms including the improvement in the quality of the lives of hitherto excluded people and the community capacity that is built during the process of communities reaching out to help.



Home-in-Queanbeyan proposes providing a highly disabled group of people with severe mental illness with a home and with assistance to re-enter the workforce or to participate in meaningful ways in their community. Others, who do not live at Home-in-Queanbeyan but who live in our local communities, will be supported to stabilise or improve their housing

situation so that they too can have improved quality of life.

Addressing Homelessness For People With Mental Illness - What Works And Helps

This section discusses research findings about what works best in addressing homelessness among people with mental illness. A number of important strategies emerging from the literature are outlined including the following.

- Promoting and increasing community awareness and ownership of the problems experienced by homeless people with severe mental illness;
- Providing permanent, independent housing;
- Providing housing and support suited to the individual needs of a group of people with severe mental illness who have high and complex mental health care and support needs;
- Providing housing and support which addresses the social and psychological needs of residents as well as practical needs;
- Providing housing and support which helps residents to feel a part of the local community and to feel like they belong and have a home.

The way in which the proposed Home-In-Queanbeyan is consistent with the literature is then explained.

Community Wide Ownership Of The Problem

Roseanne Haggerty (2005), an Australian researcher, studied and reported on responses to chronically homeless groups including people with mental illness and drug or alcohol abuse in other Western countries and concluded that those communities that have made the best inroads into addressing homeless are those which have:

- **Identified who is homeless** - they know who they are and where they are - the emphasis has shifted from numbers and approximations to known people;

- **Housed people as a first step** - whether that be in independent housing with support services that travel to the home, or purpose-built accommodation combining affordable and independent accommodation with support services;
- **Built partnerships** with mental health, healthcare, corrections and foster care systems whose discharge policies and practices may unwittingly result in homelessness; and
- **Engaged the community** as well as all levels of government in addressing the known problem locally - they have educated the public about the vulnerable circumstances of the chronically homes and communicated ways for the entire community as well as individuals to support the effort to address homelessness.

Home-In-Queanbeyan is making progress in each of these areas. To some extent, awareness of the need for a Home-In-Queanbeyan arose from the work of a community-wide and interagency group that has been meeting for several years to build partnerships between services in Queanbeyan so that those who fall between the gaps in services including homeless people with mental disorders, might have their needs addressed. There has been local collaboration to identify homeless people with severe or chronic mental disorder and to develop a concept of the type of accommodation which might begin to address the high and complex needs of this group. Home-In-Queanbeyan organisers have worked hard to increase community awareness and understanding of the problem and are beginning to articulate ways in which members of the community can assist. People are coming forward to donate and contribute money, professional or business expertise, personal talents and time. People are also beginning to express a desire to reach out and help Home-In-Queanbeyan residents with their day-to-day needs and to help them come to feel like they belong in our community.

Home-In-Queanbeyan is based on sound principles as it is:

- *Helping to identify individuals with severe mental illness who are homeless;*
- *Based on partnerships;*
- *Seeking to provide permanent independent but supported housing; and*
- *Actively engaging the whole community.*

The Importance Of Providing Permanent Housing

Martinez & Burt 2006 in an American study reported on the outcomes of providing permanent supportive housing for homeless people with mental illness in San Francisco. One program comprised 104 single-room occupancy units and the other 57 units. Both programs provided an array of onsite services provided by local interagency collaboration including case management, psychiatric care, health care and vocational training. Service use was voluntary and not a requirement of residency. Analyses compared service use during the two years before entry into supportive housing with service use during the two years after entry. The researchers found that housing placement significantly reduced service use:

- Percentage of residents with an emergency department visit decreased from 53 to 37 percent;
- The total number of emergency department visits reduced from 457 to 202; and
- The likelihood of psychiatric hospitalisation decreased from 19 to 11 percent.

The Home-In-Queanbeyan model significantly improves on the single room San Francisco model in a number of ways including:

- The style of unit that is being proposed being more like an apartment with a self-contained kitchenette, separate bedroom, bathroom, living area and private outdoor courtyard;
- The proposal of a large but homely, shared living area including a dining room where communal meals can be prepared and shared;
- The proposal of shared outdoor grounds and facilities;
- There is more of an emphasis of the facility being a part of the community and being provided by the community.

The Home-In-Queanbeyan model is similar to the San Francisco model in that it proposes bringing health services to residents as well as supporting residents to access services in the community.

In a ground-breaking New York-based study, Culhane et al (2001) evaluated the impact of providing supportive housing for homeless people with severe mental illness on the utilisation of the public health, corrections and emergency shelter systems. Supported housing options included scattered-site housing with community-based support and single room occupancy housing (independent housing linked to either community-based or site-based service support) and community residential facilities including long-term treatment facilities and adult homes. The researchers found that prior to placement in housing, people with severe mental illness used on average \$40,449 US per person per year in such services. Placement in housing programs was associated in reductions of \$16,282 per housing unit in the first two years of placement. During this initial period a modest cost of \$995 per unit occurred. The study concluded:

As in other service interventions for people with severe mental illness, service use often increases temporarily following placement, as tenant's unmet health and psychiatric needs are more likely to be identified and treated once they receive regular, periodic case management services (Pollio et al 2000). If this were the case here, one would expect service use to decline and stabilise over time, producing net cost savings in successive years (2001:19).

The study was not able to include all direct or indirect costs associated with service use by homeless people nor was it able to measure many of the potential benefits of the housing initiative. For example, residents of supported housing programs are reported to be more likely to secure voluntary or paid employment (Hud 1994) and to experience an improved quality of life. This lead Culhane et al to further conclude:

Investments in supported housing have also been shown to be associated with improved neighbourhood quality and property values (Arthur Andersen et al 2000). Last, the social value of reduced homelessness, and of providing protection for the disabled, while not possible to translate into economic terms, constitutes an important if less tangible net benefit to society. Taken together, these unmeasured costs of homelessness and benefits of the housing intervention would have increased its already significant net benefit (and potential cost savings) were all such costs and benefits included in this study (2001:29).

Studies evaluating different models of supportive housing have also demonstrated the importance of resolving a person's housing problem by providing permanent housing in the first instance (Tsemberis & Eisenberg 2000). St Vincent's Mental Health Services and Craze summarised research findings about what assists people to maintain housing once obtained.

The point being that access to and maintenance of stable housing depends on:

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

Other factors at play in this model include income support, employment services and ongoing housing assistance. The backdrop to all of this is having a supportive environment consisting of family, friends, neighbours... (2005:28).

A further vital factor is for there to be a community that is aware and accepting of people with mental illness.

Home-In-Queanbeyan will address the well-documented barriers to homeless people with severe mental illness maintaining stable housing. It will also provide a means by which community awareness and acceptance of people with mental illness continues to be raised.

Accommodation Suited To Individual Need

Studies have repeatedly demonstrated that people with mental illness prefer to live independently rather than in a group home environment. If they were to live in a group home, people with mental illness prefer a small one to a large one (Schutt & Goldfinger 1996). In recent years there has been debate about which is the best model for providing housing for people with severe mental illness. These include 'housing first' (independent housing linked to support), residential programs and transitional housing models. In the first, independent apartments are offered without assessing readiness and without making housing availability contingent on engagement with treatment services. Residential programs vary in size and approach but generally incorporate comprehensive on-site clinical and support services. Transitional housing models often provide housing as an extension of mental health services and the level of support is varied according to a person's mental health and as the person's psychosocial needs varies.



All models have been reported as having both strengths and weaknesses. 'Housing first' type programs may not be able to provide sufficient support needed by a small group of severely impaired people whose needs are complex. Residential programs might result in institutionalised living in a community setting whilst transitional housing programs may break down because of a lack of appropriate entry and exit options (ie nowhere to transit to and from). In a review of the major approaches, Rog 2004 found that, generally once housed with adequate supports homeless people with severe mental illness were less likely to be hospitalised regardless of the housing model.

However, recent findings emerging from the National Evaluation of the SAAP Program in Australia suggest that the picture might not be that straight forward and that some groups of homeless people including those with severe mental illness may need longer term supportive housing if their situations are to stabilise and if there are to be improvements in their social functioning. St Vincent's Mental Health Services Melbourne and Craze discussed the SAAP Evaluation's finding that homeless people who have more complex needs disproportionately use crisis and short-term support services and may be less likely to achieve independent housing. The researchers suggest:

Equally, it is plausible that programs focused on longer-term support and medium-term housing are more likely to assist people to achieve independent housing (2005:19).

Locally, there is significant anecdotal evidence to suggest that a number of people with



severe mental illness with high and complex care needs do require long term and intensive support if they are to avoid homelessness or to avoid living in make-shift arrangements under bridges or in disused railway buildings for example. Some will require the support to be onsite whilst others will be able to manage with support being provided on an outreach basis to their homes. It is likely that some will require both longer-term support and longer-term housing, an option that does not currently exist in the south-east region of NSW.

Home-In-Queanbeyan proposes to provide tailored support services for those whose mental health care and psychosocial support needs are so complex that they cannot be adequately addressed by existing services and programs. A permanent home until it is no longer needed is a key component of the Home-In-Queanbeyan

proposal.

The uniqueness of the Home-In-Queanbeyan model lies in the high and complex needs of the target group as well as proposing a permanent home affording independent and private living in a communal and supported environment.

Housing And Support Services Need To Be Responsive To A Person's Social And Psychological Needs As Well As Practical Ones

People with mental illness who have been homeless for a period of time need time to adjust and have a range of emotional and psychological needs that might not be evident at first. Some on becoming housed in their own apartment report an enormous sense of relief that helps them to establish new routines whilst others report a 'shakiness', a sense of isolation and no longer feeling connected to anyone (Davidson et al 1996). The latter group often lack meaningful activity and have minimal contact with anyone. Housing and support services need to be able to help people regain confidence, re-make their way in the world, and build new relationships (Freeman et al 2004). Without this, people can soon find they are living in 'institutions of one'.

Home-In-Queanbeyan, by providing personalised support to help residents participate in meaningful activity and to build new relationships and networks, will prevent the situation of 'institutions of one', whereby people with mental illness live in isolation and neglect trapped within their own four walls.

A Sense Of Fitting Into Community

St Vincent Mental Health Services Melbourne and Craze (2005:29) studied research by Yanos et al (2004) who reported that people housed after long periods of homelessness felt safe for the first time:

They felt that they fitted into the community where they now lived, and described themselves as feeling human again. Being housed improved their self-esteem, hope and interest in the world around them, and translated into actions such as showering, looking after the place, having a set of keys and independence.

People regardless of their psychiatric diagnosis or substance abuse have been shown to prefer to be living in their own place, in a place that they can call home. Fitting into their community and there being a good fit between the person and their environment has been found by researchers to be an important determinant of outcome.

Home-In-Queanbeyan will be both provided and supported by the community. A high level of community involvement will assist residents to feel accepted by the community and to have a sense of home and of belonging.

Home-In-Queanbeyan will be evidenced-based by:

- *Promoting and increasing community awareness and ownership of the problems experienced by homeless people with severe mental illness;*
- *Providing permanent, independent housing;*
- *Providing housing and support suited to the individual needs of a group of people with severe mental illness who have high and complex mental health care and support needs;*
- *Providing housing and support which addresses the social and psychological needs of residents as well as practical needs;*
- *Providing housing and support which helps residents to feel a part of the local community and to feel like they belong and have a home.*

What People With Mental Illness Told Us

Two focus groups were held, one at St Benedict's in Queanbeyan and the other, at the Extended Care Unit at Kenmore in Goulburn. The 15 people who attended these groups had a number of things in common including:

- Severe mental illness;
- Significant problems in being able to live independently; and
- Few or no appropriate accommodation options

Most had experienced homelessness or were currently at risk of becoming homeless.

Over a meal, the participants discussed with our team the type of housing or accommodation they felt they needed. A number of topics were discussed including:

- What they wanted most;
- What the independent apartment or unit should be like;
- What shared space should be provided;
- What the grounds should be like;
- What support should be provided;
- What rules should there be and how should these rules be decided; and
- Overall design of Home-In-Queanbeyan.

Participant's views in relation to each topic are summarised in turn.

What They Wanted Most

Participants in our focus group told us that they wanted a home and did not want to be homeless. They all stressed that they wanted to feel safe and have a place they could call 'home'. Security was a big issue as most had experienced very unsafe living circumstances. They wanted a home they could have for as long as they needed it and which was connected to on-site support. Without a permanent home and without onsite support, our participants doubted that they would ever be able to stay well enough for long enough to gain the skills they needed to increase their capacity to live independently

What The Independent Apartment Or Unit Should Be Like

Participants did not want to live in sub-standard accommodation nor did they wish to live in a bed-sit or in shared accommodation. They wanted an apartment or unit that could enable them to be as independent as they could be. Participants stated that it would be important for their independence to have a kitchenette, separate bedroom and living room, their own ensuite bathroom and toilet and a private outdoor area like a courtyard. Participants suggested an intercom security system between each individual unit and administration, particularly to enable each resident to determine whether they wanted visitors and who they wanted as their visitors.

What Shared Space And Facilities Should Be Provided

Participants suggested that the communal areas should be significantly large but homely and should include facilities that all residents could use and share eg:

- Kitchen;
- Dining room;
- TV and recreation room with quiet areas eg library and reading area and area for visitors;
- Gym room;
- Music room;
- Activities area for crafts, hobbies, board games, pool table, table tennis.

Participants also suggested private rooms for consultations with health professionals and counsellors and for one:one tuition.

What The Grounds Should Be Like

Participants suggested that the grounds should be homely and allow for combined activities as well as ‘chill-out’ space. Suggestions included community garden, garden and tool shed, BBQ area, sheltered all-weather area and a smoking area. Participants stressed the importance of the grounds being well lit at night.

What Support Should Be Provided

All participants stressed that they would prefer support to be onsite and available 24 hours a day. As one resident said:

I know with support, I could do things that I have always wanted to do. But I also know that if support isn't there then I won't do anything – I'll just stay in my room and get sick.

When asked what they needed support for, participants stated they needed support to start doing all the things that people need to do each day including banking, shopping, cleaning, washing, cooking, mixing with others, joining clubs, doing some study, having some interests and hobbies, taking steps toward being able to work, having a holiday, making and keeping appointments and managing their medication and health care.

I want to do what everyone else does. I want a job, I want to make friends and want to do normal things.

Some participants said that because of past experiences and because of their illness they hardly ever want to keep seeing their mental health case manager but they know they should. Some said that if they had an independent support person who knew them well and who could go with them to appointments that they would be far more likely to keep seeing mental health services.

The suggestion was made that perhaps there could be a respite room near the central administration area for residents who were becoming unwell but not sufficiently unwell to warrant hospitalisation. Another suggestion was for a room where visitors could stay briefly.

What Rules Should There Be And How Should These Rules Be Decided

Participants said that Home-In-Queanbeyan should have rules and that all residents should sign a contact-like agreement whereby they agree to keep the rules. The participants stressed that key rules should include looking after one's own unit (with support if necessary), no violence, no property damage, contributing in some way to the maintaining of communal facilities, reporting of visitors, observing fire safety, no use of illegal substances, drinking alcohol in moderation and paying rent. Participants said it would be important for residents to have formal meetings as well as informal shared times so that they can have direct input into the management and running of their home, ‘Home-in-Queanbeyan’. Suggestions made to foster ‘ownership’ included:

- Resident representation on the Board of management;
- Social club and social activities;
- Regular shared meals;
- Communal celebrations eg Easter, Christmas etc;
- Suggestion box; and
- Shared roles and responsibilities.

Overall, the participants at the focus groups stressed the need for Home-In-Queanbeyan to:

- *Provide a high quality home that a person could call 'home';*
- *Provide a home for as long as it is needed;*
- *Ensure intensive onsite support;*
- *Provide a home-base for independent living; and*
- *Support residents to become active members of the community.*

The Contribution Of Home-In-Queanbeyan

The Home-In-Queanbeyan model does not propose a group home nor does it propose a collection of institution-like bed-sits. Rather the Home-In-Queanbeyan model proposing a permanent home affording independent and private living in a communal and supported environment for a group of people with severe mental illness whose needs are too great for existing housing and accommodation support programs. Home-In-Queanbeyan sets for its target group those with the greatest levels of disorganisation, impairment and disability who otherwise would remain caught in a cycle of homelessness, hospitalisation and institutionalisation whether the latter occurs in a mental health or correctional facility or in isolation in the community. Home-In-Queanbeyan will also have an outreach capacity and will work in tandem with other existing and new programs including the NSW Health Housing and Accommodation Support Program (HASI) and Commonwealth Government based programs providing counselling, personal helpers and mentors, support workers and employment and training assistance and support.

CONCLUSION - THE BENEFITS OF HOME-IN-QUEANBEYAN

The literature and research shows that by Home-In-Queanbeyan targeting a group of people with severe mental illness who no existing service has the capacity to assist effectively and significant benefits will result including:

- Reduced government costs;
- Reduced societal costs;
- Reduced unmeasurable costs arising from disability, premature death and isolation;
- The harnessing of the concern, care, goodwill and resources of the community
- The building of social capital; and
- A replicable and transferable model to other Australian communities.

Importantly, by the community of Queanbeyan finding a solution to a distressing local problem, community confidence and solidarity will increase and further seemingly intractable local problems will also be remedied.

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