Homelessness vulnerability

Homelessness

A person is considered homeless if they live in a dwelling that is unsafe, unstable, lacking privacy, without access to space for social relations and where they have no ability to control living space (ABS, 2012b)[1]. This includes sleeping rough (without a roof), staying in guest or boarding houses, living in a car, "couch surfing" with family or friends or any accommodation where there is severe overcrowding. Homelessness is one of the worst forms of social and economic exclusion. Being homeless makes it difficult to engage in education, employment and creates vulnerability to violence, victimisation and poor health (Steen, 2018).

On Census night in 2016, 116,427 Australians were classified as being homeless, which represents a 14% increase in homelessness in the 5 years from 2011 to 2016 (ABS, 2016). Rough sleeping, the most extreme form of homelessness, rose nearly 20% between 2011 and 2016 (ABS, 2016). Aboriginal and Torres Strait Islander peoples make up 3% of the Australian population, however they accounted for 20% of the homeless population on Census night (ABS, 2016). There are some issues with the definition of homelessness in this population, that is, some Aboriginal and Torres Strait Islander people who were considered homeless in the Census would not consider themselves homeless. However, this estimate of Aboriginal and Torres Strait Islander homelessness is still likely to be an underestimate, since Aboriginal and Torres Strait Islander people are underenumerated in the Census (ABS, 2016).

The relationship between homelessness and mental health

While having either mental illness or being homeless can negatively impact an individual, having both can be particularly debilitating (Steen, 2018). Estimates of current diagnosed mental health conditions in the Australian homeless populations range from 31-80%, which is significantly higher than the rate of mental health conditions in the general population (20%) (AIWH, 2018; Spicer, Smith, Conroy, Flatau, & Burns, 2015; Teesson, Hodder, & Buhrich, 2004; Witte, 2017).

The relationship between housing and poor mental health is bi-directional (Brackertz, Wilkinson, & Davison, 2018). Mental health issues can lead to homelessness, but homelessness also amplifies poor mental health. The stress, isolation and trauma typically associated with being homeless (particularly rough sleeping) can exacerbate previous mental health problems and lead to the development of mental health problems such as anxiety, depression and substance misuse. It can also become a circular problem (Steen, 2018). An Australian study of nearly 5000 homeless people found that 15% had mental health issues prior to becoming homeless, but 16% developed mental health problems after they became homeless (Johnson & Chamberlain, 2011). Additionally, those with mental illness are more vulnerable to other risk factors for homelessness, including domestic family violence, alcohol and other drug addiction, long term unemployment, financial crisis and transition from care/custody (Brackertz et al., 2018).

There is a strong link between problematic alcohol/drug use and homelessness. Reports from the Specialist Homelessness Service in Australia indicate that 20% of their clients were leaving or had recently

[1] ABS Australian Bureau of Statistics

left an alcohol and drug rehabilitation centre (AIHW, 2018) and other Australian studies report that almost half of the homeless individuals in their study had a substance use disorder (Spicer et al., 2015; Teesson et al., 2004). There is also a strong relationship between homelessness and domestic violence, with 38% of Specialist Homelessness Service users reporting they had experienced domestic violence (AIHW, 2017), which represents a 33% increase over the past 5 years (AIHW, 2017). Finally, those who experienced homelessness *and* mental illness in Australia were 40 times more likely to be arrested and 20 times more likely to be incarcerated (Westoby, 2016).

Benefits of secure housing

The benefits of secure housing include physical shelter, safety, privacy and social inclusion. Secure housing helps facilitate the development of better relationships (within families and between individuals and the community) and provides the stability to allow for the development of daily routines. A person's home is also part of their personal identity.

Previous research has indicated that greater choice in housing improved wellbeing (Nelson et al., 2007) and improvements to housing quality led to better mental health functioning over time, as compared with individuals whose housing remained the same quality (Bond, Egan, Kearns, Clark, & Tannahill, 2013). Living arrangements that foster good relationships in the home and community have been linked to improved quality of life and mental health and decreased service use (Aubry, Duhoux, Klodawsky, Ecker, & Hay, 2016; Nelson et al., 2007). Furthermore, people with mental illness who move to neighbourhoods with less crime and fewer run-down properties show a reduction in their use of mental health care services (Harkness, Newman, & Salkever, 2004).

Barriers to secure housing

People with mental illness have a greater tendency to experience unstable living arrangements, for example, a greater number of moves and inadequate housing (Brackertz et al., 2018). A secure living arrangement allows people to have greater focus on mental health treatment and rehabilitation, as opposed to focusing on securing housing (Bleasdale, 2007). The following issues have been identified as needing to be addressed to provide more and better housing/services for people with lived experience of mental health illnesses.

- There is a shortage of affordable and available appropriate, stable housing for people with mental illness (Brackertz et al., 2018; Queensland Council of Social Service, 2018).
- Only households with two minimum wages can afford to rent from the private rental market in Brisbane, without experiencing significant financial distress (Queensland Council of Social Service, 2018).
- There are long social housing waitlists. In June 2016 there were approximately 195,000 households on the waitlist for social housing in Australia. As at June 2016, 47% of households had been waiting for more than 2 years for appropriate housing (AIHW, 2017).
- Lack of adequate support means that discharge from inpatient care is a significant risk factor for homelessness (Brackertz et al., 2018).
- Programs that integrate housing and mental health are effective, but do not meet the level of demand for these services (Brackertz et al., 2018).
- Behaviours that accompany certain mental illnesses such as anti-social behaviour, delusions and lacking ability to manage finances can make retaining tenancy problematic and increases the chances of being evicted or denied access to private rental housing (Jones, Phillips, Parsell, & Dingle, 2014). Thus, tenants are sometimes evicted for manifestations of their mental illness, which was the reason why they were originally housed.

Housing and mental health support programs

A variety of programs have been shown to be effective in helping support consumers with mental health and housing difficulties, depending on the consumer's specific needs (Brackertz et al., 2018). Reported benefits include:

- improved consumer mental health
- improved consumer social connectedness
- cost savings in health for the government
- reduced hospital admissions and length of stay in hospital
- modest improvements in education and work (Brackertz et al., 2018).

One example of a successful supportive housing program is Brisbane Common Ground (BCG). This housing supplies 146 modern units in a 14-storey building in a central location in Brisbane. BCG aims to help low-income individuals to secure stable housing, improve their quality of life and decrease their use of services. Researchers used linked data to measure and compare service usage in the 12 months prior to commencing living at BCG (i.e. while the person was homeless) and service usage in the 12 months during which the person was a tenant at BCG. Tenants in supportive housing had fewer mental health episodes or days as an admitted patient and less police contact (as a victim or perpetrator). Even after factoring in the cost of providing BCG, housing a previously homeless person saved $13,100 per tenant per year in reduced service usage (Parsell et al., 2016).

Youth homelessness and mental health

Youths aged 12-24 years account for 25% of the homeless population (ABS, 2012a), including those who are experiencing homelessness with their family. It is estimated 53% of homeless 13- to 25-year-olds had been diagnosed with a mental health condition in their lifetime, with nearly one quarter having had a severe disorder (Flatau, Thielking, MacKenzie, & Steen, 2015; Lawrence et al., 2015; MacKenzie, Flatau, Steen, & Thielking, 2016). Youths aged 15 to 19 years with a serious mental illness were 3.5 times more likely to have spent time away from home (32.2%), relative to the general population (8.6%) (Mission Australia, 2017). These individuals commonly reported that they had spent time away from home because they felt they could not return home. Youths who had spent time away from home reported significantly higher levels of concern about family conflict, depression, stress and suicide than those youths who had not spent time away from home (Mission Australia, 2017). Self-injury and attempted suicide rates are significantly higher for homeless youth, relative to the general youth population (Flatau et al., 2015; National Mental Health Commission, 2012). Predictors of youth homelessness include family violence, child abuse, parental drug/alcohol misuse and youth or adult mental illness (Brackertz, Fotheringham, & Winter, 2016). Over one third of Australian homeless youths report that violence in their home had escalated to the point of police involvement (MacKenzie et al., 2016).

A recent Australian study compared the costs associated with mental health treatment for youth who were homeless versus unemployed (i.e., another disadvantaged group) (MacKenzie et al., 2016). Homeless youth spent an average of nearly four nights per year in a mental health facility or detox/rehabilitation centre, while none of the unemployed youth spent any time in these facilities. Overall, the annual cost of health service usage for homeless youth was $8505, compared with $1761 for unemployed youth.

Queensland Health support for people experiencing homelessness

When providing care to those experiencing homelessness and mental health issues, it is essential to create a non-threatening and supportive atmosphere, address basic needs first

(e.g. food and shelter) and provide accessible care.

Each HHS has a Homeless Health Outreach Team (HHOT) including social workers, occupational therapists, nurses, psychologists, psychiatrists, General Practitioners and Indigenous Health workers. The HHOT aims to improve the health of people experiencing homelessness and reduce homelessness through collaboration to enable access to the appropriate supports.

The Homeless Health Outreach Team (HHOT) provides health service to people within the HHS who are experiencing homelessness, mental health issues and substance misuse issues. The HHOT provides:

- assessment and intervention services to people experiencing a diverse range of mental health concerns, including psychosis, mood disorders, anxiety, substance misuse and suicidal thoughts
- an extended hours assertive outreach service to people where they reside in the community or where they access food and support
- support through linking people with appropriate community services
- transitional support may be provided where a person accessing the HHOT team moves out of the HHS.

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