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Professor Stephen King
Presiding Commissioner
Mental Health Inquiry Productivity Commission
GPO Box 1428
Canberra ACT 2601

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Dear Professor King,

I appreciate the opportunity to make a submission to the Productivity Commission's inquiry into mental health. Professor David Copolov AO, Monash University, suggested I make a submission on issues related to the homeless mentally ill.

For almost 40 years I have provided primary health care for homeless people in inner Sydney; I have also had experience at a policy level in mental health, suicide prevention and in alcohol and substance use problems - in government and non-government organisations. (see brief CV below)

I commend the Commission on its broad frame of reference for mental health in the draft report.

My comments relate to services and social issues and do not address economic costs which are beyond my expertise.

A significant contribution to the economy is most unlikely from the population groups, subject of this submission, but there would be substantial costs. There could be some substitution of less costly early and community interventions replacing later more costly institutional interventions.

Access to appropriate housing will make demands on social spending and access to welfare payments, to which affected persons are entitled to alleviate their impoverishment, will be an increased charge on the social welfare budget.

Implementing more appropriate primary health care services for this population group, outreach mental health services, social support and support for frontline agencies including non-government organisations, will lessen the expenditures on tertiary hospital services, psychiatric and addiction facilities, policing and the criminal justice system.

Despite the lack of an economic payoff, society will benefit by being a socially just and caring community with a sense that all persons are valued and deserve to live "a contributing life".

Yours sincerely,

Submission on mental health and homelessness to the *Productivity Commissions Draft Report* on mental health from Emeritus Professor Ian Webster AO

The submission is in four sections:

A: Areas in the draft report which require attention

B: What needs to be done for homeless and mentally ill homeless people

C: A commentary on health and related issues in homeless people with special reference to mental illness

Brief CV

Attachment – case study - DSP and related issues in the homeless mentally

The perspective of this submission comes from working as a physician with homeless and mentally ill people.

I commend the *Commission* on the comprehensive nature and coverage of the analysis and report; I specially commend the emphasis on the "investment in services beyond health".

It is unfortunate that governments respond to concerns about mental health and suicide prevention by focusing on mental health services rather mental health issues arising out of social and cultural influences – in early life, on families, and, from social marginalisation in a competitive and self-absorbed culture.

The first two reports of the *National Mental Health Commission* (2012 and 2013) – "a report card" on mental health – took such a wide perspective.

There were three seminal ideas.

Everyone, especially a person with a mental health problem, is entitled to live "a contributing life"; that <u>recovery</u> in mental illness should be seen in terms of the person's experience and not the criteria set by service providers; and, thirdly, that mental health interventions and support should be guided by the experience of those who live with a mental illness.

A: Areas in the draft report which require attention

There are some areas in the draft report which need strengthening.

- The barriers for persons with mental illness in accessing the *Disability Support Pension* and the *National Disability Insurance Scheme* and the punishing inadequacy of *NewStart* funding for the most disadvantaged in our community. (See the opinion piece from *Pearls and Irritations* in the attachment.)

- The report refers occasionally to alcohol and substance use problems, and related problems, without acknowledging how deeply embedded these problems are in the seriously mentally ill. (See data in *People living with psychotic illness in 2010: The second Australian national survey of psychosis*, reference 33.)

- The report deals inadequately with the role of alcohol and substance use in causing mental illness and the large overlap between alcohol and substance use disorders

(and addiction) with mental illnesses (dual diagnosis). And the difficulties in getting help and support for people with these co-occurring problems. Co-occurring mental and substance use disorders create severe problems for families.

- The high rates of mental disorders in the homeless and borderline homeless population. Homeless families are commonly headed by a woman who is often mentally ill or suffering from alcohol and substance use problems and/or disorders. This is an important issue, as the children suffer in their development and education foreshadowing a life trajectory of mental incapacity and related problems.

B: What needs to be done for homeless and mentally ill homeless people

Helping homeless people is not a one-way street as each of us can be inspired by people we meet on the streets and the way they survive. They are honest; there is nothing to hide. Their thinking and ideas are refreshing. More than that, it is an existential experience, which teaches each of us about what is important in the human condition and the essence of humanity and about ourselves.

Objectives in the care of homeless people

We so often hear of the 'revolving door syndrome' and a sense of hopelessness and defeat. Therefore, it is important to set reasonable objectives for the health and social problems of homeless people.

1. First, housing. The objective here should be to provide secure home-like places and personal space for disadvantaged people. As a first step, for the long-term homeless, this should mean an environment of privacy, personal space and access to the usual amenities of living.

2. Second, primary health and social care.

    - Access to primary care services in a non-alien environment in which the homeless person is accepted as a citizen and treated with dignity.
    - A coordinated (multifaceted) response to multiple (compounding) needs.
    - Acceptance that the health and related problems are part of a social/health predicament rather than a problem of a single diagnosis.
    - Advocacy for the person to other services to which they are entitled as citizens. In other words, providing links that will actually work in transition to relevant services they may need – the "chain of care".
    - Realistic goals for re-housing with linked in support services.

Problems for homeless people in the current Sydney environment

The situation in inner Sydney appears to be deteriorating as result of –

    - Reduced availability of boarding house places.
    - Decreasing beds and management options for intoxicated persons, "sobering up" shelters/" Proclaimed Places"
    - Changes in mental health services and the demography of mental illness.
    - Changes in the patterns of drug and alcohol use.

- Tightening of access to welfare payments.
- The orientation of Non-Government Organisations to targeted, outcome orientated programs which has meant declining access to services for the most complicated and needful cases. These persons are more likely to end up on the street. In my opinion, these changes have followed the contractual funding arrangements certain NGOs have made with Commonwealth Government.
- Closure either permanently or temporarily of some major inner-city shelters especially for women and children.
- Increasing rates of imprisonment, with consequential "criminalisation" of individuals.

The potential for innovation

Examples of innovation which should be supported by government and community.

- Modern homelike accommodation, this can be seen in some European centres, but is rarely achieved in Australia.
- The availability of two 'drop in' primary health care services for the homeless in Sydney at the Matthew Talbot Hostel, Woolloomooloo and at the Exodus Foundation in Ashfield.
- Nurse practitioners providing treatment and care within the homeless environment, for example at the Matthew Talbot Hostel medical clinic, Woolloomooloo, Sydney.
- GP divisions taking up the health care of homeless people (Sydney, Melbourne and some rural areas)
- Networks of service provision: see, for example, the network of mental health, health and agency services in inner Sydney through the Sydney Local Health District.
- Creating pathways to access entitlements – for example, out-posting of housing and welfare officers from government agencies to the services used by homeless people.
- Alternatives to hospitals, for example, St. Vincent's Hospitals in Melbourne and Sydney have created alternative accommodation for some homeless people needing a period of on-going care.
- Acceptance and "empowering" programs, for example, the course in *Liberal Arts* run through the *Australian Catholic University* and collaborating organisations known as the *Clemente Australia Program*.
- New approaches to living and public housing and support to for the homeless mentally ill.
- "Compassionate" care in hospital *emergency departments* can improve the health outcomes for marginalised people.[1]

Recommendations:

1. Provide funding for primary health care clinics/services for homeless people in cooperation with divisions of General practice and/or state government departments of health.
2. Provision of funding for outreach psychiatric and drug and alcohol services to engage with homeless people and, to support non-government agencies and Primary Health Networks.
3. Greater access to the full range of mental health services including (as referred to above) outreach mental health services, outpatient treatment services and in-patient admission and rehabilitation.
4. Primary health care services for the homeless should be linked with, and work in collaboration, with a range of other services to support homeless people. For example, outreach services for income support, learning programs, and a range of support programs for conditions such as gambling, alcohol and other drug problems.

5. Special services and provisions for services to homeless young people and homeless women.
6. Greater access to the full range of alcohol and other drug services, notably – places of refuge and asylum such as "sobering up shelters" or "Proclaimed Places", detoxification places and services, and rehabilitation in group programs and especially pharmacotherapy.
7. Greater access to supported accommodation for those with persisting mental health disorders and alcohol and other drug problems and related medical conditions and disabilities.
8. Strong emphasis in funding programs for continuing care (the 'chain of care') and follow-up services in all human services provided for homeless people.
9. Special access programs for the mentally ill with addiction problems to services tailored for transient populations of homeless people.[2]
10. Greater recognition of the special skills of nurses and medical practitioners who work in these difficult environments.
11. Greater flexibility in funding for Medicare subsidised services to encompass the special characteristics of this transient and disadvantaged population.
12. Consideration be given to special funding arrangements for homeless services as current Medicare reimbursements do not cover the costs of prolonged consultations necessary for people with complex disorders. Furthermore, homeless people have often lost their Medicare cards and other means of personal identity.
13. Pharmaceutical Benefits arrangements especially for the mentally ill who are homeless (high prevalence, high morbidity rates and severity, greater complexity, high treatment needs, casual and intermittent contact). Special concessions for this group are needed
14. Greater flexibility in approval for Pharmaceutical Benefits for the special needs of this population with its high prevalence of mental illness and other chronic conditions.

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C: A commentary on health and related issues in homeless people with special reference to mental illness

The homeless lack security of tenure of accommodation, a safe and adequate physical environment, supportive social relationships and compatibility and the ability to pay for accommodation. Their fundamental losses are of privacy and personal space, loss of control and autonomy, and, loss of dignity and identity.

> (I had a patient – a mentally ill homeless woman with anxiety, panic disorder and depression from sexual abuse in childhood, including by priests. She enrolled in an arts course at the University of New South Wales as this enabled three things: the student ID card gave her an identity, she had access to a locker, and she could have a shower.)

Homeless people have rights

The UN Declaration of Human Rights (Article 11) states – parties *"recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions."* [3]

The right to adequate housing derives from the right to an adequate standard of living and from economic, social and cultural rights.

The UN Committee on Economic, Social and Culture Rights said that the right to housing is not a narrow or restrictive interpretation of shelter as merely being a roof over one's head or of shelter being seen exclusively as a commodity; rather it is the right to live in security, peace and dignity. [4]

The Commission on Human Settlements and the Global Strategy for Shelter states: "*Adequate shelter means ... adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities – all at a reasonable cost."* [5]

On becoming homeless

On becoming homeless a person soon becomes fatalistic – accepting the circumstances, adopting the *habitus* of a 'homeless person', sinking into obscurity and helplessness, too ashamed to make contact with family and past friends; some give up on life.

In England the front-line workers speak of the 'three-week rule" described in *Still dying for a home.* [12] If an alternative intervention is not available in the early period an inexorable downhill course will ensue. Staff in youth services in Kings Cross, Sydney, say that if contact is not made within 24 hours of a young person arriving in the Cross, the young person's course will be downhill from then on.

Who are the homeless?

The long-term homeless are mainly adult and elderly men; women form a higher proportion of the younger age groups. There are people of all age groups and backgrounds – young people, poets and writers such as George Orwell. [6]

I have observed in Sydney more families and children and more groups from other ethnic and cultural backgrounds. Groups such as Aboriginal people, Pacific Islanders, people from rural areas, the poorly educated and the illiterate, and the physically and mentally ill are over-represented. Homeless women are more evident in the inner Sydney in recent years.

Many point to the increasing number of young people. A relatively higher proportion of young homeless people have problems of mental illness and alcohol and substance use problems.

The risk of homelessness

The problem of homelessness is often attributed to an individual's failings. This is especially the case when "alcoholism" and the "derelict alcoholic" is the public face of homelessness.

The Royal College of Physicians has said,

> *"there is growing support for the argument that the health problems associated with homelessness are primarily <u>an indication of the failure of housing policies</u>. To date, effort has been focused on improving access to health and social care, but such special schemes can only have a limited effect on the long-term health profile of homeless people if the root cause of their ill health, homelessness, persists."[7]*

Those at higher risk of homelessness are individuals with mental illnesses, inadequate social skills, substance use problems, communication problems – hearing, sight and speech, disabling conditions and chronic illnesses, and childhood disadvantage leading to difficulties in close relationships and intimacy and a failure to establish meaningful family and adult relationships in later life.

In my experience, there is often a history of childhood neglect, childhood sexual and/or physical and psychological abuse. Very often the homeless person's childhood has been in an institution or foster home.

While there are these personal characteristics which underpin a person's vulnerability it is the social and structural factors which need to be acted on. These include – lack of available and affordable housing/accommodation, social inequalities and poverty, unemployment, access to appropriate and relevant education, inadequate family support, targeted social welfare policies which restrict access to income support through tight (and unreasonable) eligibility criteria and a punitive rather than an enabling facilitatory approach to the unemployed and disabled.

Add to this, the lack of community-based health services and rehabilitation for the groups with the highest burden of chronic disabling mental and physical conditions.

Why are mental disorders so prevalent in the homeless population?

As socio-economic inequality increases the seriously mentally ill and the homeless are differentially severely affected.[8][9] Much contemporary social policy reflects a retreat from welfare as services are 'targeted' and eligibility criteria are tightened and concurrently there is a scarcity of low-cost housing; all act to squeeze the most vulnerable into the streets and night shelters. [12][10]

It is as if the mentally ill are victims of a pincer movement squeezing them out of accommodation settings. They are rarely admitted for asylum but still need services and support in the community, but these services are inadequate for the needs. It is commonly

thought that the high rate of mental illness among the homeless is due to the closure of psychiatric beds; but de-institutionalisation, as a deliberate policy, has been occurring over many decades.[11] The prisons 'accommodate' a disproportionate number of inmates with complex mental and substance use problems.

A remarkable statistic is that 3.3% of New York's population spent some time in homeless centres between 1988 and 1993.[12] Men with schizophrenia and substance abuse disorders tend to be concentrated amongst the homeless population in the inner city, whereas seriously mentally ill women are more widely distributed across suburban areas.[13]

Mental illness and substance use disorders in the homeless

A high proportion of homeless people have been shown to have a mental impairment.[14] [15] [16]

At Matthew Talbot Hostel in 1993, 41% of the men had mild to severe cognitive impairment.[17] The doctors and nurses working in the clinic estimated 25% had a mental illness.[18] My personal opinion, is that at least 50% of the men and women seen at clinics for the homeless (Matthew Talbot Hostel and Exodus Foundation) have serious problems of the mind or brain.

The staff of inner-city agencies in Sydney in 1997 estimated that among homeless people: 25% had cognitive impairment, 20-25% had psychotic disorders, a high level of major depressive and anxiety symptoms in the past 12 months, and, many had more than one disorder.[19]

The *Research Group in Mental Health and Homelessness* described the mental health and disabilities of inner Sydney homeless people in 1998.

> *"Homeless people are clearly one of the most deprived groups in the community. Three in four have a mental disorder. Co-occurring disorders are common. Many have chronic physical disorders. Almost all have experienced at least one episode of extreme trauma in their life. On most measures of morbidity, the young are at least as impaired as the older person."*

They found that 75% of the homeless people had at least one mental disorder, 23% of men and 46% of women had schizophrenia, 49% of men and 15% of women had an alcohol use disorder, 36% had a drug use disorder, 33% had a mood disorder, 26% an anxiety disorder and 10% cognitive impairment. Also, 93% reported at least one experience of extreme trauma in their life (for women this was 100%) and one in two women and one in ten men reported they had been raped. Every second person had at least one chronic physical illness and 9% of people reported being seropositive for Hepatitis B or C.[20]

The *National Drug and Alcohol Research Centre* at the University of New South Wales has continued to study mental health and alcohol and drug problems among the homeless; their work and that of others continues to show similar findings.

Living with psychosis

The study *People Living with Psychotic Illness 2010* showed high rates of chronic health and social problems. General practitioners reported high levels of poverty and social problems in this group. There were high rates of obesity, heart and respiratory disease and chronic pain. They had frequent contact with the general health services and one in three had been

recently admitted to a psychiatric facility and one in five were on a Community Treatment Order. Most of these people were unemployed and on welfare support and many were on lists for public housing and others were homeless.[21]

Alcohol and substance use and misuse

Substance use is a major part of the work of the health and welfare agencies involved with the homeless. Death rates are highest in this group.[11]

The importance of alcohol dependence as the primary problem is often exaggerated and masks the personal and social pathology, such as chronic pain, physical and mental illness and disability in homeless people. Alcohol and drug use can be seen to be the poor person's analgesic when access to treatment is difficult, if not impossible.

A UK study of rough sleepers described alcohol misuse affecting one third to a half of rough sleepers. [11] One in five of the men at the Matthew Talbot Hostel in 1974 said alcohol was the cause of their present situation. [7]

Common diseases are common

A study of rough sleepers in the UK found that they suffered from the same conditions as the general population, but more often and more severely. [22] In New York City the rates of common diseases in the homeless were two to fourteen times higher than in a matched sample of the urban population in a National Ambulatory Medical Care Survey.[23]

Records from a Massachusetts' shelter in 2014 showed: 82% were physically ill, 68% had schizophrenia-spectrum disorders, 35% affective disorders, 45% substance use disorders, 37% had co-occurring psychiatric and substance use disorders and physical illness, and, 76% had been involved in the criminal justice system.

There are high rates of illness and delayed development in children of homeless families and their mothers have higher rates of mental illness.[24]

The main groups of diseases from which the homeless suffer can be characterized as diseases of destitution. These patterns are seen in similar groups wherever they are located.

Death rates

Life is short for the homeless and the seriously mentally ill.

A 10 year follow up of 708 homeless people in Sydney, 506 who had schizophrenia, showed 83 had died. This is a death rate four times higher than the general population. [25]

The mortality of homeless people in Philadelphia was four times that of the general population.[26] Among rough sleepers in London, Bristol and Manchester, between 1995 and 1996, death rates were 3.6 to 5.6 times greater than the general population, with an average life expectancy of 42 years. [27]

These patterns are very similar to the mortality experience of people diagnosed with a mental illness. A Western Australian study, in 2001, of the users of mental health services in Western Australia (approximately 8 per cent of the population) showed the high rates of physical illness. The reported death rates in this group were 2.5 times higher than the general

population and the group accounted for half the state's suicides. The excess deaths were due mainly to heart disease. The suicide rate was increased twofold and there were higher rates of infectious disease. Hepatitis C and HIV and a range of other physical conditions were more common than in the general population. (Coglan et al., 2001)$$$$$

Changing epidemiology

Forty years ago, studies of the homeless, such as Alan Jordan's work in Melbourne of several hundred homeless men, referred to "alcoholism", mental asylums, brain damage and prisons. [28]

During the same period, at the Matthew Talbot Hostel in Sydney, the *First Aid cabinet* contained three medicines – Dilantin (phenytoin) for fits, thiamine (Vitamin B1) for Wernicke's encephalopathy caused by high alcohol intake, and aspirin for pain. Now the medicine cabinet is a veritable "pharmacy store" containing psychotropic drugs, antidepressants, antibiotics and anti-virals and other medicines – a graphic picture of how the epidemiology of disease and disability has changed in the inner-city homeless population.

The health risks in the homeless population are continually changing. For example, a study in Melbourne in 1970s made no reference to HIV/AIDS, hepatitis B and C, no reference to drug abuse and passing mention only of mental illnesses.[29] Yet these are the major problems of today. At the Exodus Foundation Medical Clinic in Ashfield we run screening programs for hepatitis C and prescribe treatment when indicated.

Exposure to environmental and health risks

In the shelters of the 70s and 80s the homeless person would get no more than a crowded bunk bed and an open wire basket for their belongings. No privacy; everything was visible. Living conditions in the shelters have improved since then but still need to provide more personal space and autonomy.

Apart from the health problems that increase a person's vulnerability, there are specific social determinants operating in the environments of the homeless which expose them to increased health risks:

- Overcrowding which leads to cross infection, exposure to psychological stresses and violence.
- Lack of privacy which exposes the person to humiliation and loss of esteem, creating psychological distress, causing the person to further marginalised and labelled as "mad" or an "alcoholic".
- Contamination and lack of hygiene exposes the person to skin infections and infestations (body lice and scabies etc.) and bacterial and fungal infections of the feet.
- Violence and theft – being "mugged", fearful of contact with others, loss of possessions and identity e.g. Medicare cards, birth certificates etc.

Compounding needs

Having multiple disorders is typical of many homeless people and creates complex needs; needs which then interact and compound.

Not only is this a problem caused by conditions from which the person suffers, but it is a problem made worse by the specialisation of services.

Specialist services have generally developed around institutions, facilities and technologies. When a person with multiple problems presents for treatment, the questions become: Who should be admitted to a psychiatric hospital, mental health unit, or a hospital bed? Who should be admitted to a residential rehabilitation unit or to a detoxification centre? The criteria for admission tend to favour 'clean skins' rather than those with complexity; services and facilities have usually been designed around a culture of one problem.

Diagnostic categories can amplify the difficulties for people with overlapping conditions.

Diseases are intrinsic conditions, within the person, whereas the needs of the homeless mentally ill person are to do with disablement and social predicaments. There are also definitional issues, as the symptoms and behaviours by which mental illnesses and addictions are diagnosed are nonspecific and overlap between diagnostic groups.

In the face of such complexity and ambiguity, a diagnostic label is not as relevant as the objectives and outcomes of any proposed intervention.

Whatever the cause of a psychotic episode, or depression, or suicide risk, the prime decision is to manage the condition safely.

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Brief Curriculum Vitae:

Ian Webster is a physician and Emeritus Professor of Public Health and Community Medicine of the University of New South Wales. He was Foundation Professor and Head of the School of Community Medicine at UNSW.

He has held senior appointments in the Faculty of Medicine, University of New South Wales, including Clinical Dean of the South Western Sydney Clinical School, and had appointments at Monash, Sheffield and Sydney Universities.

He was Chair of the Australian Suicide Prevention Advisory Council from 1998 to 2015 and is presently Chair of the Advisory Committee of the Centre for Primary Health Care and Equity, University of New South Wales. He was Foundation Chair of the Alcohol Education and Rehabilitation Foundation (AERF) now known as the Foundation for Alcohol Research and Education (FARE) and he was appointed National Mental Health Commissioner from 2012 to 2014. He chaired the NSW Ministerial Advisory Group on Alcohol and Drugs from 1999 to 2013 and was a member of an expert advisory committee to the NSW Law Reform Commission from 2011 to 2013.

At the time of the Hawke Government, in 1985, he chaired the national consultation, "Drugs in Australia: National Action", prior to the establishment of the National Campaign Against Drugs later to become the National Drug Strategy. He was interim Director of the National Drug and Alcohol Research Centre in 1986-87. In 1992 he chaired the review of the National Campaign Against Drugs for the Commonwealth Government, "No Quick Fix."

He has chaired several Commonwealth and State Government inquiries and reviews in disability, health, mental health and alcohol and other drug problems.

He worked as a specialist physician in Whyalla, South Australia, in public hospitals in the UK and Australia and from 2003 to 2017 in the Shoalhaven Area of NSW.

For more than forty years he has been a physician to the homeless at the Matthew Talbot Hostel, Woolloomooloo and the Exodus Foundation, Ashfield, Sydney. He was President of the Governing Council of the Ted Noffs Foundation and is now a Patron of the Foundation.

His research and publications have been in medicine, community health, alcohol and other drug problems, mental health, homelessness and social issues.

In June 1995 he was appointed as an Officer in the Order of Australia and in 2009 received the Prime Minister's Award for outstanding work in the field of drugs and alcohol.

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