Micah Projects

Submission to the Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders

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Introduction

Micah Projects is a not-for-profit organisation committed to providing services and opportunities in the community to create justice and respond to injustice. Micah Projects provides a range of support and advocacy services to individuals and families according to their needs and capacity. These include supports and services for: housing and homelessness, domestic and family violence, early childhood and parenting, integrated healthcare, social inclusion, and people who experienced abuse as children in institutional or out of home care settings.

Micah Projects strategic plan highlights the organisation's commitment to providing integrated services to reduce the silos that participants are required to negotiate access to seek the range of services that they require to have a quality of life. In 2021 Micah Projects provided services to 11,081 people across Brisbane in 2020-2021.

In providing our services we have obtained insight into the diversity of experiences and mental health and wellbeing needs of individuals and families across a lifespan. In addition, we have unique insights into the existing gaps in services. Throughout the transitions to adulthood, the themes that emerge

include childhood and intergenerational trauma, mental illness across all age groups, separation from family due to child protection, poverty, and social exclusion. Alongside these is the growing divide created by housing affordability, unemployment, homelessness, access to appropriate healthcare and services and, for many, the correctional and justice systems.

For over 15 years Micah Projects provided a range of psychosocial support services prioritising people who are homeless or at risk of homelessness. These services changed over time with the implementation of NDIS and the loss of Queensland Government block-funded programs. People who may not be eligible for NDIS are now experiencing further isolation and poor quality of life that arises without access to appropriate support and services.

The needs of this group are complex. We support a significant number of people who have long standing and severe mental illness across many of our programs. Participants present with suicidal ideation, and co-occurring drug and alcohol use. These are often in combination with other support needs such as disability, acquired brain injury and significant histories of institutional care as children and as adults. Many participants report ongoing experiences of trauma. Nine out of 10 (89%) of people accessing our homelessness service have a mental illness with almost two thirds (61%) who have a dual diagnosis. Half (52%) have a physical health condition in addition to mental health and substance use issues.

Micah Projects is the regional domestic and family violence service (Brisbane Domestic Violence Service). We see significant unmet need for mental health services arising from the trauma of violence against women. An added complexity and contributing risk is their childhood trauma and significant ongoing trauma. Sometimes this is intergenerational due to the removal of their children into child safety services. Our Children and Families Hub at Hawthorne supports children in early childhood to access a safe and educational space whilst experiencing domestic violence, homelessness, or other family adversity such as mental health concerns.

Micah Projects provides services to adults who, as children, were in out of home care and experienced abuse in institutional settings. Micah Projects has supported survivors for over 20 years to have their experiences of abuse and neglect and the life-long impact of childhood abuse on mental health and wellbeing recognised. Micah Projects provides early intervention services to young pregnant and parenting women in Brisbane and Caboolture and services to children under 5 years at the Hawthorne Children and Families Hub.

Our submission is based on our experience of the gaps and barriers we have, and continue to, encounter in providing assistance to the people we support to access the mental health services they need. In the sections below we address the Mental Health Select Committee Inquiry Terms of Reference.

A. The economic and societal impact of mental illness in Queensland

The economic and social impact of mental illness is well documented. Our experience of supporting people with multiple health and social needs has identified that the issue of where people live, who they live with, and how they are supported is fundamental to addressing mental health needs.

Queensland Government investment will continue to increase for acute services, crisis intervention, and law and order costs.

A holistic system that invests across the lifespan from infants to older adults in a balanced way is fundamental to addressing these needs. Investing in mainstream, universal services plus targeted services for specific populations is needed to avoid the ongoing escalation of mental health needs to a crisis.

Funding and program development that looks at mental health through a silo lens, and not one of the social determinants of health and wellbeing, inclusive of recognition of basic human rights of each person, will continue to create significant demand for acute services. A collaborative and multi-disciplinary approach is necessary to improve the quality of life of individuals and families. Enhancing clinical care through more holistic and integrated trauma-informed systems of care will also provide economic benefit across government. This requires a system that enables the right care at the right time, to reduce the compounding and escalation of unmet needs, trauma, and exposure to harm that occurs when individuals' reality is ignored or minimised.

Currently the over-representation of people living with a mental illness amongst the homelessness is unacceptably high. People are cycling between homelessness, hospitals, criminal justice system and inadequate housing. When housing is accessed without integrated support, the isolation alongside unmanaged mental illness leads to people returning to homelessness. Within this population Aboriginal and Torres Strait Islander people are over-represented ranging between 25% and 40% of people experiencing homelessness.

People with mental health concerns are often isolated, unwell, and poorly supported in the community. Their options for care end with the acute and tertiary care system and often the wrong systems such as corrections. This can create a spiral of adversity that increases the risk of homelessness, or imprisonment, long term unemployment and isolation, despair and suicidality. People with mental health difficulties are at risk of premature death due to suicide, overdose, or unmanaged chronic illness. People with mental health difficulties are also often disconnected from culture, family, and both informal and formal support systems. Heath and Social inequity continue to grow.

The mental health of individuals is connected to the health and wellbeing of communities. Without the diversity and accessibility of mental health programs, people's behaviour and lifestyle can spiral into one of harm to self and others, and disconnection from services, resources, and entitlements. Every system of government – be that child protection, corrections, justice, courts, domestic and family violence, drug and alcohol services, sexual assault, police, hospitals, housing – needs to work together with community not-for-profit organisations to improve the mental health and wellbeing of Queenslanders from prenatal to infant care, young people, families, single adults of all ages, inclusive of gender identities, disability, culture, and sexuality.

As a whole system, government working in partnership with community services, we need to strive to reduce the adversity that people living with a mental illness are left to slide into. People living with mental illness are currently being penalised due to a lack of understanding by the systems of care that should be supporting them of the impacts of trauma and mental illness on the choices and behaviour

of individuals. Many are left without options to seek support, information, or appropriate services that recognise the link between behaviour and trauma.

The underlying issues of childhood trauma, intergeneration trauma from child abuse in families, and in institutional care, government policies and practices have all been spelt out in so many Inquiries and Royal Commissions such as Stolen Generations, Forgotten Australians, and the Institutional Response to Child Sexual Abuse. Whilst some recommendations have been dealt with, the ongoing needs around accessibility of mental health services have rarely been implemented. To do so requires significant enhancement of investment and the provision for a greater range of services to support people redressing the impacts. Additionally, educating the workforce and organisations about the need for cultural change in how our systems of care operate remains neglected. Fundamental to this change is working in partnership with people living the experiences and impacts of mental illness and trauma.

Whilst some progress has been made, it has not gone far enough. Individuals, their families, and advocates, need to be involved in the decisions which impact on them. They require access to the fundamental resources of housing, income, family support services, therapeutic services, healthcare, and participation in the community in line with their ability to do so. All of which often require assistance to navigate the system.

To achieve this, a system needs to be deeply grounded in partnerships and a collaborative approach to planning, policy development, and service implementation and evaluation. The emphasis needs to be on the needs of the person. Due to lack of resources, individuals may be screened out of the service system rather than screened into a system which provides a diverse range of options especially around the intersection of drug and alcohol, mental illness, and trauma. We constantly see people with co-occurring addiction unable to access appropriate mental health and wellbeing services.

B. The current needs of and impacts on the mental health service system in Queensland

The mental health system in Queensland is under-resourced and this requires immediate and urgent attention. In addressing this underfunding, it is important that a response is not only to increase funding to the hospital system. As a community organisation committed to improving the lives of people living with a mental illness and the associated consequences of poverty, homelessness, and criminalisation, not only is financial investment required but so too is a shift from siloed funding models to program design with an emphasis on trauma informed and sensitive interventions.

The existing plan for Queensland's mental health, and alcohol and other drug services (Connecting Care to Recovery 2016-2021; Queensland Government, 2016) outlines a system which includes community treatment, community support, and bed-based services in hospitals and community settings. However, resource constraints mean that available resources end up being narrowly focused on clinical, and often pharmaceutical, treatments, and crisis responses.

Access to other important services and supports is insufficient. For example, the current number of outreach drug and alcohol workers for the Brisbane region is inadequate. Adequately resourced psychological therapies, drug and alcohol counselling and case management, and psychosocial

supports are required to enable people with mental illness to enjoy secure housing, meaningful relationships, and meaningful engagement in work, study, creative arts, or other purposeful activity. Queensland needs to enhance the role of partnerships with community-based organisations that are enabled to facilitate integrated responses, across the range and scope of interventions from early intervention, crisis/acute care, treatment, to therapeutic and psychosocial support in line with the specific and diverse needs of different population groups. A shift is required from the separation of roles around clinical care (hospital and public sector) and psychosocial care (community organisations) to one that invests across government and non-government initiatives to a broad range of population groups that can provide integrated care.

Consideration should also be given to provision of some women's only mental health units given the high rates of trauma arising from the experiences of violence against women as children, young women, and adults. A specific trauma-informed approach and understanding of complex trauma would be of great value.

While the NDIS offers psychosocial supports for those who are eligible and able to successfully access the Scheme, many people miss out. This may be due to the need to evidence a permanent disability which can be challenging for those with mental illness. Or it may be due to the lack of advocates and supporters to assist in navigating the system.

Recent research has identified the heavy administrative burden placed on people trying to access services such as the NDIS, and has demonstrated that, for people who have complex lives, the application processes may constrain their capacity to demonstrate their needs and hence their access to supports (Brown et al., 2021).

Respecting human rights in inpatient care

The current practice of having every inpatient mental health unit in Queensland locked is a breach of human rights. More specifically, it is inconsistent with rights protected under the Human Rights Act 2019 (Qld): the right to freedom of movement (section 19) and the right to liberty and security of the person (section 29). As an organisation committed to human rights, Micah Projects opposes this practice and recommends that it cease immediately.
We accept that there may be circumstances in which locked doors will be required in inpatient mental health services. We recommend that this is only implemented in the following circumstances:

a. An assessment of the impact on human rights is undertaken;
b. The assessment demonstrates that the limitation of human rights created by a locked door is justified and proportionate and that less restrictive alternatives have been considered; and
c. The lock is implemented for a set period with an identified review date.

The Queensland Human Rights Commission provides a guide for public entities (see Queensland Human Rights Commission, 2021) which includes a detailed process for assessing the human rights impact of a policy, decision, or practice. The Queensland Government also provides resources for government services (Queensland Government, 2021).

C. Opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including alcohol and other drugs and suicide prevention):

a. across the care continuum from prevention, crisis response, harm reduction, treatment and recovery.

Micah Projects proposes five models to support better outcomes for people with mental illness across the continuum of prevention, crisis response, harm reduction, treatment, and recovery:

1. Prevention and Early Intervention: Children and Families Hub and outreach services – for early intervention and prevention of poor mental health outcomes in early childhood;

2. Integrated housing access, support, and healthcare in the form of crisis, harm reduction, treatment, and recovery of vulnerable people with mental illness, addiction, or currently homeless, in boarding houses, or exiting prisons and hospitals living in the community;

3. Social inclusion – recovery support and connections for people with peer support, meaningful activities, training, employment, and professional clinical support.

4. Mobile multidisciplinary teams providing integrated in-home, healthcare, housing and social support across the systems of care that is appropriate to individuals and or families and housing type:

    a) People living with the impacts on mental health and addiction who are homeless, transitioning to housing to sustain tenancy to support harm reduction, and management of healthcare to prevent return to homelessness;
    b) People with severe mental illness and addictions living in social and community housing, private rental, or leaving corrections;
    c) People who have presented to hospitals for suicidal ideation to provide follow up support and connection with services, and resources in the community;
    d) Child and Family mental health and early childhood family support teams.

5. Supportive housing – the well-evidenced Housing First approach as part of a treatment and recovery model for vulnerable people with severe and persistent mental illness and co-occurring multiple chronic medical conditions.

Prevention: Child and Family Mental Health

There is growing awareness, research, and evidence about the importance of investing in supporting the early years of a child development. This not only ensures children, with the support from their parents and caregivers, can reach their developmental milestones, but also the importance of the early years on life outcomes as young people, adults, and parents. The prevalence of mental health issues impacting on women in pregnancy, and on children from perinatal to 5 years needs to be considered in creating a mental health system for all. This not only supports people in the present, but also prevents the long-term impacts over time.

Significant evidence exists showing that the exposure of children to adverse experiences in their early years has the potential to create vulnerability to compromised mental and physical health. Brain science provides the evidence that critical connections are shaped by our earliest relationships, environments, and experiences. It is the arrangement and strength of these initial connections that allow the development of increasingly intricate and interrelated systems of the brain (Royal Foundation Centre for Early Childhood, 2021).

The experience of Micah Projects highlights that some children and families are at greater risk of experiencing adverse events. Higher risk includes living in poverty, homelessness, children exposure to domestic and family violence, children with parents in prison, and the experiences of young pregnant and parenting women. Over the past 7 months alone, 466 children under the age of 5 years and their parents have presented to Micah Projects seeking services across homeless, domestic violence, early intervention, and supportive housing services.

The intergenerational issues of the Stolen Generation, as well as adults who were in care of child protection services as children and those who experienced forced adoptions, have presented to Inquiries the inadequacy of response, services, and understanding of service systems on the impacts of their childhood trauma on their lives as parents today and associated impacts on parenting and children.

The Family Inclusion Network, which supports parents who have children in the child protection system, advocate strongly that they themselves are not offered the services they require to support them with their own health and the health, wellbeing, and development of their children prior to child protection intervention.

Many parents have attempted to access support and healthcare, however they report that eligibility requirements, waiting lists, and absence of family support and children's services are constant barriers which put them at risk of removal of their children to the child protection system. Whilst parents accept that sometimes intervention may be necessary, many believe that an intervention focussed on supporting them as parents to care for their children, to have access to services, housing, and healthcare, may avoid the removal of their child.

Such an approach would assist in the prevention of trauma and psychological distress on both parent and child that comes with separation, loss, and grief. This is evident by the increasing demand on child protection services in the absence early intervention services. The poor life outcomes for adults who were in the child protection system are well documented.

Micah Projects advocates that a greater link between early childhood and maternity services for women with notifications for their unborn child would have positive outcomes for children, parents, and the child protection system by supporting the health and wellbeing of women and children through pregnancy, childbirth, and early childhood

Opportunities to invest in improving the outcomes for children and families

In response to the rising number of preschool children presenting through homelessness and domestic violence services and building on the early intervention work with young pregnant and

parenting women, Micah Projects has been working towards building our capacity to support women through pregnancy and in their parenting in their early years.

Micah Projects has been guided by the evidence of the inclusion of early childhood programs through implementation of Parents as Teachers in our YMYW program in Brisbane and Caboolture. Both programs are targeted responses with young pregnant and parenting women (under 20 years of age Caboolture, 25 years in Brisbane) and strong partnerships with antenatal and post-natal care. This is achieved by working with Mater Mothers in Brisbane and Metro North Caboolture Hospital Maternity. These programs need to be expanded to meet the demand for services and to be able to provide services for a longer period when necessary. Critical to their success is that they provide integrated responses to the needs of parents around their housing, health, social support needs, and early years education to support parents understand and care for their children's developmental needs and milestones. Working in a two generational framework with both parent and child improves the mental health and access to services and resources for all members of the families.

In relation to preschool children who are presenting with parents over 25 years, Micah Projects has been developing the Children and Families Hub which includes the provision of childcare whilst parents, mostly mothers, are addressing homelessness, domestic violence, and related health issues.

Children and Families Hub: More investment needed

Family crisis and trauma, such as domestic and family violence, homelessness, mental illness, addictions, has a significant impact on all members of the family. While support for parents is crucial, dedicated support focused on the needs of children is also vital. Program funding to support children in the context of their family is currently a gap in the system. It is also unclear which department is the lead agency for the development of partnerships and who has the role of advocacy for investment in supporting perinatal and early childhood outcomes.

Early childhood is a critical developmental period, laying the foundations for secure relationships and emotional regulation, cognitive functioning and learning, communication, and physical development (Queensland Government, 2020). Adversity and trauma can disrupt this development and targeted efforts are required to mitigate the effects of such experiences. Evidence shows that a specialised, integrated, 'nurturing care' approach is most impactful in supporting early childhood development in the face of adverse experiences (Moore, 2021).

Elements of this approach include:

- Safe, educationally rich, and developmentally appropriate spaces and programs including occasional childcare;
- Trauma-sensitive environments for children;
- A two generational approach educating parents about childhood development whilst supporting parents (e.g., the Parents as Teachers approach);
- Group based programs and peer advocate roles which strengthen community and peer connections. Research shows that there are often no community spaces where children and parents can meet and connect (Moore, 2021);
- An integrated model which provides, or links to, assertive outreach, housing, health and wellbeing. And legal services for mothers and children.

Micah Projects recommends consideration be given to further investment into evidence-based models embedded in community organisations and programs such as Young Mothers for Young Women. Programs such as these provide a cohesive package of support and educational service through home visiting, group connections, family assessments and screening for early childhood developmental milestones, partnership with maternity care, with integrated collaboration and networks amongst services providers more widely.

Micah Projects currently operates the Wellspring Children and Families Hub in Hawthorne that puts this approach into practice. The Hub model is based on the ARACY NEST framework (Goodhue et al., 2021) and provides highly valued services including an occasional childcare program. The Hub has been unable as yet to secure recurrent funding despite pilots and evaluation demonstrating the need and effectiveness of the model.

The model of the Hub is to create collaboration between services providing case management to parents, mostly women, and supporting preschool children to access a safe, nurturing, and educational environment during a time of crisis for the family. This includes workers engaged with women and children in homelessness programs, domestic violence refuges and regional services, supporting families in child protection system and young pregnant and parenting women.

In order to care for children without the presence of the parent, Micah Projects is a registered Early Childhood provider in an accredited setting for occasional care. This provides an integrated response that brings together family support, specialist domestic violence services, and child protection, to support the wellbeing of both the mother and the child during a time of significant psychological stress.

The occasional childcare staff are able to assist parents identify developmental issues, refer children to screening for developmental support as part of ensuring school readiness, and to provide a steppingstone for parents to gain confidence to use mainstream childcare services on an ongoing basis.

The work of the Queensland Centre for Perinatal and Infant Mental Health (Queensland Health) needs to be expanded. To back up the work of the Centre, investment in community-based partnerships and services need to be funded to facilitate a targeted response to the diversity of population groups such as the examples that Micah Projects has outlined.

International, national, and local evidence clearly identifies that early childhood interventions and services that are both universal and targeted in their approaches are critical however lack funding. These programs have the potential to make a difference in the lives of children and families.

We need to not just focus on the response to crisis and illness, but also focus on building the protective factors with parents and their children if we want to prevent the prevalence of mental health issues on children and families now and into the future. Investing in the early years, by investing in parents, and access to services will prevent homelessness, domestic violence, long-term mental illness, and child protection interventions.

We need to invest to build communities and families to create a more healthy and nurturing society rather than leave people in communities and families that struggle living without a home, living with violence, and isolated from informal and formal support networks. There is ample evidence on why this should be done and how.

In Queensland, we have years of neglect in investing in early intervention programs, across government. This needs to be addressed so that a more balanced approach can be achieved. However, the investment needs to be a scale that will demonstrate a difference across Queensland (see Attachment 1).

In 2020, the Family Inclusion Network submitted a budget submission advocating to government that $150 million, including $10 million capital funding, be allocated to Child and Family Hubs to fund occasional childcare, mobile multidisciplinary teams including health professionals, early childhood and family support teams to create family wellness plans with flexible brokerage funding and direct services provision. This included support for a Child and Family Wellbeing Unit and Centre for Excellence. This could be located with the Queensland Centre for Perinatal and Infant Mental Health.

Crisis Response, Harm reduction and Treatment

Micah Projects has established effective models to address the over representation of people living with a mental illness who are homeless, experiencing domestic violence, and living unsupported in social and community housing. Micah Projects promotes a Housing First approach supported by multidisciplinary outreach teams to support people on the streets, in boarding housing, crisis accommodation and vulnerable in social and community housing. We have been building capacity over the past 10 years to deliver integrated healthcare with funded community services focused on outreach to people who are experiencing homelessness and or vulnerably housed by integrating services from multiple funding sources which are often time limited.

Micah Projects has experience of successfully integrating health and other supports, illustrating what successful service coordination looks like for the most vulnerable. Current programs and initiatives include Street to Home assertive outreach and after-hours services, providing healthcare and housing-focused community services. These have been operating since 2010, with a team comprised of registered nurses and community workers with a range of human service qualifications. The nursing staff also support the afterhours Domestic Violence Service providing support to women placed in hotels, and co responding with police after hours, many with mental health presentations.

This has been funded by Queensland Government Department of Community, Housing, Digital Economy and the Arts – homelessness program, management of public intoxication program and Metro South, Metro North for After Hours Nursing Service. Evaluation of Street to Home After hours nursing services undertaken by Professor Luke Connelly demonstrated clear reduction in hospitalisations and Emergency Presentations with an economic benefit of $6.45 - $9.9 million dollars for an investment of $503,000.

Integrated Community Based Health – Hub and Spoke Model Incorporating Mobile or Outreach Multi-disciplinary, and Multi-agency Response

Through partnerships and collaboration, the following initiatives have been growing over the past 5 years to build an eco-system with people who are experiencing homelessness including rough sleeping and inappropriate boarding houses, and people vulnerable in social and community housing.

Inclusive Health Partnerships

Inclusive Health and Wellness Hub – this service provides access to GPs, Nurse Practitioners, dental care, and wellbeing programs and provides a supportive environment for acupuncture, massage and myotherapy, podiatry by working in partnership with homelessness, domestic violence, and mental health psychosocial support teams. The teams link people with GP and Hub services and provide follow up healthcare when required. This enables healthcare to be provided that incorporates the social determinants of health. A subsidy is provided by Queensland Health to enable the employment of the administrative and nursing staff and operating costs for the Hub. MBS billing enables us to employ doctors. This enables time for integration of care with hospitals and community services.

Homefront

Homefront works with people who are homeless or at risk of homelessness and have complex clinical physical and mental health needs. They present frequently to the Emergency Departments or are hospitalised. They often neglect their healthcare when living in boarding houses, social housing, or rough sleeping. Referrals are received from Street to Home.

The team deliver integrated care using an outreach model to improve health and wellbeing outcomes for participants and support effective and appropriate use of primary care and acute health services whilst also focused on accessing and sustain housing. Services include collaboration with the Princess Alexandra Hospital and Mater Hospital, Brisbane South. With further resources the model could be expanded and or replicated across all hospital catchment areas

Domestic Violence Nurse

The domestic violence nursing service has been funded for 3 years by St Vincent's Healthcare. The nurse works with homelessness and domestic violence teams to provide follow up and direct clinical support and assistance with navigating services and supports for the many women who require mental health support and recovery. The nurse works in partnership with Safer Lives Mobile Service a team within Micah Projects Brisbane Domestic Violence Service.

The team works after hours as a 24/7 service supporting women in the community who are displaced from their home or do not have a home, and those who are experiencing domestic, family, and sexual violence. Women may be referred to a refuge, access alternative housing in the community, or return safely to their home. This team could greatly benefit by the inclusion of mental health practitioners and psychosocial support workers. This would provide a continuum of care to assist women in their transition to safety and recovery and in accessing housing. Staff need to be well trained in trauma informed and trauma sensitive service provision in both direct support and navigation of the systems impacting on their lives and safety.

Principles of practice

All teams and services work from a harm reduction principle, providing direct care and service to reduce harm during times of crisis, and to educate around harm reduction in relation to drug and alcohol use, suicidal ideation, and mental illness.

The integration of hospital clinicians with GPs is critical to provide assistance with medication management, health assessment, and self-management in the community. Too many people are discharged without the support or acknowledgement of their capacity to be able to undertake successful self-management of their health in the community. They are reliant on emergency services and hospital presentation.

With the prevalence of mental illness amongst people who have experienced homelessness or are tenants of community or social housing, the evidence is clear. The service system needs to scale up our capacity to do more outreach in both primary healthcare and specialist mental health, drug and alcohol response, follow up care for suicidality, working in collaboration with homeless and housing providers.

People living in environments that are detrimental to their health and waiting long periods of time to access housing and healthcare are in a constant and prolonged state of crisis. Many are suicidal due to despair about their circumstances and not being able to see a way out of the situation. The reality of poverty, the housing affordability crisis, and experiences of violence and abuse cannot be ignored as part of the healthcare response. The lack of access to clinical care results in deterioration of mental health further limiting their ability to address the other issues.

We need to scale up the mental health services by taking clinical supports and case management service to people where they are at. Reliance on a hospital-based system which requires presentation and or admission to hospital to be referred to a mental health community-based service is leaving many without services and increasing the financial burden when support in the community could prevent these presentations. As demonstrated in Attachment 2, cost analysis demonstrates that community-based services can reduce the rates of presentation to the Emergency Department and hospital and prevent recidivism for corrections through the provision of housing and healthcare.

Micah Projects is currently seeking funding from government, Primary Health Networks (PHN), philanthropy, and corporate donations to implement a Mobile Medical Service based on the learnings of the last 5 years (see Attachment 2 for further details). This service would be embedded with the existing services as Hub-and-Spoke model with the Inclusive Health and Wellness Hub and Micah Projects homelessness and domestic violence teams. Integral to this, is the multi-disciplinary approach integrating GP and nursing services. Once established, we envisage further integration with specialist mental health consultants.

A mobile medical and mental health service for the most marginalised groups needs to be a crucial component of a mental health system to both support people whilst experiencing homelessness. Just as important is the need to support people when they are housed so as not to continue the cycles of homelessness and acute mental health presentations.

A comprehensive mental health system will ensure that there are multiple entry points to the clinical and psychosocial supports that individuals and families need. This can occur through the creation of Hubs. Specialist mental health hubs may provide a centre where people assess a range of services and support. However, the centres also need to incorporate outreach.

To achieve integration requires embedding mental health services in diverse systems for populations that are appropriate to culture, gender, across all age groups, disability, and sexuality. This will achieve enhanced outcomes rather than standalone mental health services only. Both are required to have a holistic and accessible system, to address the over representation of people seeking support through homelessness services who have a mental illness, and embedding mental health responses with homelessness services.

Services also need to be accessible across a 24/7 timespan, where communities demonstrate the need. Brisbane clearly needs 24/7 to stop the cycles of crises. During the COVID lockdown, when people were accessing emergency housing in hotels, Micah Projects provided 24/7 services. This enabled greater engagement, particularly with people who were unable to sleep due to anxiety or other factors, who were experiencing suicidality, or were impacted by substances. These experiences do not only occur during business hours. Data collected through our screening processes provides insight: From a group of 989 adults, one in five people (200) self-reported that they had been taken to hospital against their will in the past 12 months for suicide attempts, psychotic episodes, or overdoses.

Drug and alcohol services

Many people who are living with a drug and alcohol addiction have significant difficulty being understood and being able to access services. In fact, people are often told they need to address their drug and alcohol issues before being able to access mental health services. Critical to drug and alcohol support is understanding the cycle and ways in which trauma impacts on a person over time. Traumatic memories and experiences, as well as depression and anxiety are connected to substance usage.

Currently the system is based on provision of treatment to people who are agreeable to admission for treatment and rehabilitation. There is a lack of services available to meet the demand for detox and rehabilitation services. We need more residential options but also, we need in-home detox and rehabilitation programs.

Integrating drug and alcohol nurses into our homelessness team was an effective strategy that we were able to explore during COVID with the support of a once-off funding. During this time nurses worked with the homelessness teams in providing case management to people who were pre-contemplative to treatment, supporting them in harm minimisation and their primary health needs whilst also focused on housing options. This often led to interest in accessing treatment and recovery services. Additionally, the nurses were able to support people post-rehabilitation to access housing. Most importantly, through case management, the team were able to support our participants to prevent and minimise relapse.

Recovery including Treatment – ensuring a continuum of care: Outreach Support and Advocacy Teams (case management and Treatment)

Micah Projects recommends further investment is made into models that support people across systems of care that they need to access for a quality of life, including healthcare and a home. These models include a continuum of the services that we have identified for crisis intervention and support for people when they are housed.

For example, the Home and Healthy Consortium is a recently formed consortium with the Aboriginal and Torres Strait Islander Medical Service, Woolloongabba and YFS Logan to provide psychosocial support and systems navigation to assist people to effectively navigate across systems such as housing, physical health care, drug and alcohol, mental health, and social enterprise in order to access and sustain housing. The service is designed to support access to NDIS through acting as connector for individuals with severe mental illness and co-occurring conditions. This program assists people, and their informal support networks, to identify and follow up on their recovery and housing goals, providing psychosocial support. The aim of the program is to lead to an improved sense of wellbeing, stability, and reduction in the number of people with a mental illness who are also homeless. The program is funded for 2 years by Brisbane South PHN.

There are well documented and evidence-based outreach programs that provided integrated in-home clinical and psychosocial support to people in their home. The Pathways Housing First program in the USA has implemented community based assertive outreach and treatment teams with step down case management teams to support people self-managed in the community.

There is strong evidence for the effectiveness of a Housing First approach. An evaluation of this approach in the “At Home” project in five sites with over 2,000 participants was conducted by the Mental Health Commission of Canada. They found positive outcomes for housing stability, housing quality, appropriate use of services, quality of life, and community functioning, as well as net cost savings: for every $10 invested there were cost savings of $21.72 (Canadian Mental Health Commission, 2021). A key aspect of this approach is integrated case management and clinical care embedded in homelessness and housing initiatives. In addition, the Australian Government Productivity Commission highlighted the value and need to expand the range of Housing First Projects in Australia (Productivity Commission, 2020) .

Social inclusion – pathways to employment training and meaningful activity and connection to community

Over the past 15 years, social participation and inclusion for people living with a mental illness has been articulated as a vision for the mental health system. However, the investment into enabling this to happen has decreased significantly over the years with the transition to NDIS.

The rates of unemployment and limited access to training or meaningful activity is very high for people with a broad range of mental health experiences. This contributes to the rates of homelessness due to income not being sufficient to pay for current rates of rental. People are also penalised because they cannot maintain employment that is offered through job networks resulting in a penalty with their Centrelink Payments.

Limited access also contributes to social isolation. Micah Projects and other non-government services provide social connections and in-home supports to people living in the community but with limited resources. Breaking the social isolation and supporting people to sustain their tenancy using within home supports is a critical success factor in enabling stability for people living with a mental illness. Whilst government has often flagged social enterprise to support people living with mental illness, there has been limited investment.

Micah Projects operates two cafés for the dual purpose of social connection and training and employment. A business model is used to operate two cafés so as to enable community participation. With a subsidy from Skilling Queenslanders for Work, training for eight trainees a year (57 completed over 4 years) has provide a pathway to employment for 31 participants since 2017. Many of these participants reported mental illness as their main barrier to employment.

The success of the funding model to support the operation of the business to enable and support inclusion is hard to assess. The cafés are designed to use a business model. However, the aim is also to create a place for social inclusion and offer specific events for connection with the people we work with. The café provides a community pantry, meals that are free, and Pay It Forward coffee or beverage to people in the community.

Micah Projects is very interested in expanding this model to be inclusive of mental health practitioners to support people in the community rather than limitation to presentation to the hospitals. The UK Hope Café model (Northamptonshire Healthcare, 2022) has funded community cafés that are open to provide a safe place or connection and access to a skilled mental health professional after hours. Whilst the Queensland Government has funded a café model, they have been based in hospitals adjunct to Emergency Departments. The models need to be expanded to the community-based models that could facilitate access to peer and professional support whilst reducing social isolation and loneliness and unnecessary presentations to the Emergency Department and hospitals.

Participation in meaningful activity should be a key objective for those accessing the mental health system. We recommend investment in recovery services include meaningful activity, employment opportunities, or both. Linking individualised case management with group work that has a range of foci, such as art and storytelling, is also effective as it builds social capital and trust within organisations. This has been a proven program design for psychosocial support programs.

Micah Projects and Communify are funded through the Queensland Government Department of Communities, Housing, Digital Economy and the Arts to provide in-home support to individuals transitioning to social housing. In addition, the funding aims to assist in community connections to connect people with peer support, and community activities such as community meals, art groups, and exhibitions. Micah Projects, through the HIVE team and Communify support people who are not yet accessing NDIS but who have a long-term disability, chronic illness, mental health barriers, or other conditions that impacts on their day-to-day functional capacity and ability to participate in the community. The programs provide in-home supports and community connection programs to support and enable a healthy sense of identity and a sense of role and purpose in personal and community life.

The Community Connections program works in collaboration with our social enterprise cafes, Hope Street Café and Hope on Boundary Café.

Supportive housing

The inter-connectedness of mental health, housing and other needs is well known. Homelessness can exacerbate or trigger mental illness. Serious mental illness is a significant contributor to poverty and insecure housing (Brackertz et al, 2018).

It is difficult for people to improve their mental health unless they have secure housing. Therefore, a Housing First approach is critical for people with serious mental illness. For the most vulnerable (particularly those with low prevalence, more severe mental illness), maintaining their housing requires ongoing mental health services as well as ongoing tenancy support and other services such as disability support and chronic disease management.

While the NDIS can fund Supported Independent Living and Specialist Disability Accommodation, as noted above there are significant barriers for the most vulnerable in accessing these supports (system navigation support). Even if a person is successful in having funding for these supports approved, finding appropriate providers remains a challenge.

Together with the other members of the Brisbane South PHN Partners in Recovery Consortium, we documented this integrated approach in the *Housing First: A foundation for recovery* toolkit. The toolkit sets out the evidence of the benefits of a housing first approach for people living with severe and persistent mental illness who are homeless or vulnerably housed. It also details strategies to implement the approach (Attachments 3-5).

Our experience with people who are homeless is reflective of the broader research. Mental health conditions are the most common health issue reported by people we support who are homeless. Data from the Brisbane Zero "Know By Name" list of rough sleepers for 2021 indicates:

- Nine out of ten (89%) people sleeping rough report a mental health condition;
- More than half (61%) have both a mental health condition and substance use problems;
- Half (52%) report mental health, substance use, and physical health conditions;
- Three out of four (73%) report recent or past abuse or trauma
  (see also Attachment 6).

Ending Homelessness through Supportive Housing for people with mental illness, addictions, suicidality, and co-occurring health conditions

Access to housing is only part of the solution for people experiencing homelessness and the added complexity of mental health, drug and alcohol use, and trauma. Once housed, people with mental health needs require the support to sustain their housing.

Supportive housing is a proven solution to the complexity of issues that are facing many communities and for addressing the rising numbers of people from all ages and circumstances that are experiencing homelessness. Supportive Housing can be adapted and tailored to meet the specific issues and circumstances across the population of people such as age, gender, culture, sexual identity, and

specific circumstances such as health status, individual or family compositions, histories of institutional care and offending, and experiences of violence and trauma.

Supportive housing combines the creation of affordable housing with tenancy support, safety and services such as health care to assist individuals or families who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing is an evidence-based intervention, with specific staff ratio to tenants, approaches to services, and quality standards for housing and service operations.

Supportive Housing is for priority population groups who have the lowest income and require more intensive support combined with subsidised housing. The people we work with are priority population groups that often cycle in and out of institutions such as jail, hospitals, correctional facilities, or those who are in institutional care but could be living in the community with appropriate healthcare, safety, and support. Children and families who have repeated episodes of homelessness, may have barriers such as disabilities, mental illness, additions, experiences of domestic, family and sexual violence, and engagement with child protection system which prevent them from accessing and sustaining housing and provide a quality of life for their family.

The services in supportive housing are intensive, flexible, tenant driven, voluntary or negotiated, housing based. The responsibility for engagement with tenants rests with the service provided, a tenant is not evicted if low engagement. Services are required to use motivational interviewing skills, assertive engagement and be trauma informed to draw tenants into the services that they are seeking including understanding the tenancy obligations, accessing healthcare, service coordination with specialist providers, coordination with tenancy and property management, community connections and enjoyment.

Supportive Housing is not transitional housing with a program – tenants have secure tenancy and ongoing support to sustain the tenancy and have a quality of life with their tenancy not being conditional on participation in services.

Micah Projects supports all forms of housing types as part of a housing system. However, Micah Projects advocates for a more planned endorsement and implementation of Supportive Housing in Queensland.

Supportive housing has been limited to projects rather than developing a comprehensive supportive housing policy and framework for the growth and building of more supportive housing units. Supportive housing units can be allocated with in a housing complex or can be single site. Micah Projects supports the replication of the model and scale of Brisbane Common Ground, with proximity to services including hospitals to ensure continuity of care, service coordination where appropriate and effective exits from hospital to supportive housing.

A single site supportive housing site is urgently needed for people with mental illness and co-occurring addictions, chronic disease with mix of hotel style units and adaptable single units, common areas for healthcare, treatment and education, community, and peer support. This would enable a reduction in the over representation of people with a mental illness who are currently trapped in homelessness.

Supportive housing for children and families that focused on a safe and educational environment for children and families with appropriate supports addressing child and family mental health and safety from domestic, family and sexual violence are also urgently required.

During COVID, the Emergency Housing Response clearly demonstrated what could be achieved when there is urgency and the will of government to provide people experiencing homelessness with a home, as temporary as it was. The placement of over 1,700 people in hotels coupled with outreach services 24/7 demonstrated what could be achieved. Through use of a common intake and screening tool of people housed and supported through this period, the data demonstrates the need for Brisbane as a community to develop a plan to build 500 units of supportive housing prioritising individuals and families and children. This needs to be prioritised as quickly as possible to reduce and end homeless for the number of people who are currently trapped in homelessness or inadequate or unsustainable private rentals.

This has become more urgent with the impact of COVID on property prices leading to higher rentals and reduction in number of properties available for rental. Housing coupled with mental health services and or integrated approaches are necessary.

Since 2010 Micah Projects has actively advocated for Supportive Housing to become part of the Queensland Housing System so ending homelessness can be a reality for more people, including those experiencing mental illness living on the streets, in cars, unsupported boarding houses, and couch surfing.

The Australian Government Productivity Commission (2020) Mental Health report outlines the need for and supports a Housing First approach that inclusive of Supportive Housing as part of a continuum in the housing system with appropriate mental health services embedded to support tenants of the housing.

The effective cost of supportive housing has been well documented internationally with the cost per night for supportive housing offsetting costs compared to the cost of a night in prison, in hospital, in mental health facilities, or in presentation to the Emergency Departments. Micah Projects has also demonstrated in the cost evaluation conducted locally, as detailed below. Through the Brisbane Zero campaign, we are seeking to replicate this research, however this is dependent on the availably of data.

Brisbane Common Ground – partnership between Common Ground Queensland and Micah Projects funded by Queensland Government Housing and Homelessness Partnership Agreement.

Brisbane Common Ground is the first purpose-built, intentional supportive housing project in Queensland comprising of 146 units, with a social mix prioritising 50% tenants who were sleeping on the streets and 50% who have low income. All tenants are eligible to access the integrated support services. The most common service for low-income tenants has been mental health support.

Common Ground Queensland is funded to provide tenancy, property and security and concierge services. Micah Projects provides on-site tenant support as part of the concierge team 24/7, service coordination, case management through planned support and advocacy, and opportunities for community engagement within the building and in the local community.

Mater provides Micah Projects with philanthropic funding to integrate a nurse within the team 7 days a week. This integrated health care provides direct clinical support such as wound care, medication management, and health assessment which provide tenants with assistance to self-manage their health and wellbeing. Many tenants live with mental illness, co-occurring addictions, and chronic disease. Through a data driven process these tenants are identified through the "Know by Name" list with organisations working with rough sleepers who have high support and physical and mental health care needs to maintain their tenancy at Brisbane Common Ground.

Critical to the work of the support team is liaison with other community services, healthcare providers, and education and training providers. A rigorous analysis of cost offsets of this service found that the cost to the Queensland Government were reduced by $13,100 for each tenant – after accounting for the cost of providing the supportive housing (Parsell et al., 2017). Regarding public mental health services in particular:

- The number of mental health episodes decreased by 65% in the 12 months after commencing supportive housing tenancy;
- The time spent in mental health treatment decreased by 61%; and
- The cost to government for mental health services decreased by 65% (Parsell et al, 2017).

Common Ground Queensland and Micah Projects undertook a research project to explore the adaption of supportive housing to families to support reunification, end homelessness, and reduce involvement in child protection system with a grant from the Community Benefit Foundation.
In 2021, the Keeping Families Together Supportive Housing Pilot Project was funded by Department of Communities, Housing, Digital Economy and the Arts included 20 families; and of these 73% of parents were experiencing mental health issues. Evaluation of the pilot demonstrated positive outcomes for housing (95% of tenancies sustained), child protection (reduced involvement), and family stability. Parents reported that they developed greater confidence in their knowledge and ability to parent, and children improved their developmental progress (Korsakoff et al, 2021). The Supportive Housing Keeping Families Together Initiative has been funded for a further 4 years.

b. across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services, non-government services and services funded by the NDIS

It is very clear that all levels of government, private providers, and not-for-profit organisations need to work in partnerships to build eco-systems that are accessible and embedded in the issues that people are experiencing in their lives. One model of care does not suit the diversity of the Queensland population and the regions and local areas that people live. Place based responses are important, as well as targeted services and models to address the needs of vulnerable population groups such as children and families, women experiencing domestic, family and sexual violence, as well as people across all ages and cultures who are experiencing homelessness, and living with mental illness and the impacts of lifelong trauma.

For these population groups it is necessary for funding models from the State and Commonwealth Government to support organisations to build the infrastructure and sustainability of supports rather than continue the silo approach to funding models and the top-down approach of one size fits all for diverse populations and locations.

As we have outlined in the five models of services that Micah Projects provides, we need clinicians. However, MBS funding alone does not cover the costs of the work of building collaborations with people with mental health complexity, engagement and relationship building with hard to reach cohorts of people, or the service integration that is required. The Inclusive Health and Wellness Hub is an example of the combination of both State funding and MBS funding enabling a quality clinical service that is connected both to where people are living and integrated with other community services and resources.

As highlighted through the experiences of Brisbane Domestic Violence Services, we have not been able to achieve the connection we need to support women with therapeutic services over a longer period of time. Whilst we have tried to connect in with private practitioners the MBS billing does not cover the costs necessary for practitioners to work together. Also, there is a shortage of availability of psychologist, mental health nurse practitioners, and mental health registered social workers.

For participants of Micah Projects, their circumstances, family composition, and life experiences impact on their mental health and wellbeing. The common threads of poverty and limited income prevent them from accessing the services they need access to. Many people report and provide feedback on the difficulty in accessing services, lack of money for transport, limited availability, and lack of integrated care between different providers.

D. The experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers

Micah Project strategic plan has a foundation pillar of supporting people with lived experience to have a voice in the development and continuous improvement of programs and advocacy in relation to the policies which have impact on their life. To do this, Micah Projects supports training and direct participation in the opportunities for people with mental health difficulties who are often marginalised and excluded.

Whilst each of our service areas have included and supported people in different ways, we are undertaking to develop an organisational framework for the participation of people who live with adversity and disadvantage, whatever that may be. However regardless of the entry point, all our participants have highlighted the impact on their mental health and wellbeing of not be listened to or heard and not having opportunity to influence the change that is required for greater access to and satisfaction with services. There is currently very limited funding available to embed supporting people to participate and share their experiences across the systems that impact on their life within organisations and services.

E. The mental health needs of people at greater risk of poor mental health

People who are on low incomes or homeless are at greater risk of poor mental health. The rate of homelessness among people living with a mental illness is unacceptably high and this is particularly true of people with severe mental illness. The Supportive Housing model is a key solution, alongside integrated health, case management and social inclusion programs.

At Micah Projects we see many women and families who have experienced trauma, crisis, or stress such as domestic and family violence, sexual violence, homelessness, and child protection involvement often leading to the removal of children from parental care. The long term experience of domestic and family violence can have a significant and enduring impact on children, impacting brain development, learning, reduced capacity to regulate emotions, attachment issues and reduced sense of safety (Forke et al, 2019; Perry & Dobson, 2013).

For those who experience shorter-term psychological distress, mental health services such as psychologists are critical for supporting transition to stability and for building future resilience. The current model for most people with a need for mental health support for psychological distress is through GPs and private psychologists, subsidised by Medicare. These are a Commonwealth responsibility and state-based mental health services should not duplicate this. However, there are significant barriers to accessing these services for the people we support. These include:

- Cost – finding a bulk-billing or low-fee psychologist is difficult if not impossible, due to increased demand for services and increased utilisation of psychologists by NDIS funded programs and services;
- Availability – demand is outstripping supply as the number of people seeking help for mental health concerns rises, and an increasing number of psychologists close their books to new referrals. This is particularly an issue for children and young people;
- Accessibility – for the people we support, being able to see someone in a safe, inclusive, accessible space is important. Many mainstream services do not meet these criteria. Availability of childcare and transport also affects women's ability to access these services.

Private psychologists are often not an option for many of the people we support. We are fortunate to have two wonderful psychologists who work on-site at our Young Mothers for Young Women programs in Brisbane and Caboolture 1-day a week, providing bulked-billed services in an accessible environment. We could fill 5-days a week with appointments if they were available. While this private model is good, it is never going to be enough or work for everyone.

Micah Projects Brisbane Domestic and Family Violence Service has experienced a lack of available mental health services for children who have experienced complex trauma. Parents have reported lengthy waiting periods to access mental health services for young people, with expected wait periods of 12-18 months. This in turn impacts the ability of young people to effectively engage in education and form appropriate social relationships.

The need for holistic responses that incorporate an understanding of the impacts of complex trauma and understanding of the impacts on the relationships between mothers and their children is essential to supporting future generations and reducing the impacts of long term and complex trauma, where the current inability to access services exacerbates and compounds the impacts.

We recommend that access to free or low-cost short term mental health services for vulnerable people experiencing psychological distress should be part of the Queensland mental health system. This is in line with the recommendations of the Royal Commission into Victoria's Mental Health System, which consistently referred to "people living with mental illness or psychological distress" as the target group for the Victorian mental health system. It is an important response in the context of the market failure that is currently apparent.

The Royal Commission into Institutional Responses to Child Sexual Abuse highlighted, through personal sessions from people with lived experience and the panels and case studies, the lifelong impact of child abuse. The report highlights the impact on the mental health of survivors over their lifetime and the need for more trauma informed mental health systems of treatment, recovery, and ongoing care. To date, these recommendations have not been widely understood within the Mental Health system across Queensland. Micah Projects would recommend that Queensland Health identify a strategy and funding to support the victims and survivors of child abuse in institutional settings and their families.

Maternal and child health should also be a priority from pregnancy and through early childhood so as to prevent rapid deterioration of the mental health of mothers and children and to prevent future prevalence. Supporting the protective factors of motherhood is protecting children in their physical development and their mental health and wellbeing. No family can provide the environmental, psychological, and physical safety for their children to be born and grow through their development milestones whilst being forced to live with violence or to be without a home.

When parents and caregivers are faced with the lack of resources to provide for their children, to meet their aspirations for their children, their mental health and wellbeing as parents is impacted. Mental health and substance use are two significant drivers of child protection intervention. This population of parents need options to support them care and protect their children within an eco-system of informal support and professional assistance before long term removal of children is determined.

Mothers and their children who are separated at any stage of a child's development need access to mental health support services. The grief arising from the separation of children at birth needs specific attention especially in how it can be prevented for short term imprisonment, or short-term interventions due to domestic violence and homelessness. For the mental health of both mothers and their babies, services and housing need to enable them to remain together safely.

Populations with drug and alcohol use, co-occurring mental illness and suicidality

The Queensland Government website states that alcohol, tobacco, and other drug use in Queensland accounts for an estimated 4,300 death and over 65,000 hospital admissions. Queensland needs to include a broader range of services and resources to meet the needs and vulnerability of this population and their families and carers. Investment in drug and alcohol services is extremely low compared to the cost of law and order, courts and corrections which impact on the daily lives of people living with illegal substance use.

Micah Projects recommends that Queensland Health broaden the range of services available to people both within the hospital system and also within community-based services including homelessness services. Some examples would be in the Nurse Practitioner and Clinical Nurse service and in providing therapeutic day programs. Activities the Nurse Practitioner and Clinical Nurse lead teams to provide include:

- Physical and mental health triage, assessment, and care to enhance awareness of mental and physical health co-morbidity;
- Management of infections and adverse effects relating to poor injecting practice;

- Hep B vaccination and blood born virus (9BBV) testing;
- Hep C testing and treatment;
- Dispensing, monitoring, and reporting the effects of medicine;
- Identification and management of alcohol related liver disease and alcohol related dementia.

We also advocate for the investment in therapeutic day programs ensuring diversity to meet different population groups needs. Such programs will:

- Provide intensive, structured intervention through day programs;
- Implement pharmaceutical benefits scheme subsidised Naloxone (THN) program. Recent evaluation of the Australian Government pilot in NSW, SA, and WA demonstrated the effectiveness of saving lives from overdose. The evaluation shows three lives were saved a day by allowing people at risk of experiencing or witnessing an opioid overdose or adverse reaction to access naloxone without cost, without a prescription, and from a variety of settings (such as justice and corrections, general health services, alcohol and other drug use services, pharmacies, and non-government organisations);
- In-home withdrawal and detox programs expanded across a range of services and sites.

F. How investment by the Queensland Government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support

The State Government currently has a siloed approach to mental health, drug and alcohol services, primary health, and chronic disease management. There is an urgent need to fund programs that are delivery an integrated response to these health issues as well as to the social determinants of health such as housing, food security, transport, income, employment, and community connections.
Funding models need to be less prescriptive on eligibility and more focused on outcomes and flexibility to adapt and change to meet the needs of participants rather than rigid reporting of outputs. Recognition of the infrastructure costs and platforms that enable partnership and integration need to be recognised for not-for-profit organisations. Too often healthcare systems want the community services sector to take up referrals and deliver outcomes without appropriate management and operational costs being built into the grants.

The Commonwealth and State governments both need to work together to provide a program of funding that supports and maintains integration. This will never happen just on a fee for service model.

The current system does not work well enough for some population groups. To do better requires a targeted approach. The cooperation and principles of partnerships between Commonwealth and State government and with the not-for-profit sector are limited by the constant shifting of responsibility about primary care systems and hospital systems without a clear focus on the benefits to the person / citizen who has a right to healthcare regardless of their circumstances. People with drug and alcohol use problems experience stigma and judgement in how they can access services to support both harm to themselves and others, or engagement in treatment and recovery programs. The underlying recognition of unresolved trauma and the lifelong legacy of trauma in childhood is well documented but has been slow to translate into practice and funding models that support

healing and recovery. This includes enabling access to alternative therapies that provide support for healing from traumatic experiences.

Health inequality continues to grow and health costs are rising. Health equity is the value that everyone should have a fair opportunity to attain their full health potential and that none should be disadvantaged from achieving this potential if it can be avoided. The individual market driven funding models do not work for everyone and have created health inequality. Funding models are the solution to reduction of healthcare costs and increased accessibility to the combined clinical and psychosocial supports that people living with a mental illness require. Block funding to organisations can create the glue for integration and better outcomes for individuals and for the system.

The Queensland Government should also look at the integration of planning and funding across the range of services including Aboriginal and Torres Strait Islander, multi-cultural communities, the housing and homelessness sector, domestic, family, and sexual violence, women's strategy, community connections, and neighbourhood and recovery centres that might support an integrated approach with mental health services. The integration of these services will work to enhance the mental health and wellbeing of Queenslanders and their communities. A women's health strategy would also assist in planning and investment recognising is the specific contexts that impact on women's mental health and wellbeing, such as maternity and reproductive health, and impacts arising from the prevalence of violence against women.

Queensland Treasury could consider developing a collaborative budgeting framework that complements the economic development of Queensland but also focuses on the health and wellbeing outcomes of citizens.

G. Service safety and quality, workforce improvement and digital capability

In order to provide effective integrated care services, the not-for-profit sector is developing its capacity for clinical governance. Provision of one off funding to support this development would enable the capacity of the sector to grow in development of the infrastructure organisations need to provide safe, quality services. The cost of clinical governance also needs to be built into contracts as a recognised management or operational cost. Additionally funding models for not-for-profit need to recognise the market costs of employing clinicians.

There is currently a shortage of workforce to support many of the models of care that are needed to make a difference. We promote greater access and training for Nurse Practitioners to work in the community across the speciality of mental health, primary healthcare, child and family mental health, maternity, drug and alcohol, and to help address the social determinants of health.

A significant shortage of psychiatric clinicians for both paediatric and adult groups is also evident. Forward planning for the training of psychiatric and mental health clinicians to help address the growing needs of the population and at-risk groups is needed.

Micah Projects would like to see homelessness recognised as a special population group alongside rural and remote and Aboriginal and Torres Strait Islander peoples due to the specific strategy and workforce required to meet the needs of this marginalised population.

H. Mental health funding models in Australia

We call on the Queensland Government develop to develop a supportive housing plan that can:

- Clearly identify the subsidy required to not-for-profit housing providers and the investment into embedded integrated mental health services;
- Identify land from across government departments on which supportive housing could be built;
- Identify the mix of single site models and scattered site models;
- Set targets for the number of people housed and timeframes;
- Identify alignment with healthcare and social services, and new investment required to provide support services.

We call on the Commonwealth and State Governments to identify ways to invest in funding models that:

- Support the combination of block funding and MBS funding to integrated care models;
- Identify ways in which nurse lead mental health and drug and alcohol teams can be funded to broaden the reach of service through outreach and hub type programs that are appropriate to local place-based responses;
- Build partnership agreements across housing, homelessness, domestic violence, primary health and mental health;
- To identify funding that supports models of integration with flexible funding agreements;
- That the true costs of services are reflected in services agreements to not-for-profit providers.

I. Relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental Health Inquiry Report.

The Royal Commission into Victoria's Mental Health System recognised the need for state mental health services to provide psychosocial supports (which they called "wellbeing supports") as well other forms of care and treatment. The Commission, which was based on extensive consultation and research, identified that a core function of community mental health and wellbeing services is *integrated treatment, care, and support*. This includes four components: treatments and therapies; wellbeing supports; education, peer support and self-help; and care planning and coordination (Final Report Volume 1, 2018).

Furthermore, the Commission proposed that these services should be provided in a partnership model including public health services and non-government organisations (Final Report Volume 1, 2021). The existing plan for Queensland's mental health and alcohol and other drug services recognised the need for improved integration and collaboration both within state-funded services and with other health and social services, and the consequences of failing in this regard (Queensland

Government, 2016). Our proposed improvements for the Queensland mental health system, as outlined above, are in alignment with these recommendations.

Conclusion

Investment in a strong mental health system will pay dividends for Queensland not only in terms of improved capacity for individuals to live with dignity, but also enhanced ability to manage other aspects of their lives, such as physical health concerns and housing, and enhanced ability to contribute to the community, through working, studying, caring for others, creating art or volunteering.

Summary of recommended improvements

1. Adopt a trauma informed approach to the provision of integrated and holistic care, both within Queensland Health and in the investment into community-based services. All aspects of the Mental Health System from prevention, early intervention and crisis intervention, recovery and forensic mental health require more investment. Such an increase into investment should be balanced across all sectors not simply as a continuum from hospital to community. Direct access from community to community-based clinical and psychosocial support that can provide integrated accessible healthcare and social support to the diversity of need and populations ensuring cultural and individual diversity of need is respected, with dedicated funding to culturally and gender specific services – including supporting the Indigenous Managed Community controlled organisations.

2. Ensure service provision is in line with Human Rights which would require immediate reversal of the decision for all Queensland Mental Health wards to operate as locked wards. Unlock doors on all inpatient mental health units and only reintroduce locks in specific circumstances if an assessment has been made to demonstrate that this is a justified and proportionate measure.

3. Adopt and adequately resource the following models to support better outcomes for people with mental illness across the continuum of prevention, crisis response, harm reduction, treatment, and recovery, to be implemented in partnership with relevant housing, social, and health services:

    3.1. Prevention and Early Intervention: Children and Families Hub and outreach services – for early intervention and prevention of poor mental health outcomes in early childhood;

    3.2. Integrated housing access, support, and healthcare in the form of crisis, harm reduction, treatment, and recovery of vulnerable people with mental illness, addiction, or currently homeless, in boarding houses, or exiting prisons and hospitals living in the community;

    3.3. Social inclusion – recovery support and connections for people with peer support, meaningful activities, training, employment, and professional clinical support.

3.4. Mobile multidisciplinary teams providing integrated in-home, healthcare, housing and social support across the systems of care that is appropriate to individuals and or families and housing type:

a) People living with the impacts on mental health and addiction who are homeless, transitioning to housing to sustain tenancy to support harm reduction, and management of healthcare to prevent return to homelessness;
b) People with severe mental illness and addictions living in social and community housing, private rental, or leaving corrections;
c) People who have presented to hospitals for suicidal ideation to provide follow up support and connection with services, and resources in the community;
d) Child and Family mental health and early childhood family support teams.

3.5. Supportive housing – the well-evidenced Housing First approach as part of a treatment and recovery model for vulnerable people with severe and persistent mental illness and co-occurring multiple chronic medical conditions.

4. Adopt and adequately resource a holistic and integrated approach to care and support as a foundational principle of the mental health service system, so that it includes social care and support as well as clinical care. This means focusing not only on the management of symptoms but a broader focus on social relationships and engagement in meaningful activity to support recovery and quality of life.

5. A Mental Health System, that is grounded in partnering and coordination between systems that are all responding and embed mental health services with other services and service system that people may need, including drug and alcohol, other health services (for physical health conditions), and supportive housing , community/ social enterprises, creative arts.

6. Increase the availability of accessible, trauma-sensitive mental health services for people experiencing psychological distress, such as women who have experienced trauma, domestic and family violence, or homelessness.

7. Develop a supportive housing plan that can:
   - Clearly identify the subsidy required to not-for-profit housing providers and the investment into embedded integrated mental health services;
   - Identify land from across government departments on which supportive housing could be built;
   - Identify the mix of single site models and scattered site models;
   - Set targets for the number of people housed and timeframes;
   - Identify alignment with healthcare and social services, and new investment required to provide support services.

Attachments

1. Give all our children a healthy start Fact Sheet
2. Outreach Medical Service for people experiencing homelessness and the vulnerably housed
3. Housing First: A foundation for recovery
4. Housing First Fact Sheet
5. Integrated healthcare for people with mental illness who are homeless or vulnerably housed Fact Sheet
6. Homelessness in Brisbane Fact Sheet - Individuals (aged over 18) 2020

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Perinatal and early childhood intervention

Early intervention can mitigate the effects of exposure to trauma, adversity and crisis on perinatal and early childhood development. This can improve long term health, wellbeing and development outcomes for children. Early intervention includes...

- Safe, educationally rich, and developmentally appropriate spaces and programs for babies and young children.
- Trauma-sensitive environments for children.
- A two generational approach educating parents about childhood development whilst supporting parents (e.g., the Parents as Teachers approach).
- Targeted case management for the most vulnerable families
- Group based programs and peer advocate roles which strengthen community and peer connections.

  Research shows that there are often no community spaces where children and parents can meet and connect. Such connections are an important support for good mental health.
- An integrated model which provides, or links to, assertive outreach, housing, health and wellbeing services for mothers and children, legal services.

Micah Projects YMYW programs and Wellspring Children and Families Hub are examples of putting this approach into practice. The Hub provides highly valued services including an occasional childcare program, supported playgroups, and other group programs for parents and children.

February 2022

For more info, contact Micah Projects: karyn.walsh@micahprojects.org.au

$150m

in investment can support additional outreach workers and an evaluation for our child and family hub.

1. Media Handout: 30 September 2019 Child and Family Performance Statistics, Depatyment of Child Safety, Youth and Women.
2. Poverty in Australia 2018, Australian Counsil of Social Service in partnership with UNSW
3. Specialist Homelessness Services data 2018–2019, Australian Institute of Health and Welfare (AIHW).
4. Brown, Alison, "11 prep and year 1 students suspended from Queensland schools every day", Brisbane Times, September 12, 2018.
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5. Australian Early Development Census, 2018.

Interior content adapted from...

Australian Research Alliance for Children and Youth, *The Nest* Action Agenda: Improving the Wellbeing of Australia's Children and Youth While Growing our GDP by over 7%

Seattle University's 'Project on Family Homelessness' http://projectonfamilyhomelessness.org/portfolio/infographics/

Ascend at the Aspen Institute, 5 key components of the Two-Generation approach http://ascend.aspeninstitute.org/two-generation/what-is-2gen

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MICAH PROJECTS
Breaking Social Isolation Building Community

Queensland Government

MICAH PROJECTS

Give all our children a healthy start

Breaking the cycle of disadvantage, trauma and developmental delay.

Perinatal and infant Mental Health Services can help break the cycle,

with integrated investment and commitment across

- child safety
- housing
- health
- education
- employment
- community-based services.

Many vulnerable families are living with uncertainty and emotional risk as they feel exposed to child protection interventions due to poverty, domestic and family violence, poor health, housing stress, homelessness and in many cases long-term unemployment. We do not want these barriers to leave children and their families behind and isolated from services, resources and opportunities in the community.

Causes of toxic stress, trauma, and intergenerational disadvantage

Parental mental illness + substance misuse

66% of parents with children in child protection have past or current substance use issues[1]

Poverty

1 in 6 children nationally[2]

Child Abuse + neglect

42% of parents with children in child protection were abused as a child[1]

Domestic + Family Violence

49% of parents with children in child protection had experienced DFV within the last year[1]

Homelessness

In 2018–19, 5,381 children (0–4) presented to Queensland Homelessness/DV services[3]

Family involvement in justice system

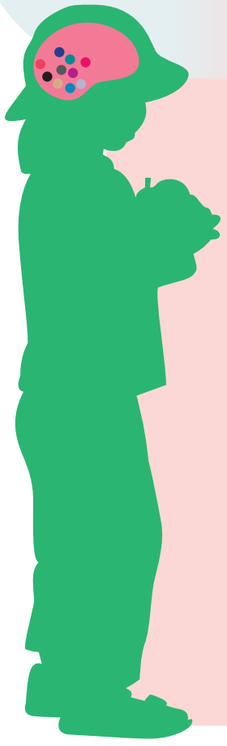
Medical trauma

Exclusion from early learning + school

11 prep/year 1 students are suspended from Queensland schools every day[4]

Separation from loved ones

Parental crises and stress



Developmental Consequences

Adverse childhood experiences (ACEs) cause chronic stress during childhood. Typically, the more adversity a child experiences, the higher their risk of long-term consequences into adulthood.

Chronic stress and trauma alter the brain, diminishing a child's ability to learn, regulate their emotions and behaviours and interact socially.

Percentage of Queensland children vulnerable in 2012[5]

- **9.3%** were vulnerable to lack of confidence and underdeveloped social skills.
- **7.6%** were vulnerable to issues with emotional development and regulation.
- **9%** were vulnerable to developmental issues with communication.
- **11.6%** were vulnerable to issues with health, independence and motor skills.
- **6.8%** were vulnerable to developmental issues proficiency/interest in language and literacy.

Giving all children a great start

Breaking the cycle of trauma using a **Two-Generation approach** and a trauma informed system.

Family wellbeing

Individualised family plans with flexible funding (brokerage)

Multidisciplinary outreach teams:
• Nurses • Legal • Parent advocates
• Family support workers
• Early childhood • Housing

Housing + Economic

- Housing stability
- Housing First approach
- Flexible funding enables housing support
- Multidisciplinary responses
- Work readiness
- Adult literacy

Specialist young parents programs

Developmental approach to parent and child

Peer support workers

Social support

- Child and Family Hub activities
- Peer and family networks
- Strengthen community connections
- Reduce social isolation

Early childhood education

Free, accessible, quality early childhood education and care located in Child and Family Hubs designed to meet local needs and gaps in services

Home visits to support safe, nurturing environment and education

Break the cycle of trauma

Health + wellbeing

Continuum of care from pregnancy to school age

Early childhood screening and assessment interventions for development delays

Nurse led multidisciplinary teams

Results

- ↑ Family wellbeing
- ↑ Safety at home, learning and growing
- ↑ School readiness and early childhood services
- ↑ Health and support to achieve developmental milestones
- ↓ Entry into child protection, homelessness and hospitals.

February, 2022

Inclusive Health Partnerships

MICAH PROJECTS

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Outreach Medical Service for people experiencing homelessness and the vulnerably housed.

Taking clinical care and support to the most vunerable in Brisbane.

The case for investing in outreach medical services as part of an integrated healthcare system with vulnerable populations is well established. Over five years Micah Projects and partners have been working towards creating greater access for people who are experiencing homelessness or are vulnerably housed.

The establishment of the Inclusive Health and Wellness Hub — comprising of 9 part-time GPs, dentistry, nursing, acupuncture, massage and Myotherapy — has enabled 1,980 people to register as patients. The Hub is open Monday to Friday, 9–5, with limited weekend services by specialist dental and GPs.

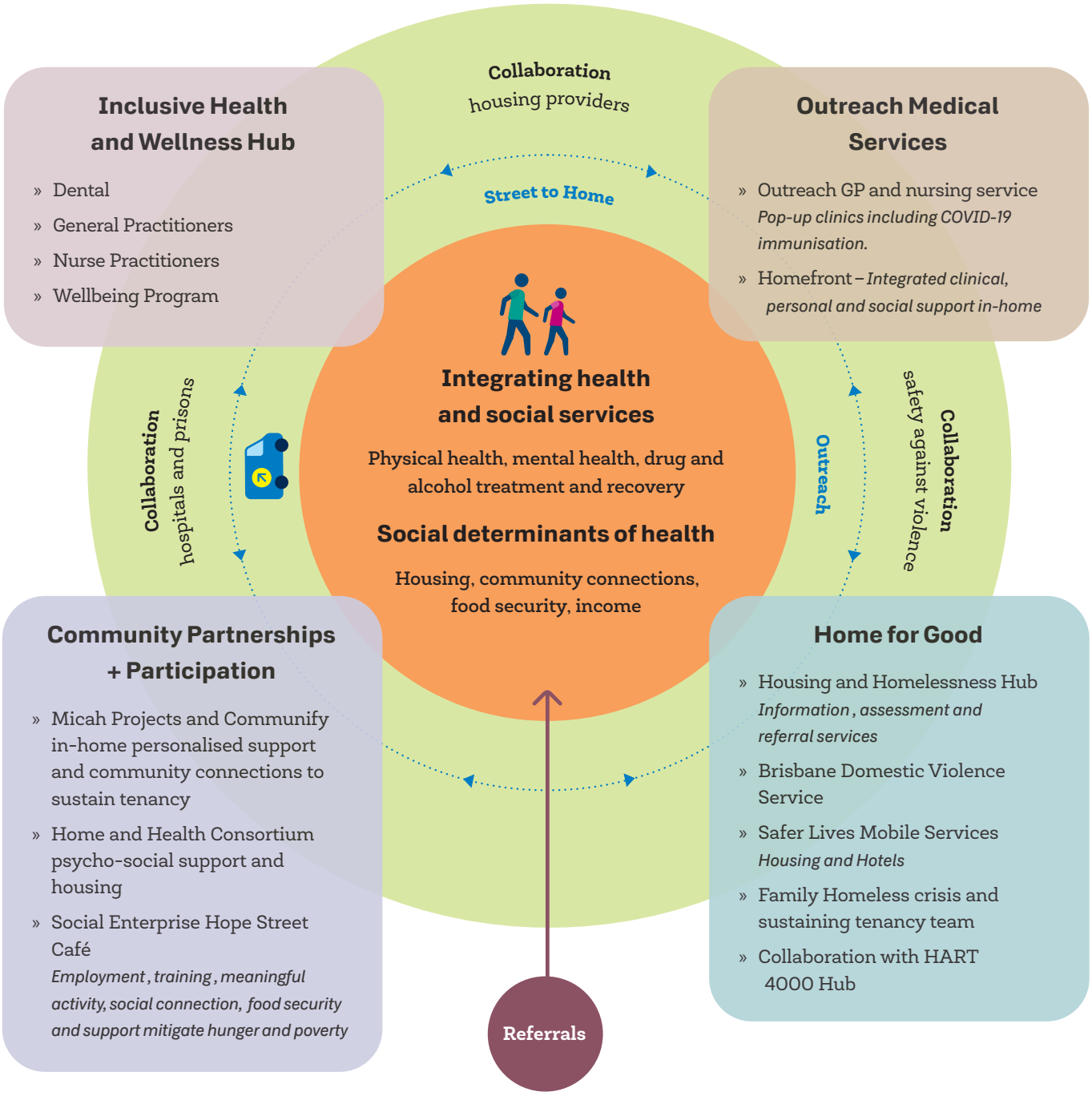
During COVID-19, Micah Projects and Inclusive Health and Wellness Hub have undertaken mobile pop-up clinics on the streets, in emergency accommodation, in social housing units and at community based centres such as Kurilpa Hall, Street Chaplaincy in Fortitude Valley. These clinics have successfully administered over 1000 vaccinations.

The **Hub and Spoke model** of expanding clinical care from the Hub to community outreach and pop-up clinics has proven successful in reaching more people who are marginalised by mainstream health and community services. This population has high hospital and ambulance/police utilisation and multiple health needs that remain unmanaged and unmet until acute care is needed. Additionally this model enables greater collaboration and integration with community housing and homelessness services.

Whilst hospitals create virtual wards to provide hospital-in-the-home services for many conditions, they often don't reach more marginalised populations who don't have a home or safe housing situation. This leads to more frequent hospital presentations for a range of conditions that could be supported in their home.

The operation of a recurrently funded Outreach Medical Service would provide an important pathway to ensuring a more continual reach of services. This would improve accessibility to healthcare and improved outcomes for participants experiencing homelessness or vulnerable in their home.

Many participants are unable to get to appointments or maintain routines to keep appointments. **Taking clinical care and support to the people is a much better option.**



Specialist Homelessness Services, Specialist Mental Health Services, Alcohol and Other Drug Services, Sexual Violence services, Queensland Police Service, Mater Health Services, Princess Alexandra Hospital, Royal Brisbane Women's Hospital, Prince Charles Hospital

Building an ecosystem through partnerships – connecting systems and services to improve access to housing, healthcare and community services to people experiencing homelessness and vulnerable in social housing and boarding houses.

> **“ We have to put a reduction of** health inequality at the center of our public health strategy and that will require actions on the social determinants of health.
> – Michael Marmot

Outreach Medical Services

An outreach medical service team consists of a GP, Nurse and Support and Advocacy Worker. The team is provided with administrative support, plus a van fitted out to take healthcare to people.

The team is responsible for:

- clinical governance and oversight
- in-reach to hospitals, emergency accommodation, boarding houses
- outreach to patients in their homes and on the street (home visiting)
- developing patient integrated care plans and reviews
- pop-up street and community clinics
- collaborative relationships: embedded within homeless service system and hospitals
- follow-up discharge planning
- ensuring continuity of care with After-Hours Street to Home nursing
- being flexible, responsive and innovative in solving problems to remove barriers to care.

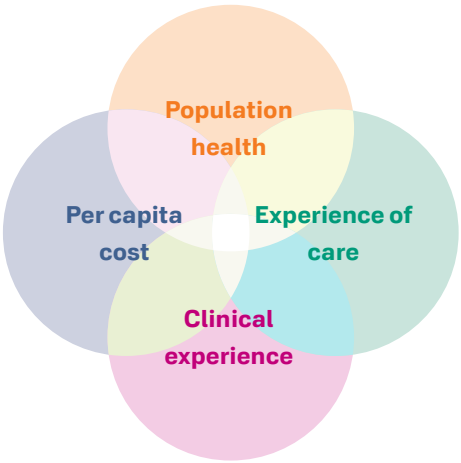
Clinical Services

- Health assessment.
- Service integration.
- Integrated care plan with mental health, drug and alcohol and social support services.
- Wound care.
- Medication prescription, reviews and management.
- Preventative screening.
- Hepatitis C testing and treatment.
- COVID-19 and flu vaccinations.

Budget

Wages	$685,000
Operating	$215,909
TOTAL	**$900,909**

Micah Projects is seeking investment by government, philanthropy and corporate business to make an Outreach Medical Service a reality to increase our impact in improving health outcomes and reducing health inequality.



The IHI Framework

The Institute for Healthcare Improvement (IHI) framework describes an approach to optimising health system performance.

- Improving the health of populations.
- Improving the patient experience of care (including quality and satisfaction).
- Improving clinical experience.
- Reducing the per capital cost of healthcare.

The Benefits

In 2013, Professor Luke Connelly BA(Econ) MEconSt, PhD (Qld) undertook an economic evaluation of outreach after hours nursing services demonstrated economic value. For an investment of $503,000 to outreach nursing services he conservatively estimated a $6.45 million fall in costs for hospital use and inpatient presentation.

An investment of $900,909 for an outreach medical team, could:

» double the fall in costs to hospital systems detailed in the 2013 economic evaluation of outreach nursing services
» improve access and healthcare outcomes for up to 1000 individuals annually
» improve experiences and satisfaction with services provided
» improve access to clinical care
» reduce the cost of homelessness on hospital systems.

> “ **Equity is not merely what we do or how we** think. Equity is the character and culture that our organisations seek to embody.
>
> – Marcus Littles, *Frontline Solutions*

The Evidence

Since 2010, Micah Projects has been building local evidence and adapting innovation through partnerships.

» *Impact Report: Mobile Health Service for people experiencing homelessness or are vulnerably housed* https://issuu.com/micahprojects/docs/2022_mp-ihp-impact-report
» *An economic evaluation of the Homeless to Home Healthcare after-hours service* https://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf
» *Pathways Hospital Admission and Discharge Pilot Project. Summary of the first two years Dec 2014–Dec 2016* https://micahprojects.org.au/assets/docs/Factsheets/2017-Pathways-2-Year-Summary-Report.pdf
» *Integrated Care Demonstration Model: Homefront—an evaluation* https://micahprojects.org.au/assets/docs/202108-Wound-Care-Report.pdf
» *Wound Care Services: Report to Micah Projects on the cost of providing wound care services to people who are homeless.* https://micahprojects.org.au/assets/docs/202108-Wound-Care-Report.pdf
» *COVID-19 Vaccination Pop up Clinics* https://mailchi.mp/cccba3284c70/jn14aqko5e?e=c07c107918

Housing First: a foundation for recovery

Breaking the cycle of Brisbane's housing, homelessness and mental health challenges

partnersinrecovery
supporting mental health and wellbeing

phn
BRISBANE SOUTH
An Australian Government Initiative

MICAH PROJECTS INC
Breaking Social Isolation
Building Community

Housing First
a foundation for recovery

Breaking the cycle of Brisbane's housing, homelessness and mental health challenges

Funded by Brisbane South PHN PIR Consortium
An Australian Government Initiative

Photography: Craig Holmes

November 2016

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We acknowledge the Australian Government's investment in the Partners in Recovery (PIR) program, Brisbane South PHN – lead agency for PIR in Brisbane South, and the 10 PIR partner organisations – Aftercare, The Benevolent Society, Brook RED, FSG Australia, Gallang Place, Harmony Place, Micah Projects, Neami National, Richmond Fellowship Queensland (RFQ) and Stepping Stone Clubhouse.

We acknowledge all stakeholders who contributed to the Mental Health, Housing and Homelessness Plan, the Southside Care Coordination Panel, the Lived Experience Advisory Group, and the *Housing First: a foundation for recovery* community action plan and associated Integrated Healthcare and Housing First Fact Sheets – specifically:

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Michael Tansky, Shelley Elliot, David Meddings, John Araneda, Sarah Burns and Kayla Godwin – *Micah Projects PIR Team*

Janelle Kwong, Ross Westoby, Kim Rayner, Maria O'Connor, Jo Bennett and Maria Leebeek – *Micah Projects*

Micah Projects Backbone and Communications Team

John Mendoza – *ConNetica*
Stephen Harvey – *Harvey Risk Management Pty Ltd*
Roundtable attendees

Rod Buchner and Renee Lee – *Service Integration Coordinators, Metro South Addiction and Mental Health Services*
Panel attendees

Lyndall Baker, Wayne Jaye, Michael Nycyk, Brian Sparks, Malcolm Hull and Lesley Houston – *Lived Experience Advisory Group*

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Housing First: a foundation for recovery

Artwork:
Coming Together by Luke Roma, Rocky Boy, Jagalingu Man from Rockhampton Region, 2013

This painting represents all Indigenous and Non Indigenous Australians coming together without malice or discrimination.

Our commitment to Reconciliation

We acknowledge the Aboriginal and Torres Strait Islander peoples (First Peoples) of Australia as the traditional owners and custodians of this land and that this was never ceded by them at any time. We acknowledge the impact of colonisation on the First Peoples and the trauma this inflicted on their lives, their culture and their rights to live on their traditional lands. We acknowledge and support their rights to self-determination, land and culture.

We acknowledge the over representation of First Australians who experience homelessness. We recognise that invasion and subsequent trauma and loss (cultural loss, family separations, incarceration, and racism) contribute to the mental distress of Aboriginal and Torres Strait Islander Australians. We are committed to working with Indigenous leaders, agencies and communities to create homes, and strengthen connection to family, culture and community for their own people.

Executive summary

As organisations that have worked with people experiencing homelessness and mental illness for over 20 years, we have witnessed people trapped in a revolving door of homelessness, hospital admissions, incarceration and housing instability. We have seen people traumatised as they attempt to meet their basic needs for food and shelter in a complex system. We have observed the multi-abuse trauma resulting from a lifetime of poverty, violence and abuse overlaid with the heavy burdens of stigma, shame and discrimination. We have witnessed people employ coping mechanisms for their trauma that both retraumatise and exacerbate stigma – such as alcohol and other drug use, self-harm and risky behaviours.

We know these issues are interconnected, and yet, we have not made inroads in connecting our fragmented systems of care which respond to substance use, homelessness, and mental illness. Our failure to respond to people trapped in this revolving door of expensive emergency services costs us all; both in the long term human cost of failing to meet people's basic rights to safety, dignity and psychological wellbeing, and the costs every year to health and social care systems.

Now is the time to take action – with a Queensland Housing Strategy, a new Housing First roadmap to ending homelessness in Brisbane, and mental health reforms driving planning and innovative investment at the local level.

The good news is that we know what works to end the cycle of homelessness and mental illness: *Housing + Supports*. Long-term housing is critical to recovery from mental illness, and community-based multidisciplinary supports are critical to staying housed and breaking the cycle of homelessness. Known as Housing First, this approach needs leadership to join up disconnected healthcare, housing, homelessness and community services. It also requires investment to deliver long-term housing to people with mental illness and embed outreach multidisciplinary clinical teams in community services.

This action plan advocates for the implementation of Housing First for mental health in Brisbane. It outlines four straightforward strategies for achieving this – **know who needs Housing First; close housing gaps; close service gaps; and implement Supportive Housing**.

Our advocacy for a Housing First approach is the result of recent work to understand what we need to do to create lasting change within a human rights framework for people who are chronically homeless and highly marginalised. We acknowledge the role of the consumers and lived experience movement, and the emerging neurodiversity movement, in advocating for non-pathologising supports, acceptance of diversity and protection of human rights. It is our hope and belief that this plan honours people's fundamental rights to housing, safety, dignity and self-determination.

Background

The *Housing First: a foundation for recovery* toolkit has been developed by the **Brisbane South PHN (BSPHN) Partners in Recovery Consortium** – a group of 10 non-government organisations partnered with BSPHN and funded by the Australian Government Department of Health to support people with severe and persistent mental health issues, along with their carers and families, to address their complex care needs and improve their wellbeing.

The interconnected values informing the PIR approach to mental health care are:

- **Recovery oriented:** creating opportunities for the person to resume control of their situation
- **Culturally competent:** integrating culture to work in cross-cultural situations
- **Trauma informed:** creating opportunities for survivors to rebuild control and empowerment.

The 10 non-government PIR organisations that partnered with BSPHN are:

- Aftercare
- The Benevolent Society
- Brook RED
- FSG Australia
- Gallang Place
- Harmony Place
- Micah Projects
- Neami National
- Stepping Stone Clubhouse
- Richmond Fellowship Queensland

As organisations supporting people with severe mental illness, we observe that so many of the people we support are trapped cycling between homelessness, hospital and corrections systems. Consequently, their mental health suffers and deteriorates over time. **We have come to understand that without addressing housing as a priority, our efforts to support people with their recovery are constantly hampered.**

In 2014, BSPHN funded Micah Projects to work with stakeholders to develop shared solutions for providing better housing outcomes for people with severe mental health issues. Micah Projects conducted a literature review, and engaged mental health specialists ConNetica, to facilitate a workshop and Roundtable with Brisbane stakeholders. After comparing the evidence of different models, ConNetica concluded that the Housing First approach provides a "substantive and qualitative improvement in harm minimisation, health outcomes, material benefits, social inclusiveness and psychological wellbeing for those… provided with permanent housing."[1] ConNetica also recommended that Brisbane agencies invest in a collaborative project to build greater service integration and care coordination.

The PIR consortium have invested in a coordination project in line with the ConNetica recommendations. In 2016, BSPHN again funded Micah Projects to initiate coordinated housing solutions in partnership with Metro South Addiction and Mental Health Services, and PIR, housing and community mental health service providers. Terms of Reference, Protocols and Referral Forms were developed, the Southside Care Coordination Panel and Lived Experience Advisory Group formed, and commenced taking referrals in July 2016.

As a group of agencies, we are committed to changing our practices and the systems we work within to bring Housing First to people with severe mental illness. The culmination of our recent work is this action plan and associated fact sheets on Housing First and Integrated Healthcare models. We have worked together to understand Brisbane's housing, homelessness and mental health challenges, and map out how Housing First can be implemented for people with mental illness in our community. As organisations who are supporting people with recovery, we understand the crucial importance of getting clinical treatment services to people wherever they are. This report provides models, evidence and recommendations for how that can be achieved – primarily through embedding multidisciplinary teams in community services and integrating those services with permanent housing.

This Housing First for Mental Health plan demonstrates how a Housing First evidence-informed approach to ending homelessness assists people who are homeless and living with mental illness to move quickly into permanent housing.

1 Mendoza, J. Hervey, S. (2015) *Improved Outcomes for people with Severe Mental Illness and Housing Solutions.* Brisbane, Australia: ConNetica and Micah Projects.

Homelessness services at Turbot Street, Brisbane during 500 Lives 500 Homes Registry Fortnight 2014.

Photography: Patrick Hamilton

Understanding Brisbane's housing, homelessness and mental health challenges

What lies beneath – multi-abuse trauma

In Brisbane, there is a growing percentage of people who are cycling through our hospital, corrections, homelessness and mental health systems. People trapped in this cycle are not only experiencing mental illness, but are also often victims of multi-abuse trauma. This frequently involves sexual assault, domestic violence, and/or child abuse, layered with trauma from the coping strategies of substance misuse and self-harm. Stigma, discrimination and oppression add trauma to people who are Indigenous, sex and gender diverse, have a disability or are from other minority groups. This discrimination exists even in our service system.

Fragmented care leads people to bounce through crisis systems of care, unable to access the supports they need. The failure of our systems to provide adequate housing, income and trauma-sensitive support to people, often through generations, has led to people experiencing homelessness, incarceration, and intergenerational poverty. Our First Peoples are still experiencing racism, poor healthcare and housing, incarceration and child removal. These experiences all add layers of abuse across people's lifetimes.

Understanding Brisbane's housing and mental health challenges means understanding the complex and interconnected nature of multi-abuse trauma and the way this impacts on mental illness and homelessness. What follows are some of the key factors which intersect in people's lives to create barriers to wellness and housing stability.

Homelessness and mental illness

In 2014-15 Brisbane's homelessness services supported 2807 people (27%) who had been diagnosed with mental illness.[2]

Mental illness and homelessness are interconnected. It is becoming increasingly clear that people experiencing homelessness have higher rates of mental illness than the general population.[3] People with mental illness also have much higher rates of homelessness and housing instability.[4] The reasons are multifaceted, and include social isolation, inadequate health and social supports, insufficient affordable housing stock, poverty, challenging behaviours when unwell, stigma and discrimination.[5]

Housing insecurity and homelessness also act as a significant risk factor for poor mental health.[6] Homelessness is a traumatic event with lifelong psychological impacts on children, young people and adults.

A survey of Australians who are homeless found that 73% met diagnostic criteria for Post Traumatic Stress Disorder (PTSD).[7] Most participants were exposed to multiple traumatic events with over 97% having experienced more than four traumatic events in their lifetime. This compares with a 4% rate in the general community. These figures confirm established research showing that adverse childhood experiences predict increased odds of experiencing homelessness as an adult, as well as a higher incidence of mental and physical health problems.[8]

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6 Baker, E., Mason, K., Bentley, R. & Mallett, S. (2014). Exploring the Bi-directional Relationship between Health and Housing in Australia. *Urban Policy and Research, 32*(1), 71-84.
7 O'Donnell, M., Varker, T., Cash, R., Armstrong, R., Di Censo, L., Zanatta, P., Murnane, A., Brophy, L., & Phelps, A. (2014). The trauma and homelessness initiative. *Report prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner SouthCommunity Health and VincentCare Victoria.* Retrieved from https://www.sacredheartmission.org/sites/default/files/publication-documents/THI_Report_research%20findings.pdf
8 Montgomery, A. E., Cutuli, J. J., Evans-Chase, M., Treglia, D., & Culhane, D. P. (2013). Relationship Among Adverse Childhood Experiences, History of Active Military Service, and Adult Outcomes: Homelessness, Mental Health, and Physical Health. *American Journal of Public Health*, *103*(Suppl 2), 262–268.

Jessica and Charlotte in their home.

Photography: Katie Bennett

"I've got bipolar and get depressed without a cat. Charlotte loves it here. She's still in a kitten stage and runs around the flat. The room is excellent and you get the city lights." *Jessica*

Psychosocial disability and deinstitutionalisation

As institutions for people with disability closed in Queensland, we have seen some Queenslanders experience opportunities to live in the community with choice and control over housing, supports and friendships.

However, these choices and opportunities have not been afforded to all. Many people continue to miss out due to a lack of the housing, healthcare and personal supports needed to buffer against the ongoing effects of ableism and multi-abuse trauma. The consequence of these systems failures is that many people with psychosocial disability are trapped in cycles of insecure housing, homelessness, acute psychiatric care, alcohol and other drug treatment, and hospital admissions.

In Brisbane, 5.5% of people accessing homelessness services, stated they were in a psychiatric hospital unit in the previous 12 months. 5% had been in a corrections facility, and 2% had been in rehabilitation.

A total of 19.6% of people accessing Brisbane's homelessness services are known to have been in an institutional setting in the year beforehand.[9]

9 Queensland Government. (2015). Department of Housing and Public Works Data source: 2014-15. *Confidentialised unit record files (CURF).* Brisbane, Australia: Unpublished raw data.

Substance use and physical health conditions

In 2014-15 Brisbane's homelessness services supported 2046 people seeking assistance with mental health issues, drug/substance use and alcohol use.[10]

Mental illness and substance use occur together very frequently, and are deeply interconnected challenges, often precipitating and interacting negatively with one another. Alcohol and other drug use are coping mechanisms for dealing with the trauma of homelessness, the distress of mental illness and their associated challenges. Both mental illness and substance use are barriers to accessing housing. Stigma and discrimination are exacerbated for people who are homeless when they have addictions or mental illness.

People with mental illness have poor physical health, with high rates of co-existing medical conditions and shortened life expectancies:[11]

60% have a co-existing physical illness (12% in general population)

- 6x more likely to have dental problems
- 3x more likely to have cardio-vascular disease
- 2x more likely to have respiratory disease
- 2x more likely to have diabetes

-20 years
Likely to die 20 years earlier

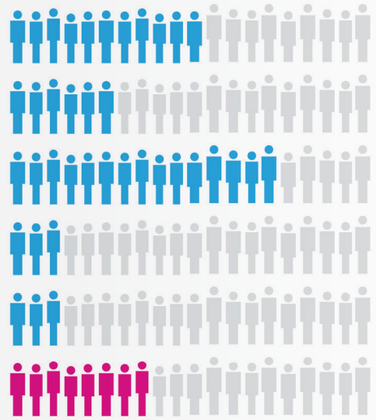
constitute approximately **one third** of all avoidable deaths

There is a growing body of evidence that Australians experiencing homelessness also have high rates of co-existing physical health conditions, such as infectious diseases, skin and respiratory conditions, and cardiovascular diseases.[12] In addition, people experiencing homelessness have a pattern of accessing high cost emergency care and poor engagement in primary healthcare programs. In our services, we are seeing people who present with a familiar pattern of these interrelated issues.

10 Queensland Government. (2015). Department of Housing and Public Works Data source: 2014-15. *Confidentialised unit record files (CURF).* Brisbane, Australia: Unpublished raw data.
11 Australian Government. (2015). Equally well: Quality of life; equality in life. *The Australian national consensus statement on the physical health of people with a mental illness.* Retrieved from https://consultations.health.gov.au/national-mental-health-commission/594530eb/user_uploads/national-consensus-statement---online-consultation-draft.pdf
12 Wood, L., Flatau, P., Zaretzky, K., Foster, S., Vallesi, S. and Miscenko, D. (2016) *What are the health, social and economic benefits of providing public housing and support to formerly homeless people?*, AHURI Final Report No. 265, Australian Housing and Urban Research Institute Limited, Melbourne.

Health needs of people homeless or at risk of homelessness in Brisbane

People homeless or vulnerably housed experiencing mental illness



- 56% Physical health condition — 9.95% unknown
- 32% Psychotic symptoms — 30.6% unknown (likely under-reported)
- 74% Psychological distress — 9.2% unknown
- 15% Alcohol use — 21.7% unknown (likely under-reported)
- 15% Substance use — 23% unknown (likely under-reported)
- 3+ 35% Three or more conditions (likely under-reported)

Partners in Recovery Service data[13]

People experiencing homelessness

Families with a parent 25 yrs or over

- 40% Mental health condition
- 16% Physical disability
- 45% Asthma
- 37% Substance use
- 14% Heart disease

Individuals 25 yrs or over

- 56% Mental health condition
- 25% Physical disability
- 25% Asthma
- 67% Substance use
- 55% Dental condition
- 28% Heat exhaustion

500 Lives 500 Homes Families Data[14] | *500 Lives 500 Homes Individuals* data[15]

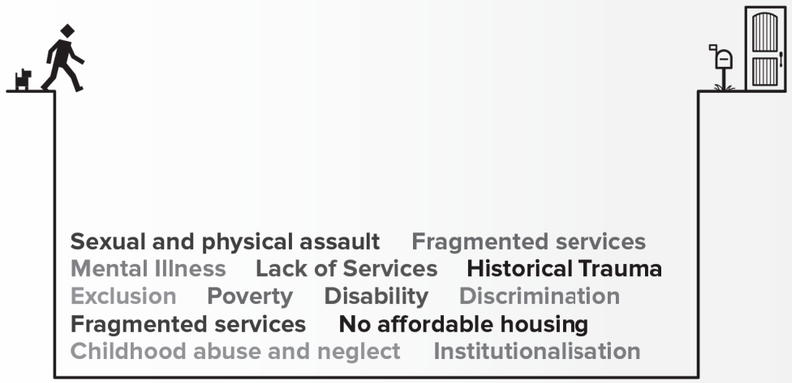
13 Brisbane South PHN (2016), Partners in Recovery Service Data Source 2013 – 2016. *Unmet psychological and physical health needs of people who are homeless and accessing*, Oct 2013 – June 2016 (n=764). Brisbane, Australia: Unpublished raw data.
14 500 Lives 500 Homes. (2014). *Emerging trends VI-SPDAT adult families fact sheet*. Retrieved from http://micahprojects.org.au/assets/docs/Factsheets/2014-500-Lives-Adult-Families-factsheet.pdf
15 500 Lives 500 Homes. (2014). *Emerging trends VI-SPDAT adult individuals fact sheet*. Retrieved from http://www.500lives500homes.org.au/resource_files/500lives/2014-500-Lives-Adult-Individuals-factsheet.pdf

Service system failures

The experience of being homeless with mental illness increases the likelihood that people will interact with multiple parts of the housing, health, corrections and social services systems. However these systems are characterised by fragmentation and a lack of planning and coordination at a local level.[16]

We must also acknowledge that discrimination exists in our services. There are barriers to accessing support if you are homeless, have a disability, transient, poor, Indigenous, LGBTI and/or marginalised in other ways. In Brisbane, our healthcare services actively discriminate against people with addictions, turning people away from services if they are affected by alcohol and other drugs or failing to identify and treat co-occurring mental and physical health conditions. We have an underfunded Alcohol and Other Drug Service system which cannot meet people's mental health needs, and so people with substance use issues are suffering from both discrimination and a lack of services.

When housing and healthcare services are also poorly coordinated, getting housed and recovering from homelessness and mental illness can be an insurmountable challenge. People in Brisbane are experiencing trauma from the very systems that were designed to help them. ***We have to do better***.



16 Australian Government, Department of Health. (2015).'Response to Contributing Lives, Thriving Communities', *Review of Mental Health Programmes and Service*. Canberra, Australia; Commonwealth of Australia. Retrieved https://www.health.gov.au/internet/main/publishing.nsf/content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf.

Chrissy (right) moving into her new home assisted by PIR worker Sarah.

Photography: Craig Holmes

Housing First for mental health

Our commitment to implementing Housing First underpins this plan.

What is Housing First?

Housing First is a recovery-oriented approach to ending homelessness that assists people experiencing homelessness to quickly move into independent and permanent housing. For too long, people who are homeless with mental illness have been forced to jump through hoops, such as accessing psychiatric or case management services, and demonstrating personal change before being deemed 'housing ready'.

Housing First means there are no conditions that have to be met before the person moves in. They do not need to agree to psychiatric or substance use treatment. Services offered are voluntary, with the responsibility for engagement resting with the service provider, not the tenant.

Recovery, consumer choice and self-determination

Housing First considers people who are homeless with mental illness to be full citizens with rights to housing and self-determination over whether they access treatment and other support services. Housing First recognises that it is the role of professionals to be proactive in engaging people in services that assist them to stay housed, and fulfil their role as tenants, neighbours and citizens.

Housing First is a recovery oriented model, having features that are critical to people's recovery journey:[17]

- Housing is a choice; not a placement and not an institution
- Housing is low-barrier (sobriety is not a precondition to accessing housing)
- Housing is physically and emotionally safe and stable
- Housing First tenants have the same rights and responsibilities to be good neighbours and tenants as any other tenant, and are supported to meet these responsibilities
- Stability is a priority. If tenants move out (by choice or through not meeting tenancy agreements), every effort is made to connect them to safe housing and recovery supports.

Stephen on his balcony at Brisbane Common Ground.

Photography: Katie Bennett

"I'm sick a lot of the time and have to do something about the drinking. I can't keep putting myself through this. Micah has offered to help but I want to do it myself. Now I'm in a relaxed place it should be a lot easier for me." *Stephen*

Supportive Housing

A Housing First model for Brisbane

Supportive Housing is a Housing First model that involves the intentional and long-term connection of secure and affordable housing with support. Services coordinated with supportive housing are focused on tenancy sustainment and coordinated access to other specialised and community-based services. Supportive Housing is effective for people who need safe housing that is closely integrated with support services – typically, people who have been chronically homeless and/or people with complex or high support needs, including people with mental illness. One of the critical components to supportive housing for people with mental illness is the coordination with multidisciplinary healthcare teams as a strategy to sustain tenancy and reduce crisis hospital presentations and care. This coordination enables early identification and proactive support to people whose mental states are impacting on their wellbeing, ability to be good neighbours and to stay housed.

Supportive housing does not mean institutional care or supported accommodation. People have their own leases and access to supports is voluntary. **Supportive housing is still a recovery-oriented approach**, but is offered to people who have a long-term need for support to stay housed. Supportive housing can be delivered via onsite support, or via outreach services coordinated with tenancy management.

Integrating healthcare

Multidisciplinary healthcare supports integrated with housing, community and clinical services are needed in Brisbane. People who are homeless, tenants of boarding houses, share housing and social housing have inadequate access to clinical and community services. This is due to the complex nature of people's physical and mental health needs, the impacts of these overlapping issues on their housing, and the barriers to accessing mainstream healthcare supports.

Assertive Community Treatment (ACT) is an evidence-informed, community-based model for delivering specialist assertive outreach to people with mental illnesses. The teams include members from the fields of psychology, nursing, substance abuse and vocational rehabilitation. Multidisciplinary teams provide proactive and intensive support with a focus on housing, daily living and quality of life (rather than symptoms). ACT teams use assertive outreach to proactively engage individuals in treatment, including people with mental illness who don't meet eligibility thresholds for public mental health services. This could include people living with depression, anxiety, complex trauma, addictions, or with emotion regulation or executive functioning challenges.

In the USA and Canada, ACT has been shown to substantially reduce inpatient and emergency hospital visits and is more satisfactory to consumers than other types of community-based care. When integrated with safe long-term housing, such as in the Pathways to Housing approach, ACT teams have been demonstrated to achieve excellent housing retention outcomes. In a longitudinal study[18], 80% of the participants assigned to Pathways to Housing were in stable housing after 12 months, compared with 24% in the alternative continuum of care approach.

17 National Council for Behavioural Health, *Options, Not opponents: Housing First and Recovery Housing,* http://www.thenationalcouncil.org/BH365/2016/08/23/options-not-opponents-housing-first-recovery-housing/, 2016

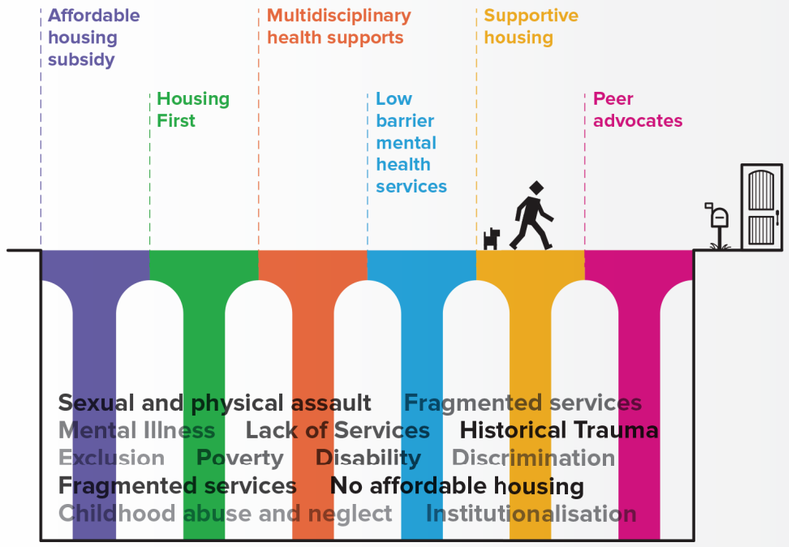
18 Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing first, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Housing First works

There is strong evidence that:

- We can house people with complex mental and physical health challenges, without first addressing health challenges
- Providing housing integrated with support services is a highly effective solution to ending homelessness and improving people's physical and mental health
- Coordinating Housing First approaches with multidisciplinary healthcare teams is critical to this success.

Recent research across Brisbane, Sydney and Melbourne,[19] has found that people who have been homeless with multiple social and health challenges can successfully exit homelessness and stay housed using a Housing First approach. Furthermore, in Brisbane they reported that time spent in secure housing was associated with reduced symptoms of psychological distress and improvement in measures of quality of life (using validated measures). This research reflects a body of international evidence for the successful outcomes and cost effectiveness of Housing First approaches. In a 2000 participant trial of Housing First in Canada, they reported that Housing First delivers a "large and significant impact on housing stability" and "clear and immediate improvements" to quality of life.[20]



19 Parsell, C., Johnson, G., & Button, E. (2013). *Street to home: a national comparative analysis*. St Lucia, Australia: Homelessness Research Partnership with the Department of Families, Housing, Community Services and Indigenous Affairs, Institute for Social Science Research.

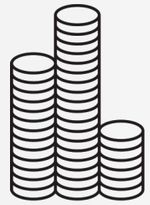
20 Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., & Aubry, T. (2014). *National at home/Chez soi final report.* Calgary, AB: Mental Health Commission of Canada.

Housing First is cost effective for Brisbane

A 2013 research project into the cost effectiveness of Housing First in Brisbane found the overall cost to the health, justice and community service systems reduced substantially as individuals transitioned from homelessness to housing. This was due largely to the reduction in use of justice services, with the cost to police and courts dropping from an average of $8,719 per person per annum to just $2,172.[21]

In Brisbane, Micah Projects evaluated the Homeless to Home Healthcare after-hours service in which nurses worked with an outreach team of housing-focused community workers where the Housing First approach was embedded to get people housed. The evaluation estimated an avoidance of $6.9M in hospital and emergency department costs for an investment of $500,000.[22]

By comparing pre and post utilisation data at a point in time with 41 tenants, the Hope St Brisbane Common Ground Supportive Housing Evaluation found that $1.12M less was spent across health, corrections and specialist homelessness services compared to when tenants were homeless.[23]



$2.14M

cost avoidance after 12 months of the Pathways Pilot Program
by reducing ED presentations and hospitalisations

$13,100*

saving per tenant at Brisbane Common Ground
Comparing service utilisation costs between when a person is homeless and when they are housed with support.

Pathways Hospital Admission and Discharge data[24] | *Brisbane Common Ground data*[23]

* Cost saving was calculated at a fixed point in time.

21 Mason, C., & Grimbeek, P. A. (2013). *Housing First approach to homelessness in Brisbane, Sustaining tenancies and the cost effectiveness of support services*. Brisbane, Australia: Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

22 Connelly, L. (2015).*An Economic Evaluation of the Homeless to Home After Hours service*. Brisbane, Australia; Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf

23 Micah Projects (2015). *Brisbane Common Ground Evaluation snapshot.* Retrieved http://micahprojects.org.au/assets/docs/Publications/2016-BCG-Snapshot-for-Screen.pdf.

24 Rayner, K., & Westoby, R. (2015). *Pathways Hospital Admission and Discharge Pilot Project: Twelve Month Evaluation Report January 2015 – December 2015*. Brisbane, Australia: Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Factsheets/2016-IH-Pathways-Summary-for-web.pdf

Lotus, a Micah Projects Support and Advocacy Worker and Sue, an Inclusive Health Pathways Clinical Nurse, providing an integrated health and housing response to Tammy as she settles into her new home.

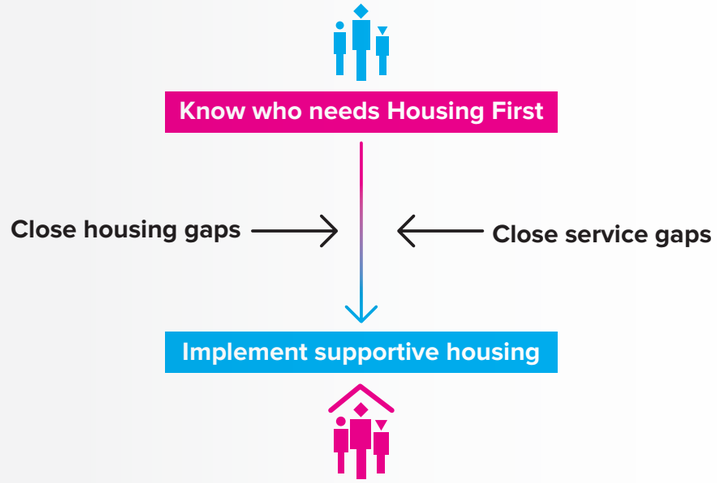
Photography: Lachie Douglas

Strategies for change

A Housing First approach underpins each of our strategies for addressing Brisbane's mental health and homelessness challenges.

Housing First:

- is an evidence based solution to end homelessness for people with complex mental health challenges
- addresses current unmet needs for housing and support in a way that reduces fragmentation and (with appropriate investment) can increase access to multidisciplinary healthcare supports embedded in community services
- employs values that align with consumers and psychiatric survivors' advocacy for self-determination and choice to access non-pathologising supports
- is recovery oriented, giving people the best chance of recovery from homelessness and multi-abuse trauma.



Strategy 1: Know who needs Housing First

If we want to end homelessness for people with mental illness, we have to know each person by name, and understand their health and housing needs. We need a picture of individual need, as well as unmet need across the system. Right now, we have a broad idea of the number of people with mental health challenges accessing homelessness services, as well as the number of people accessing PHNs who are homeless or vulnerably housed. We do not know the overlap between these sources of data, nor the very different housing and support needs of each person.

To achieve this, we will implement a **Brisbane Mental Health and Housing First Action Group**, which will include representation from across health, housing, corrections, community services and peer advisors. This group will:

1. Develop a by-name register of people who are homeless with mental illness, which is a subset of Brisbane's Register of people who are homeless
2. Establish shared screening and assessment tools, in line with Queensland's new Mental Health Act and work undertaken as part of our national mental health reforms
3. Establish coordinated entry across mental health, housing and homelessness systems leveraging existing reform efforts in these separate systems – e.g., implementation of a stepped care approach (mental health), the work of 500 Lives 500 Homes (homelessness).

Care Coordination Panels

The Southside Care Coordination Panel (The Panel) was recommended as a solution to mental ill-health and homelessness in the *Final Report: Improved Outcomes for people with Severe Mental Illness and Housing Solutions, ConNetica, August 2015*[25]. The Panel commenced in May 2016 – bringing together government and community services to provide a coordinated approach to assessing and planning responses to the needs of people living with severe and persistent mental illness who are frequently presenting at Emergency Departments, have multiple admissions to inpatient units, and have long stays in hospital. Some people with multiple diagnoses do not think they are unwell and refuse to take medication after discharge from hospital, avoid follow-up contact with mental health services, have no or few referral pathways, have difficulty finding safe housing and risk eviction due to complaints about their behaviour, experience persisting chronic dental and chronic health problems, and have regular contact with police, courts and prisons.

The Panel addresses identified issues and barriers through planning, implementing and reviewing strategies and interventions required to support people whose needs cannot be resolved by the person, one organisation alone or by working in isolation. The Panel does not replace existing service delivery models. It provides a means for closer working partnerships, improved communication and monitoring to evaluate the effectiveness of collaboration.

Strategy 2: Close housing gaps

We cannot end homelessness while the supply of housing does not match demand. We know that there is under-utilised stock in Brisbane; however, we also know that demand currently far exceeds supply. We need to work together to create more housing that matches what is needed, and engage the whole community in innovative solutions to our supply problem.

What do we know about the housing gap?

- 2807 people with mental illness access Brisbane's homelessness system over a 12 month period
- 769 people with unmet accommodation needs and mental illness access Brisbane South PHN over a three year period
- $134,506.68 was spent on accommodation by Partners in Recovery (mental health supports) in one year, more flexible funding spent on accommodation than on any other item (36% of total flexible funds).

25 Mendoza, J. Hervey, S. (2015) *Improved Outcomes for people with Severe Mental Illness and Housing Solutions.* Brisbane, Australia: ConNetica and Micah Projects.

Housing First: A Roadmap to Ending Homelessness in Brisbane recommends that the Queensland Government **establish a Social and Affordable Housing Trust fund** to increase the supply of affordable and social housing. Any efforts to implement concrete action to increase demand must ensure an **allocation of affordable housing for people with mental illness** which matches the proportion of homeless people with mental illness and psychosocial disability in Brisbane – 25-30%. A proportion of this affordable housing should be allocated to **Supportive Housing** and this is outlined more in Strategy 4.

Further, given that housing is a known crucial element to recovery from mental illness, Governments and their commissioning bodies should **allocate funds for housing rent subsidies** for people with mental illness. In implementing mental health reforms, PHNs have been tasked with developing innovative, coordinated services for people with severe and complex mental illness. Rent subsidies are one such innovation with proven outcomes for people with complex mental health and substance use challenges.

Strategy 3: Close service gaps

It is unacceptable that those people in Brisbane who have the most need for support to recover from multi-abuse trauma are the most impacted by obstacles such as underfunded services, fragmented systems of care, discrimination and other barriers to the services they do access. If we want to enable recovery from homelessness and mental illness, we need to address these gaps. Provision of adequate clinical and community services to people in the community is not only critical for the people's wellbeing but also for neighbourhood and community safety.

Ending a fragmented system of care requires bringing together primary healthcare, mental health care, alcohol and other drug treatment, and social supports. We call on the Queensland Government to **invest in multidisciplinary health supports embedded in community care services**, where there are fewer barriers to access and engagement. These health supports can be provided through outreach, such as with **Assertive Community Treatment teams based in community organisations**, and in community-based clinics, like the proposed for Brisbane. A Housing First approach intentionally connects these multidisciplinary supports with housing, by ensuring that:

- people who are homeless or at risk are prioritised for supports
- multidisciplinary healthcare teams outreach to people's homes
- homelessness services, and health clinics are co-located with housing services
- housing access and retention is an outcome for supports.

We know that people in the community who are survivors of psychiatric care can be strong advocates for their peers, and recommend that a **network of peer**

advocates are supported to provide information, education and advocacy as people access and engage with the service system.

We must invest in **services to sustain tenancy for people who are at high risk of becoming homeless** due to mental illness, and co-occurring substance misuse, disability, and health conditions.

We need to proactively **plan for the loss of services to high need and vulnerable populations** as Queensland Government funding transitions to the National Disability Insurance Scheme. An investment in community care is needed to respond to people who might not meet NDIS eligibility and/or have needs beyond the scope of NDIS, which have previously been met by these services.

Strategy 4: Implement Supportive Housing

Supportive Housing involves the intentional and long-term connection of secure and affordable housing with support that is focused on tenancy sustainment and coordinated access to other specialised and community-based services. It is an evidence based solution for people with multiple, complex barriers to ending homelessness and high support needs (due to psychosocial disability, multi-abuse trauma and/or multiple co-occurring physical and mental health, and addiction challenges).

We recommend that the Queensland Government, in partnership with PHNs and non-government organisations, **establish a Supportive Housing Taskforce for Brisbane** to focus on unmet need in supply of housing and supports to sustain tenancy. This taskforce will look at how we can access and bring together resources from the Queensland Government, PHNs, and the National Disability Insurance Scheme to help us to **create a mix of single and scattered site permanent Supportive Housing for people with mental illness.**

Darren with Social Inclusion worker Emma on a boat trip with 'The Hive'.

Concluding statements

People with mental illness in Brisbane face huge challenges as they struggle to recover from the interconnected and devastating impacts of homelessness, addiction, and multi-abuse trauma, and the stigma, discrimination and retraumatisation they face in a fragmented system.

These challenges have impacts on people's health, with so many developing life-threatening physical health conditions, substance use disorders, and severe mental illness. As service providers, we have witnessed lives being cut short by untreated physical health conditions and suicide.

We want to do better.

We know what works. Housing First is already ending homelessness in Brisbane, changing lives and saving money across service systems. Integrating supports with housing, including multidisciplinary healthcare supports, and giving people choice to voluntarily access supports, restores dignity and enables people to start the process of recovery.

However, it will take **commitment from Government and community leaders** working together to address critical gaps in housing, healthcare and supports. It will take bold steps, and new approaches to funding and partnerships, to embed multidisciplinary healthcare in community services and to implement Housing First innovations such as Supportive Housing.

We can no longer afford to work alone, watching people struggle with their own complex trauma in a complex system. Every child and adult who is suffering now is one too many. It is time to work together to implement what we know works to restore dignity and wellbeing – Housing First for mental health.

Glossary

Addiction
A physical or psychological need for a habit-forming substance, such as a drug or alcohol

Assertive Community Treatment
An Evidence-Based Practice Model designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been met by more traditional mental health services

Co-existing / Co-occurring Conditions
People who have substance use disorders and/or mental health conditions existing simultaneously

Homelessness
The experience of living without conventional accommodation (sleeping rough or in improvised dwellings), frequently moving from one temporary shelter to the next or staying in accommodation that falls below minimum community standards

Housing First
A recovery-oriented approach to ending homelessness that assists people experiencing homelessness to quickly move into independent and permanent housing

LGBTI
Lesbian, Gay, Bisexual, Transgender and Intersex peoples

Marginalised
To be placed in a position of marginal importance, influence or power

Mental Health
A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community

Mental Illness
A health condition that changes a person's thinking, feelings, or behaviour (or all three) and that causes the person distress and difficulty in functioning

Substance Use
Any time someone consumes alcohol or other drugs

Multi-Abuse Trauma
When an individual is impacted by multiple co-occurring issues that negatively affect safety, health or wellbeing. Examples of co-occurring issues include: childhood abuse or neglect, domestic violence, societal oppression, intergenerational grief, homelessness and incarceration

Multidisciplinary Healthcare
Healthcare that occurs when professionals from a range of disciplines, but with complementary skills, knowledge and experience, work together to provide the best possible outcome for the physical and psychosocial needs of a patient

National Disability Insurance Scheme (NDIS)
A social reform in Australia initiated by the Australian government for Australians with a disability

Neurodiversity Movement
A social justice movement that seeks civil rights, equality, respect, and full societal inclusion for individuals who have a brain that functions in ways that diverge significantly from the dominant societal standards of "normal"

Primary Healthcare
The first level of contact individuals, families and communities have with the health care system

Psychiatric Survivors Movement
A diverse association of individuals who either currently access mental health services or who are survivors of interventions by psychiatry, or who are ex-patients of mental health services

Psychosocial Disability
The experience of people with impairments and participation restrictions related to mental health conditions

Recovery Paradigm
An approach to mental illness or substance dependence that emphasises and supports a person's potential for developing new meaning and purpose in their lives as they grow beyond the effects of their illness

Supportive Housing
A housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities

Supportive Housing Scattered-Site Model
Units in apartment buildings spread throughout a neighbourhood or community that are designated for specific populations, accompanied by supportive services, with individual leases and a separation between tenancy management and support

Units within a single property or building providing housing for a range of supportive housing populations, with individual leases and a separation between tenancy management and support

The document
Housing First: a foundation for recovery
was produced by the
Brisbane South PHN Partners in
Recovery Consortium (Nov 2016)

For more information:
info@micahprojects.org.au
micahprojects.org.au

Brisbane South PHN Partners in Recovery Consortium

benevolent SOCIETY aftercare fsg Australia Freedom • Social Justice • Growth Stepping Stone Clubhouse

BROOK red Gallang Place Harmony Place Multicultural Mental Health & Wellbeing

MICAH PROJECTS INC Breaking Social Isolation Building Community

neami national Improving Mental Health and Wellbeing

rfq recovered futures RICHMOND FELLOWSHIP QUEENSLAND

phn BRISBANE SOUTH An Australian Government Initiative

Housing First

Housing First is a proven approach that connects people experiencing homelessness with long-term housing **as quickly as possible and without preconditions**. Housing First is guided by the belief that a safe home is a human right and a basic need that must be met before attending to personal issues. The model is based on evidence that people, even with long histories of homelessness, mental illness or addictions, can achieve housing stability in long-term housing if provided with the right supports.

Core Elements of Housing First

Assertive outreach to engage and offer housing to people with a mental illness who are homeless.

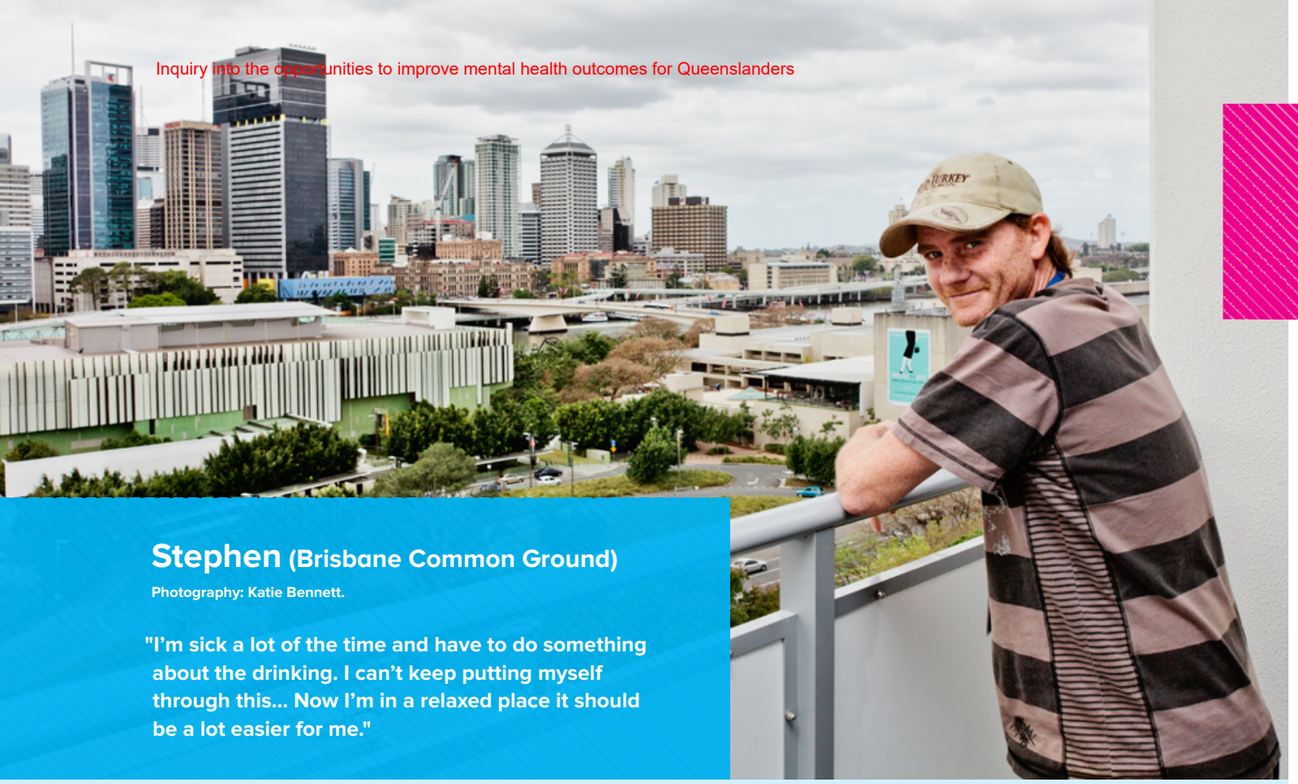
Immediate access to permanent housing. If, due to housing stock, the initial housing placement is short-term, the program commits to housing the person in long-term housing as fast as possible.

A harm minimisation approach that supports people to reduce the risks and harmful effects associated with substance use and addictive behaviours but does not require abstinence to access or keep housing.

Individualised, recovery-oriented supports. Supports are readily available, however Housing First programs do not require participation to remain in housing. Support services are proactive in their efforts to engage tenants.

Social and community inclusion is an intentional part of Housing First program design. Housing is non-stigmatising, and support services provide opportunities for engagement in education, hobbies, culture and employment.

Breaking the cycle of homelessness. As well as focusing on tenancy sustainment, Housing First programs also ensure there is no exit to homelessness and that people who leave for short periods (e.g. due to hospitalisation) can return.

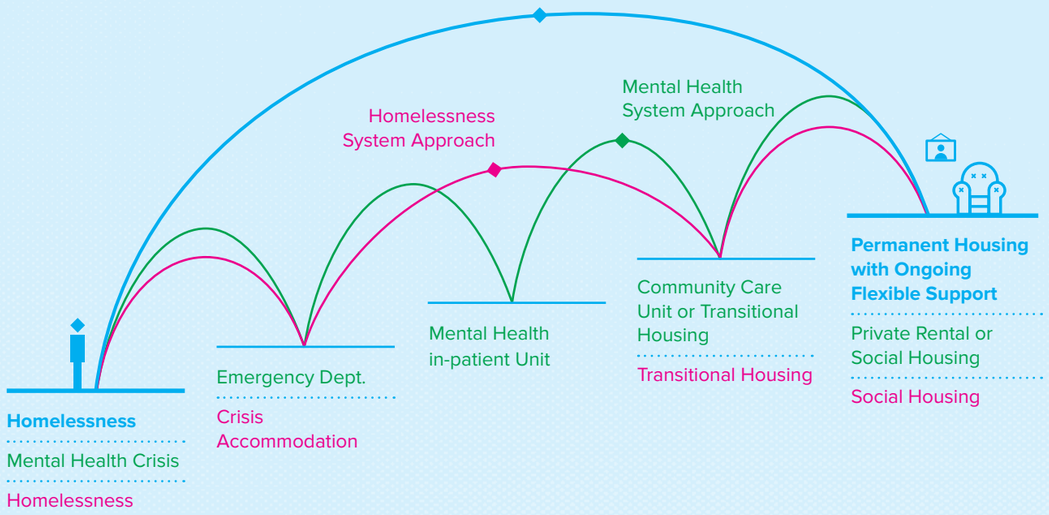


Stephen (Brisbane Common Ground)

Photography: Katie Bennett.

"I'm sick a lot of the time and have to do something about the drinking. I can't keep putting myself through this... Now I'm in a relaxed place it should be a lot easier for me."

Housing First Approach



The Housing First Difference

A housing first approach is different to traditional 'treatment first' approaches, where people progress through a series of programs with expectations that they have addressed any substance use, living and social skills, or mental health issues before accessing long-term housing.

Supportive Housing

Supportive housing involves the intentional and long-term connection of secure and affordable housing with support. It is an innovative and proven model which follows the Housing First approach. Supportive housing is effective for people who need safe housing that is closely integrated with support services – typically, people who have been chronically homeless and/or people with complex or high support needs, including people with mental illness.

Scattered Site

Units or houses spread through a neighbourhood or community that are designated for specific populations, with support provided through home visits. Offers people independence in their housing with support to stay housed, and connection to communities of choice.

Single Site

Housing developments in which units or the whole building are designated as supportive housing and support providers are based on-site. Offers people a community within their housing, close access to support and often increased safety due to on-site security personnel or security systems.

Pathways to Housing

One of the first and most researched models of supportive housing is Pathways to Housing. Operating since the 1990s in New York, and now implemented around the world, the model brings housing together with a recovery-oriented Assertive Community Treatment (ACT) team for people who have experienced both mental illness and homelessness. ACT teams are multidisciplinary and are on-call 24 hours a day, seven days a week. Pathways to Housing has achieved excellent housing retention outcomes. In a longitudinal study[1], 80% of the participants assigned to Pathways to Housing were in stable housing after 12 months, compared with 24% in the alternative continuum of care approach.

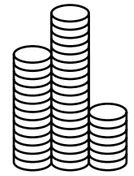
80%

of Pathways to Housing participants in stable housing after 12 months[1]

Brisbane Common Ground

Brisbane Common Ground is Queensland's first single site supportive housing initiative. The model is based on the successful New York City Common Ground with a mix of low income and formerly homeless tenants and closely coordinated support, tenancy management and security services. Although Brisbane Common Ground targets people who are chronically homeless, the majority of tenants also have a diagnosable mental illness.

An evaluation of the effectiveness of Brisbane Common Ground found that it has removed barriers for people with support needs experiencing chronic homelessness to access housing, and fostered the conditions for tenants to sustain housing[2].



$13,100

saved per tenant at Brisbane Common Ground[2]

Comparing service utilisation costs between when a person is homeless and when they are housed with support. Cost saving was calculated at a fixed point in time.

Housing First is Effective

Housing and Accommodation Support Initiative (HASI)

The Housing and Support Initiative (New South Wales) and Housing and Support Program (Queensland) are Australian programs implementing Housing First principles. These programs operate as partnerships between Housing, Health and Community organisations, providing long-term social housing with clinical and non-clinical support.

An evaluation of the NSW HASI[3] reported:

There were 1000 mental health consumers supported each year, with schizophrenia the most common diagnosis (65%)

More than half of partipants had a co-existing condition, such as alcohol or drug dependency, physical health condition or intellectual disability

The initiative saw a reduction in hospital admissions and mental health symptoms

There was an increase in housing stability and improvement in people's ability to participate in:

- community
- education
- employment activities

At Home / Chez Soi

'At Home/Chez Soi' was a four-year project in five cities across Canada that aimed to provide practical, meaningful support to Canadians experiencing homelessness and mental health problems.

The project offered housing with services to more than 1000 Canadians and has been the world's largest trial of Housing First, comparing the outcomes of the participants with a control group who were accessing services as usual in their communities.

At Home / Chez Soi[4] found that Housing First:

Rapidly ends homelessness, delivering a large and significant impact on housing stability

Is a sound investment, with every $10 invested resulting in an average savings of $21.72

Creates shifts from people accessing crisis and institutional services to accesing community-based services, and people with previously unmet needs accessing support services

Delivers clear and immediate improvements to quality of life, including substance use and mental health symptoms

The Housing First Fact Sheet was produced by the Brisbane South PHN Partners in Recovery Consortium (Nov 2016)

1 Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing first, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

2 Parsell, C., Petersen, M., Moutou, O., Culhane, D., Lucio, E. & Dick, A. (2016). *Brisbane Common Ground evaluation: Final report*. Brisbane, Australia: Department of Housing and Public Works.

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4 Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., & Aubry, T. (2014). *National at home/Chez soi final report*. Calgary, AB: Mental Health Commission of Canada.

Integrated Healthcare

...for people with mental illness who are homeless or vulnerably housed.

There are thousands of people with mental illness in Brisbane who are cycling through our health, corrections and homelessness service systems. They frequently have significant co-existing health conditions, which are not managed well by a system that is fragmented and excludes people with mental health or addiction challenges.

Redesigning Health Services

There are proven solutions to addressing the health needs of people with mental illness and co-existing complex health conditions. We can redesign healthcare services that are:

Trauma informed. Services that are designed to respond to the impact of trauma, by incorporating an understanding of trauma into their work, **building physical and emotional safety** for people, and providing them as much choice and control as possible.

Low barrier, low threshold.
Low barrier services are accessible and user friendly, and remove major barriers to accessing services, such as staff attitudes, complex procedures and eligibility criteria. Outreach to people in their homes and other community settings is one of the best methods for **increasing accessibility of health services**. Low threshold programs work within a harm minimisation framework and offer treatment without requiring individuals to completely abstain from alcohol and illicit drug use.

Multidisciplinary. Services that include professionals from **a range of different healthcare professions** with specialised skills and expertise. When supporting people with mental illness, addictions, and chronic health conditions, multidisciplinary teams should include alcohol and other drugs (AoD), mental health, and primary healthcare professionals.

Integrated with community services.
One of the best ways to address barriers to accessing healthcare and service fragmentation is to **embed outreach health services within community services**, such as homelessness programs. These programs are already providing outreach support to marginalised populations and working with people on important needs that support health and recovery, such as housing and income stability.

Pathways to Housing

Assertive Community Treatment (ACT) + Housing First

Pathways to Housing is a Housing First program for individuals with serious mental illnesses, long histories of homelessness, and often co-occurring substance abuse. Originating in New York, the Pathways to Housing model has been replicated and evaluated nationally and internationally and has a twenty-year track record of success for ending homelessness across 100 cities throughout the United States, Canada and Europe.[1]

Pathways to Housing offers people affordable, permanent housing alongside intensive support to stay housed and improve wellness. In a longitudinal study[2] **80% of participants were in stable housing after 12 months**, compared with 24% in the alternative 'continuum of care' approach.

Crucial to the success of Pathways to Housing is the integration of Assertive Community Treatment teams within a Housing First model.

Assertive Community Treatment (ACT) is an evidence-based practice model that provides intensive and highly integrated treatment, rehabilitation and support services to people with mental illness whose needs have not been met well by traditional mental health services. ACT teams are multi-disciplinary, **collaborating to deliver integrated supports** in the person's home (or other living settings). The staff-to-consumer ratio is small (1:10) and services are provided 24/7 for as long as needed.

ACT teams use assertive engagement to proactively engage with people living on the streets, in unstable housing, or in long-term social housing. This includes people who don't meet eligibility thresholds for public mental health services, such as people living with depression, anxiety, complex trauma, addictions, or with emotion regulation or executive functioning challenges. ACT teams assist people to find housing and **continue to provide support and treatment** until the person has resolved their needs.

Pathways to Housing ACT team service delivery model:

Intensive and frequent contact with people

Assertive outreach

Focus on community-based health triage, symptom management and everyday problems

Time-unlimited services

A Team approach to shared case management

- Team Leader
- Clinical Psychologist
- Drug and Alcohol Practitioner
- Community Participation Worker
- Peer Support Worker
- Psychiatrist
- Primary Health Care Nurse
- Mental Health Recovery Specialist
- Administration Assistant

Reduced...

- Deterioration in physical and mental health
- Overuse of Emergency Departments, hospital admissions, police, ambulance and other crisis services
- Homelessness

Improved...

- Treatment and recovery
- Housing stability
- Family and social functioning
- Participation in training and employment initiatives

Mental Illness | Interrelated Challenges

Homelessness

27% of people accessing Brisbane's homelessness services each year (2800+ people) have been diagnosed with mental illness[3]

56% of homeless adults surveyed in Brisbane have a mental heath condition[4]

73% PTSD rates estimated in people who are homeless in Australia[5]

5.5% of people accessing Brisbane's homelessness services have been discharged from a psychiatric hospital in the past year[6]

94% of people with mental illness have been homeless or without suitable housing at some time in their lives[7]

Multi-abuse trauma

People who are homeless with mental illness have high incidences of trauma in their lifetimes. Homelessness itself is a trauma. Multi-abuse trauma occurs when someone is impacted by multiple co-occurring issues that negatively affect their safety, health or wellbeing. Examples of co-occurring issues include:

- childhood abuse or neglect
- domestic violence
- societal oppression
- intergenerational grief
- homelessness
- incarceration

Substance Misuse

50% of people with mental illness also have a drug or alcohol problem[8]

67% of adults who are homeless in Brisbane have substance use issues[9]

19% of people accessing Brisbane's homelessness services identify mental health issues, and alcohol and other drug use as a reason for seeking support[10]

Stigma and discrimination

People with addictions are burdened with stigma which makes it difficult to access treatment. Healthcare services often exclude people who abuse alcohol and other drugs and fail to treat co-existing physical or mental health needs

Physical Health Conditions

60% of people with mental illness have a co-existing physical illness[11]

54% of Brisbane's rough sleepers experience three or more of–mental illness, substance misuse and physical health conditions[12]

$38.5K Health cost for a person who is homeless in Brisbane over one year[13]

Fragmented services

Our primary healthcare, AoD, and mental health care programs are disjointed, and also not connected with homelessness, housing and community support services. People with multiple, co-existing health issues who need to access all of these supports struggle with the complexity of this service system

Sarah (PIR) and Chrissy

Photography: Craig Holmes.

"Sue and Anna [from Inclusive Health] were great. You could tell they really cared about me and there was absolutely no judgement ... Then Sarah and the Partners in Recovery program came into my life and everything changed."

– Chrissy

The Integrated Healthcare Fact Sheet was produced by the Brisbane South PHN Partners in Recovery Consortium (Nov 2016)

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2 Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing first, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

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10 See note 3 above

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Unlocking systems
to end homelessness

BRISBANE ZERO

Findings and Outcomes
1 January 2020–31 December 2020

Homelessness in Brisbane

individuals – 18+ years

This fact sheet provides information about 906 adult individuals who experienced homelessness in 2020.

Brisbane Zero partners use the innovative "Know By Name" approach to learn who is homeless and match their needs to appropriate support.

On average, adults surveyed were **40 years old**, had **slept rough 24 times** in the past year, and had been **homeless 4.5 times for a total of 5 years**.

Adults who have experienced homelessness have high levels of vulnerability – that is, they have a high level of need for not only housing, but also health services and other support services.

'Acuity'

'Acuity' tells us what kind of housing and support people need. Of individuals surveyed...

- **Low Acuity**
  One in twenty (5%) simply need affordable housing.
- **Medium Acuity**
  More than a quarter (28%) need affordable housing and short-term support
- **High Acuity**
  Two thirds of people (67%) need Supportive Housing: permanent, affordable housing with embedded healthcare and community services.

Demographics

36% identified as female

64% identified as male

0.7% identified as intersex, transgender, or x

24% identified as indigenous

Health

25% Asthma

16% Dehydration

15% Hepatitis C

39% Dental problems

69% Recent or past experience of trauma

30% Substance Use (SU)

84% Mental health condition (MH)

61% **Dual Diagnosis** (SU + MH)

31% **Trimorbid** (Physical health + SU + MH)

Self-reported Emergency Service Usage

42% Ambulance transport

52% Presentations: Accident & Emergency

28% Custody occurrences

Disability

21% Acquired brain injury/head trauma

11% Physical disability that limits housing or capacity to live independently

19% Intellectual disability, learning developmental disorder

Institutional History

19% Institutional care as a child

13% Youth detention

28% Watchhouse/prison

Inclusion and Community Support

63% No meaningful daily activity/lack planned activities

36% Harm to self or others

33% Unresolved legal issues

Front: Roy has the keys to his new home to share with his dog, Inca.

Below: Susan moves into her new home after a decade of homelessness.

BrisbaneZero is a community-wide collaborative effort to break the cycle of homelessness for families, young people and adults in Brisbane. We work as a local member of the Australian Alliance to End Homelessness.

The campaign has three goals:

- to prevent homelessness,
- to reduce homelessness
- to end homelessness

brisbanezero.org.au

Partners in the Brisbane Zero Campaign use a tool called the "Vulnerability Index–Service Prioritisation Decision Assistance Tool (VI-SPDAT).

This survey collects information about health, housing and support needs, and results in calculation of an overall "acuity" score.

'Acuity' refers to the level of need and the degree of support required.