Pathways in and out of homelessness in Sydney

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Introduction

- Background and context
- Data from our clinic study
- Discussion and limitations
- Some pathways out of homelessness
- Our plan for addressing homelessness among the mentally ill
A short history of deinstitutionalisation

• In 1950, Callen Park had 4000 patients
• By 1977 Rozelle Hospital had 400
• By 1983, when the Richmond Report came out, it was under 200
• Rather than recommending closure of hospitals, the main recommendation of the report was treatment of the mentally ill, who were by then in the community
The Richmond Report

- “Fund or provide services in the community”
- “Development of community residential units”
- “Reduce size and number of S5 hospitals”
- “Crisis teams … [and] … assessment services in general hospitals”
Sydney homeless hostels in 1990

- Matthew Talbot Hostel up to 450 beds, now 99
- Edward Eagar Lodge @ 180, now 97
- Foster House @ 250, now about 95
- Swanton Lodge @ 200, now closed
- Women’s refuges much smaller
- E.g. about 1000 beds now under 300
- Buhrich et al 1998 – 350 M, 57 F beds
The “Perfect Storm”

- 1990 Mental Health Act
- The recession we had to have
- The Sydney property price boom
- Well meaning boarding house regulation
- The ice age (and the advent of hydroponic cannabis and the decline in the real unit cost of alcohol)
History

- Established in 1938 at the initiative of Cardinal Gilroy
- The first site was the unused St John’s church in Kent Street
- The second site was the old wool store at Young Street, Circular Quay
- Moved to current site in 1965
- Refurbished in 1972, 1992 and 2009
- Had as many as 450 beds in four dormitories, now 98 beds in mostly single rooms
Matthew Talbot Homeless Services Inner City Include

Matthew Talbot Hostel
Vincentian House (women, single parents and families)
Frederick House (aged care hostel)
Matthew Talbot Community Support
Matthew Talbot Hostel provides

- Crisis accommodation
- Meals, clothing, showers and laundry
- Welfare services such as housing, Centrelink
- Outreach support for people placed in the community
- Ozanam Learning Centre
- Clinic
Matthew Talbot Hostel Clinic

- Nurses 7 days, GP 2 mornings, dispenses medication to up to 80 patients
- Podiatry, optometry, smoking abatement, metabolic clinic, cardiology
- 0.6 FTE mental health nurse
- Two psychiatrist clinics
- Can prescribe and administer Clozapine
Homeless clinic study

• Consecutive presentations to clinics at MTH, EEL and FH from 21.7.08 to 31.12.16
• Demographic, clinical and sociological data extracted from the notes
• E.g., diagnosis, treatment, comorbid conditions, pattern of homelessness, forensic history etc etc
Results

• N = 2388, 93% male, mean age 42
• 56% DSP (7.8% under Protective Office)
• 59% homeless more than a year, and 34% had slept in the open
• Psychotic illness, mainly schizophrenia, 51%, 66% had substance use disorder and 80% had a history of substance use
• Other diagnoses ABI 14%, ID 5%
• Trauma history 42%
1 Overlap between the three key sample characteristics: diagnosis of psychosis, diagnosis of substance use disorder, and chronic homelessness

- B. Substance use
  - 462 (19%)
  - 365 (15%)

- C. Homeless for more than one year
  - 122 (5%)

- A. Psychosis
  - 533 (22%)
  - 227 (10%)
  - 271 (11%)
  - 191 (8%)

A. Psychosis (1222, 51%)
B. Substance use (1587, 66%)
C. Homeless for more than a year (1388, 58%)

Total number of patients attending the clinics: 2388; number of people not included in A, B, or C: 217.
Pathways to homelessness

• Release from prison (28%)
• Discharge from psychiatric hospital (21%)
• Loss of public housing tenancy (21%)
• Financial problems because of gambling (12%)
• Long term homeless and rough sleepers more likely to have multiple conditions
Homeless with psychosis

- 1222/2388 (51.2%) – clinic sample
- Less likely to have been married or to have worked >1 year
- 72% on DSP, 12% under PO
- 30% released from prison
- 22% reported loss of public housing tenancy
- 72% treatment resistant, 36% on depot
Limitations of the study

- Clinic population, rather than a census sample
- Many people with obvious disorder refuse to attend
- However, includes many non-residents of hostels and rough sleepers
- Mostly about men, who have more disabling illness (although 25% of homeless reported to be women)
Prisons – our new asylums

- 5-7% (700 to 980) prisoners have scz
- A third of prisoners are on remand
- Interface between prisons and the community not well managed
- Penrose hypothesis (1939)
- However, now rotate between prison and the homeless sector, rather than psychiatric hospitals
Substance use

• The elephant in the room
• Poly substance use – daily cannabis, payday ice users, opioid meds more than heroin, benzos less common, ETOH ++
• Live rough to save money for substances
• A cause or an effect of homelessness?
• Impedes recovery, rehousing
• 85% smoke tobacco – adds to poverty
Pathways out of homelessness

- Housing department accommodation common – usually via priority housing
- Some supported group homes
- Travel to cheaper locations
- Recovery from illness and substance use and return to employment and family
- High mortality
- Many chronically homeless
Homeless with psychiatric disability

- Lack of suitable housing for people with cognitive deficits or limited living skills
- Flats unhelpful with no living skills
- Community support models inefficient
- Low skilled patients dependent on meals and other free services
- Few intermediate places
- Licensed boarding houses too costly
“Housing First”

- Housing First principle for the homeless mentally ill, in order to treat other conditions
- Treatment of physical and mental health better if housed
- Substance use shown to decline
- Costs to other services goes down
Habilis model

• Purpose built, 30-40 sqm with bathroom
• 20 per cluster
• Support staff during the day, caretaker
• Visiting psychiatrist and mental health nurse
• Long term
• As per Richmond recommendation, 1983
Preventative interventions

- Crisis rental assistance
- Involuntary admissions to treat co-morbid substance use
- Rapid rehousing of prisoners on release
- Flexible transfer arrangements
- A range of tenancy support
- Security in housing estates
Conclusions

• Pathways to homelessness usually multifactorial
• Often due to a combination of substance use and impaired social skills or coping style
• Failure of mental health and other services
• Solution is a range of housing models to respond to various kinds of disability