Homelessness Mental Health and Incarceration

Written by Nikki Barrowclough as a personal account and summary of the Parramatta Region Homelessness Interagency's Issues Forum April 2014, Parramatta.

The grey, shuffling figures of the homeless are like a shadow population. We pity and fear these troubled souls whenever they emerge from doorways, park benches or from the back of abandoned buildings, since they seem at once hopeless, and threatening. We don't see *their* fear, their despair, their panic attacks or their infinite loneliness because we can't fathom their lives.

These are the visible homeless. There's another, floating population of people that 'couch-surf,' moving from temporary accommodation to temporary accommodation, whether in refuges, boarding houses or the homes of family or friends.

Homeless people often end up in prison. It's also well known that a significant number of the prison population, and the homeless, suffer from mental illness. Indeed, an Australian Institute of Health and Welfare report estimated two years ago that one-third of prisoners entering the prison system are already mentally ill. And poor mental health is a key risk factor for homelessness, as a 2013 Mental Health Commission report pointed out. Still more research shows that some people develop a mental illness *after* becoming homeless.

So the Forum on Homelessness, Mental Health and Incarceration held by the Parramatta Region Homelessness Interagency on April 30 was a timely and powerful reminder of the complicated interrelationship between mental illness, homelessness, and prison.

Dr Joe Garside, who was one of five speakers at the forum, and is Senior Career Medical Officer with the Western Sydney Local Health District and the Mental Health Homeless Outreach Team, and clinical lecturer in Psychiatry at Sydney Medical School, summed up the situation when he said that a very vulnerable part of the population is being criminalized.

His fellow speakers were Eileen Baldry, Professor of Criminology in the School of Social Sciences, and Deputy Dean at the Faculty of Arts and Social Sciences at the University of New South Wales; Louis Schetzer, Senior Policy Officer, Homeless

Persons Legal Service, Public Interest Advocacy Service; Lorraine Winterbottom from Cana Communities and Nagle House, Darlinghurst; and Peter Carroll, Chaplain at Silverwater Correctional Complex.

Their compassion as they discussed all of the issues, barriers and challenges faced by some of society's most disadvantaged men and women was evident. Equally obvious was their frustration at how such a situation has come to exist: namely, that mentally ill people are so highly represented in both the homeless and prison populations.

Dr Garside in particular didn't mince words.

"It's a little unfortunate that if you're a famous sportsman who commits a drug offence, you can be diverted away from the criminal justice system. If you're a sociopath entrepreneur who commits an offence, you can be diverted away from the criminal justice system," he said.

However, homeless, mentally ill people didn't know that diversions away from criminal justice existed for them too, and they often lacked the support services to advocate for them.

Dr Garside also said that he'd had to explain Section 32s to more than a few psychiatrists, and how it can be used – in conjunction with a proposed, suitable treatment plan - to ask a magistrate to find someone not guilty on the grounds of mental illness.

He'd had patients who'd been remanded for up to 12 months for offences that most people wouldn't even be charged with – and if they were, they would be bailed and the matter heard very quickly.

"One of the problems is that without an address to send people to, it's very hard for the police to actually bail some of these people," he said. "We're talking about people caught up in a number of vicious cycles. They're mentally ill, they've fallen homeless, and they bounce between prison and hospitals. A very large number of them use drugs and a lot of them commit crimes. And one of the harshest vicious cycles these people find themselves caught up in, is that committing a crime, going to prison, reduces your prospects of being eligible for housing. It reduces your ability to get employment in the future. It moves your social network away from you. It's the reason why someone's family says, 'Look, he may have an illness, but he's bad and I don't want to have anything to do with him.'"

Dr Garside spoke at length about 'Peter,' a 42 year old man with schizophrenia who became homeless after developing delusional ideas that the place where he lived, was unsafe. He thought that people were going to arrive and attack him.

With nowhere to live, he stopped taking his medication and his mental health deteriorated. He attacked someone at a train station and ended up in remand for assault, partly as a consequence of having nowhere to live.

Peter's periods of homelessness dated back to his adolescence. He hadn't progressed beyond Year Nine at school. Consequently he could barely read and write, which is especially problematic for homeless people because applying for housing means having to fill out forms and use computers. Often, they're unable to do either.

Peter was also a longtime heavy drinker, had used a variety of drugs and had displayed antisocial behavior since adolescence. However, as Dr Garside said, while some homeless people can be very nasty, antisocial behavior can also result from having a mental illness, being itinerant and having nowhere to live. Peter had been a victim of a number of assaults himself, suffering several head injuries. He was on the disability support pension, and had hardly any contact with his family. Essentially, he had no social safety net at all.

People like Peter were hard to engage and could also be very unlikeable. Consequently, they were often regarded, incorrectly, as untreatable. When Peter started receiving proper treatment, he became better within two months. He stopped taking drugs and is now housed, thanks to an NGO. "People can get well after what may be decades of inadequate treatment," stressed Dr Garside, before adding that it isn't an "overwhelming" experience treating people like Peter. It's extremely rewarding.

Professor Baldry, whose groundbreaking work over 25 years has focused on the area of prisons, homelessness, mental health and cognitive disability in the criminal justice system, spoke about a remarkable study she helped lead, involving data linkage and merging.

In essence, she and her colleagues collected the lifelong, institutional information of 2731 people who were or had been in prison. Most of them had known mental health disabilities (including alcohol or other drug disorders), or cognitive impairment.

The data came from all of the NSW Criminal Justice agencies (Police, Juvenile Justice, Corrective Services, Courts, Legal Aid), as well as the human service agencies (including Community Services, Housing, and Ageing, Disability and Home

Care). More information came from the 2001 NSW Inmates Health Survey (updated in 2009), and the NSW Department of Corrective Services State-wide Disability Service Database. The Reoffending Database from the Bureau of Crime Statistics and Research, revealed what had happened to every single one of those 2731 people in court.

The interconnections between people who'd been homeless and had mental health disorders or cognitive disabilities, and the relationships they'd had with all of these government agencies over their lifetime, emerged from this wealth of data.

Not surprisingly, housing and homelessness was key.

A majority of them had sought housing assistance, including rental assistance, for various reasons such as spending frequent periods in prison, or because of escalating mental health problems that had caused conflicts with neighbours. (Dr Garside, in his talk, said that homeless people may be ineligible for public housing because they've damaged property in the past. Sometimes they owe a lot of money through not paying fines for unpaid bus fares, or for minor shoplifting. They may have turned up at a crisis accommodation centre unable to produce ID, like a Medicare card, when asked. Or they may have been violent or threatening at some of those centres, and barred from returning for a set period).

Sadly, in Professor Baldry's study, 28% of those who had experienced homelessness were indigenous - and indigenous women were significantly more likely than anyone else in the cohort to have been homeless.

But it was those with complex needs (more than one diagnosis and with other behavioural issues), who had by far the worst outcomes. For instance, the average age of first police contact was significantly lower than those who had a single diagnosis, or no diagnosis, and this group also had significantly more convictions and imprisonments even though their offences were almost all in the lowest 10% of seriousness (usually theft and road traffic/motor vehicle offences).

Many of them had experienced homelessness and unstable housing as young people, and a significant number were accommodated in refuges and other crisis accommodation. They also had higher rates of eviction.

Importantly, Professor Baldry argued that it's society that disables people.

"We see high rates of people whose families have been in public housing, who have not had employment and themselves have disabilities and are caught up in the criminal justice system. So there are a lot of family issues. But so much of it is about the capacity of the place around you. If that place can support you, you're a lot better

off than if everyone around you is sinking. There is also the issue of identification," she added.

Most of the people in the study did not have their mental and cognitive disabilities identified until they went to prison. And yet it wasn't as if no-one had ever noticed they had mental health problems. Comments made in early police records revealed the opposite. 'This kid has problems,' was a typical example.

But as Professor Baldry also said, they came from poor, disadvantaged backgrounds, and were brought up in areas without good, systemic support services. Discrimination, especially against Aboriginal people, was part of the equation as well. As children, they were simply ignored, or else it was decided they were too difficult to deal with. And the people who ended up being their care managers, were police.

She concluded that "negative synergistic interactions" between agencies and services create complex needs. "The person doesn't create the complex needs. Our systems do," she said.

" We know that there are some models of care where people disappear completely for up to a year from our data and when we investigate, we find they were given intensive, case-managed support which was a wraparound service."

Of course, it can be a challenge is to get the homeless to stay in one place long enough for people to build a relationship with them - *and* they have to be willing to take treatment.

Dr Garside pointed this out, before suggesting that there's an evolution of mental health services that is possibly contributing to the problem as well: namely, deinstitutionalisation and today's lack of asylum.

"The focus on admitting people to hospitals or providing community mental health care has drifted towards 'immediate dangerousness,' and unfortunately the focus on suffering and disability and the possibility of an adverse outcome at a distant future date, has been lost. Once again that's the consequence of what (limited) resources are available for mental health services," he said.

There has to be greater co-operation and co-ordination between services, and also an awareness of the different ways that people could be diverted away from the problems that compromised their prospects for the future, such as the programs that are available for people with alcohol and drug problems. There are also diversion programs for people to work off debts to the state. Simply by going to a mental health team and having treatment, a homeless person can work off several hundred dollars per visit, he said.

The links between re-offending and homelessness, and homelessness after exiting prison, featured in two of the talks: Peter Carroll's, and Louis Schetzer's.

The lack of social housing and housing affordability was an obvious issue. But sometimes there were less obvious reasons for why some ex prisoners with nowhere to live, decided they preferred the more 'stable' environment of prison – or alternatively, the streets over housing.

Peter Carroll spoke movingly about the sense of shame that ex prisoners often feel, and their terror at having to face people in their communities. One man, an inmate for 12 years who was about to be released, said that his biggest post-release plan was to commit a crime, so that he'd be taken back to prison. This was common, said Mr Carroll. "It's the most named, post-release plan. The most unnamed one is suicide," he added.

Louis Schetzer spoke about a consultation project organised by the Public Interest Advocacy Centre in 2013, called Beyond the Prison Gates. Interviews were conducted with 26 people, mostly men, aged mostly between 35 and 50, who had recently been released from prison into homelessness and housing crisis. They were generally much older than the average age of prisoners in New South Wales, had low education levels, and most had a history of drug and alcohol abuse or mental illness. Twenty- three of them had been in prison on more than one occasion. Disturbingly, over one third of them had slept rough on their first night out of prison, or had experienced some form of primary homelessness. Several reported leaving prison and then being unable to secure a bed in crisis accommodation. This was especially problematic if they'd been paroled to a particular crisis accommodation service, and had arrived there only to be told that a bed wasn't available – placing them in breach of their parole. Sometimes, as soon as they disclosed that they'd just come out of prison, they were denied accommodation.

There were those, too, who described a sense of isolation and loneliness as they faced the daunting task of fitting back into society.

"The cultural, environmental and social shift in people with mental illnesses, coming off the street is enormous," said Mr Schetzer, describing how some participants believed they were being judged by neighbours and housing officials. They felt out of place and wanted to return to the streets.

But those who'd had the support from services and access to counseling, saw housing and stable accommodation as important symbols of hope that promised a new life.

It was a powerful message – one that also came through strongly in a short film, Homefull, which was presented at the forum by Maree Freeman, CEO and Artistic Director of Sydney's Milk Crate Theatre, whose ensemble of performers have all experienced homelessness. The happiness on one woman's face as she closed her eyes – she had never dared close her eyes before, in case she was "hurt" – was unforgettable.

The same sense of hope was reflected again when Lorraine Winterbottom described the work done at Nagle House in Darlinghurst, a transitional house for women who are alienated from society, and suffer from mental illness, from drug and alcohol addictions, and from homelessness.

One woman who came to Nagle House from prison, with nowhere else to live, celebrated her birthday, built strong relationships with staff, and gained enough confidence to enroll in a TAFE course – all in three months.

Another woman, alcohol dependant and suffering from a neurological degenerative disease, stayed at Nagle House for several months. Her circumstances are still sad, but in one way at least, her life has changed for the better.

"The lasting memory I have of her is that I found it inconceivable that she could be so alone," said Lorraine Winterbottom. "There was no one in her life. No friends, no family, no acquaintances. She has moved out of Nagle House and there is concern that she'll again become homeless. But the thing she achieved is that there are now people in her life who meet with her on a regular basis, just to spend time with her."

Following the talks by the five speakers, there was a question and answer session, before forum participants split into discussion groups. Their subjects were: were Legal, Supported Accommodation, Housing with a focus on Housing NSW's protocol Framework for MultiAgency transition planning to reduce homelessness), Mainstream Services (including employment and training), and Mental Health and Health.

There were many suggestions about strategies and approaches that could make a real difference to people's lives now - and which sometimes illustrated the complexities of working with homeless people. The point was made that one difficulty for psychiatrists using S32s, was when homeless people themselves didn't want the term 'mental illness' put into their court reports. Therefore, a more palatable form of words needed to be used.

The fact that people who are incarcerated are not offered treatment until immediately before their release, and are then transferred directly to hospital, was another concern.

The stand-out wish list of suggestions included:

Mental health awareness training for front line staff. A one stop shop/phone number to direct clients to the right service. More flexibility in types of housing and eligibility. Early assessment for young people caught up in juvenile justice and incarcerated. A program for pre-release of prisoners that would include cooking/bill paying skills.

Perhaps the most compelling suggestion though, was one made unofficially by someone who said that information gets sanitised the higher it goes, so that the people at the top don't get anxious.

But it was essential to create pain for them. The lives of the homeless depend on it.

Parramatta Region Homelessness Interagency held the Homelessness Mental Health and Incarceration Issues Forum in April 2014 in Parramatta. It was attended by over 100 not for profit and government service providers and decision makers from across the Sydney Metropolitan and ajoining areas. The Forum:

- discussed the issues, barriers and challenges faced by homeless people with mental illness who have been incarcerated/ are likely to be incarcerated, and effective strategies, models of care and policies
- provided the opportunity for people to learn also more about strategies and approaches that are proving effective on the ground in meeting the needs of these people
- and provided a forum for people to discuss ways that service providers and decision makers could implement approaches and programs that could make a real difference to people's quality of life *without* waiting for additional funding or changes to legislation.

The Forum was Opened by Georgina Warena; Chairperson, Parramatta Region Homelessness Interagency; Manager Cardinal Freeman Centre and Our Lady of the Way.

MCs: *Maggie Kyle, Community Capacity Building Officer Parramatta City Council; Michael Wright Director, Homelessness, Outreach & Food Services, Parramatta Mission*

Speakers:

Eileen Baldry; *Professor Criminology, School of Social Sciences; Deputy Dean, Faculty of Arts and Social Sciences*

Joe Garside; *Senior Career Medical Officer, Western Sydney LHD; Mental Health Homeless Outreach Team; Clinical Lecturer, Discipline Psychiatry Sydney Medical School*

Louis Schetzer; *Senior Policy Officer, Homeless Persons Legal Service, Public Interest Advocacy Service*

Lorraine Winterbottom*; Cana Communities & Nagle House, Darlinghurst*

Peter Carroll, MSC *Chaplain Silverwater Correctional Complex*

The film, Homefull , Milk Crate Theatre Film was shown and introduced by Maree Freeman, *CEO & Artistic Director Milk Crate Theatre*

The Parramatta Region Homelessness Interagency engaged Nikki Barrowclough as an independent writer to record her personal understanding and summary of the Forum.