THE FAMILY AND COMMUNITY DEVELOPMENT

COMMITTEE

Inquiries into the Provision of Supported Accommodation
for Victorians with a Disability or Mental Illness

Submission:
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United Nation’s Convention on the Rights of Persons with Disabilities

Preamble

e...Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others,
j...Recognizing the need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support. (emphasis added)
m...Highlighting that most persons with disabilities live in conditions of poverty and in this regard recognizing the critical need to address the negative impact of poverty on persons with disabilities, (emphasis added)

Have agreed as follows:

Article 1—Purpose
Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2—Definitions
(3)...”Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose OR EFFECT of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamentals in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. (emphasis added)
Article 19—Living independently and being included in the community
b...Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.
Article 28—Adequate standard of living and social protection
d...To ensure access by persons with disabilities to public housing programs.
(emphasis added)

United Nations 2006

Letter received by C. Storm, dated April 18th, 2008:

Dear Mrs Storm, Thank you for your correspondence of 13 March 2008 to the Minister for Housing regarding the social housing units at the former Commonwealth Games Village in Parkville. The Minister has asked that I reply on his behalf....

Port Phillip Housing Association advises that 81 of 82 units have now been allocated to tenants, with the remaining 1 UNIT being allocated by the Disability Trust for PEOPLE WITH A RANGE OF DISABILITIES...

Ken Downie, A/g Executive Director Housing & Community Building

(*1, end-notes, emphasis added)

Fourteen social dwellings are still to be built “down the track” at Parkville, according to a Department of Human Services (DHS) housing officer I spoke to in 2007. These are to be townhouses, of higher amenity than the units, and will be built closer to houses sold by the Consortium. They may, then, be judged as too good for mentally or physically disabled persons by the Consortium and the Government. That is, unless we are fortunate enough to have a reversal of Government policies from 2002–2009. (*2)

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I thank the Committee for the opportunity of presenting a submission regarding social housing for those with a physical disability or mental illness. This submission concentrates upon the housing needs of the mentally disabled, persons who suffer from a serious mental illness (SMI). This group is basically made up of those who have schizophrenia or bipolar disorder, both of which present with symptoms of psychosis and paranoia, and those with severe clinical depression. These persons’ needs are the same as ours but their lives are extremely complicated by the severity and complete unpredictability of these diseases’ most serious symptoms.

The ability of the severely mentally ill to survive and maintain a social role in life is made immensely harder by social stigma from all levels of society. Stigma from political and bureaucratic leaders has manifested itself, in particular, by the dearth of adequate, affordable, secure long-term social housing provided for the mentally ill over the last 20 years. These years encompass the period when large numbers of severely mentally ill persons were deprived of shelter by 1990s Government fiat...let there be no more mental hospitals. This could be seen as reasonable, since the experiment of deinstitutionalisation had begun decades earlier in many nations; generally it was partially successful when its two stages were done in an ordered manner; that is, the 1st stage finished and then the 2nd stage commenced. Here in Victoria the second stage was done first and destruction of all stand-alone psychiatric hospitals was effected expeditiously. The severely mentally ill who survived that catastrophe, and who also experienced the suicides of those who could not, still await a strong, well-planned effort to provide at least a major part of the first stage of deinstitutionalisation, now some 15-20 years overdue. The seriously mentally ill need community support centres, day clinics, acute beds for severe crisis care, PARC rehabilitation beds and, most critically, adequate, stable, affordable, secure, long-term housing.
The Government knows that in 2001 the World Health Organization (WHO) stated that such infrastructure must provide for 100% of the severely mentally ill. (*3) The U.N. Convention states that the disabled must have access to public housing. Our Government has chosen, in the Parkville Gardens development, to allow one token unit for "persons with a range of disabilities". Although Port Phillip Housing may seem to be at fault, it is the Government which is responsible for legislation about the disabled and to the WHO, which assesses Australia as a nation in the "high resource group", from which the highest standards of treatment and service are expected. (WHO World Atlas of Mental Health, 2005)

In the last 15-20 years our most vulnerable citizens, those who suffer a severe mental illness, which per se brings great social exclusion, have been those most ignored by all governments, federal and state, in their disposition of social housing. It is now the Committee's privilege to have a major role in righting this tragic social wrong.

Homelessness

The basic reasons for homelessness are poverty, unemployment, physical and/or mental health disability, drug disorders, domestic violence. Recently, in most developed countries, homelessness has been categorized:

- primary homelessness; persons without accommodation, who live on the street
- secondary homelessness; persons who live in temporary shelter, persons who move from one shelter to another
- tertiary homelessness; persons who live in boarding houses, hostels or caravan parks for short or medium stays
Primary and secondary homelessness in Victoria mean that every night about 21,000–23,000 men, women and children have to ‘couch-surf’, sleep in cars or sleep rough on the streets, despite the efforts of the charity organizations who do their best to help. Such a tragic situation exists, ultimately, because of Treasury’s and our Governments’ particular ordering of priorities over 20 years. Our resources are often used for what may be seen, by concerned persons, as less than urgent projects. This is the ultimate stigmatisation of our mentally ill; it flows down from the the top to possibly a majority of our citizens.

The homeless of Australia are so politically ignored as a real and significant part of our society that I have been unable to find any state or federal entity with enough interest to collate or research their deaths.

We are not alone regarding this total lack of concern:

It can be strongly argued that a review of current literature reveals a paucity of research addressing the issue of suicide among homeless adults...what does a clinician answer when asked where suicide ranks in this population? Are there particular risk profiles of homeless persons who have completed suicide...Indeed, do we even have a reasonable evidence-based estimate of how many homeless persons die each year in this country [U.S.A.] from ultimate and irrevocable acts of self-destruction? ...With so many vulnerable lives at stake, the call for clinically applicable research could not be more urgent. (*4, emphasis added)

My contact with DHS was similar. My question, a few weeks ago, “What is the suicide rate of homeless persons?” DHS person, “That’s a very interesting question. A psychiatrist asked me that about two years ago.” We talk, he goes off for a few minutes, on return says “I’m sorry, we don’t know.” Implicit in that statement, of course, is “And we’re not trying to find out”.

6
It is sometimes considered, in psychosocial terms, that the U.S.A. does not rank highly as a steward for its citizens who are seriously mentally ill. Indeed, as late as 2005 it had no national mental health plan. But it did begin a housing plan eight years ago and, from 2005-2007, lowered the mentally and physically disabled homeless by 30%. (*5)

Which makes these statistics very significant:

U.S.A........222 homeless per 100,000 population (*6)
Australia...500 homeless per 100,000 population (*7)
Victoria.....460 homeless per 100,000 population (*8)

The mentally ill and homelessness

Minister Neville states that “...without the foundation provided by stable housing, self-management of an individual’s mental health problems is extremely difficult, along with any move toward recovery and participation in the community.” (*9, emphasis added)

The Human Rights and Equal Opportunity Commission (HREOC) Report said that “...one of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness—or recovering from it—is difficult even in the best of circumstances. Without a decent place to live it is virtually impossible.” (1993 : 337, emphasis added)

David Wright-Howie, Council to Homeless Persons, believes that 60—70% of Melbourne’s inner city homeless suffer from a serious mental illness, according to his workers’ anecdotal evidence. Of these, it is expected that about 30% have schizophrenia, the most dire of all mental illnesses, with an 11—13% global mortality rate. About 85% of these deaths are by suicide.
The following two statements are indictments of our society:

A report by Wesley Mission indicated that 75% of participants in their study [in Sydney] had a mental illness. Within this mentally ill homeless population the report found that 29% had schizophrenia...These figures should be contrasted with prevalence among the general community, which is 1%. That means that homeless people are 29 times more likely to suffer the effects of schizophrenia than those in the general community. (*10)

We allowed deinstitutionalisation to proceed without providing alternative services and supports. Studies have repeatedly shown that 80% of the homeless, living in rooming houses, shelters, squats and rough, have a diagnosed mental disorder...A Latrobe University study of 403 homeless persons found that one-third had attempted suicide and a similar number had deliberately harmed themselves....David Wright-Howie agrees. “People are being discharged from hospital with nowhere to go. It’s worse in the country. In Gippsland it’s really appalling.” (*11)

Australia is one of the countries cited in this statement by the WHO:

De-institutionalization has not been an unqualified success... governments have not allocated resources saved by closing hospitals to community care, professionals have not been adequately prepared to accept their changing roles and the stigma attached to mental disorders remains strong...in some countries, many people with mental disorders are shifted to prisons or become homeless. (*12, emphasis added)

An American journalist brilliantly nails the state of the seriously mentally ill homeless, in both our countries, in a few illuminatingly tragic lines:
Most homeless individuals with severe psychiatric disorders are not being treated. Most of them have anosognosia and are not aware they are sick, but legally we protect their right to remain sick... **It’s as if we suddenly respected the “right” of Alzheimer’s patients to wander wherever they please.** Sounds ridiculous, but that’s basically the situation with so many of the people we call “homeless.” (*13, emphasis added)

And, whether we like it or not, he nails us too. **We are letting this happen.**

The prevalence of severe mental illness in Victoria is 3%; that is, 115,000 persons of some 5,000,000. About 10,000 receive private care, about 60,000 are treated by the MHS (which is locked down at <60,000 clients). About 45,000 persons, **48% of those suffering a serious mental illness in Victoria, have no specialist mental health care or treatment:** **an uncounted number of the untreated will become homeless and an uncounted number of those will commit suicide.** (*14, emphasis added)

In Victoria we have a very high rate of homelessness for what is, in global terms, a wealthy and developed state. We have also had governments which have not hesitated to use the phrase “world’s best practice” to describe a business coup, a sporting event, a road tunnel or an unnecessarily renovated art gallery or concert hall. **Priorities must change so that we can boast about “world’s best practice” social housing for Victoria’s homeless, beginning with the mentally and physically disabled.**

**“World’s best practice” care for the seriously mentally ill**

Three essentials elements constitute first class care for those who suffer from severe mental illness; medication, psychotherapy and adequate, stable, secure, affordable long-term housing.
Medication is necessary in the attempt to prevent psychosis, paranoia and other symptoms of severe mental illness. Medication is adequately dispensed – for those seriously mentally ill, about 50%, who do receive treatment.

Psychotherapy. The meaning here is that of counselling, one on one, by a clinical psychologist or psychiatrist. It should not be necessary to discuss psychotherapy, but the point must be made that it was stopped in the mid-1990s for MHS clients for economic reasons. It was not a clinical decision. It is the antithesis of good clinical care. To know this is to have a clearer picture of the older (30-55 years) severely mentally ill, who were suddenly and traumatically deprived of two of their three necessities for a decent life within an indecently short period. There has been no MHS research as to how the cessation of psychotherapy and the action of deinstitutionalisation may have affected the lives of the seriously mentally ill. Or their deaths. But to see the spike of suicide deaths by MHS clients and the untreated mentally ill in the mid/late 1990s makes it possible to draw one’s own conclusions as to how the withdrawal of psychotherapy and shelter affected those with a severe mental illness. (*15)

The seriously mentally ill population has struggled through the last 15-20 years, trying to stay alive. They are the great battlers of Australia. Through these times they have never been given a “fair-go” by governments. Their courage is immense as they battle against their fearful incurable diseases. These vulnerable persons have lived, as Minister Neville recently noted, “...through the unfinished service improvement agenda of the last 15 years.”. (*16, emphasis added)
I see the agenda as not "unfinished" but barely begun. There was no social housing increase when hospitals were destroyed and suicide rates rose alarmingly in the mid-1990s. Our Government’s downgrading of social housing (*2), and present intentions for the 2000s, as seen in Mr Downie’s letter, augur no change in the short to medium term future. The seriously mentally ill must be housed.... adequately...This is essential for their optimal survival, quality of life and potential productivity.

**Stable, secure and long-term housing for the seriously mentally ill**

“We need a mental health system in Victoria that provides world-class care for everyone – from those with anxiety and depression to those most vulnerable people who live with severe mental illness complicated by other social and physical health problems.”

*Because mental Health Matters, page v, Minister Neville*

Homelessness is far from being only a social issue for the mentally ill. It is a life or death issue. As in no other disease, lack of adequate housing controls the course of severe mental illness. A person whose illness can be made more stable by drugs and psychotherapy, so that there are fewer mental health crises, may still not reach their potential if he or she does not have an adequate secure home.

The U.S.A. public housing success is based on a simple concept:

“The benefits of providing long-term housing for people with a mental illness in conjunction with access to appropriate support has been demonstrated by various successful programs, for example ‘Pathways to Housing’ in the U.S.A. This a housing first model that provides people
with a psychiatric disability with their own apartments, and then offers intensive and individualised clinical and social support services aimed at addressing clients’ emotional, psychiatric, medical and human needs. A key element of the program’s success is its emphasis on long-term housing solutions.” (*17, emphasis added)

To have reduced homelessness by 30% from 2005-227 is a record to be applauded and emulated.

The Mental Health Council of Australia (MHCA) states that it is “… essential to recognise that people with a mental illness are a distinct group with diverse needs that may not be addressed by general homelessness services.” The Council would support “homelessness initiatives that would recognise people with a mental illness as a specific target group, and contained strategies specifically to meet their needs.” (*18, emphasis added)

Will the Committee please note that the MHCA plans to publish a Paper on housing for the mentally disabled early next year, basically in answer to the Federal Green Paper, which may not have covered SMI needs thoroughly?

One matter for the Committee’s consideration is that we do not necessarily have to provide, for the seriously mentally ill, units such as were built at Parkville, the classic suburban-type unit, for about $350,000. “Adequate” housing can mean small, private, clustered, pre-fabricated, innovative. For example, I can visualise Moonee Valley race course land, with a large number of houses in small clusters, heated, insulated, comfortable, safe. This does not have to mean “future slums”. As health improves, SMI persons can become proud of making a garden community before moving on to employment and perhaps housing outside their housing development. Lateral thinking has to be used to get 100,000 homeless persons housed in Australia. With the financial crisis and the Federal Government’s increasing
determination to build new infrastructure **This is the infrastructure which must be built.** Great good could result from this economic crisis if the most needy were housed and, therefore, productive work made for many of those who may become unemployed.

To illustrate what is meant, when this paper is submitted there will be a New York Times’ article sent to each of the Committee’s parliamentary email addresses about some very small houses. These are certainly not suitable for families but would be suitable for the seriously mentally ill, some physically disabled and single persons. They are eminently superior and preferable to a homeless life.

**The economics of housing the seriously mentally ill**

The Department of Health and Aging (DHA) writes regarding SMI needs:

> Within the international literature there are a number of models proposed for people with severe mental illness...Rog, (2004), found that once housed, people with severe mental illness who were homeless stayed housed with supports and are less likely to be hospitalised regardless of the specific housing model. **The key was having access to affordable housing.** For people who are homeless and mentally ill, any stable housing has a dramatic improvement on outcomes such as residential stability, use of institutional settings such as hospitals, detoxification facilities, the justice system...there is a need for more evaluative research related to homelessness and mental illness. (*19, emphasis added*)

The conclusions cited by the DHA are found across all “high income group countries” (as defined by the World Health Organization, 2005) who have researched the subject. These data have prompted the DHA to list the following key findings from that research:
• residential stability is an attainable goal for most people with serious mental illness
• formerly homeless people with severe mental illness are an important resource
• substance abuse is a major factor in homelessness among people with a severe mental illness
• housing stability, appropriate psychiatric treatment and increased income lead to an improved quality of life
• consumer needs and preferences should be considered (*20)

In 1993 the HREOC “Burdekin Report” offered advice which has been basically ignored by all our governments for 15 years:

Furthermore, access to appropriate housing has been recognised as an important aspect in the success or failure of a person living with mental illness remaining in the community. Unsuitable accommodation, or none at all, can erode or destroy the benefits of treatment or rehabilitation received in hospital. (*21, emphasis added)

The MHCA, in a media release tellingly entitled “Fix Mental Health and You Fix Health” (June 24th, 2008), notes that mental illness causes 25% of the burden of disability for all diseases. It receives about 10-12% of all health budgets. Serious mental illness is the leading cause of years lost to disability...24%, or around 330,000 years. If budgets were related to the burden of disability, as they should be, the seriously mentally ill could all be housed.

The report by the Boston Consulting Group, (BCG), Improving Mental Health Outcomes in Victoria: the next wave of reform, which the Victorian Government must be commended for commissioning, finds that a group
liable to “fall between the cracks” of Commonwealth-and State-funded parts of the MHS are those who “have a chronic mental illness and require stable, long-term housing and a wide range of support needs that vary in intensity over time.” (p.22) The BCG also sees that SMI access to non-clinical support services such as housing, employment and drug treatment “is critical in recovery from, and the management of, mental illness” (p.23) “...there is a solid case for investment if the overall gains to the economy are considered, even before the significant social benefits to individuals, carers and communities are taken into account...In addition to the value captured by Governments, a reduction in the burden of mental illness generates economic gains for individuals and their employers, leading to an overall gain in GDP terms.” (p.40) There is further information in “Chapter 6: the case for investment,” And more than economic concern; more compassion, indeed, than is shown by many other persons and entities. “Improving the MHS will also improve social outcomes. These gains may be greater than those to be had in many other areas of social policy, given the extreme distress that gaps in the treatment and support of people with mental illness can cause. (p.22)

BCG states that ongoing increases in funding are needeed beyond the already significant increases announced by Victoria and the Commonwealth and note the UNDER-SERVICING OF CONSUMERS with chronic mental illness who require stable long-term housing. (pp.40-43)

THE ETHICAL IMPERATIVE OF HOUSING THE SEVERELY MENTALLY ILL

For many persons “the doctrine of human rights goes beyond law and forms a fundamental moral basis for regulating the contemporary geo-political order. For them, they are democratic ideals.” (*22)
The doctrine of human rights does not even INFORM the practice of some of our laws. The World Health Organization and Victoria’s Mental Health Act both state that we must care for all our seriously mentally ill. We care for only about half of our seriously mentally ill in a manner which might, until Ms Neville’s advent, have well been described as relaxed. Indeed, a minister once wrote, in praise of the MHS, that it “operates reasonably well most of the time”. A large number of our severely mentally ill, about 48,000, are left alone, in seemingly benign neglect, to live an untreated ‘do-it-yourself’ life which frequently ends in homelessness, malnourishment and death: natural, suicidal or homicidal. Only the latter are noted. By the media.

Access Economics reports that the suicide rate among Australians with schizophrenia has increased 400% in the last 40 years and money saved through deinstitutionalisation has failed to flow into community services. 84% of persons with schizophrenia who died in 2001 killed themselves. (*23) Much has degraded since then. It should be noted that the suicide rates to be found in the Victorian Chief Psychiatrists’ Reports of the 2000s are of questionable substance. “Put another way, the risk of suicide for schizophrenia patients is 20 to 50 times higher than for the general population...If such figures [most are not shown] are apposite for Australia, it is apparent that figures made available by the Victorian Office of the Chief Psychiatrist have serious flaws.” (*24)

The Australian Bureau of Statistics (ABS), 2005, regarding 10 year suicide charts, states, “Although death rates for suicide appear to have fallen, these deaths have been under- enumerated in recent years so the actual trend in suicide deaths is not clear”. ABS is too restrained. “Under- enumerated” translates “Records are falsified, or not kept.” Either action is culpable. So serious a matter clearly warrants investigation.
Australian Governments are ethically obliged to provide housing:

As a party to the ICESCR [International Covenant on Economic, Social and Cultural Rights], the Australian governments at all levels are under an obligation to progressively implement the right to adequate housing. This requires “concrete”, “targeted”, “expeditious” and “effective” steps, including budgetary prioritisation. (*25, emphasis added)

I take issue with the Australian Human Rights Commission’s use, in 2008, of the phrase “progressively implement”. The Commission knows that Australian Governments have made considered decisions to basically ignore the disabled homeless for the last 20 years. Governments may not now choose the easier route of progressive implementation. They have dismissed that for far too long. They must now accept the moral imperative of immediate action. This imperative is demanded by the silenced voices of the seriously mentally ill who died during this time. Some died from the severity of their disease, but many died who could and should have been saved, and many deaths were deliberately discounted and uncounted. Housing should have been made ready before de-institutionalisation, the great “unnhousing”. Then came non-housing and re-institutionalisation into prisons and streets, graves and urns. Reparation must be made. Reparation may only be effected by housing those who have been able to survive this cataclysm.

Australian Governments are legally obliged to provide housing:

Forty years after we signed the ICESCR Covenant, in a report to the United Nations Human Rights Council in 2006, the United Nations Special Rapporteur on Adequate Housing, Miloon Kathari, found that Australia had
“failed to implement its legal obligation to progressively realise the human right to adequate housing...particularly in view of its responsibilities as a rich and prosperous country. [30]...The result is what the Special Rapporteur described as a national housing crisis affecting many sections of the population.” (*26, emphasis added)

This catastrophic housing crisis took 20 years to be emphasised as such...by a visitor. The harm of those decades of awareness of the situation and the deliberate policy of not allowing “budgetary prioritisation” to help house our most vulnerable has to be faced.

“Homelessness is identified in the Federal Green Paper as ‘one of the most important markers of social exclusion.” (*27) The Mental health Council of Australia would argue that mental illness is also one of the most important markers of social exclusion, particularly in situations in which people with a mental illness are unable to access needed psychosocial services.

The Australian Human Rights Commission regarding SMI needs:

- Homeless people affected by a mental illness have a range of special needs that require specific types of accommodation and support services. Currently, however, there is a critical shortage of appropriate and affordable housing for homeless people with a mental illness and all such needs are being ignored... A human rights response to homelessness would involve all levels of government committing to and taking concrete and targeted legislative policy and budgetary steps toward the full and immediate realisation of the human rights of homeless persons. (*28, emphasis added)
The most totally excluded persons in our society are the severely mentally ill. Often unhoused, untreated, uncared about, stigmatised, abused, injured, killed, they also have the fearful distinction of being the ONLY GROUP of "MOST SEVERELY ILL" of ANY of our health services who do not receive what is the best care necessary for survival and as good a recovery as may be possible.

The WHO defines mental health as "a state of well-being in which the individual realizes his or her own capabilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community." (Factsheet #220)

Mental health is possible for the majority of persons who have a serious mental illness, at least for most of the time. Build the mentally ill stable, affordable, adequate, secure, long-term housing and you fix mental health. Fix mental health and, as the MHCA said, you fix health.

I urge the Committee: take to heart, as well as to mind, the suffering and death caused by so long a period of objective neglect. Use this moment to insist on the housing of the severely mentally ill. If ever any matter demanded bipartisan political action, this is it. Give them mental health. No finer legacy can proceed from the Committee's parliamentary careers than your being able to say, proudly, "Our Committee fixed mental health"

Respectfully submitted,
This submission is offered in memory of my daughter Anne and her brave spirit. She was spared homelessness but suffered all the depredations and tragic diminishings of severe paranoid schizophrenia. She finally found peace by suicide, violently and alone, one of thousands who have died because of total despair. They are now united, a vast cohort: unknown, uncounted, unresearched, “under-enumerated”. We love them for ever.
End-notes, attachments

1....K Downie letter, attached

2....CGV social housing, attached

3....World Health Organisation Report, 2001, p.114

4....Journal American Psychiatric Association, 57:447, April 2006 “Where is the Research on Homeless Persons and Suicide?”


6....Based on figures of 666,300 homeless, 300 million population, taken from 5, NYT article

7....Based on figures of 100,000 homeless, 20 million population

8....Based on figures of 23,000 homeless, 5 million population

9....“Because Mental Health Matters”, p.32, Ms Neville, Green Paper

10..“Homelessness and Accommodation, Schizophrenia foundation, N.S.W.

11..The Age, December 19th, 2004, “80% of homeless have a mental disorder”, Peter Ellingsen

12..The World health Organisation Report, 2001, p.51

13.. Briefing paper, Homelessness, p.6, Treatment Advocacy Center, U.S.A.

14..”Because Mental Health Matters”, p.27

15..Australian Bureau of Statistics, 10 year suicide rate, attached

16..”Because Mental Health Matters”, p.13

17.. Which Way Home, p.12, Mental Health Council of Australia

18..Which Way Home, pp.13, 15
19...*Homelessness and Mental Health*, executive summary, p.2, Department of Health and Aging

20...*Homelessness and Mental Health*, section 1.7, p.1

21...*National Survey of Mental health and Wellbeing 1999*, Section 3, p.29

22...*Refinding the Plot: recovering a Sense of Direction in Mental Health Services in Australia*, p.9, Menzies Centre for Health Policy

23...The Age, August 6th, 2002, “Schizophrenic suicide up 400%”.

24...*Psychiatry, Psychology and the Law 12.2*, November, 2005, p.265, Dr Ian Freckleton SC

25...*Homelessness is a Human Rights Issue*, p.5, Australian Human Rights Commission

26...“*Homelessness is a Human Rights Issue*, pp.6,11

27...” *Which Way Home*, p.6

28...”*Homelessness is a Human Rights Issue*, pp.5, 11
Ms Caroline Strom
93 Field Street
CLIFTON HILL 3068

Dear Ms Storm,

Thank you for your correspondence of 13 March 2008 to the Minister for Housing regarding the social housing units at the former Commonwealth Games Village in Parkville. The Minister has asked that I reply on his behalf.

In 2002, it was determined that after the conclusion of the Commonwealth Games (Games) in March 2006, 200 units in the Games Village were to be made available for social housing. Of these, 100 were for aged care and 100 were to be social housing. This would provide a lasting legacy in that the Games Village would provide affordable housing for low income Victorians.

In August 2006, it was determined that the ownership of 100 units of accommodation, at the former Games Village (82 existing and 18 new constructs), would be transferred to one or more registered Housing Associations for social housing purposes. The remaining 18 units are still to be constructed and the Department of Infrastructure (DoI) has yet to formalise a building schedule, however a contract end date has been established for completion by 2011. These 18 units will be allocated at a later date to a Housing Association.

As you may be aware, during the Games in March 2006, the Athletes’ Village accommodated 6,000 people in houses, apartments and demountable units. After the Games, the developer removed all the temporary structures and commenced re-fitting the houses and apartments for permanent residents.

On 30 March 2007, the Director of Housing released a Request for Tenders (RFT) to all registered housing agencies seeking submissions for ownership and management of the 82 units. The RFT closed on 26 April 2007.

Port Phillip Housing Association and Loddon Mallee Housing Services Limited were the successful tenderers. Port Phillip Housing Association will own and manage the 82 social housing Units and Loddon Mallee Housing Services Limited will construct an additional 61 units
in regional and rural Victoria. The Disability Housing Trust is making $2M available in exchange for nomination rights to 20 of the 143 units.

This outcome demonstrates that Housing Associations are able to leverage the Government's investment in social housing to deliver 143 units, whereas traditional procurement models would have only delivered 82 units.

In addition, the construction of units in rural and regional Victoria means that the legacy of the Commonwealth Games is spread across Victoria and also provides units which are specifically targeted to house people with a disability.

In September 2007, 75 of the 82 completed units became available for accommodation for low income Victorians. The remaining 7 units were completed in March 2008.

Port Phillip Housing Association advises that 81 of the 82 units have now been allocated to tenants, with the remaining 1 unit being allocated by the Disability Housing Trust for people with a range of disabilities.

The Government is committed to expanding the supply and improving the quality of public and social housing properties across Victoria with a $510 million funding boost over four years announced in the most recent Budget.

Thank you for your interest in the provision of social housing at Parkville. If you have any further queries please contact Mr Robert Macbeth, Manager, Social Housing Sector, on (03) 9096 9807.

Yours sincerely

[Signature]
Ken Downie
Director of Housing &
A/g Executive Director Housing & Community Building
Commonwealth Games Village (CGV)...social housing, 2000...2009

A chronological history of the CGV/Parkville offers awareness of past intentions and priorities, from 1999-2009, of Treasurers, the Department of Human Services and Government leaders regarding the matter of our disabled persons and their urgent need for housing. Intention must change!

1...K. Downie letter:
In 2002 it was determined that after the conclusion of the Games 200 units were to be made available for social housing. Of these, 100 were for aged care and 100 social housing. This would provide a lasting legacy in that the Village would provide affordable housing for low income Victorians.

2...October 23rd, 2002, Media release, Office of Premier:
Mr Bracks said he was proud the government had achieved an additional 200 housing units...after the Games, social housing for 200 households will be integrated across the site...and reflects the Government’s strong committment to social and environmental policies.

3...The Age, November 11th, 2002, William Birnbauer, Royce Millar:
The State Government has been accused of excessive secrecy and making misleading statements about its plans for the 2006 Commonwealth Games...Last month the Premier said one in five of the new homes...will become public housing after the Games...Justin Madden said the development included 1000 permanent dwellings, 200 of which will be retained as public housing...Australand and the Citta property Group said the 200 social housing figure included a 100 bed aged-care
The remaining 100 houses would be a mix of rented public housing and low-cost social housing.

4...February 25th, 2003, Media release, Minister Madden:
The Games Village Development will create an important legacy for Victoria...social housing for 200 households.
The word "household" persists. In no way can an aged-care bed be re-defined as a household or a dwelling.

5...May 27th, 2003, The Age, Royce Millar:
Former Labor deputy prime minister Brian Howe...called on the State Government to be firmer with the consortium, which, he said, was set to make big profits from developing the state-owned former Royal Park Psychiatric Hospital.

6...August 5th, 2003, Media release, Minister Madden:
The Government has also improved on its plans... to provide 200 social housing dwellings.

7...August 8th, 2003, letter to Age, Minister Madden:
The facts about the Games village. The Commonwealth Games Village will not be built on "21 hectares of Royal Park", as claimed by Kenneth Davidson (Opinion, 7/8)...The report also confirms that the Government will deliver a minimum of 200 units of social housing. Davidson continues to claim a figure of only 100...Age readers deserve analysis based on fact rather than Davidson’s ignorant assertions.

8...October 25th, 2004, Media release, Minister Madden:
Four apartment blocks for social housing after the Games are complete.
9. October 8th, 2006, Media release, Minister Madden:

When the development is complete it will include 14 social housing townhouses, a 100 bed aged care hostel and 720 apartments—86 of which will be allocated to social housing.

Mr Madden’s statement is the first one I have found which, belatedly, offers the truth. Except, of course, for Mr Davidson’s “ignorant assertion” 3 years earlier.

(Points 1–9, all emphasis added)

10. October 30th, 2006, Media release, Minister Broad:

Minister Broad said the first tenant [moved] into the 100 unit social housing development at the CGV on the weekend.

In early 2007 I was able to find out that 4 social housing units at Parkville were managed by Melbourne Affordable Housing and had tenants. In late 2007 I spoke to a DHS officer who said no further units could be allocated because the Department of Infrastructure had to restore kitchens after the games. Why? The developer was contracted to do that. And so, through the winter of 2006 and the rather more severe one of 2007 these units were empty while thousands were homeless in Melbourne. 81 social housing units were allocated in 2008. One unit has been or will be given to persons with a range of disabilities. This accounts for the 86 social housing units. I am unable to find out when the 14 social housing townhouses will be built. The social housing regarding Parkville Gardens and the mentally and physically disabled has a distinct aura of “world’s worst practice”.

3
## SUICIDE BY STATE OR TERRITORY (a), number of deaths, age-standardised rate

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(a) State or Territory of usual residence.
(b) Year of registration.
(c) Age-standardised death rate per 100,000 for the five-year period 2000 to 2004, using estimated resident population for Australia (persons) at 30 June 2001 as the standard population. Direct method of standardisation. Includes deaths of persons aged under 15 years.
(d) Rate of age-standardised rate for state/territory to corresponding rate for Australia.
Suicide Attempts and Homelessness

VISN 1 MIRECC researchers have found an alarmingly high rate of recent and lifetime suicide attempts in a study of over 7,000 homeless people with mental illness. Over half (51.3%) reported an attempt sometime in their lives and 8% reported an attempt in the past month. Lifetime suicide attempt rates in this homeless group are 12-15 times that seen in the general population (3-4%) and over 7 times that seen in general samples of people with mental illness (7%). Rates were higher among those who were homeless for the first time. This suggests that the shock of becoming homeless can serve as a trigger for a suicide attempt. Notably, recent suicide attempters were highly likely to have been recently discharged from a hospital and to have received outpatient mental health services. However, their current homeless status and recent suicide attempts suggest that service levels were insufficient. This study highlights the vulnerability of homeless people with mental illness as a group at risk for the most tragic of psychiatric clinical outcomes. Efforts to house and properly treat these particularly vulnerable people may reduce the risk of unnecessary deaths due to suicide. This study also shows that homeless people at highest risk for suicide attempts are highly likely to come in contact with the mental health system, giving clinicians an opportunity to identify and aggressively manage their suicidal symptoms. MIRECC researchers Rani Desai, Wen Liu Mares, David Dausey and Robert Rosenheck conducted this research.