There is a long acknowledged association between homelessness and mental illness. People with a mental illness are more likely to be homeless than the rest of the population, and people who are homeless are more likely to have a mental illness than the rest of the population. Irrespective of the direction of cause and effect, conversations concerning homelessness and mental illness often focus, explicitly or otherwise, on those who have well established illness and who have, or have had, some connection to mental health services. However, while the longevity of mental illness means that older young adults, the middle-aged and the elderly often feature prominently in discussions concerning the mentally ill, the bulk of the onset of mental illness occurs among young adults and adolescents. Approximately 80 per cent of the onset of mental illness occurs before the age of 30.

This is important because the period from the onset of puberty through the mid to late 20s is a time of enormous biological, social and vocational development. The onset of mental illness in this phase of life has the capacity to disrupt many aspects of these developmental processes. At best this may result in mild disruption. At worst, in one or more of these domains there can be a derailment of this development leading to significant disability.

Psychotic illnesses (such as schizophrenia) are associated with significant impairment across a range of functional domains such as housing, employment, physical health and relationships. For example a representative Australian sample of people with psychosis found that 12.5 per cent had been homeless in the last 12 months and five per cent were currently homeless, over two-thirds were not employed; 66 per cent were smokers and 42 per cent obese; and, 60 per cent being single and never having married (1). In particular the figures for homelessness are comparable with international 12 month data for people with psychosis (2). It is also well known that the first five years after the onset of a psychotic illness is the period in which the factors associated with poor outcome accrue and peak levels of disability are reached (3). Left to develop to their maximum, these levels of disability are more likely to persist through life (4). However, early intervention has the capacity to reduce or prevent the development of disability.

Early intervention in psychosis is an Australian innovation that has developed significantly over the last 25 years. Working with people identified as being at high risk of developing psychosis, or those who have a first episode of psychosis reduces rates of transition to psychosis, limits the longevity of symptoms of psychosis, improves functional outcomes and is cheaper than standard care. It is also known that making a quick functional recovery (that is, getting back to school and work, having a place to live etc. within the first 14 months of treatment) predicts not only whether or not people will be living independently, studying and working at 7.5 years but also how well their symptoms will be. Interestingly making a quick symptomatic recovery (that is, no longer experiencing hallucinations or delusions by 14 months) did not predict how well a person would be going at 7.5 years.

However, while early intervention improves functional outcomes it does not completely bridge the gap between those with psychosis and the general population. In order to do this
it has been found in some domains of functioning that early intervention needs to be augmented with other specific interventions. For example, augmenting early intervention with evidence-based vocational intervention greatly improved rates of return to work and school, to the point that they were nearly at the rates of employment and school participation seen in the general community (5). While employment is one thing, having a stable place to live is at the core of recovery. Attending to employment, school, physical health or nearly any other aspect of life is made significantly more difficult if there is no stable accommodation from which to launch efforts on these other areas of functioning.

Unfortunately, there is currently only one specialised early psychosis centre in Australia where the mixture of clinical and other functional interventions is available. Although funds were committed in the 2011 Federal Budget to open 16 early psychosis centres nationally, none have opened to date. One might be entitled to feel pessimistic as to the chances of any opening in the remaining months of the current government.

Whether it is under this government or the next, a number of steps are required to address not just homelessness for young people with psychosis, but broader functional recovery.

1. **Ease of access:**
   Only about 13 per cent of young men and 30 per cent of young women with mental health issues access the care they need. The development of headspace has been a welcome development in this regard, but the roll-out of headspace is not yet complete and for those with greater care needs, such as those at-risk for, developing, or with a first episode of psychosis, the care infrastructure does not yet exist. This needs to be urgently addressed.

2. **Geographic coalescing of services:**
   Mental illness attacks multiple domains of a person’s life. However, in dealing with the consequences of this one illness, an individual often has to access a number of services and service systems such as housing support, health, employment and education and Centrelink. Many of these exist in different offices and settings, and the burden of negotiating around all these agencies can fall on the person with psychosis. This is difficult in that their organisational capacities may be diminished through their illness or they may just lack the transport options to effectively get from place to place. Making these services available in the place where health care is accessed would reduce the burden and make it more likely that the individual would use the service and that the people managing the individual in each of the agencies would have more regular and effective communication.

3. **More and better accommodation options:**
   In research presented at the 2010 Australasian Society for Psychiatric Research Conference we showed that nearly 10 per cent of young people with psychosis were being discharged from an inpatient unit to less stable accommodation than that from which they had been admitted to the inpatient unit. Although *The Road Home* says that this should not happen, the pressures on hospital staff to discharge people to cater for others who need beds combined with a lack of options means that this will continue to happen. Given the particular needs of young people with psychosis coming out of hospital an expansion of the Youth Psychiatric and Residential Care (Y-
PARC) scheme would be good. This would allow a step-up/step-down option for discharge and potentially an alternative to hospitalisation in the first place.

4. An increased focus by mental health staff that accommodation is a key part of recovery and therefore is their business as much as the reduction in symptoms. This does not mean that they have to do it all themselves, but they do need to be aware of what resources they can access, how to access them and how to ensure a good outcome for their client.

There is no doubt that many other valid suggestions could be made. A stable place to live safely is the first step in recovery for young people with psychosis. From this base, no young person with psychosis should any longer have to believe that they cannot achieve what they wanted to in life. It is important that as workers, carers, policy makers and other stakeholders we actively work to put this first step in place.

Footnotes