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3 July 2019

Royal Commission into Victoria's Mental Health System
PO Box 12079
A'Beckett Street
VICTORIA 8006

E: contact@rcvmhs.vic.gov.au

Dear Commissioners,

Re: The Wyndham H3 Alliance: Response to the Royal Commission into Victoria's Mental Health System

On behalf of The Wyndham H3 Alliance (The Alliance) as Chair of their Strategic Partnership Group, we welcome the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System.

The Alliance is made up of several organisations from the housing, health and homelessness sector operating in Wyndham, working together to address housing vulnerability across the spectrum of housing needs against a backdrop of increasing demand for services, declining affordability, lack of appropriate housing options, in one of the largest growing areas in Australia.

The Alliance aims to support integration and build capacity in the system, ultimately achieving better outcomes for those at risk of/are experiencing homelessness.

As part of this systems approach, The Alliance have identified Mental Health as one of the key issues in Wyndham that needs to be addressed in order to most appropriately support some of the most vulnerable in our community.

The submission aims to provide important insights that this unique model can offer, highlighting some key issues and offering recommendations.

For more information, please do not hesitate to contact Lynn Ritchie, H3 Project and Service Integration Officer at [redacted]. We look forward to continuing to participate in the Royal Commission into Victoria's Mental Health System, as opportunities arise.

Yours faithfully,

Kriss McKie*
Chair, The Wyndham H3 Alliance and Manager Community Planning and Development, Wyndham City Council

Encl. The Wyndham H3 Alliance, Royal Commission into Victoria's Mental Health Services – report submission.

c.c. The Wyndham H3 Alliance

*Signed by: Donna Aston, Acting Manager Community Planning and Development, on behalf of Kriss McKie

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

The Wyndham H3 Alliance

JULY 2019

About The Wyndham H3 Alliance

Established circa 2004 as a cross sector collaboration and advocacy network, The Wyndham H3 Alliance (The Alliance) evidenced the significant and growing issue of homelessness in Wyndham and the inadequate service system response to those needs. As such, in 2017, the Department of Health and Human Services Victoria (DHHS) announced funding to several alliance partners to deliver a range a suite of services over a four-year period

The Alliance has been established to address housing vulnerability along the spectrum of housing needs by increasing access to housing supply, providing support, building capacity, and addressing issues that lead to housing vulnerability for people of the Wyndham community.

The Alliance seeks to fulfil its vision and mission through a collective impact approach that:

- provides holistic, client-centred wrap-around services;
- leverages and connects the multiple services offered by its partners;
- develops and maintains a shared information system that responds to housing vulnerability for people in Wyndham; and
- provides permanent supportive housing for people with complex needs who are experiencing chronic homelessness.

The Alliance aims to take a holistic, client-centred approach by addressing housing vulnerability along the spectrum of housing needs, including by providing tailored support to those facing immediate housing crisis as well as early intervention with at-risk groups.

The Alliance provides sustainable housing by increasing access to housing supply (purchasing / developing stock and increasing access to private rental), providing the support needed to sustain a person's housing options, and building capacity and addressing issues that have caused housing vulnerability.

In addition to housing support, wrap-around services delivered and leveraged through the Alliance include health, alcohol and other drugs, mental health, legal, financial, emergency food and basic needs, family violence support, youth support services and other allied support services.

The Alliance's approach is designed to be scalable to meet the needs of the dynamic and changing growth environment in the City of Wyndham and is built on current government policy direction and opportunity in order to maximise the impactful and efficient use of new funding and resources while also building on the strengths of existing services and models.

The Alliance model is supported by the continued development of a coordinated and collaborative local support service system between the Alliance partners and other related local services.

Taking a place-based approach not only strengthens service support and delivery, but also works to strengthen referral pathways and networks, build community awareness of services and needs, and support creative, timely and more efficient service response across the sector.

The Alliance is comprised of the following organisations:

- Wyndham City Council
- Unison Housing Limited
- Bolton Clarke Homeless Persons Program (HPP)
- Cohealth
- Melbourne City Mission
- Uniting Wyndham

- West Justice
- Whitelion
- Mercy Mental Health
- The Salvation Army
- Wyndham Community Education Centre

There are several cohorts that have been identified as at higher risk within the Wyndham area. Mental Health has been a consistent, strong theme coming through from Alliance partners through the Operational Partnership Group and Strategic Partnership Groups which support and steer the Alliance. While the Royal Commission into Victoria's Mental Health System is shining a light specifically on the mental health system, we would argue that the intersectionality of mental health and homelessness requires a broader systems review to achieve effective recommendations. As such, The Alliance is happy to provide the commission with this report identifying issues and opportunities we deem of value.

While The Alliance catchment is the municipality of Wyndham, the member organisations are not limited to this catchment and can confidently assert that the learnings and recommendations we share with the Commission can be extrapolated to wherever homelessness and mental health coexist.

Mental Health and Homelessness

The interconnection between homelessness and mental health issues is well established and documented. Private and government reports alike consistently identify this fact.

The Australian Housing and Urban Research Institute (AHURI) and others have regularly generated research in this area. Findings include:

- "Long-term physical and mental health conditions are major risk factors for homelessness... People having access to appropriate health services is an important aspect of assisting them to manage their condition, exit out of homelessness and reduce the risk of repeat episodes of homelessness." (AHURI report: The cost of Homelessness and net benefit of Homelessness programs: A National Study 2013)
- "Persons experiencing both homelessness and mental ill-health represent a hard to reach group for service providers ….. There are four categories of persons with severe or chronic mental illness who are homeless… 1. People who are homeless and do not receive any services to support their mental health issues… 2. People who are attended to and hospitalised by medical practitioners but who are not adequately supported when released back into the community. .. 3. People who are treated in a psychiatric facility in hospital and remain hospitalised without a discharge or exit strategy back into the community. ..4. People who experience primary or secondary homelessness in substandard and insecure tenures who struggle to manage their mental health …. their homelessness perpetuates their mental health issues. (AHURI report for MIND Australia: Trajectories: the interplay between mental health and housing pathways - A short summary of the evidence: 2019)
- "Many of those things which prevent mental ill-health and enable a contributing life lie outside the formal health system, in areas such as housing, education, employment, welfare and justice"(p 222). It cites "optimal care includes access to supports other than health alone. The provision of housing with support is also identified as key for people with severe and complex mental illness. In the modelling of the pathway for a person with schizophrenia, stable housing was identified as crucial to enabling access to other services" (p 166). (National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC)

The above research is born out in National, The Alliance and Mercy Health data:

- "People 15 years and over who reported having a mental health condition were more than twice as likely to have experienced homelessness in their lifetime, compared with people who did not (25% compared with 10%)." (ABS: Mental Health and Experiences of homelessness, Australia, 2014)

- Mental Health was a consistent, strong theme in presentations/service users to Initial Assessment and Planning at Unison Housing with 25% of all presentations June 2017- June 2018 identifying mental health as an issue. (The Alliance 2017-2018 data report)
- 92 Mercy Mental Health inpatients in 2017-2018 identified as homeless, representing 7.5% of separations for the year. Of these, 73 (79.3%) were discharged to a private residence/accommodation. The remainder were either transferred to another health care area (7.6%) or left against medical advice (12%). It is not possible to establish from the data how suitable or unsuitable the accommodation for these people is over the long term. Private residence can include temporary lodgings secured as crisis accommodation. Also, these figures are expected to be an under representation as the broad definition of homelessness is not always applied. (Mercy Health: Briefing Paper: Mercy Health Ethics Committee March 2019)

Response to Terms of Reference

A number of The Alliance member organisations work specifically in mental health and as such could have input relevant for every Term of Reference item being explored by the Commission. We are aware that these organisations are making their own Royal Commission submissions and can speak to additional items. For the purpose of this submission, The Alliance will respond only to TOR items that correlate directly to our combined work.

Item 2.3
How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:

- Strengthened pathways and interfaces between Victoria's mental health system and other services

As noted above the relationship between mental health and homelessness is reciprocal, complex and routinely involves multifactorial risk and perpetuating factors. As a result, supporting individuals experiencing mental illness and homelessness will routinely require connection not only with already complex mental health and housing service systems, but also engagement with other service systems like health, AOD and justice. Navigating the current housing and mental health systems is challenging enough for stably housed, psychologically robust individuals. For those who are homeless, struggling with mental illness and often a range of other issues, system navigation itself can provide an insurmountable barrier that will often see clients opt out and accept circumstances such as rough sleeping or staying in unsafe housing options.

The Alliance structure

Improving and simplifying system navigation for our clients has been a major priority for The Alliance. To achieve this;

- most initiatives funded under The Alliance were designed as partnership programs
- additionally, The Alliance activity is focused on improving pathways for all members, including non-funded members and other service providers outside The Alliance via working groups and negotiated access pathways.

While the latter is achieving improvement in collaborations, The Alliance experience suggests that partnership programs most effectively achieve service system coordination.

Programs such as the Rough Sleeper initiative demonstrates this. It brings together mental health support services, health care and housing. Since October 2017, the program has maintained 12 fully tenanted properties with a further 12 rough sleepers supported in the community. 92% of clients achieved comprehensive physical and mental health assessments and assessments of AOD, living skills and legal needs. 87% of clients maintain engagement with Cohealth mental health and Bolton Clarke nursing support with the other 13% having sporadic contact.

In the same period work undertaken to improve pathways between clinical mental health (non-funded) and homelessness services (funded), while achieving improvements, has not significantly impacted the practice of discharge from the psychiatric inpatient unit to crisis or poor-quality housing options. As such admissions do not currently provide a pathway out of homelessness for mental health patients.

Strengths:

- Good will and shared values developed in The Alliance structure itself corrects some of the service siloing that is routinely evident. It supports systems to ask each other to change their standard practice methods in response to the needs of the client cohort we are jointly seeking to benefit.

Issues/limitations:

- The Alliance identifies a key challenge in achieving consistent processes across the clinical mental health and housing/homelessness service systems is the differing performance indicators and priorities of these systems. Acute clinical mental health services lengths of stay are too short to achieve positive housing outcomes through standard housing referral processes and the standard practice of discharges to low quality/short term housing options without established housing/homelessness service links routinely sees discharged patients return to homelessness and often back to acute psychiatric crisis and readmission.
- Staff retention in member agencies has posed significant challenges for The Alliance. Impacts on progressing the strategic work of The Alliance have been felt, but also in establishing enduring collaborative care arrangement which are heavily reliant on relationships and momentum. Having a designated service integration officer has mitigated these limitations to a degree as the intellectual property and history of the group is to a degree held by this function.

Recommendations:

From these learnings The Alliance recommends:

1. that Mental Health clients have established, appropriate housing options and pathways to such housing within the housing/homelessness service systems, especially for clients who are confined to psychiatric inpatient units' long term due to lack of suitable discharge options and those in known high risk scenarios such as transitioning from inpatient care or sleeping rough.

2. Ideas to achieve this include:

    a. Growing and aligning Transitional Housing capacity towards mental health clients to address the immediate crisis within an established model of care
    b. IAP service model be resourced for assertive engagement with homeless mental health clients, especially during the key risk period of discharge from hospital. A model for this is currently provided by Launch Housing into Alfred and St Vincent's Psychiatric units with positive evaluations around it providing a genuine pathway out of homelessness
    c. Exploring Head Leasing and Landlord/Real Estate Accreditation Schemes to improve quality and affordable access to private sector rental housing for mental health clients who historically experience barriers to achieving and sustaining private rentals.
    d. Supported housing models that embed service partnerships and shared performance targets are to be encouraged. Examples such as the Common Ground model in Elizabeth St in Melbourne and in Adelaide are effective and see housing, support and clinical services work together. Alternatively, small cluster supported housing such as MIND Disability Supported Housing programs which offer robust, secure housing and mental health support services are also effective models.

3. that like The Alliance, government departments routinely work together to look to the needs of clients whose situation is affected by issues that straddle service systems. That the lens of intersectionality be applied to these cohorts. For the needs of a clients who experience mental illness and have stable

housing and the supports that housing affords are fundamentally different from other clients with the same mental illness whose daily priorities are basic safety and shelter. While the first group may make great inroads with access to evidence-based medications and psychosocial therapies, the lack of progress for the second group is likely not an issue of lack of availability of mental health treatments, but due to the impact's homelessness has on their mental health recovery.

4. that practical, operationally focused cross-sectoral networks such as The Alliance be encouraged and resourced

Item 4

How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health, including but not limited to people:

4.2 Living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities

As referenced previously, people who experience homelessness and mental health issues routinely present with a number of additional areas of need. Co-occurring substance abuse issues, cognitive deficits due to Intellectual Disability or Acquired Brain Injury and physical health complaints are commonplace, especially when homelessness has become a persistent issue. It is not only logical, but substantiated in evidence that stable, appropriate housing is essential for gains to be made not only around the management of a mental illness and lasting resolution of homelessness, but also with any of the comorbidities.

Housing First

Up until the early 1990s, the assumption underpinning program design was that long-term homeless people with mental health and/or substance abuse issues needed treatment before they could be offered permanent accommodation. However, by the early 1990s there was increasing evidence that this approach was not working. The Housing First approach emerged in response to this system shortcoming in the US, arguing that is was more effective to provide people with permanent housing and then deal with their mental health and/or drug and alcohol problem.

The Housing First model has gained widespread attention around the world because several evaluations have found that it produces better results than other methods.

In Victoria, the Melbourne Street to Home Program is based on a 'Housing First' model and was initially funded in 2010 as part of a National Partnership Agreement on Homelessness. This program has been able to secure positive outcomes with the long-term homeless as well as support them to maintain their housing. (Evaluation of the Melbourne Street to Home Program: Final Report. Johnson and Chamberlain, RMIT University, March 2015)

Assertive Outreach

Assertive Outreach is a key component of the Housing First Approach, seeking to engage people who are homeless and have complex needs. Assertive outreach is a persistent and purposeful approach for people who do not present to, or have difficulty engaging with housing, homelessness and health services.

Assertive outreach grew out of the mental health Assertive Community Treatment model and was developed to provide mental health services to people who failed to attend or dropped out of treatment.

With Assertive Outreach the person's needs, wants and priorities are put first and responses tailored accordingly. Workers need to be flexible, responsive and reliable.

The Alliance Rough Sleeper Program incorporates key elements of Housing First:

- Targeted assertive outreach and engagement of vulnerable rough sleepers.
- Health assessment, care planning, clinical care (as appropriate) for all clients.
- Intensive assistance to access and maintain housing.
- Active support that enables clients to engage and stay engaged with relevant support and health services and treatment options.

- Case management model of care coordination.

Strengths:

- Recruitment of clients to a partnership model facilitates free communication between and thus enhanced coordination of partner agencies during all phases of the client's involvement in the program, removing barriers that commonly exist between health and specialist homelessness services
- The partnership between Bolton Clarke Homelessness Persons Program and CoHealth Mental Health Outreach Support has been a great strength as evidence by the high proportion of clients who have engaged with physical healthcare and mental health care follow up, social connectedness, material aid relief, daily living skills, improved natural supports, community connection and legal support.
- Designation of twelve social housing properties specifically for clients of the program
- The relationships facilitated through The Alliance have improved referral pathways into alliance member services. E.g. outreach clinical mental health assessment for hard to engage clients.
- The assertive outreach model has enabled reliable regular contact with program participants. This in turn increases the opportunity for developing substantive, therapeutic relationships with clients and for persistent efforts for achieving follow up with external providers. E.g. Linkage to health/ mental health treatments and appointments by allocated worker trying daily to locate client.
- Intensive support provision both before and after housing is secured.
- Repair and strengthening the client's natural support network.

Issues/limitations:

- Timely access to appropriate housing is the perennial issue when working with homeless individuals. While the rough sleeper program included twelve one-bedroom properties for rough sleepers, these were tenanted within three months of the program commencing. There remains a critical shortage of social housing in the Wyndham area. New clients to the program are now faced with protracted delays in achieving good housing outcomes.
- Capacity in external agencies to provide their services in a similarly accessible manner e.g. Pressures in the clinical mental health and housing IAP systems limit the amount of outreach engagement or appointment rescheduling they can offer this cohort. Access to Neuropsychiatric and Dual Diagnosis specialist assessments remains a challenge
- Confidentiality constraints limit free communication between agencies outside the formal program partnerships
- NDIS rollout has created additional barriers to accessing community mental health support for this cohort. Rough sleepers are largely unable to navigate access pathways into the scheme without significant specialised, mental health support from an experienced and skilled workforce.

Recommendations:

5. The Alliance advocate that Housing First and Assertive Outreach models of service delivery be expanded in order to be accessible for all people who are chronically homeless and "living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities". These models of service must include social housing for the cohort.
6. That government ensures there is capacity within the associated service systems, notably clinical mental health, AOD assessment and counselling services, housing IAP services, neuropsychiatry assessment services to be able to create much greater accessibility to their services for this cohort. e.g. While Mercy Mental Health has a Homeless Outreach Psychiatric service, the unmet demand for general clinical services has limited the capacity for Mercy Health to deliver an assertive outreach model in recent years. Growth must more closely align with demand to avoid the loss of intensive outreach models of care.
7. That the blockages in supported transitional housing programs are addressed by growth in social housing stock generally.

8. That diverse supported housing and housing with support models be available to avoid a one size fits all paradigm and enable genuine client centred / tailored models of care. This includes expansion of existing housing models, such as transitional and social housing and implementation of new approaches such as permanent private rental subsidies to address the shortage of social housing.

Early intervention/ Prevention of escalating complexity and chronicity of homelessness – Youth

Melbourne Street to Home found that a Housing First model is beneficial for the full client cohort, but that achieved sustained improvement in housing circumstances was more difficult to achieve with clients who first became homeless as teenagers. It is posited that this outcome relates to a lack of 'cultural capital' (education, social skills, knowledge, self-confidence and other non-material assets) for this cohort as adults when compared to those who first become homeless as adults. The lack of 'cultural capital' was attributed to the findings that:

- the mean age for the youth pathway cohort was 13 when they first became homeless
- 40 per cent had been in the state care and protection system which suggested they had usually come from seriously dysfunctional families and were likely to have experienced sexual abuse, physical abuse or neglect, and to have grown up in poverty; and
- 57 per cent had left school before year 10

(Evaluation of the Melbourne Street to Home Program: Final Report, Johnson and Chamberlain, RMIT University, March 2015.)

The Alliance Youth Programs

The Alliance programs aim to engage and support young people for an early pathway out of homelessness and toward developing the 'social capital' their journey to date has not fostered.

The Youth Cluster Program is a 1-2 year supported housing program for 10 young people (16-25yo) provided as a partnership program between Melbourne City Mission and Unison Housing. The intention is that it be delivered in a purpose built 'cluster' facility plus another 6-month support for smooth transition to independent housing. The program will focus on linkage to education, training, employment and intensive casework to enable young people to work towards personal goals and address any issues that may be preventing them from progressing to independent living. At present the service is purely an outreach one as the facility is not yet built. As such housing access relies on mainstream options.

The Whitelion Outreach Housing Support Program is currently very similar to the MCM outreach program described above. Identifying and assertively engaging homeless young people and working towards developing skills and pathways to stable housing and education/employment.

Young People Rent Subsidy program provides private rent subsidy for 2 years to enable individuals who are homeless due to insufficient income (e.g. Newstart and Youth Allowance) to access affordable housing and have time to achieve access to more substantial incomes that could support full rental ongoing.

Strengths:

- Provides time and opportunity to build the skills (social capital) to successfully move out of recurrent homelessness and address co-occurring issues such as mental illness, trauma and substance abuse.
- As assertive engagement models they are not reliant on commitment from young people, who even without complex psychosocial adversities, developmentally would not be able to readily and consistently commit to a course of action.

Issues/limitations:

- Access to housing appropriate for the younger age group, especially longer-term unsupported options that are financially and socially viable long term is a marked service gap

- Cluster model strengths around learning through relationships in your home environment also introduces challenges of being able to support the most severely impaired and behaviourally risky individuals due to the impacts their behaviours can have on their co-residents' recoveries. Young people with significant mental illness and personality problems may struggle to sustain a cluster model of care.

Recommendations:

9. Significant growth in safe, affordable housing stock that suits the needs of young people and addresses the access barriers of cost and discrimination due to age or mental illness
10. Increased pathways and strategies for young people to move into paid employment and off Centrelink benefits, especially for those with co-occurring health and/or mental health issues
11. Reduce barriers to housing by increasing Newstart and reduce barriers to housing by stopping punitive measures around income support or housing wait lists that see incomes discontinued or removal from wait lists
12. Ensure there are varied models that support young people who experience mental illness and homelessness
13. Intervene earlier in emerging personal or familial crises to minimise the entry of teenagers into homelessness and the compounding structural disadvantage and adverse health outcomes associated with it.

Early intervention/Prevention of escalating complexity and chronicity of homelessness – Adult

The Alliance has programs aimed at supporting family units and single adults via timely inputs to maintain housing or to achieve pathways to regain affordable housing when housing crisis arises. In this way we aim to reduce the likelihood that housing crisis can turn into protracted homelessness. 'Complex' clients are developed over time with layering of additional issues, one on top of the other. Preventing the accumulation of additional complexity such as homelessness is an essential strategy to address the client cohort of TOR *Item 2.4.*

The Alliance early intervention programs for adults

Mortgage Stress and Housing Stress Program delivered by West Justice Legal Service identifies legal and advocacy options to prevent home ownership breakdown.

Early Intervention and Housing Support Program delivered by Uniting Wyndham is time limited support for tenancies identified as being at risk.

Private Rental Access Program, a partnership program of Uniting Wyndham and Unison Housing, support and facilitate 'warm' referrals into private housing options.

Strengths:

- Provide options to divert housing crisis from becoming chronic homelessness
- Mitigates some structural risks e.g. stigma with accessing private rental for people with mental health issues

Issues/limitations:

- Issues that bring adults into homelessness are frequently related to much broader structural and societal issues. e.g. Poverty, insufficient affordable housing for rent or purchase, banking system impacts, access to employment, income protection system issues, stigma

Recommendations:

14. Continue to work towards improved housing affordability – purchasing and renting
15. Emphasise support of family units to be safe, nurturing, enabling structures that can grow healthy, capable, resilient children who are ready to manage their lives independently as adults.

Item 4.4 In contact, or at greater risk of contact, with the forensic mental health system and the justice system:

Due to the compounding risk factors that mental illness and offending are in relation to homelessness, the client cohorts of The Alliance programs often present with the additional complexity of contact with the criminal justice system. The Alliance has no programs targeted to this particular client group, however, Housing First programs, particularly those using scattered site formats such as The Alliance Rough Sleeper program have been found to promote reductions in offending and reconviction among people who were homeless and had current mental disorders and histories of involvement with the justice system. (Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial. Julian M. Somers, Stefanie N. Rezansoff, Akm Moniruzzaman, Anita Palepu, and Michelle Patterson).

Issues:

- Association with antisocial individuals is a key risk factor for predicting future offending. The practice of housing individuals with co-occurring mental health issues, homelessness and offending into low quality rooming houses, caravan parks or shared accommodation which also houses prison discharges will only serve to increase risks for this cohort
- Excessive incarceration rates for this cohort due to barriers for achieving bail and parole such as lack of proactive engagement with legal supports, lack of suitable housing or acute psychiatric presentations that impair capacity to instruct legal representation

Recommendations:

16. That Housing First and Assertive Outreach models of service delivery be expanded in order to be accessible for all people with mental illness who are chronically homeless and in contact with forensic mental health system and/or the justice system. These models must include housing options including social housing and permanent private rental subsidies.
17. Expansion of the very successful Health Justice Partnership run by Bolton Clarke Homelessness Persons Program and the Mental Health Legal Centre to increase access to justice for people with mental health challenges who are further marginalised by the experience of homelessness. Proactive resolution of charges has avoided incarcerations for their clients
18. That clear processes and resources are established to enable rapid engagement of legal advocates under the Guardianship and Administration Act such that legal representation can be given instruction for bail/parole applications.

CONCLUSION

The National Mental Health Commission (NMHC) review of mental health services and programs in 2014 affirmed the importance of stable housing and housing support as prerequisites for mental and physical health and wellbeing. It found that early access to housing is important for those with lived experience of severe and complex mental illnesses and that equitable access to mainstream housing is important to reduce the negative mental health effects of stigma. The report identified the need for governments to address the fragmentation and inefficiencies in the service system, including linkages with housing services, the need to provide housing alternatives to psychiatric institution and to adopt 'person-centred' funding models. In addition, it overtly endorsed the uptake of models like Housing First.

The Alliance supports the holistic and client-centred service system advocated by the National Mental Health Commission and are happy to provide additional input if requested.