VincentCare
Engage. Enable. Empower.

Submission to the Royal Commission into Victoria's Mental Health System

Version 1.0
July/2019

VincentCare is committed to the principles of social justice and aims to ensure that every individual is treated with dignity and respect regardless of their ability, cultural background, ethnicity, gender identity, sexual oprientation or religion.

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Contents

Introduction

VincentCare Victoria welcomes the Royal Commission into Victoria's Mental Health System and commends the Victorian Government's readiness to examine the challenges facing our mental health system and envision how to better meet the needs of all Victorians.

As providers of services for disadvantaged and vulnerable people throughout metropolitan and regional Victoria, VincentCare staff observe the high representation of people presenting at our homelessness services with mental ill-health. The intersection between housing, homelessness and mental health is undeniable – people experiencing poor mental health are more likely to end up homeless, while the experience of homelessness or insecure housing also leads to worse mental health outcomes.
This submission responds to four of the questions posed by the Commissioners:

- What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
- What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
- What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
- Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Our responses to these questions are based on over 65 years working with people experiencing homelessness and disadvantage.

Section One explains the relationship between housing, homelessness and mental health.

Section Two considers the shared risk factors and drivers of poor mental health and homelessness.

Section Three identifies the three major challenges that we believe should be prioritised to improve mental health for people experiencing homelessness; affordable housing shortages, fragmented service delivery and insufficient and inappropriate services to meet demand.

Section Four identifies two model interventions that can address these challenges – one of which is currently operational in Victoria and can be scaled up, and one that was previously operated nationally.

Through this submission, VincentCare Victoria wishes to demonstrate an ongoing commitment to working with the Victorian Government to improve health and wellbeing outcomes for all Victorians.

Yours sincerely

Quinn Pawson
Chief Executive Officer
VincentCare Victoria

About VincentCare Victoria

VincentCare Victoria was established by the St Vincent de Paul Society Victoria in 2003 to deliver services for disadvantaged and vulnerable people; including those who experience homelessness, live with disability, are ageing and socially isolated, and experiencing substance dependency or abuse. VincentCare provides a range of services to people throughout metropolitan and regional Victoria, including specialist services in homelessness and rehousing, community aged care, alcohol and drug treatment, trauma and mental health, family violence, disability and youth support. Our responses include direct services with individuals and groups of people as well as building capability into local communities.

VincentCare Community Housing is a registered housing provider, used by VincentCare Victoria to provide residential property ownership, stewardship and tenancy and property management. VincentCare Victoria manages over 215 crisis, transitional and long-term accommodation units on behalf of the Victorian Department of Health and Human Services. It owns a further 63 Independent Living units targeted to adults aged 55 years and older. We work with the occupants of our various owned and managed housing stock to address drivers of disadvantage and vulnerability including homelessness.

6,086 people accessed VincentCare's services in 2018. Clients range from children to seniors, however the majority (56%) of clients were aged between 25-54. 7% are of Aboriginal or Torres Strait Islander descent, and 72 languages other than English were spoken by clients. Three quarters of VincentCare Victoria's clients (74.9%) are dependent on Centrelink payments as their main income source, 15% have no source of income and 7% are paid employees. Experiences of trauma amongst clients are almost universal, with most client's first experiencing trauma in childhood.

Working with the Australian Centre for Posttraumatic Mental Health and three other agencies, VincentCare Victoria collaborated to develop the Trauma and Homelessness Initiative. The findings of this project inform our current model of practice that emphasises trauma awareness, physical and emotional safety, combined with a strengths-based approach and opportunities to rebuild control.

Recommendations

Recommendation 1: VincentCare Victoria strongly encourages the Victorian Government to leverage the significant research into trauma within new commissioning frameworks and ensure a universal approach to trauma and recovery across related service sectors.

Recommendation 2: Any reforms to mental health services must consider the impact of trauma experienced by women and children as a result of family violence, and ensure responses are consistent and complementary with reforms occurring in response to the 2017 Royal Commission into Family Violence.

Recommendation 3: Increase the number and type of mental health residential treatment options for people being discharged from acute care, including step down facilities and transitional housing, to ensure acute mental health patients are not discharged into homelessness or crisis accommodation.

Recommendation 4: Consider targeted expansion of specialist services for communities experiencing multiple drivers of disadvantage, including responding to the mental health needs of Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, and people from culturally and linguistically diverse communities, including refugees and asylum seekers.

Recommendation 5: Expand financial assistance to assist more people to enter and maintain private rental.

Recommendation 6: Double spending on social housing to be in line with other states and territories in Australia.

Recommendation 7: Plan to deliver 3,000 new social housing properties each year for the next 10 years.

Recommendation 8: Mandate that 5% of properties in developments larger than 30 units are designated as social housing.

Recommendation 9: State government services that were provided prior to NDIS should not be discontinued for people who are eligible for them but are not eligible for the NDIS. This includes social inclusion programs and 'low barrier to entry' programs.

Recommendation 10: Undertake a review into the effectiveness of ACIS telephone triage, what improvements can be made, and if alternative services are needed.

Recommendation 11: Review privacy requirements relating to client and patient information to assess if better information sharing is feasible while continuing to protect the rights and privacy of the service user.

Recommendation 12: Develop performance metrics for providers of mental health, housing and homelessness services (both departmental and external programs funded by government) that incentivise coordination of services and information sharing.

Recommendation 13a: Discharge policies in hospitals and psychiatric care facilities require clear direction to ensure people are not discharged without adequate planning for their social and economic wellbeing. A comprehensive, state-wide discharge policy is recommended, with

adequate resourcing for hospitals staff to undertake thorough and appropriate discharge assessments and plans.

Recommendation 13b: Where there is no option but to refer patients to homelessness services, adequate communication protocols need to be established to ensure continuity of care.

Recommendation 13c: The state-wide discharge plan should require timely and proactive follow-up of patients to ensure they are being supported through community mental healthcare and other social supports they may need.

Recommendation 14: Expand availability of dual diagnosis treatment, both in the community and in residential settings.

Recommendation 15: Support mental health service providers and alcohol and other drug rehabilitation services to integrate dual diagnosis into their treatment models.

Recommendation 16: Remove geographical restrictions on accessing treatment and allow consumers to choose their preferred provider.

Recommendation 17: Commit to ongoing funding of existing OACs and the provision of mental health services within these centres.

Recommendation 18: Support the creation of OACs for groups that are currently less likely to use these services including women's only centres, family-friendly drop-in spaces, centres for Aboriginal and Torres Strait Islander people and centres catering to the LGBTIQ communities.

Recommendation 19: Develop a program for people experiencing chronic homelessness to support them into housing and in self-directed recovery.

Section One: Housing, Homelessness and Mental Health

Key Points

- Housing, homelessness and poor mental health are inextricably linked.
- A person with mental illness is more than twice as likely to experience homelessness compared with a person without mental illness.
- Living with mental illness makes a person more vulnerable to becoming homeless, however the experience of homelessness also results in a diminution in mental wellbeing.
- 28% of people presenting to specialist homelessness services are experiencing mental illness, while traumatising events have been experienced almost universally.
- Access to safe, stable and affordable housing is a crucial prerequisite to recovery from poor mental health.

VincentCare staff see the inextricable link between homelessness and poor mental health in every facet of their work. Many of the men, women and children who come through our services clearly display psychological distress or symptoms of mental illness. Some were experiencing poor mental health prior to becoming homeless. For others, homelessness has precipitated the onset of mental illness. The experience of VincentCare staff is validated by government data sources and academic research.

A person is more likely to become homeless if they have prior experiences of mental illness or trauma. In 2014, the Australian Bureau of Statistics' General Social Survey found that people who reported having a mental health condition were more than twice as likely to have experienced homelessness in their lifetime than a person without a mental health condition (25% compared with 10%), and more than twice as likely to have experienced homelessness in the previous ten years (15% compared with 6.1%). (Australian Bureau of Statistics, 2016). Around one in three people experiencing homelessness suffer from poor mental health[1]. The Specialist Homelessness Services (SHS) Annual Report 2017-18 (Australian Institute of Health and Welfare, 2018b), found 28% of people experiencing homelessness were also experiencing a current mental health issue. This percentage has increased steadily for the past five years from 22% in 2013-14.

A 2011 study undertaken with 4,291 people experiencing homelessness in Melbourne found 31% were experiencing mental health challenges. Of these, around half had mental health issues prior to becoming homeless, while the rest developed mental health issues after becoming homeless (Johnson & Chamberlain, 2011).

Johnson & Chamberlain's (2011) findings demonstrate that while mental health can often be a precursor to becoming homeless, the experience of homelessness can also be a cause of poor mental health. People experiencing homelessness suffer far higher rates of stigma and discrimination, social isolation and fear for their personal safety. Unsurprisingly, these experiences lead to emotional distress, anxiety, depression, and substance misuse (Davies & Wood, 2018; Johnson & Chamberlain, 2011; Roussy et al., 2015).

VincentCare Victoria strongly believes that by ensuring people have stable, secure and affordable housing, they will have greater capacity to prioritise and improve their mental health. This is addressed further in Section Three.

[1] Accurately quantifying the prevalence of mental illness amongst people experiencing homelessness is challenging with estimates varying from 12% to 82% (Australian Institute of Health and Welfare, 2011)

Section Two: Drivers, Risk Factors and Barriers

Key Points

- Homelessness and poor mental health share many of the same drivers and risk factors, including trauma, poverty, stigma and discrimination, social isolation, family violence, time spent in institutions, and problematic use of alcohol or other drugs. The comorbidity of these drivers demands a holistic and coordinated response.
- Trauma is almost universal amongst people experiencing homelessness. VincentCare Victoria strongly encourages the Victorian Government to adopt a trauma-informed approach to any reforms implemented as a result of this Royal Commission.

In addition to homelessness and poor mental health unfavourably impacting on each other, the two challenges share many of the same risk factors. People experiencing adverse social, economic, and environmental conditions challenges (often spoken of under the umbrella term of 'disadvantage') are more vulnerable to both homelessness and poor mental health outcomes.

The Specialist Homelessness Services Annual Report 2017-18 notes that of the 81,000 Australians experiencing both homelessness and poor mental health, over half were also experiencing other vulnerabilities such as harmful use of alcohol and other drugs or family violence (Australian Institute of Health and Welfare, 2018b). Other common risk factors commonly seen in VincentCare Victoria's services include inter-generational poverty, historical or recent experiences of trauma (particularly childhood trauma), social isolation, family violence, unemployment and time spent in institutional settings (such as out-of-home care, psychiatric hospitals, and incarceration).

These risk factors, considered below, and the experience of homelessness and mental illness, are so deeply interconnected that only holistic responses are likely to have meaningful impact.

Trauma

VincentCare Victoria works from the starting point that people using our services will almost universally have experienced some form of trauma, either prior or subsequent to experiencing homelessness. This position has been developed though over 65 years' in working with people experiencing homelessness, but also through our 2012-2014 collaboration with the Australian Centre for Posttraumatic Mental Health and three other agencies[2] to develop the Trauma and Homelessness Initiative (THI).

Of 115 clients interviewed for THI, 97% had experienced more than four traumatic events (compared to 4% of the general population). Such events are 'more than merely stressful' (Cash et al., 2014). They include serious threats to one's life or personal safety, or witnessing the death, injury or suffering of others. These events are profoundly overwhelming and frightening, resulting in feelings of anxiety, humiliation and vulnerability. As explained by Cash et al. (2014) 'trauma exposure usually begins in childhood, is a precipitant to becoming homeless, and then escalates upon becoming homeless. Trauma may lead to mental health problems which lead to social and relationship difficulties which in turn maintain homelessness. Similarly, mental health difficulties might lead to social relationship difficulties which increase the risk of trauma exposure and homelessness.'

[2] Sacred Heart Mission, Mind Australia, and Inner South Community Health

The THI study concluded that 73% of participants would meet the criteria for a current diagnosis of posttraumatic stress disorder, with 88% of those also having high rates of comorbidity with other disorders including depression, substance misuse and psychosis (Cash et al., 2014). This correlates with Taylor and Sharpe's 2008 study, which found that posttraumatic stress disorder was 27 times higher among homeless adults in Sydney when compared to the general population (41% vs 1.5%).

Experiences of trauma impact on the way people see themselves and the world around them and as a result, their behaviours. Participants in THI reported feelings of hopelessness, anger and anxiety. 62% had trouble in regulating their emotions that manifested as panic attacks, hyper-vigilance, and strong cravings or urges. As a result, 93% experienced interpersonal difficulties, and risk-taking behaviours were common (41%), including substance use, placing themselves at risk of physical or sexual harm, and self-harm/suicide attempts (Cash et al., 2014; O'Donnell et al., 2014)

Practitioners interviewed by THI stated that the impact of trauma on client's behaviour significantly impacted on their ability to form and maintain positive social relationships, which in turn lead to difficulty in maintaining housing and employment. Without the two pillars of a living income and stable accommodation, practitioners noted their clients were at risk of entering a cycle of crisis (O'Donnell et al., 2014).

Recommendation 1: VincentCare Victoria strongly encourages the Victorian Government to leverage the significant research into trauma within new commissioning frameworks and ensure a universal approach to trauma and recovery across related service sectors.

Family Violence

Family violence is a common source of trauma for women and children, and the leading cause of homelessness for all users of specialist homelessness services (Australian Institute of Health and Welfare, 2018b). Women who experience family violence are significantly more likely to experience mental illness, with the 2008 Australian National Mental Health and Wellbeing Survey showing that amongst a sample of 1,218 women who had reported gender-based violence, there were significant rates of mental illness, including anxiety, depression, substance misuse and posttraumatic stress disorder. '(Brackertz, Wilkinson & Davison, 2018). The additional trauma and harm experienced by women and children, who become homeless when seeking to escape family violence cannot be overstated.

VincentCare Victoria recognises the extensive work being undertaken by the state government in relation to family violence. As this work continues, it is essential that any reforms to mental health services reflects the impact of trauma experienced by women and children as a result of family violence and ensures responses are consistent and complementary.

Recommendation 2: Any reforms to mental health services must consider the impact of trauma experienced by women and children as a result of family violence, and ensure responses are consistent and complementary with reforms occurring in response to the 2017 Royal Commission into Family Violence.

Poverty

Poverty is the overwhelming cause of homelessness, and a significant risk factor for mental illness. Amongst Australians living in the lowest income quintile, one in four people report either high or very high psychological distress. This is five times higher than for those living in the

highest income quintile, where only one in 20 experience this level of psychological distress (Isaacs et al., 2018). This is consistent with the literature from other high income countries (World Health Organization & Calouste Gulbenkian Foundation, 2014) which shows poverty and debt are 'strongly associated with depression suicide, drug dependence, and psychotic disorders' (Issacs, 2018). Importantly, studies in Europe and the USA have also demonstrated that when people's financial situations improve, symptoms of psychotic disorders tend to decrease and psychological wellbeing increases (Isaacs et al., 2018; World Health Organization & Calouste Gulbenkian Foundation, 2014).

Poverty also acts as a barrier to recovery. People struggling to meet their basic daily needs are not able to devote their scarce time and finances to supporting their mental health, and are less likely to seek primary and preventative care than the general population (Davies & Wood, 2018).

In Australia, the key drivers of poverty are stagnated income growth for people on low incomes, inequitable taxation policies and the low rate of income support payments provided by the federal government (Davidson et al., 2018). These factors are largely the remit of the federal government, and VincentCare Victoria acknowledges the limited means through which the Victorian government can address them. There are, however, a myriad of other policy responses the State Government could implement to minimise the impact of poverty; particularly in the areas of social housing, homelessness support, urban planning, healthcare, energy prices, and public transport.

Leaving Institutions

Leaving institutions, whether psychiatric care, incarceration or out-of-home care, places people at high risk of experiencing comorbid homelessness and mental illness. In 2017-18, over 4000 people presented to specialist homelessness services after leaving adult prisons and youth correction centres, nearly 500 young people presented having left out-of-home care and nearly 800 were transitioning from some other form of care arrangement (Australian Institute of Health and Welfare, 2018b). Regardless of the institution, the vulnerability to both homelessness and poor mental health on leaving can be attributed to insufficient transition support and a lack of appropriate accommodation options.

Incarceration

Most people experiencing mental illness are law-abiding, yet this group is overrepresented amongst people coming into contact with the justice system (Select Committee on Mental Health, 2006). This is attributable to socio-economic disadvantage, including homelessness. 43% of Victorians who enter prison are experiencing homelessness and 54% report having been diagnosed with a mental health disorder (Australian Institute of Health and Welfare, 2018a). Under current practice, if a person experiencing homelessness and poor mental health is arrested, it is common for them to be placed in police custody both for their own safety and due to a lack of available alternatives, such as acute care beds and emergency accommodation.

On leaving prison, 45% of Victorian prisoners require short-term or emergency accommodation (Australian Institute of Health and Welfare, 2018a). By exiting prison into homelessness, these people are twice as likely to return within nine months. This cycle between incarceration and homelessness creates severe instability, in which people are unable to work towards improved mental health.

Out-of-Home Care

The Victorian government's recent extension of out-of-home care to the age of 21 has been a very welcome development, reducing this cohort's severe vulnerability to homelessness, mental health issues, unemployment, early parenthood and interaction with the justice system.

The *Children, Youth and Families Act* (2005) also requires that young people are supported in transitioning to independent living with financial support, housing, education and training, employment support, legal advice, access to health services, however, while policies are in place to deliver these supports, historically, many young people leaving care have had little or no transition planning (Victorian Ombudsman, 2010). In embracing the Home Stretch model, additional funding must also be allocated to providing transition support, including ensuring case managers have enough time to spend with clients and carers.

Discharge from Acute Care

A significant proportion of acute mental health patients are homeless prior to admission to acute care (CHP consultations, 2019).

Generally, patients are discharged from acute care into community mental health care, and protocols are intended to support those who need it into housing and support programs. Unfortunately, a lack of appropriate accommodation options can lead to delays in discharging patients (reducing availability of much needed acute beds) or to discharge into unsuitable housing. In 2016-17, more than 500 people presented to homelessness services following discharge from a psychiatric facility, a 45% increase on the previous three years (Mental Health Victoria, 2018). The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13 (Australian Institute of Health and Welfare, 2018b).

Leaving acute care into homelessness ensures poor mental health outcomes; both undermining the treatment already received and reducing the likelihood of the patient continuing with outpatient care. By contrast, a Queensland study found that a transitional housing treatment model that provided time-limited housing, intensive living skills training and clinical case management averted an average of 22 days of further in-patient care per patient (Brackertz, Wilkinson & Davison, 2018). This challenge is explored further is Section Three.

Recommendation 3: Increase the number and type of mental health residential treatment options for people being discharged from acute care, including step down facilities and transitional housing, to ensure acute mental health patients are not discharged into homelessness or crisis accommodation.

Problematic Substance Use

Poor mental health amongst people who use alcohol or other drugs problematically is statistically more common than not. Data from the Australia's Illicit Drug Reporting System found '63% of Victorian participants who self-reported illicit drug use also self-reported poor mental health (Roussy et al., 2015). The most prevalent disorders co-occurring with drug and alcohol misuse are depression, anxiety and to a lesser extent, psychosis (Department of Health, 2013). Compared with people experiencing either a mental illness or substance dependency, people with a 'dual diagnosis' (concurrently experiencing poor mental health and substance misuse) are more likely to experience stigma (Roberts & Maybery, 2014b), have higher rates of physical health problems and severe illness, suicidal behaviour, social isolation, antisocial behaviours (including violence), incarceration and homelessness (Department of Health, 2013).

Social Isolation, Marginalisation and Discrimination

Like other drivers discussed here, it is impossible to distinguish social isolation as a driver of homelessness and poor mental health, from the inverse effects of homelessness and mental illness on creating social isolation (Flatau et al., 2010; Priebe et al., 2012).

The cycle of marginalisation is evident: anti-social or challenging behaviours associated with mental illness have a significant effect on a person's ability to maintain both interpersonal relationships and housing. Without stable housing, a person's ability to participate in their community is reduced – employment becomes harder to gain and maintain, they may lack the money to participate in social events, their connection to geographical place is disrupted and contact is lost with friends and family. As a person becomes more socially isolated, securing and maintaining housing becomes harder and access to emotional and financial support reduces (Brackertz, Wilkinson & Davison, 2018).

Some communities, including Aboriginal and Torres Strait Islander people and LGBTIQ+ people experience greater risk of both mental illness and becoming homeless yet are underrepresented in accessing homelessness services. This can be attributed in part to the higher rates of social isolation and discrimination experienced by these groups that can cause effects 'ranging from low self-esteem to a higher risk for developing stress-related disorders such as anxiety and depression' (Mays, 2015). For instance, experiencing racism is strongly linked with psychological distress, low self-esteem, stress, substance use and attempted suicide among Aboriginal and Torres Strait Islanders. (Zubrick et al., 2010). Barriers to accessing services can compound disadvantage experienced by some community groups. The expansion of specialist services to meet the needs of communities experiencing multiple drivers of disadvantage is strongly supported by VincentCare.

Recommendation 4: Consider the targeted expansion of specialist services for communities experiencing multiple drivers of disadvantage, including responding to the mental health needs of Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, and people from culturally and linguistically diverse communities, including refugees and asylum seekers.

Section Three: Priorities for Addressing Poor Mental Health and Homelessness

Key Points

- VincentCare Victoria has identified affordable housing shortages, service fragmentation and insufficient supply of appropriate mental health services as the three greatest challenges for people experiencing homelessness and poor mental health.
- Ensuring people have stable, secure and affordable housing is a crucial prerequisite for stable/improved mental health. This demands that housing affordability and shortages in public and social housing be addressed.
- The mental health sector is seriously under-resourced, with insufficient capacity to meet demand. Without significant increases in funding to mental health services and allied social supports, there will be no improvement to the mental health of Victorians.
- This investment must go beyond acute services towards early intervention and prevention through both social strategies and community level services.
- The fragmentation of service provision means people experiencing homelessness are falling between the gaps due to a lack of access, coordination and information sharing between service providers.
- People experiencing homelessness with ill-mental health need services that are targeted to reach them.

The following section identifies three mental health priorities for people experiencing or at risk of homelessness:

- Affordable housing shortages
- Insufficient mental health services to meet demand and a lack of appropriate services for people experiencing homelessness
- Service fragmentation.

Affordable Housing Shortages

Reducing housing stress and addressing homelessness are essential first steps towards giving people the stability and security needed to achieve mental wellness. Presently, Victoria faces a dire shortage of public, social and affordable housing. Some policy advancements have been made towards addressing this shortage in the past five years; through family violence programs, the Homelessness and Rough Sleeping Action Plan and the Private Rental Assistance Program, however the investment needed is far greater.

Every person needs a safe place to live, however what that means will depend on their lived experience and preferences. For people living with mental illness, this can mean anything from stable private rental to supported housing. In recognising that people's needs will change over time, a mixture of short-term crisis and transitional accommodation, medium-term supported housing and permanent, affordable homes are required.

Rental Affordability

Inflating cost of living, low wage growth and a population boom have resulted in more people renting overall, as well as a greater proportion of people renting. This has forced the cost of most rental properties up, placing low to medium income earners under significant stress, and forcing others into homelessness and sub-optimal accommodation such as rooming houses, caravan parks and other temporary accommodation.

2017 estimates from the Australian Bureau of Statistics estimates suggest that 142,000 households are struggling to meet their rental costs (Council to Homeless Persons, 2019), while Anglicare's annual Rental Affordability Snapshot for 2019 found that across Victoria, only 274 properties were affordable to people on income support payments without causing rental stress (defined as accommodation costs exceeding 30% of household budget). In metropolitan Melbourne, only 83 properties were affordable to people on income support, and then only to those receiving the slightly higher payment associated with the Aged Pension, Parenting Payment or Disability Support Payment. For a single person receiving the lower Newstart or Youth Allowance payment, there was no affordable and appropriate rental housing anywhere in Victoria (Anglicare Victoria, 2019).

Recent investment to continue the Private Rental Assistance Program (PRAP) is very welcome news. As providers of the PRAP program for the Hume-Moreland region, VincentCare Victoria can attest the significant success of this program in assisting people to find, secure and sustain private rental housing. With additional funding, more people experiencing or at risk of homelessness could be supported into private rental housing.

VincentCare also currently manages Family Violence Head Leasing packages on behalf of the Department of Health and Human Services. To date, VincentCare has managed 84 tenancies within 70 head lease packages, using a 9 month financial subsidy model. The goal at the end of the subsidy is lease novation at 9-12 months. The results to date are:

Active tenants	32
Tenants vacated inside 12 months*	45
Lease novations	7
Total	84

* 30 of the 45 failed tenancies were due to rent arrears

As demonstrated by the low number of lease novations and high number of vacated tenancies, the current 9 month financial subsidy model is not providing enough time for people to stabilise, obtain paid employment and be in a position to afford private rental (the head leasing packages are always offered within areas of comparative affordability).

Recommendation 5: Expand financial assistance to assist more people to enter and maintain private rental.

Public and Social Housing

During the 2018 election, the Victorian government committed to building 1000 new public housing properties over three years – while this was welcome it reflected a tiny fraction of the public housing required. Currently, Victoria's spending on social housing is half the national average (Council to Homeless Persons, 2019).

35,000 households (82,500 people) are on the waitlist for public housing in Victoria. The waitlist increases by 500 people a month and tens of thousands of additional people who are eligible for social housing do not apply because the wait time is excessive (in metropolitan Melbourne, the waiting time for a single bedroom property can be 5-12 years, and for a 2 bedroom property 3-5 years). Over 40% of people who are sleeping rough and receiving outreach assistance remain on the street because they are waiting for housing. This wait often exceeds eight months and may only be temporary or crisis accommodation when it is provided (Council to Homeless Persons, 2019).

In order to keep up with current population growth and maintain the current proportion of social housing, Victoria must build 1,800 dwellings per year, or 30,800 by 2036. To meet actual demand that reflects the increasing number of people experiencing housing stress, Victoria would need to build an additional 6,000 dwellings per year. The housing and homelessness sector have called for an increase of 3000 public and community owned homes per year for the next decade to meet the shortfall.

Recommendation 6: Double spending on social housing to be in line with other states and territories in Australia.
Recommendation 7: Plan to deliver 3,000 new social housing properties each year for the next 10 years.
Recommendation 8: Mandate that 5% of properties in developments larger than 30 units are designated as social housing.

Insufficient and Inappropriate Mental Health Services

There has been serious underinvestment into mental health for over two decades, resulting in access to mental health services in Victoria being nearly 40 per cent below the national average, and tens of thousands of people missing out on desperately needed services (Mental Health Victoria, 2018).

Despite having higher rates of mental illness than the general population, people experiencing homelessness face greater barriers to accessing services. When Victoria's mental health care system struggles to meet the needs of people who are well connected to public services, have enough money to pay for out-of-pocket costs, and can navigate the complexities of the fragmented service provision, it is unsurprising that this system largely fails to meet the needs of people experiencing homelessness, who are 'far less likely to access primary care and preventive health services than the general population' (Davies & Wood, 2018).

Practical and Interpersonal Barriers to Service Access

Barriers to accessing services may be both practical and interpersonal. In addition to the challenges brought about by service fragmentation, barriers to service access for people experiencing homelessness include the accessibility of the service location, out of pocket costs, cost of transport, being contactable for appointments and knowing how to access services. The THI study found that 35% of respondents had not gotten professional help because they did not know how, 11% did not trust anyone to help them, 11% believed that no one would understand their situation, 7% noted the cost associated with seeking help, and 9% said they did not feel ready to seek help (Cash et al., 2014). The following should be considered by the commission:

- The regular experience of stigma, social isolation and discrimination can leave people experiencing homelessness feeling inadequate, judged or stereotyped by health practitioners and other service users (Davies & Wood, 2018). The desire to avoid these feelings often overwhelms the desire to access help, resulting in avoidance of mainstream services.
- Extreme poverty experienced by most people living in homelessness is a major barrier to accessing mainstream services. Free and low-cost services are highly limited, geographically allocated and have long wait-times.
- Most people experiencing homelessness are reliant on public transport. This can limit the services that are practically accessible to them, but also adds a cost that they may be unable to meet. The current trial to provide free public transport to people experiencing homelessness in Victoria is a welcome development, however the cost to the service providers who distribute these travel passes is likely to limit availability.

- Being able to book appointments and be contacted by service providers can also present a significant barrier. If someone does not have a mobile phone, with call credit and a reliable means to charge the battery they are likely to miss out on essential communication. If email or online bookings are required to secure an appointment, access to the internet and a degree of computer literacy is essential. Likewise, if appointment bookings are sent by mail (as remains common with many specialist appointments through the public system), people without a fixed address will not receive them.

To support people experiencing homelessness, mental health services need to 'met them where they are', including through open access centres, supported housing, outreach and in-reach programs. These models of service provision are covered in Section Four.

The impact of NDIS

Victoria's already strained mental health system has been further depleted in the past three years as community-based care has been drastically cut in order to fund the National Disability Insurance Scheme (NDIS). While a small number of people will significantly benefit from improved treatment as recipients of NDIS, many more are being left without needed care. The closure of block-funded programs, especially those with a 'low barrier to service' is having a huge impact on Victorians living with severe mental illness who are not be eligible for an NDIS package (Smith-Merry et al., 2018).

In discussions with colleagues in our sector, we have found approximately 20% of clients using mental health and social inclusion services are eligible for NDIS and have been supported in applications.

The other 80% are not eligible, including people with severe and episodic mental illness. This includes:

- People with dual diagnosis i.e. addiction and severe and episodic mental illness
- People with complex needs i.e. homelessness and severe and episodic mental illness
- People over 65 i.e. highly isolated and with a severe and episodic mental illness

We are deeply concerned that the loss of mental health services and care for people who are not eligible for an NDIS package will be seriously detrimental. As the government undertakes the difficult work of transitioning to the NDIS, we note the following statement from the NDIA:

> *The NDIS does not, and was never intended to, replace other government support systems, such as the mental health system or community-based support or treatment for people living with mental health conditions. The mainstream mental health system continues to be responsible for the broader group of people who require community based psychosocial support outside the NDIS (Australian Broadcasting Corporation, 2018).*

The continuation of community-based services is essential for the wellbeing of all Victorians who experience mental health challenges, but particularly for those who are alienated from mainstream services.

Recommendation 9: State government services that were provided prior to NDIS should not be discontinued for people who are eligible for them but are not eligible for the NDIS. This includes social inclusion programs and 'low barrier to entry' programs.

Acute Community Intervention Service Telephone Triage

The Acute Community Intervention Service (ACIS) telephone triage service warrants particular mention for the insufficiency of the service. ACIS is intended to provide a centralised contact point for assessment and referral when a person's mental health needs are beyond the capacity of people around them, including social service providers. This may be in instances of rapid onset illness and distress, acute relapse of a pre-existing mental illness or severe and acute psychological distress with risk of serious harm to the person or others.

Regrettably, the delayed and inadequate assistance provided and lack of alternative avenues for assistance prevents people with mental illness accessing the treatment that they need in times of crisis.

VincentCare Victoria staff report that calls to this service have extremely long wait times to speak to clinician. These delays can result in clients becoming upset and agitated, escalating situations from manageable to hostile.

Guidelines state that a clinical triage scale should be used 'to determine the urgency and nature of the response required' (Department of Health, 2014), however VincentCare Victoria staff have found that even in situations of high need, responses are underwhelming with deployment of assistance being very rare and far too many calls being referred to police. Only when the service user is known to the area Public Health Network (PHN) and is failing to comply with a mental health order is assistance forthcoming.

It is essential that this service be able to provide adequate support in a crisis, without turning problems of mental illness into a public safety issue to be managed by police. Consideration should be given to whether the service has enough clinicians available to take calls, sufficient response teams and what systems are in place for people to be connected to clinical mental health services without delay.

Recommendation 10: Undertake a review into the effectiveness of ACIS telephone triage, what improvements can be made, and if alternative services are needed.

Fragmented Service Provision

Fragmented service provision is a major barrier to people accessing the mental healthcare they need. Presently, mental health services are delivered through a patchwork of programs, institutions and providers; including acute and clinical services, community mental health services, forensic mental health services and those delivered through Public Health Networks and the National Disability Insurance Scheme. In addition to these services, numerous other social supports underpin good mental health and are provided by government agencies other than health services and through the non-profit sector.

A lack of linkages between mental health providers and allied social services is resulting in worse mental health outcomes for people experiencing homelessness. This can be attributed to:

- Siloed housing, homelessness and mental health policy
- Funding for discreet purposes that disincentivise integration
- Poor channels of communication (between government services and externally)
- Privacy legislation that prevents information sharing
- 'Cultural clashes' between sectors (including differing perspectives on treatment of mental illness)
- Disjointed state, federal and local services
- Differing terminology and problem definition

  (Brackertz, Davison & Wilkinson, 2019; Flatau et al., 2010; Roberts & Maybery, 2014a)

This problem does not just exist for housing and homelessness providers – literature on disability services and child protection have also noted that collaboration with the mental health sector is problematic (Roberts & Maybery, 2014a).

Recommendation 11: Review privacy requirements relating to client and patient information to assess if better information sharing is feasible while continuing to protect the rights and privacy of the service user.

Recommendation 12: Develop performance metrics for providers of mental health, housing and homelessness services (both departmental and external programs funded by government) that incentivise coordination of services and information sharing.

As a service provider, VincentCare has noted several key points at which fragmented services fail our clients; in the coordination of patient discharge, in supporting people with complex needs, and in the geographical fragmentation of services. These three areas are addressed below.

Patient Discharge Coordination

A key time at which communication and coordination fails is when people are leaving acute care (see also, Section 2). VincentCare staff have noted that patients experiencing homelessness have often been discharged by acute mental health services and hospitals without any accommodation, leading clients to present unexpectedly at homelessness services with no information available regarding ongoing mental health support or treatment plans. This type of response often means that homelessness services are immediately required to find suitable and

appropriate accommodation, while trying to contact the discharging service to obtain a copy of the discharge summary. A lack of information can result in clients being placed in inappropriate accommodation (such as hotels) as a last resort. In instances where acute mental health services and hospitals work collaboratively with homelessness services, clients receive a more thorough assessment of their needs and are thus able to access more appropriate accommodation.

Notably, the psychiatric discharge guidelines on the Department of Health website, written in 2002, makes only a single reference to housing support (Department of Health & Office of the Chief Psychiatrist, 2002). There are no references to housing or accommodation in the more general hospital discharge guidelines from 2011, other than to state that specialist clinics should 'facilitate connections with primary care and other community-based services so that patients receive appropriate post-discharge care' (Department of Health & Human Services, 2011). Both policies are is clearly in urgent need of updating, with greater consideration to the social supports required following discharge.

Recommendation 13a: Discharge policies in hospitals and psychiatric care facilities require clear direction to ensure people are not discharged without adequate planning for their social and economic wellbeing. A comprehensive, state-wide discharge policy is recommended, with adequate resourcing for hospitals staff to undertake thorough and appropriate discharge assessments and plans.

Recommendation 13b: Where there is no option but to refer patients to homelessness services, adequate communication protocols need to be established to ensure continuity of care.

Recommendation 13c: The state-wide discharge plan should require timely and proactive follow-up of patients to ensure they are being supported through community mental healthcare and other social supports they may need.

Dual Diagnosis

People experiencing concurrent mental illness and substance misuse issues (termed 'dual diagnosis') are often denied services due to fragmented service provision. While the Victorian Department of Health (2013) has acknowledged that 'dual diagnosis demands an integrated approach to assessment and treatment in both specialist mental health and alcohol and other drug services' this is not reflected in practice.

Currently, there are very few places available for people with dual diagnosis to access residential treatment in Victoria and community-based services are also limited. A 'No Wrong Door' approach has been advocated by the Victorian Government since 2007, which would allow people to instigate care at any service. Unfortunately, VincentCare staff have noted numerous instances where alcohol and other drug rehabilitation services are reluctant to work with people with mental health issues, while mental health services commonly refuse treatment due to an 'abstinence only' service model.

In recognising that integrated responses are the most effective form of treatment for dual diagnosis, we encourage the Victorian government to expand the availability of these services. Further, as the data shows dual diagnosis is 'common rather than exceptional' (Department of Health, 2013) responses from specialist mental health services and alcohol and other drug services will need to improve.

Advocating a 'No Wrong Door' approach (whereby services can be instigated and coordinated from any service point) has not been enough to effect meaningful change in the past 12 years. An evaluation of a Victorian dual diagnosis capacity-building initiative found that 'clinical mental health organizations were particularly unwilling to drive No Wrong Door reform in their own organizations' and service providers claiming that the changes were primarily top-down and lacked the needed resources for implementation (Roberts & Maybery, 2014a). Government will need to support service providers in order to make integrated treatment a reality.

Recommendation 14: Expand availability of dual diagnosis treatment, both in the community and in residential settings.

Recommendation 15: Support mental health service providers and alcohol and other drug rehabilitation services to integrate dual diagnosis into their treatment models.

Geographical Catchment Areas

Victorian clinical mental health services are provided through geographic catchment areas, in which a person's place of residence determines which service or services they can access. These services are often the only available free or low-cost services, but for people without a permanent residential address, these services are inaccessible.

While services need to remain geographically dispersed, people should not be restricted to accessing mental health services within a catchment area and should be able to choose to engage with the service of their choice.

Recommendation 16: Remove geographical restrictions on accessing treatment and allow consumers to choose their preferred provider.

Section Four: What Works?

Key Points

- Mainstream services are often inaccessible for people experiencing homelessness
- We believe that programs that are flexible, consumer-led, with wrap around services and low barriers to entry have the best potential to reach people experiencing homelessness and supporting them to improve their lives.

In addition to the needed reforms outlined in Section Three, the programs highlighted below demonstrate what we believe are effective interventions to reach people experiencing homelessness who are marginalised from mainstream services.
The common features of these programs are:

- flexible service delivery
- consumer driven recovery
- low barriers to entry
- wrap around services.

Open Access Centres

Open Access Centres (also referred to as 'drop-in centres', 'open doors' or 'social inclusion hubs') provide a safe and welcoming place for marginalised and vulnerable people to socialise, shower and have meals, (Kelaher, La Brooy & Feldman, 2014). Building trusting relationships over time between clients and staff allows staff to facilitating soft entries into treatment and mainstream services. These centres play a significant role in reengaging people who are significantly marginalised, and offering access to a "one-stop shop" for services in an informal environment that does not require them to undergo an assessment or provide personal information (Kelaher, La Brooy & Feldman, 2014).

Several OACs operate in Melbourne's inner-city area, including VincentCare Victoria's Homelessness Resource Centre (previously Ozanam Community Centre), which provides a sense of community and a diverse range of housing, health and welfare services in collaboration with sector partners on an ongoing basis. The centre facilitates engagement with a wide range of internal and co-located external services, aiming to generate stable and sustainable living, autonomy, well-being and community connectedness.

On-site services include initial assessment and planning (housing response), alcohol and other drugs counselling, intensive case management, brief interventions, financial counselling, therapeutic services and capacity building, including a client volunteer program. Service partnerships include Centrelink, Inner Melbourne Legal Service, a podiatry clinic and dietitian, homeless person's dental clinic, optometry clinic, nurse's clinic, and GP clinic.

The Open Access program provides two meal services a day (breakfast and lunch) for up to 200 people, tea and coffee facilities, shower and laundry facilities, a postal service, storage space, library area and computer access. Planned activities include a music program, art therapy and recreational activities. By meeting people's immediate needs, participants can address the bigger, underlying challenges that they are facing.

This model is in line with best practice – A recent Lancet review found that psychosocial interventions are more effective when delivered within broader holistic services (Luchenski et al., 2018), while another 2018 study across 14 European countries found that the programs that most successfully reached groups experiencing vulnerability shared four key factors to success: active outreach (including long-term relationship building and non-intrusive entry points to

services), facilitating access to services (including both mental health care and to meet other needs), collaboration and coordination between services and making information on services available to marginalised groups and practitioners (Priebe et al., 2012). This 'one-stop' model is also in keeping with current reforms (such as the roll-out of the NDIS) that seek to be consumer driven and better integrate care services.

In 2014, the Melbourne School of Population and Global Health (University of Melbourne) undertook an evaluation of five OACs in Melbourne, including Ozanam Community Centre. The authors found that 'clients rely heavily on core centre services including homelessness and housing support, crisis response and referral, allied health and counselling services, and social and sports programs. There appears to be strong in-house integration between services and programs, to the extent that many clients look to centres as a 'one-stop shop' for their service needs' (Kelaher, La Brooy & Feldman, 2014).

Interviews and survey data collected during the evaluation found that more than half of OAC clients experienced mental health issues, however people benefited from an improved quality of life as a result of attendance, specifically in the areas social inclusion, physical and mental well-being, housing and life skills. Notably, 55% of respondents reported being 'better able to manage their emotional and mental health as a result of attending the centres'. (Kelaher, La Brooy & Feldman, 2014).

Despite undertaking crucial early intervention within a highly vulnerable population, these centres, like many community level services, are understaffed and underfunded, with demand for support services and programs exceeding the resources of centres.

OAC service users are predominantly Caucasian, middle-aged men (Kelaher, La Brooy & Feldman, 2014; Priebe et al., 2012). In order to meet the needs of the wider community, it is necessary that centres are able to meet the needs of a more diverse population including women, Aboriginal and Torres Strait Islanders, migrants and people who speak English as a second language and those who identify as being part of LGBTIQ communities. This may potentially be done through the development of specific services for these groups, or by implementing programs and spaces within existing centres.

Recommendation 17: Commit to ongoing funding of existing OACs and the provision of mental health services within these centres.
Recommendation 18: Support the creation of OACs for groups that are currently less likely to use these services including women's only centres, family-friendly drop-in spaces, centres for Aboriginal and Torres Strait Islander people and centres catering to the LGBTIQ communities.

Personal Helpers and Mentors Program (PHaMs) & Doorway

The Personal Helpers and Mentors Program (PHaMs) provided a flexible, community-based response for people whose lives were severely affected by mental illness, helping them to overcome social isolation and increase connections with their community.
This program had wide-scale support within the housing and homelessness sector and other social service providers for:

- Flexible delivery model
- Flexible referral model (including self-referral)
- Ability to engage those who have not been accessing services
- Ability to engage those without a formal diagnosis
- Consumer led care model.

Regrettably, as a joint State-Federal initiative, funding from this program has now been diverted to NDIS programs. VincentCare did not deliver this program but observed the high value it delivered to people experiencing homelessness or at risk of homelessness.

The Victorian Government's Doorway program had many of the same elements, and evaluations of the pilot indicate impressive outcomes including improvement in self-reported mental health, physical health and social inclusion, and reductions in time required in acute care.

An important difference however is that unlike the PHaMs program, Doorway required that participants have 'a severe and persistent mental illness' (Dunt et al., 2017). As people with a diagnosis of severe and persistent mental illness are now covered by the NDIS, there is no need for such a program, however for people *without* diagnosis who do not usually engage with mainstream services, a program such as this could be highly valuable.

Recommendation 19: Develop a program for people experiencing chronic homelessness to support them into housing and in self-directed recovery. Such a program would benefit from adopting the unique features of the PHaMs program.

Conclusion

Solving the dual crisis of poor mental health and homelessness can only be solved with significant financial investment, but how this is done matters.
These two issues can only be solved together. Homelessness and poor mental health are inextricably linked, and significant investment in social and affordable housing and integrated responses are essential.

VincentCare Victoria urges the Victorian government to prioritise the needs of the most marginalised members of our community, who are most likely to experience poor mental health, but least likely to access treatment.

Based on over 65 years' experience and a strong evidence base, we believe the best ways to reach people experiencing homelessness is through flexible program delivery that meets people where they are, and respects and responds to the extensive trauma they have experienced.

The road to recovery is long, for both the individual and for the service system we are attempting to fix. This Royal Commission is a first step. VincentCare Victoria looks forward to partnering with the Victorian government on this journey to deliver better mental health outcomes for our community.

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