Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR MICHAEL FOTHERINGHAM

I, Dr Michael Fotheringham, Executive Director of the Australian Housing and Urban Research Institute, of 12/460 Bourke St, Melbourne VIC 3000, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 In preparing this statement, I have drawn heavily on a variety of sources for the work of the Australian Housing and Urban Research Institute (AHURI), including the following reports:

(a) Housing, homelessness and mental health: towards systems change;

(b) Trajectories: the interplay between mental health and housing pathways;

(c) Trajectories: the interplay between mental health and housing pathways. A short summary of the evidence;

(d) Trajectories: the interplay between housing and mental health pathways. Report for national consumer and carer consultations;

(e) Effectiveness of the homelessness service system. Research report;

(f) Policy shift or program drift? Implementing Housing First in Australia;

(g) An effective homelessness services system for older Australians; and

(h) Housing, multi-level governance and economic productivity. Inquiry into housing policies, labour force participation and economic growth.

As the sources are AHURI sources, I have not used quotation marks when directly quoting from those sources. Should you wish to cite this statement, you should cite the relevant primary AHURI source, as AHURI maintains copyright.

3 I am giving evidence to the Royal Commission as the Executive Director of the Australian Housing and Urban Research Institute.

Background

4 I am a research and policy development specialist with experience in housing and homelessness, public health, urban and community services planning.

5 I joined AHURI in 2014 as Deputy Executive Director. I have been the Executive Director since 2017.

6 I currently serve on expert advisory panels including the;

(a) Australian Government's Cities Reference Group;
(b) Housing Supply Expert Panel;
(c) Housing and Homelessness Research Alliance;
(a) Aged Care Diversity Committee – Sub-Group;
(b) Australian Academy of Science Urban Strategy Expert Group;
(c) NHHA Data Improvement Working Group;
(d) Aged Care Reform and Housing Policy Reference Group;
(e) Urban Futures and Sustainable Living Expert Research Advisory Group; and
(d) Homes for Homes Housing Advisory Group

7 Attached to this statement and marked "Attachment MF-1" is a copy of my current curriculum vitae.

8 Attached to this statement and marked "Attachment MF-2" is a series of tabular and graphical information to support my statement.

9 Attached to this statement and marked "Attachment MF-3' is a list of references for reports I have drawn upon for my statement.

The Australian Housing and Urban Research Institute (AHURI)

10 AHURI is a national independent research network with an expert not-for-profit research management company, AHURI Limited, at its centre. As the only organisation in Australia dedicated exclusively to housing, homelessness, cities and related urban research, AHURI is a unique venture. Through our national network of university research partners, we undertake research leading to the advancement of knowledge on key policy and practice issues. AHURI research informs the decision making of all levels of government, non-government sectors (both private and not-for-profit), peak organisations and the community, and stimulates debate in the media and the broader Australian community. Our funding is received from three sources: grants from Federal and state and territory governments, contributions from our university partners, and through our professional services.

11 AHURI provides a major influence and focus on national policy discussions around housing and homelessness and the future of Australian cities. It also conducts leading research into major issues for Australian housing and urban policy. We undertake capacity building measures that develop the skills and resources of policy makers, practitioners and researchers in the housing, homelessness, cities and urban communities in Australia, convene and host the biennial National Housing Conference, and a range of evidence informed forums, one-day conferences, workshops and other events.

12 AHURI also delivers the National Housing Research Program, to ensure our research activity addresses the policy priorities of each state, territory and the Australian government, through a portfolio of priority-based inquiries and research projects. AHURI publishes and disseminates more than 20 new research reports each year as well as hosting a research library of more than 500 major reports, up-to-date analyses of current policy issues and an ongoing stream of news and commentary through the AHURI website. AHURI also provides professional services that draw on our expert staff as well as on our network of more than 400 researchers though our university partners.

13 In my role as Executive Director of AHURI, I take lead responsibility for stakeholder management with members of Parliament, senior government officials, academics and leaders in the industry and community sectors. I am also the media spokesperson for AHURI and take a leading role in the delivery of conferences, roundtables, seminars and webinars.

MENTAL HEALTH, HOUSING AND HOMELESSNESS

Definitions of Homelessness and Housing Insecurity

14 Homelessness is more than "rough sleeping" (sleeping outside of a physical structure). There are two features of homelessness.

15 The first is inadequate housing. This can include housing that is not sufficient in space, for example, a large family of six living in a small one-bedroom apartment. It can also include the lack of private space, such as couch surfing or a rooming house.

16 The second is insecure housing. This includes not having a lease, having an unknown or short tenure of stay or living in a structure that is physically insecure or unsafe.

17 If a person has one of these features, they are considered to be homeless. Therefore, housing insecurity is a feature of homelessness, not a separate concept to homelessness. Issues of housing insecurity are inseparable from homelessness, which is reflected in official and commonly used definitions of homelessness.

18 Until fairly recently, the most widely accepted definition of homelessness was that developed by Chamberlain and MacKenzie (1992; 2008). This definition was based on cultural expectations of the degree to which housing needs are met within conventional expectations or community standards. In Australia this means having, at a minimum, one room to sleep in, one room to live in, one's own bathroom and kitchen and security of tenure.

19 This definition describes three types of homelessness:

(a) primary homelessness: rough sleeping;

(b) secondary homelessness: temporary accommodation (includes people moving frequently from one form of temporary accommodation to another, including emergency housing, boarding houses or staying with family or friends, e.g. couch surfing); and

(c) tertiary homelessness: inappropriate housing (refers to people staying for longer than 13 weeks in rooming houses or equivalent tertiary accommodation).

20 The statistical definition of homelessness developed in 2012 by the Australian Bureau of Statistics (ABS) is now commonly used. This definition is informed by an understanding that homelessness is not 'rooflessness' (ABS 2012). The ABS definition provides that a person is considered homeless if their current living arrangement exhibits one of the following characteristics:

(a) is in a dwelling that is inadequate;

(b) has no tenure or their initial tenure is short and not extendable; and

(c) does not allow them to have control of and access to space for social relations; provide a sense of security, stability, privacy or safety; or provide the ability to control living space.

21 The ABS identifies six categories of homeless persons including:

(a) persons living in improvised dwellings, tents, or sleeping out ('rough sleepers');

(b) persons in supported accommodation for the homeless;

(c) persons staying temporarily with other households ('couch surfers');

(d) persons living in boarding houses;

(e) persons in other temporary lodgings; and

(f) persons living in severely crowded dwellings.[1]

22 The ABS also publishes data on people living in 'marginal housing', who are considered to be at risk of homelessness and who comprise 'people whose living arrangements are close to the statistical boundary of homelessness' (ABS 2018). This includes persons in other (less severe) overcrowded housing, as well as persons in improvised dwellings or other forms of housing such as caravan parks or manufactured homes that might also lack security of tenure.

Indigenous understandings and definitions of homelessness

[1] Census of Population and Housing Estimating Homelessness methodology, Appendix 1, released 14 March 2018.

23 Indigenous understandings and definitions of homelessness can differ from those described above and can include 'spiritual homelessness' (the state of being disconnected from one's homeland, separation from family or kinship networks or not being familiar with one's heritage) and 'public place dwelling' or 'itinerancy' (usually used to refer to Indigenous people from remote communities who are 'sleeping rough' in proximity to a major centre) (ABS 2014; Australian Insitute of Health and Welfare (AIHW) 2014; Memmott et al. 2003).

24 Indigenous homelessness is not necessarily defined as a lack of accommodation. It can be defined as losing one's sense of control over or legitimacy in the place where one lives (Memmott et al. 2003) or an inability to access appropriate housing that caters to an individual's particular social and cultural needs (Birdsall-Jones et al. 2010). Some public space dwellers who have chosen to live rough may not see themselves as homeless (Memmott et al. 2003).

The link between mental health, housing and homelessness[2]

25 There is a link between mental health, housing and homelessness. Poor housing can have adverse effects on mental health and mental health can impact on housing.

26 Evidence demonstrates a complex bidirectional relationship between housing, homelessness and mental health. A number of structural and individual factors increase the likelihood of mental ill-health onset and the likelihood of poor housing outcomes among people with lived experience of mental ill-health. For example, mental ill-health can lead to homelessness. Conversely, homelessness may act as a trigger for mental ill-health, and people with lived experience of mental ill-health are more vulnerable to common risk factors for homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment (Bevitt, Chigavazira et al. 2015; Flatau, Conroy et al. 2013; Johnson, Scutella et al. 2015a; Steen, Mackenzie et al. 2012; Stone, Sharam et al. 2015; Wood, Batterham et al. 2015).

27 Housing choice and access to secure, affordable and appropriate housing allows people to focus on mental health treatment and rehabilitation, while precarious housing and homelessness make it difficult for people to access mental health treatments and supports (Bleasdale 2007; Honey, Nugent et al. 2017; Johnson, Scutella et al. 2015a; Pearson and Linz 2011).

<u>Individual risk factors for housing instability and mental ill-health</u>

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2 Brackertz, N., Borrowman, L., Roggenbuck, C. Pollock, S. and Davis, E. (2020a) *Trajectories: the interplay between mental health and housing pathways. Final research report*, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, <https://www.ahuri.edu.au/research/trajectories> at page 11.

28 Individual risk factors for housing instability and mental ill-health include the following:

(a) **Homelessness**: The prevalence of severe and persistent mental illness is higher among homeless people than the general population (Lourey, Holland et al. 2012) and the risk of homelessness among people with mental ill-health is significant. However, an Australian study shows a reduced chance of entering homelessness among people diagnosed with bipolar disorder or schizophrenia (Johnson, Scutella et al. 2015b) as this cohort is more likely to receive formal supports (Pearson and Linz 2011). The isolation and trauma often associated with rough sleeping can also precipitate mental illness (Johnson and Chamberlain 2011).

Westoby (2016) identified four typical categories of people with severe or chronic mental illness who are homeless: (1) homeless and did not receive any mental health support; (2) attended to and hospitalised by medical practitioners but not adequately supported when released back into the community; (3) treated in a psychiatric facility in hospital and remained hospitalised without a discharge or exit strategy back into the community; and (4) experienced primary or secondary homelessness in substandard and insecure tenures, and struggled to manage their mental health.

(b) **Lack of social support**: People often draw on the financial and emotional support of friends and family during crises. The symptoms of mental illness can cause individuals to withdraw from or overtax their support networks, thereby eroding the informal resources available to them in times of crisis (Gaebel, Rössler et al. 2016; O'Brien, Inglis et al. 2002).

(c) **Alcohol and other drugs (AOD)**: Long-term substance addiction has been linked to anxiety, depression and paranoia, while people with bipolar disorder, anxiety or antisocial personality disorder are most vulnerable to alcohol or other drug addiction (AIHW 2016a; Shivani, Goldsmith et al. 2002).

(d) **Domestic and family violence (DFV)**: DFV contributes to homelessness for parents and children, and those escaping DFV are vulnerable to mental ill-health as a result of trauma associated with violence in the family home (AIHW 2016b; Gilroy, McFarlane et al. 2016; Rees, Silove et al. 2011).

(e) **Interaction with the criminal justice system**: People with mental ill-health who enter prison or forensic care are at elevated risk of housing instability and homelessness (Baldry, Dowse et al. 2012; Forensicare 2011; Johnson, Scutella et al. 2015b; Robinson 2003).

(f) **Unemployment**: Employment can mitigate homelessness by facilitating greater access to longer-term accommodation options such as private rental, while also improving mental health through feelings of empowerment and self-worth (Bond,

Kearns et al. 2012; Caton, Dominguez et al. 2005; Howden-Chapman, Chandola et al. 2011; Johnson, Scutella et al. 2015b).

(g) **Physical ill-health**: People with physical ill-health have a higher rate of entry into homelessness, and the presence of a chronic health condition predicts longer duration of, and lower rates of exit from, homelessness (Bevitt, Chigavazira et al. 2015).

(h) **Complex and high needs**: People experiencing both homelessness and mental ill-health represent a 'hard-to-reach' group for service providers (Brackertz and Winter 2016). Ineffective service responses can have significant impacts given that causation flows in both directions with regard to the worsening of mental health and homelessness (Johnson and Chamberlain 2011).

(i) **Difficult behaviours**: Some behaviours associated with mental ill-health (e.g. antisocial behaviour, delusional thinking, inability to prioritise finances) may be detrimental to a person's housing situation. For example, difficult behaviours may trigger antisocial behaviour management policies for people living in public housing, sometimes causing eviction (Jones, Phillips et al. 2014).

Quantitative evidence on the links between housing and mental health

29 Mental illness is both a cause and consequence of homelessness. A study of 4,291 homeless people in Melbourne found that 15 per cent of the homeless had mental health issues prior to becoming homeless. This challenges the community perception that mental illness is the primary cause of homelessness. The research also found that 16 per cent of the sample developed mental health issues after becoming homeless (Johnson and Chamberlain 2011).

30 As noted above in paragraph 27, behaviours often associated with mental ill health, such as anti-social behaviour, delusional thinking and the inability to prioritise finances, may be detrimental to a person's housing situation. Behaviours associated with mental illness may also trigger anti-social behaviour management policies for people living in public housing, sometimes causing eviction (Brackertz et al. 2018a). In addition, social isolation as a result of mental ill-health can further exacerbate housing crises by limiting access to emotional and financial support (O'Brien et al. 2002). Poor physical health is a common symptom of mental ill-health and can limit a tenant's capacity to maintain a healthy living environment in the home.

31 AHURI has partnered with MIND Australia in a national research study: *Trajectories: the interplay between mental health and housing pathways* (Trajectories), into the housing and mental health trajectories of persons experiencing mental ill-health. The term 'trajectories' refers to the experiences of housing and mental health over time both in relation to mobility and place by individuals who are living with mental ill-health (Brackertz

et al. 2020a). The aim of the research was to identify people's transitions through the housing and mental health systems, identify typical trajectories, and points for intervention/circuit breakers. Success of a trajectory is judged in terms of how well it aligns with an individual's capacity and needs in terms of housing and mental health (Brackertz et al. 2020a).

32 This research comprises an extensive review of the research evidence, quantitative analysis of large scale longitudinal data sets from the HILDA and Journeys Home data sets and qualitative research involving extensive one on one interviews and consultations with people with lived experience of mental ill health and their carers as well as service providers in the fields of housing and mental health in each Australian state and territory.[3]

33 Trajectories research identified five 'typical' trajectories experienced by people who are living with mental ill health (Brackertz et al. 2020a):

(a) **Excluded from help required —** characterised by a lack of access to housing or mental health care. People (especially rough sleepers) may be excluded from housing and mental health care because: they do not meet eligibility criteria (including lack of formal mental health diagnosis); they lack financial resources; housing and supports are not available, inappropriate or difficult to access (including because workers need to get consent); the system is crisis-driven, fragmented and difficult to navigate (including the NDIS).

(b) **Stuck without adequate support** — trapped in inappropriate housing, institutions, or services due to a lack of options, choice and/or long-term pathways.

(c) **Cycling —**marked by a downward spiral in which people enter into and drop out of supports repeatedly, which progressively erodes their resources. Cycling is due to inadequate transitions between services and different parts of the system, lack of clarity about which services or parts of the system are responsible for providing support, the episodic nature of mental ill-health, lack of continuity and the preponderance of short-term supports.

(d) **Stabilising —**people who have access to secure, safe, appropriate and affordable housing, ongoing mental health support, help to facilitate meaningful social connections, and financial stability, which allow them to focus on recovery and rebuild their lives.

(e) **Well-supported** — people who have the type of housing and level of care that aligns with their individual capacity and needs, and which allows them to develop their independence and achieve their ambitions beyond housing and mental

[2] *Ibid*, pages 2-3, 51-52[4] *Ibid*, pages 2-3, 51-52.

health. There is no one specific outcome that classifies as 'well supported'; rather, a well-supported trajectory aligns with a person's individual capacity and their needs in terms of housing and mental health. It means that a person has the support to develop their independence and achieve their ambitions.[4]

34 Trajectories found that poor and deteriorating mental health directly impact housing stability (as indicated by forced moves) and also financial hardship (which could undermine housing affordability and housing stability). It further found that:

(a) People with a diagnosed mental health condition had a 39 per cent increased likelihood of experiencing a forced move within one year.

(b) People who experienced severe psychological distress had an 89 per cent increased likelihood of financial hardship in the following year and a 96 per cent increased likelihood of financial hardship within two years (Brackertz et al. 2020a).

(c) The health status and use of health services have protective effects against deteriorating mental health. Good physical health reduced the length of time a person experienced mental ill-health with symptoms, reduced the likelihood of housing instability, and offered strong protection against deteriorating mental health. Conversely, people with a long-term health condition had an elevated risk of housing instability and deteriorating mental health (Brackertz et al. 2020a).

(d) People who had deteriorating mental health with symptoms but who did not access health services were 58 per cent more likely to experience a forced move within the next two years compared to those without deteriorating mental health.

(e) People who had deteriorating mental health with symptoms but who did not access health services or mental health services were 65 per cent and 36 per cent more likely, respectively, to experience financial hardship in the next one to two years, compared to those without deteriorating mental health.

(f) Self-assessed 'good' general health and 'very good' general health reduced the duration of a spell of mental ill-health by 5 per cent and 9 per cent, respectively.

(g) 'Very good' self-assessed general health reduced the likelihood of a forced move within two years by 10 per cent, and the likelihood of financial hardship within the next year and two years by 34 and 30 per cent, respectively. Importantly, it reduced the likelihood of deteriorating mental health by 80 per cent.

(h) Conversely having a long-term health condition increased the likelihood of a forced move within one year by 15 per cent and within two years by 18 per cent. A long-term health condition increased the likelihood of financial hardship within

[4] *Ibid*, pages 2-3, 51-52.

one year by 21 per cent and within two years by 24 per cent. The likelihood of deteriorating mental health increased by 38 per cent.

(i) Serious personal injury or illness negatively impacted mental health status for up to three years and increased the likelihood of a forced move in the following year by 17 per cent.[5]

Interaction between mental health and housing pathways

35 Living in unaffordable housing is detrimental to mental health for those on low incomes (Bentley et al. 2011). There is a risk that if housing affordability is not addressed as well as mental health, this could lead to a 'downward spiral' in mental health. This is also evident in research on the housing pathways of people with mental ill health.

36 People living with mental ill-health have distinct housing pathways that are characterised by more hectic housing careers, often moving between parental home, private rental, homelessness, social housing and caravan parks (Beer, Faulkner et al. 2006: 9). This variability in their housing pathways is due to the episodic nature of much mental illness, which results in periods in and out of employment, as well as significant transitions through the housing market. People affected by a psychiatric disability have a high probability of eviction and experience ongoing transitions from one tenure to the next.

37 Figure 1 (Attachment MF-2) shows how periods of mental illness have lag effects that flow through to the transitions an individual makes in the housing market. The researchers suggest public rental housing, rather than home ownership, as the outcome of the housing career for this group (Beer and Faulkner 2009).

Housing problems due to lack of support

38 People with mental ill-health face housing problems including entry into homelessness due to lack of support. This can be for the following reasons:

(a) Studies of homeless persons and those at risk of homelessness, using Journeys Home data, show that relationships such as marriage and dependent children, as well as social support are strongly protective against homelessness, but ruptures to social relationships (e.g. experience of recent violence) put people at greater risk of homelessness (Johnson et al. 2015; Brackertz et al. 2020a).

(b) People with mental ill health may not be diagnosed. A number of studies have shown that diagnosis of a mental illness reduces the chance of becoming homeless – although mental ill health is potentially disruptive for housing outcomes, it is suggested that getting a diagnosis is a predictor of getting

[5] *Ibid,* pages 34 – 45.

treatment and support, whereas those who are not diagnosed are more likely to remain at risk of homelessness (Johnson et al. 2015).

(c) People with mental illness may not be receiving adequate mental health support. One study found that approximately 77 per cent of 190 rough sleepers surveyed had some form of mental health or substance addiction issue but only 49 per cent had spoken to a mental health professional in the past six months, either voluntarily or involuntarily (Westoby 2016).

(d) People who are attended to and hospitalised by medical practitioners are often not adequately supported when released back into the community. Within a week of hospital discharge, connections to community mental health vary from 72 per cent of all mental health related hospital discharges in Victoria to 48 per cent in NSW, and 54 per cent nationally (Brackertz et al. 2020a).

Safe, secure, appropriate and affordable housing is important for mental health recovery

39 Safe, secure, appropriate and affordable housing allows people to focus their attention on mental health recovery (Bleasdale 2007; Honey et al. 2017) and can improve mental health by facilitating independence, social relationships and networks (O'Brien et al. 2002). Unaffordable housing is detrimental to mental health for low-income earners (Bentley et al. 2011; 2016; Ong et al. 2019).

40 Good-quality housing benefits tenants with mental ill health through reduced mental health care costs, greater wellbeing, and residential stability (Adair et al. 2016; Harkness et al. 2004; Nelson et al. 2007), and better mental health functioning (Aubry et al. 2016; Bond et al. 2012; Egan et al. 2013; Evans et al. 2000; Wells and Harris 2007).

41 Good neighbourhood amenity is a factor in reducing mental health care service use among people with mental ill-health (Friesinger et al. 2019; Harkness et al. 2004).

42 Housing quality factors, such as perceived security and the interior of the home, affect a person's psychosocial status and can relate to an improvement in mental health (Clark and Kearns 2012; Ecker and Aubry 2016; Nemiroff et al. 2011).

Choice and control over housing contribute to wellbeing and mental health recovery

43 Choice and control over housing and support contribute to wellbeing and quality of life for people with mental ill-health (Nelson et al. 2007). Autonomy with respect to housing aspirations, and access to housing that fosters meaningful relationships in the home and the community, are associated with improved wellbeing and quality of life, and decreased symptomatology and service use (Aubry et al. 2016; Nelson et al. 2007).

44 Control over housing can deliver indirect positive mental health outcomes to individuals through feelings of empowerment and belonging. Empowerment and personal control are

associated with greater resilience and ability to cope with stressors among people with severe mental illness (Aubry et al. 2016). The sense of belonging, engendered by stable, secure and appropriate housing, is critical to mental health recovery and reduces the risk of depressive symptoms, particularly among people in assisted living facilities (McLaren et al. 2013).

Mental ill health impacts housing and relationships

45 Trajectories undertook extensive consultations with people with lived experience of mental ill health and housing insecurity/homelessness and their carers (Brackertz et al. 2020; Pollock et al. 2020). Pollock et al. 2020 provide detailed findings on the impact of housing for mental health and relationships.

46 Consumers reported that living with family placed significant stress on their relationships, particularly if there was a lack of understanding about mental ill-health. Upon discharge from hospital, there was often little consideration of whether living with family was the best option for the person and their family. Carers reported feeling unsafe when medications, and subsequently behaviours, changed. Even when the family relationship was positive, living with family still placed significant pressure on the relationship and the carer, in some cases contributing to a permanent relationship breakdown (Brackertz et al. 2020a).

47 Some types of housing have negative effects on research participants' relationships, particularly shared housing or living with family. Privacy and space were highlighted as being important to support mental health and recovery. Shared housing often posed challenges for participants' mental health. Preferring to spend time by oneself rather than with housemates had an impact on relationships with housemates, potentially making them less forgiving if rent was not paid on time. Shared housing was often a more intense experience if the participant was not employed as housemates might then spend a lot of time together. Some consumer participants wanted to live in a shared-house environment, but only with someone they trusted and in a house where privacy was accessible when needed. Outside of having a private rental, which was often unaffordable, for most this was not possible to achieve within the housing/homelessness service sector.

48 While privacy and space were valued by many participants, isolation was often a result of the move to secure independent housing. For some participants, the process of gaining secure housing meant losing connections and living in isolation. This was seen as a difficult transition period where it was not uncommon to consider moving back into homelessness and/or a boarding house in order to be around a known community. This process was seen to take time and would be a period where added mental health support and support with community engagement could be of benefit.

49 Housing played an important role for participants who were parents who had lost access to their children. If they could secure housing, they could spend more time with their children, which gave them purpose and helped with recovery.

50 Carers described the impact of not receiving help until hitting rock bottom, including the damage done to family relationships, property and wellbeing in the months and years they were left without adequate support. Service providers noted that for some clients a formal mental health diagnosis was a tool that helped them to access support services (Brackertz et al. 2020a).

Discrimination in relation to housing

51 People living with mental ill health face several forms of discrimination in relation to housing, which in turn, impact on their mental health. This includes:

(a) **Discrimination in the private rental market.** Most people with lived experience of mental ill-health rent in the private market, yet many struggle with discrimination by landlords and neighbours, insecure tenure and housing affordability (Harvey et al. 2012; Wiesel et al. 2014).

(b) **Discrimination in entering social rental housing.** Having a diagnosis of a mental health condition is generally not enough to get priority status for social housing (i.e. particular diagnoses are not 'helpful' for accessing the system) (Wiesel et al. 2012). Furthermore, having a mental health diagnosis may work against persons being allocated a social housing property through community housing providers, as these can be reluctant to accommodate people with high and complex needs.

(c) **Discrimination within the service system.** Some people experience trauma and discrimination from within the service system, from both other residents or service users and from staff.

52 AHURI research suggests that a mental health diagnosis can be a double-edged sword. Although diagnosis can open doors to some mental health services and is necessary for accessing the NDIS, it is not enough to help access social housing. At the same time, it can involve greater stigma and therefore greater discrimination in the wider community. As a consequence, many homeless persons often do not engage with mental health services (Brackertz et al. 2020a).

The Housing First model

53 Appropriate housing is the foundation to good mental health; it can be one of the most beneficial external factors that assist a person's mental health. This is the basis of the 'Housing First Model' - that people with complex needs, including issues with housing, should have their housing issues addressed first. In the Housing First Model, the first step

is placing people in adequate housing. In conjunction with that, you must also provide 'wrap-around' services including mental health support that service the complexity of the needs that each person has. The Housing First Model is considered to be the ideal approach because when a person's housing is stable, their other needs become easier to address; whereas attempting to address other needs, such as mental health, while someone is still poorly housed is near impossible.

54 Housing First is a service model first developed in 1992 by Sam Tsemberis for the New York City Pathways to Housing organisation. The aim of a Housing First approach is to provide rapid access to permanent, supported housing for chronically homeless people (Tsemberis et al. 2004: 651). It is based on the idea that a homeless individual's first and primary need is to obtain stable, permanent housing. It is only once stable housing is obtained that other more enduring issues, such as mental health and substance misuse, can be appropriately addressed. This differentiates Housing First from Treatment First (or continuum) models, where the provision of housing is contingent upon the homeless person's willingness to access treatment services for their other issues.

55 Housing First involves five principles:

(a) **Rapid re-housing into permanent housing.** In New York, participants wait on average for 2 weeks to access housing, and program participants had high retention of housing. This is because their tenancy management involves three strategies—mandatory and automated rent payment, the capacity to change properties to resolve problems and the ability to retain a tenancy whilst the tenant is absent.

(b) **Consumer choice and control.** Consumers can choose the nature and extent of their engagement with treatment/support services. This means that continuation of housing is not contingent on accepting treatment or changing behaviours such as achieving sobriety or abstinence from alcohol and illicit substances. Nevertheless, clients are 'assertively offered' comprehensive treatment and support provided by multi-disciplinary Assertive Community Treatment (ACT) teams. They are required to meet twice monthly with a worker, and the ACT teams are available 24 hours 7 days a week and are open-ended.

(c) **Separation of housing and support services**. The pathways organisation in New York has an internal separation of housing and support, but in other cases, different organisations provide housing and support. The separation means that problems in one area (e.g. in relation to mental illness or addictions) do not affect the other (tenancies) – support is always available regardless of the person's tenure status. This gives greater choice and control over treatment and housing to the consumer – both thought to be important elements in psychiatric rehabilitation.

(d) **Recovery is ongoing.** There is an acceptance that, because the program targets people with mental illnesses (such as bi-polar, depression, anxiety and schizophrenia) recovery takes time and housing is just a first step, but recovery is consumer driven and holistic.

(e) **Community re-integration.** Housing is usually head leased from the private rental sector in 'normal' neighbourhoods (no more than 15-20 per cent of units in the block or complex are rented to Pathways consumers) – this approach is to avoid being placed into stigmatised neighbourhoods (Johnson et al. 2012).

56 The Housing First model contrasts with 'stepped' models of housing, which involve moving people from crisis accommodation into transitional housing and then long-term housing. The stepped model of housing is consistent with a 'continuum of care' welfare model. This model is underpinned by the notion that people should make progress towards solving their problems (including progress in dealing with mental illness or addictions to alcohol or substances) before they can enter permanent housing. An implicit assumption in continuum of care approaches is that chronically homeless people cannot sustain accommodation without 'restoration of behavioural self-regulation' (Kertesz et al. 2009: 500); i.e. they are not 'housing ready'. Therefore, these models required the participant to commit to addressing those problems in exchange for the opportunity to gain both independence in a permanent dwelling. Individual behavioural change is the main focus of these programs rather than housing.

57 AHURI research identifies the following limitations of continuum of care models:

(a) they are ineffective in addressing the homelessness for people who live permanently on the streets and in shelters and who tend to have poor health, problematic drug use and experience long-term exclusion from the job market;

(b) they have high operating costs;

(c) they foster dependence and reduce capacity for choice; and

(d) supports are often cut off after the person enters independent housing, just when they need the most support (Johnson et al. 2012).

58 A key philosophical underpinning of the Housing First model is the idea that housing is a human right, and therefore the provision of housing should not be made contingent upon behavioural changes or anything other than abiding by standard tenancy obligations (Stefanic and Tsemberis 2007). It emphasises the importance of long term 'permanent' housing as an important stabilising influence in a person's life that can have profound impacts in other parts of their life— this is especially important for people with mental illness.

59 Since its introduction, Housing First has become more than just a program model, but also a 'policy paradigm shift that places rapid access to permanent housing at the forefront of homelessness policy and program planning' (Johnson et al. 2012:2). The widespread use of the label has, however, sometimes led to confusion, as the 'Housing First' terminology has been applied to a range of housing programs in Australia (and internationally) that do not adhere strictly to the program tenets developed by Tsemberis and which have low program fidelity (rapid access to housing is often a missing component).

The Effectiveness of Housing First

60 The robust evidence-base for permanent supportive housing includes longitudinal outcome evaluation studies for Housing First (Johnson and Chamberlain 2015; Pearson, Montgomery et al. 2009; Stefancic and Tsemberis 2007) as well as a systemic review of research on Housing First in the US (Woodhall-Melnik and Dunn 2016).

61 The evidence shows that Housing First models are successful at delivering high levels of sustained tenancies for people with complex needs and a history of homelessness. It is also clear from the evidence that while the provision of immediate and permanent housing is essential to the success of the model, the support component is equally important in ensuring that tenancies are sustained.

62 The evidence is more equivocal on Housing First's success in achieving outcomes such as social inclusion, addressing problematic substance use and mental health issues.

63 There are few rigorous studies of Housing First's cost effectiveness. A meta-analysis using US data (Woodhall-Melnik and Dunn 2016) found (consistent with other available studies) that the cost savings from Housing First approaches are primarily due to the cost offsets in clients' reduced use of other government services, primarily the justice system and emergency medical services. However, it has been noted that cost savings do not equal the cost of providing supportive housing (Johnson and Chamberlain 2012).

64 Permanent supportive housing is also the core of the Common Ground model and its assertive outreach approach to housing rough sleepers, known as Street to Home and Way to Home.

Australian programs and evaluations of Housing First

65 The evidence from Australia confirms the effectiveness and cost effectiveness of Housing First approaches to addressing chronic homelessness and shows its positive impact on mental health.

66 Brisbane Common Ground **(BCG)** is a model of supportive housing comprising 146 units in a 14-storey building in South Brisbane. BCG aims to assist tenants sustain housing,

improve their quality of life (health, social and economic) and reduce their use of acute, crisis and emergency services. BCG targets tenants who have low to moderate incomes and/or have experienced chronic homelessness.

67 BCG is a partnership between the Queensland Government, Commonwealth Government, Grocon Pty Ltd, Micah Projects and Common Ground Queensland Ltd.

68 An evaluation showed that BCG removed barriers for people experiencing chronic homelessness with support needs to access housing, and fostered the conditions for tenants to sustain housing (Parsell et al. 2016).

69 Analysis of linked administrative data was undertaken to measure service usage in the 12 months prior to commencing a BCG tenancy (i.e. homelessness). This was compared to service usage in 12 months during which tenants resided in BCG.

70 The analysis showed that as a cohort, tenants used an estimated $1,976,916 worth of services (health, criminal justice, homelessness) in the 12 months pre-BCG tenancy commencement, compared to an estimated $852,314 worth of services in the 12 months post BCG tenancy commencement. Once the cost of providing BCG is factored in, this equates to a cost saving of $13,100 per tenant per year. In other words, housing a previously homeless person in BCG saves the government $13,100 per year per person in reduced service usage.

71 A 65 per cent reduction in episodes requiring mental health services demonstrates that the model contributes to improved mental health and wellbeing. Table 1 (Attachment MF-2) provides a summary of cost savings.

72 Australian homelessness researchers have pointed out that elements of the Housing First paradigm or approach have been apparent in Australia for some time in the way specialist homelessness programs have been offered (Johnson et al. 2012). For example, Australian homelessness providers have generally not made obtaining long term housing contingent upon receiving treatment or making behavioural changes prior to the allocation of housing. While case management has been criticised as a form of surveillance, it is also conceived as a means of client empowerment, and Australian services have embraced harm minimisation and voluntary engagement in services (Johnson et al. 2012). Even so, many homelessness programs still follow a stepped housing model, with people notionally moving through crisis, transitional and then long-term housing. Even then, there is evidence that many housing pathways are not so linear with many people cycling in and out of crisis accommodation (see section above on Trajectories research). But the key reason for a delay in accessing long term housing has more often been due to shortages of affordable housing and the lack of long term viable housing pathways, rather than programmatic reasons.

73 Australian housing researchers have argued that two elements in the Housing First model could be usefully introduced to the specialist homelessness system in Australia: rapid access to permanent housing and use of multi-disciplinary teams providing on-going support (Johnson et al. 2012).

74 More clearly branded Housing First style programs involving rapid rehousing have been developed in the Australian context, principally for the chronically homeless (e.g. by Neami National, Launch Housing and Common Ground) and have sometimes been adopted in conjunction with assertive outreach approaches (e.g. Street to Home) in which multi-disciplinary teams 'assertively' engage rough sleepers on the street or drop in centres to assist in getting them housed and then provide support in the tenancy. However there remain issues with resourcing—most specialist homelessness support services are time limited. For programs to replicate those overseas would require increased resources, including access to long term housing and health services (Johnson et al. 2012). Increasingly, homelessness researchers have also advocated for Housing First approaches to be applied to other groups like youth (MacKenzie et al. 2016). Furthermore, researchers also caution that if they are to be provided more widely, there would need to be acknowledgement of the resources needed to monitor and resolve issues for those with addictions in tenancies (Johnson et al. 2011).

75 Evaluations of Housing First style supportive housing programs or trials in Australia have shown they are successful in enabling sustained tenancies for people with complex needs and histories of homelessness, though like their US counterparts, are more equivocal around outcomes around substance abuse, mental health or social inclusion (Brackertz et al. 2016).

76 Nevertheless, the most recent and most rigorous evaluations of the Housing First model in Australia in relation to chronic homelessness have been encouraging. These involved rigorous trials and randomised control methodologies in the Journey to Social Inclusion (J2SI) project by Sacred Heart Mission in Melbourne. Evaluations of the pilot program compared the outcomes of those who received Housing First rapid re-housing treatment with a matched sample of other persons who were homeless or at risk of homelessness who were provided with normal crisis services (Johnson et al. 2011, 2012, 2013, 2014). Phase 2 of the program (which involved 180 adults experiencing chronic homelessness in Melbourne) was evaluated using a mixed methods Randomised Control Trial (Flatau et al. 2018). Outcomes from Phase 2 are summarised in Table 2 (Attachment MF-2).

77 The positive outcomes reported in the J2SI pilot program included:

(a) increased proportions of those in the J2SI group who were housed permanently (from 8.3% at baseline to 60% after 12 months);

(b) improvements in mental health, especially for those housed permanently;

(c) declines in problematic drug use, increased methadone treatment and less time spent in drug rehabilitation, especially for those housed permanently;

(d) lower health care costs for those permanently housed (but higher costs for those in the comparison group); and

(e) improvements across all aspects of self-assessed quality of life between the baseline and third wave for those in permanent housing.

78 However, there were no improvements in the employment status of the program participants or the comparison group over this period – most (just over 70%) remained out of the labour force.

79 Other evaluations of assertive outreach programs such as Street to Home which have also embraced a Housing First philosophy have also found encouraging results, such as:

(a) 70 per cent of participants were still housed after 24 months, with a 79% success for those on the adult pathway, and 62% for youth;

(b) Significant improvements in physical and mental health of participants, in the first 12 months in particular;

(c) No significant change in alcohol and substance use over 24 months;

(d) A significant reduction in use of homelessness services (from 59% to 7%); and

(e) Improvements in relationships with family and friends (Johnson and Chamberlain 2015).

80 Despite the Housing First model being considered the ideal approach, in Victoria, our system relies on a reciprocal obligation that requires a person to address their other issues first before receiving housing. This is ineffective.

The proportion of people experiencing both severe mental illness and housing insecurity or homelessness in Victoria.

81 According to data from the AIHW, around 17 per cent of all persons seeking assistance from Specialist Homelessness Services in 2018-19 cited mental health as one of the reasons for seeking assistance (AIHW 2019).

The extent to which Victorians with mental illness exiting mental health services into homelessness, and the drivers behind this problem

82 As I discuss further at paragraph 83 below, it is known that one of the key points at which people become homeless, particularly rough sleeping (the most severe type of homelessness), is when exiting institutional settings. These can be mental health facilities, public hospitals, corrections facilities or out-of-home care. Institutional discharge is a significant moment of risk when people often fall through the gaps in the service

system, leading to homelessness and negative mental health and health outcomes. There is a significant proportion of people entering homelessness from prison or remand centres, as well as younger people leaving out-of-home care as a result of reaching a certain age and no longer being eligible for care.

83 While public hospitals are not supposed to discharge into homelessness, and generally do not, there are cases when it occurs. I am not aware of any data that can demonstrate the extent of Victorian with mental illness exiting mental health services into homelessness. However, for example, in Victoria, more than 500 people presented at homelessness services in 2016–17 after leaving psychiatric services—an increase of 45 per cent since 2013–14 (Perkins 2018). The Survey of High Impact Psychosis (SHIP) study showed that 8 per cent of participants did not receive any help and had nowhere to live upon being discharged from hospital (Harvey et al. 2012). In my experience, the mental health system struggles with discharging people into homelessness more than the main health system.

Transitions between institutions are points of high risk for mental ill health and homelessness

84 Two AHURI research projects shed light on the impact of and reasons for exits into homelessness from mental health services (Brackertz et al. 2020a; Brackertz et al. 2018a). Research for the National Mental Health Commission (Brackertz et al. 2018a) identified that transition points between institutions, or in and out of institutions, can be periods of instability, which expose people to a range of stressors and challenges that can act as triggers which destabilise people. At these transition points, people can fall through the cracks in the system due to poor discharge planning, because risk factors are not identified, because there is a lack of coordination in responding to consumer needs, and because there are limited options for exit into appropriate and secure housing options.

85 Discharge into homelessness and precarious housing happens due to:

(a) inadequate discharge planning and procedures;

(b) hospitals undertaking discharge assessments in time pressured environments mean people in precarious housing are not identified;

(c) hospitals not resourced to make thorough discharge assessments and to facilitate internal transitions form one service to another;

(d) a lack of knowledge and capability in the acute sector means officers often do not know the right questions to ask to identify people who are in precarious housing or at risk of homelessness; questions about the quality of the home are not asked;

(e) frequent patients are often treated quickly and then assessed for discharge quickly, with discharge officers not asking the right questions or getting corroboration of patient answers from friends and family;

(f) delays in or lack of follow up after discharge;

(g) difficulties accessing GPs and specialists after discharge due to long wait times or specialists already being at capacity and not taking on new patients;

(h) GPs being giving insufficient discharge information; and/or

(i) patients are being discharged too quickly because of capacity constraints in the medical system.

86 This is consistent with findings from the Trajectories study. Service providers who participated in Trajectories noted that discharge processes varied between hospitals and jurisdictions, and depended on the type of admission; discharge from hospital inpatient units was identified as a key risk point for people falling through the cracks (Brackertz et al. 2020a).

87 Most often, patient discharge was characterised by:

(a) the hospital's need to discharge patients as quickly as possible to free up beds for new admissions;

(b) lack of planning that takes account of patients' medium- and long-term housing situation after discharge;

(c) lack of integration between the clinical and housing/homelessness sectors; and

(d) lack of community-based mental health supports that would allow patients to gradually step down from hospital care to independent living.

88 As a result, patients were often discharged too early and were discharged into homelessness, into short-term or crisis accommodation, or to family where this was inappropriate (Brackertz et al. 2020a).

89 The need to discharge people from hospital often led to patients being discharged into temporary accommodation (boarding houses, caravan parks), to their families (even if this was not appropriate), or into overcrowded housing. In other cases, the lack of housing options led to patients remaining in hospital longer than needed. This reliance on mostly temporary housing solutions meant that clients could not recover, could not stabilise their housing situation, and thus continued to return to hospitals. Some consumers reported

being discharged from hospitals into homelessness, often leading to long-term rough sleeping, crisis or violence (Brackertz et al. 2020a).[6]

90 Discharge planning is often problematic, and people are discharged without the needed support and sometimes without appropriate and stable housing (i.e. they are discharged into temporary solutions with family or friends, or into short-term crisis accommodation) and without appropriate follow-up after discharge. These processes are not conducive to recovery and lead to people being re-admitted because they lacked the necessary recovery support. This creates a cycle of deteriorating mental health and housing instability.

91 Data on post discharge nights may not reflect the truth, as people are sometimes discharged from hospital into a hotel for several days and then back into homelessness (Brackertz et al. 2018a).

92 A lack of clarity about who has responsibility for ensuring people are securely and adequately housed post discharge exacerbated the risk of homelessness for people with lived experience of mental ill health. There is a conceptual question about where health ends and housing begins.

93 Effective hospital and mental health institution discharge processes, or lack thereof, can have a significant impact on the prospects for improved mental health and wellbeing and housing of people with lived experience of mental illness. Precarious housing or homelessness post discharge negatively affects people's recovery, ability to access needed services, and puts them at risk of relapse.

94 An inability to access safe, secure and appropriate housing and mental health supports within the community meant that some consumers reached a point of crisis that led to admission to an inpatient unit in a hospital. Sometimes admission to hospital occurred for non-medical reasons, such as AOD, homelessness or housing crisis, due to a lack of accommodation and support options in the community. These 'social admissions' are very expensive for hospitals and are discouraged (Brackertz et al. 2020a).[7]

95 Similarly, consumers participating in the Trajectories study reported negative experiences of discharge from inpatient units, including seeing people being moved quickly through the system and discharged into homelessness. Carers reported that they felt excluded from care planning and discharge—at a cost to everyone's safety. There was a sense that clinical mental health services do not understand or appreciate the role that families and carers play in achieving improved mental health and outcomes for people with mental

[6] *Ibid,* page 70.

[7] *Ibid,* page 70.

ill-health. As a result, decisions were made that placed the family in danger, or slowed down the process of recovery (Brackertz et al. 2020a).[8]

96 Carers reported examples of a family member being discharged from acute care without their knowledge, only to return home in a distressed and frightened state. In some cases, carers talked about being the 'provider of last resort'—the place where someone is sent when all other service options have failed them (Brackertz et al. 2020a).

97 The challenge broadly is that there is not enough social housing available, and the waiting lists for housing are long. While someone who is experiencing or is at high risk of homelessness is prioritised for public housing in those discharge systems, there still remains a waiting list to obtain housing. As a result, when a mental health facility discharges a person without housing, the public housing system and social housing system do not have the capacity to assist them. This inevitably results in homelessness.

98 There is a need for a national discharge policy and a nationally consistent definition of 'no discharge into homelessness' (Brackertz et al. 2018a; Brackertz et al. 2020a).

Hospital Emergency Departments

99 Hospital emergency departments are an important access point for consumers in crisis. However, emergency departments are not designed for people with mental health issues and consumers must usually wait for long periods of time in a noisy and busy environment, which is particularly challenging when they are experiencing an acute episode of mental ill-health (Brackertz 2020a).[9]

100 Resource constraints in emergency departments mean that clients are sometimes turned away even if they are experiencing an acute mental health crisis. At the same time, the medical team in the emergency department is under pressure to find a bed for the person experiencing the current crisis. As there is acute pressure on hospital beds, this frequently means that patients in existing wards are discharged earlier than appropriate due to the need to free up beds for new emergencies (Brackertz 2020a).[10]

Duration and continuity of support

101 Service providers and consumers reported that the duration of support was often not long enough to allow for recovery and people consequently struggled to get better or relapsed. Support that was too short or inappropriate meant that consumers had negative

[8] *Ibid,* page 71.

[9] *Ibid,* page 72.

[10] *Ibid,* pages 72-73.

experiences, which in some instances made them reluctant to engage with services in the future (Brackertz 2020a).

102 Service providers reported that assisting rough sleepers was problematic, as they were often non-compliant with their medication, did not want to access services, and had complex needs (Brackertz 2020a).

103 Many services do not provide ongoing support after a person has recovered. Providers argued that there is a need for more flexibility and responsiveness in allowing people to re-access services in the event of a relapse. Consumers reported that they could maintain their housing while they were well, but this became difficult when they became unwell. Consumers also reported that hospitals focussed on stabilising patients with medication, but that there was a lack of psychological therapy within hospitals and after discharge. Limited coordination between hospitals and other service providers meant that patients found it difficult to re-establish their lives and mental health after they returned to the community.[11]

104 Mental health consumers generally exit mental health institutions and hospital settings into community mental health care, and while some enter into housing and support programs, others exit into unstable housing and inconsistent supports (Stokes 2012). Post-hospital follow up with consumers by a hospital discharge liaison officer is now common practice in Australia. However, there remain significant delays between discharge and follow up in many cases. Additionally, follow up may only be possible if the consumer has been discharged to a fixed address, with a home address also being a common prerequisite for community mental health service provision upon discharge (Stokes 2012).

105 In Western Australia, the current target is for 70 per cent of consumers to be followed up within seven days of discharge, while in NSW the rate of community follow up within seven days of discharge from public sector acute mental health units has improved from 48 per cent in 2010–11 to 63 per cent in 2015–16 (Stokes 2012; NSW Ministry of Health 2016). However, the NSW Ombudsman called for a state-wide review of discharge planning practices in mental health facilities based on failed discharge planning for over 95 people identified as ready but unable to move into the community (NSW Ombudsman 2012).

106 The SHIP second wave study conducted in 2010, found that among psychiatric inpatients admitted in the year prior to interview, a range of discharge practices were evident. At the time of discharge, approximately 58 per cent of this cohort recollected discussing accommodation options with staff, 69 per cent reported not needing further help as they

[11] *Ibid,* page 73.

had already had somewhere to live, 23 per cent needed and received help finding accommodation, and 8 per cent reported that they had not been given any help and had nowhere to live in discharge (Harvey et al. 2012). A study analysing the characteristics of 2,388 people attending psychiatric clinics in inner Sydney homeless hostels found that the pathway to homelessness for 21 per cent of patients was discharge from psychiatric hospitals (Nielssen et al. 2018).

107 Hospital and mental health institution discharge processes can have a significant impact on consumers' prospects for improved mental health and wellbeing. In WA, more than one-third of discharged public mental health hospital consumers who suicided did so within one month of discharge (Department of Health [DoH] 2009). While it is difficult to anticipate a consumer's risk of self-harm, contributory factors such as trauma can be minimised with adequate housing and supports as well as discharge officer follow up upon psychiatric hospital bed discharge.

108 Clinicians surveyed for the Western Australia Mental Health Commission inquiry into discharge and transfer practices of public mental health facilities have noted recent improvements to discharge processes in some specialist mental health hospitals. This included developing outreach programs to achieve more timely and specialist follow up and assigning priority to post-hospital follow up within five days for all post-hospital consumers (Stokes 2012).

HOUSING NEEDS AND HOUSING STOCK

The extent of unmet need for housing and homelessness services in Victoria

109 Over the next 20 years, Australia will require hundreds of thousands of more properties, in addition to what is currently being built. Currently, Victoria has the lowest provision of public and social housing within the market. Approximately, 2-3 percent of the market share of total properties in Victoria is social housing, public housing and community run housing. In other states, it is slightly higher. In other countries, it is significantly higher. Victoria performs particularly poorly due to a generation or more of underinvestment in supply of social housing.

110 The extent of unmet need for housing and homelessness services in Victoria is addressed at paragraphs 189 to 193 below.

HOUSING FOR PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

Characteristics of effective service models for people experiencing severe mental illness and housing insecurity or homelessness

111 Effective service models for housing support involve good case management and the supply of appropriate housing.

112 Numerous effective models that provide supported housing for people with mental illness already exist in Australia. However, these programs tend to be small in scale, pilot programs, geographically restricted and are not able to meet the demand for these services (Brackertz et al. 2018a).

113 Research undertaken by AHURI for the National Mental Health Commission analysed publicly available evaluations of these programs, including the NSW Housing and Accommodation Support Initiative (HASI); the Victorian Housing and Support Program (HASP); the SA Housing and Accommodation Support Partnership Program (HASPP); the SA Individual Psychosocial Rehabilitation and Support Services (IPRSS); the QLD Housing and Support Program (HASP); and the Doorway Program (Vic) (see Brackertz et al. 2018b: for a full list and summary of program evaluations).

114 Key characteristics of successful programs included:

(a) immediate access to long-term housing (public housing, community housing or private rental with rent support).

(b) coordinated approaches/partnerships between consumers, carers, NGO housing providers/landlords, and government mental health services.

(c) effective mechanisms for coordination at the state and local levels.

(d) provision of housing close to amenities and services.

(e) person-centred planning and supports.

115 Participants in the Trajectories study (Brackertz et al. 2020a) identified the following elements as being critical to being well supported and being able to achieve and sustain recovery:

(a) Ability to navigate the system, whether independently, with low-level support, with informal support (in a way that does not negatively affect relationships in the long term), or with long-term support. Consumers know what services are available and how to access them, and supports are continuously available to the person.

(b) Feeling empowered to self-advocate to services, to engage with the community as equals, to complain if there has been injustice, and to take risks.

(c) Being financially secure, able to pay rent and bills, and feeling in control of finances. The consumer has enough financial support to socialise and for recreation. They feel comfortable that they could survive financially even if they experienced a long period of ill-health.

(d) Having appropriate, secure, safe and affordable housing in the right location. Tenure is secure, regardless of how long the consumer may be absent from their tenancy due to mental health related issues (such as hospitalisation).

(e) Participating in meaningful activities, such as volunteering, employment or social activities, which provides a feeling that there is structure and purpose in life. The consumer has adequate formal support to maintain existing social relationships and build on them if needed.

(f) Having an ongoing and appropriate level of support that meets basic needs at a level to maintain wellness in the long term and having access to crisis support if needed.

(g) Ability to focus on things beyond housing and mental health—for example, returning to the workforce, studying, volunteering, or rebuilding relationships with friends or family.[12]

116 Overall, the research found clear evidence that housing is an important foundation for a person's mental health recovery and so housing should be an integral part of policy responses. This requires:

(a) **Access to safe, secure, affordable and appropriate housing** that allows for control of space; is in safe neighbourhoods with meaningful social support and connections (close to family and friends, good relationships with neighbours); and provides access to public transport, services, and opportunities for work, volunteering or study.

(b) **Connection to a trusted worker** with whom a respectful ongoing relationship can be established—someone who has the skills to assist in navigating services and who can provide advocacy and support when challenges arise.

(c) Support coordination, and assistance and advocacy to navigate the system.

(d) **Access to psychosocial support** to help with day-to-day tasks; maintaining tenancies, relationships and health; establishing and maintaining a routine; and undertaking meaningful activities.

(e) **Financial security**, either through employment or the Disability Support Pension (DSP).

(f) **Holistic support that meets the level of need**. The quantitative analysis offers strong evidence of the importance of holistic approaches that integrate housing and mental health support with social support, healthcare and financial support, and effective early intervention (i.e. mediating factors).

[12] *Ibid,* page 3.

(g) Timely access to support when needed.

(h) **Trauma counselling** to enable people to better deal with the ongoing effects of trauma.

(i) Culturally appropriate services.[13]

Support for people experiencing severe mental illness and housing insecurity or homelessness – what Victoria is doing well

117 The housing and homelessness system in Victoria is under-resourced to deal with the challenges it has. Despite this, Victoria delivers a good quality of service within the resources it has. The programs and services that exist within Victoria's primary system are effective and their outcomes are highly positive. AHURI has conducted research that demonstrates that investment in homeless support saves Victoria money in other portfolios, such as corrections, health, mental health and welfare.

118 There is a good quality of care offered by Victoria in the provision of housing support for people experiencing severe mental illness and homelessness, however the issue is lack of accessibility to the care due to limited quantity of services.

Examples of successful housing approaches in other jurisdictions

119 The Housing First Model is the ideal approach, which is discussed at paragraphs 52 to 54. Critical success factors include effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, immediate access to housing (social housing or private rental), and integrated person-centred support.

120 Many successful models of supported housing for people with mental ill health operate in Australia, however, most are pilot programs, are small in scale, localised, or have time limited funding.

121 Over the past 25 years, Australian, State and Territory governments have established a number of small-scale housing programs for people with lived experience of mental ill health, often in partnership with service providers. Most of these housing and mental health programs feature some, but not all, components of the Housing First philosophy, and therefore could be considered 'low fidelity' Housing First programs. One reason for this is Australia's social and affordable housing shortage, which limits the degree to which support programs can offer immediate access to housing. Examples of housing and mental health programs in Australia include HASI (NSW), HASP(QLD) and the Doorway (VIC) program, and are outlined below.

[13] *Ibid,* page 84.

122 Positive outcomes include cost savings to government (especially in health), tenancy stability, reduction in hospital admissions and length of hospital stay, improvements in mental health, social connectedness, and modest improvements in involvement in education and work.

123 There are numerous other housing approaches, strategies and programs, in Australia and internationally, that Victoria could learn from to better support people experiencing severe mental illness and housing insecurity or homelessness. A selection of these are described below.

NSW Housing and Accommodation Support Initiative (HASI)

124 HASI began in NSW in 2002 and involves collaboration between NSW Health, Housing NSW and NGOs to provide:

(a) accommodation support and rehabilitation associated with disability (delivered by NGOs, funded by NSW Health);

(b) clinical care and rehabilitation (delivered by specialist mental health services); and

(c) long term, secure and affordable housing and property and tenancy management services (delivered by social housing providers) (Costello et al. 2013).

125 HASI was initially targeted to meet the needs of mental health consumers with high support needs, but has since been expanded to provide a range of support. The program evaluation showed that between 2002–2012, HASI had supported 1,135 mental health consumers in NSW, ranging from very high support (8 hours per day) to low support (5 hours per week). The annual cost of HASI per consumer was between $11,000 and $58,000 (Bruce et al. 2012).

126 Positive outcomes for consumers included an overall reduction in hospital admissions and length of hospital stay, clinically significant improvement in mental health, tenancy stability, independence in daily living, social and community participation, and involvement in education or paid and unpaid work (Bruce et al. 2012). However, the physical health of consumers remained below the general population (Bruce et al. 2012).

127 The evaluation identified effective mechanisms for coordination at the state and local levels and regular consumer contact with Accommodation Service Providers as factors that were critical to the success of HASI (Bruce et al. 2012).

128 There are several HASI spin-off programs operating in NSW, including HASI Plus, HASI Aboriginal, and HASI Boarding House. HASI Plus targets a higher-needs demographic compared to HASI, providing accommodation and 16 or 24 hours of support to people

living with severe or persistent mental illness. The program is designed to assist the transition to independent community living through the provision of recovery focused, wrap-around support services including psycho-social rehabilitation, daily living skills, physical health and workforce participation. Eligibility for the program extends to persons who have been living in long term institutional care, including mental health facilities, correctional facilities and hospitals.

129 In December 2017, there were 58 HASI Plus packages available in Northern Sydney, Hunter New England and Western Sydney, which also deliver access for people living beyond these Local Health Districts (NSW Department of Justice 2017). HASI Plus is an initiative of the Mental Health Drug and Alcohol Office within the Ministry of Health NSW, and is delivered through NGOs.

Doorway (VIC)

130 The Doorway program is a Victorian Government initiative delivered by Wellways, which provides integrated housing and recovery support designed to assist people with lived experience of persistent mental ill health who are at risk of, or experiencing homelessness. Doorway is a collaboration between hospitals, housing and mental health service providers and landlords. The program links consumers with private rental housing and psychosocial support while providing time limited rental subsidy, brokerage and tenancy support (Dunt et al. 2017). The model is based on Housing First principles, but is highly innovative, as it diverges from the predominant model of providing housing via social housing providers, in favour of the private rental market.

131 Doorway supports participants to choose, access and sustain their own private rental accommodation by subsidising their rental payments where required. In addition, Doorway's housing and recovery workers support participants to develop tenancy skills and build natural support networks. Doorway creates integrated support teams for each participant.

132 Doorway housing and recovery workers are embedded in the public sector Acute Mental Health Services (AMHSs) within the relevant hospital catchment areas and provide housing and recovery inputs to care. AMHS staff also form part of these integrated support teams, providing clinical care, including case management. Other community based health services may also be involved for specialised purposes. AMHSs, and specifically the case manager, exercise governance for these different program inputs into an individual participant's care (Dunt et al. 2017).

133 An independent evaluation of the Doorway pilot program showed that during the evaluation period (July 2011–November 2013), of an intake of 77 people, 59 entered into private rental and 50 were still in residence at the end of the evaluation period. The

evaluation found that participant usage of bed-based clinical service and hospital admissions reduced significantly during the program, totalling annual cost savings to government ranging from $1,149 to $19,837 per individual. Outcomes for participants included modest improvements in the proportion of tenants in paid or unpaid employment, taking steps to find work, seeing an employment consultant, accessing education and vocational training opportunities and receiving qualifications for their vocational training (Dunt et al. 2017).

134 Properties sourced through the open rental market, the provision of appropriate rental subsidy and brokerage support and collaboration between hospitals, housing and mental health service providers and landlords were identified as critical success factors by the evaluation (Dunt et al. 2017).

Queensland Housing and Support Program (HASP)

135 The Housing and Support Program (HASP) is a Queensland Government Housing First initiative, which at the time of evaluation in 2010 involved the collaboration of Queensland Health and the Department of Communities. HASP consumers are generally in tenuous accommodation or homeless when signing up to the program, and are immediately connected with mental health services, disability support service and regular community housing. Between 2006 and 2010, there were 204 HASP consumers, 82 per cent of whom agreed with the statement that involvement in HASP had helped them achieve their goals (Meehan et al. 2010).

136 The government recorded significant cost savings as a result of the program. HASP consumers who without HASP would have been in a community care unit (CCU) saved the government approximately $74,000 annually, while consumers who would have been in acute inpatient units saved the government $178,000 annually (Meehan et al. 2010).

137 Critical success factors identified by the evaluation were a strongly targeted specific mental health service user cohort, immediate access to long term housing and key government agencies and NGOs working in collaboration (Meehan et al. 2010).

Haven Foundation

138 A successful model to assist people with severe mental illness was started in Victoria by the Haven Foundation (which has now merged with MIND Australia) and involves provision of permanent (usually social) housing, psycho-social support and social participation opportunities. The model operates in various locations across Victoria (The Haven Foundation 2020).

139 A critical element in the model is the provision of housing security through permanent housing. An evaluation of the first site offered under the program - Haven South Yarra - found very positive feedback about the program relating to satisfaction with being a

tenant, gains in independence, social participation, self-belief and illness stability (Lee et al. 2013).

International case studies

140 Two international case studies, the Canadian At Home/Chez Soi and the US HUD-VASH provide insights into how barriers to successful program delivery can be overcome.

At Home/Chez Soi

141 At Home/Chez Soi is Canada's $110 million Housing First trial, which operated from October 2009 to June 2013 in Vancouver, Winnipeg, Toronto, Montreal and Moncton and was conducted by Health Canada through the Mental Health Commission of Canada. The study was the world's largest on Housing First and focused on assessing housing stability, social functioning and quality of life among 2,298 homeless people with lived experience of mental ill health (Nelson et al. 2014).

142 The At Home/Chez Soi study found that both the treatment as usual group and intervention groups showed improvement in all outcomes over time. However, the Housing First intervention group experienced more significant and persistent improvement in all outcomes at both 12 months and program completion (Bourque et al. 2015).

143 Many systemic issues were faced during the life of the project and strategies to overcome these issues, such as stakeholder collaboration, were effective in some instances. Successful collaborative efforts with stakeholders during the life of the program included the following:

(a) Drawing on the strength of existing services in the community. In Winnipeg, project participants benefitted from access to existing services such as vocational training and food and drop-in programs.

(b) Partnerships with government agencies and departments. Securing access to housing units, mental health and homelessness services, and government income supports was critical to the project. In Vancouver, collaboration with the Ministry of Social Development helped increase access to services and substantially reduced wait times.

(c) Moncton members also spoke of the importance of partnerships with senior bureaucrats and ministers in government, while in Ontario good relationships with Ontario Works and the Ontario Disability Support Program helped facilitate timely access to income support.

(d) Landlord and landlord association partnerships. One of the major challenges in the program was the lack of affordable and available housing, particularly in

Toronto and Winnipeg where some participants waited up to five months for housing. This was mitigated by developing relationships with over 40 landlords, which helped secure more than 1,000 apartments needed across Canada. In Montreal, strong relationships with a network including clinicians, consumers and superintendents were beneficial (Nelson et al. 2014).

(e) Landlord appreciation and education events were held in some of the project sites. This is perceived to have encouraged landlords to more readily consult with service team members when issues arise, rather than notifying the police or moving toward tenant eviction.

144 Other barriers to implementation of the program included deficiencies in Moncton's public transport system, causing participants to have difficulties regularly attending medical and support related appointments. There was also a perceived lack of cultural sensitivity training among service providers, while suicidal behaviour training was also viewed by some providers as insufficient (Nelson et al. 2014).

Housing and Urban Development Veterans Affairs Supportive Housing program

145 Since 1992, the Housing and Urban Development Veterans Affairs Supportive Housing program (HUD-VASH) has operated in a joint Housing First initiative between Housing and Urban Development (HUD) and Veterans Affairs (VA). HUD-VASH provides veterans and their families with permanent supported housing, with HUD supplying housing through a voucher program and VA providing case management and supportive services through its healthcare system. Approximately 80 per cent of homeless veterans in the US experience mental health issues (Smelson and Chinman 2017).

146 A study comparing HUD-VASH groups to case management or standard care found greater housing sustainment of the HUD-VASH group and discovered a statistically significant reduction of drug and alcohol abuse among this group (Cheng et al. 2007). There was only a marginal difference in psychiatric outcomes recorded between groups.

147 Housing First programs in the US have faced significant systemic challenges in their implementation. This has included difficulty finding housing options that do not require sobriety or treatment participation, a lack of available 'moving-in cost' funds, and poor coordination with local public housing authorities. Housing First program management officers in the US developed a number of strategies to overcome these practical barriers. VA staff cultivated relationships with private landlords that were committed to housing veterans, while other strategies included holding public housing fairs, and working with local authorities to streamline bureaucratic procedures.

Housing First in Finland

148 Finland has been able to demonstrate a reduction in the number of people who are homeless by transitioning from a crisis accommodation response system, such as what we have in Australia, to Housing First systems based on long-term national strategies of prevention and early intervention. Finland experienced a 10 per cent drop in the number of homeless people between 2013 and 2016 (FEANTSA and Abbé Pierre Foundation 2018: 16). Finland is characterised by a strong and well funded social welfare system. In addition, consistent and strong political support was crucial to implementing the changes to the homelessness system.

149 In 2008, Finland was the first EU Member State to establish a National Program to reduce long term homelessness based on the following Housing First principle (Thredgold et al. 2019): 'Resolving social and health problems is not a pre-requisite to gaining a home, rather housing is a pre-requisite that will enable the many problems faced by a homeless person to be resolved' (FEANTSA and Abbé Pierre Foundation 2019: 12).

150 As noted by Pleace (2018), people in Finland who are homeless have higher and more complex needs than their comparators in other northern European nations, largely because they are individuals who have fallen through the cracks in extensive universal safety nets. In many other European states, homelessness is triggered by poverty. The Housing First model is part of Finland's integrated homelessness strategy that also includes prevention, building new social housing, and a mix of low- and high-intensity services (Thredgold et al. 2019).

151 The Finnish Government recognised that for Housing First strategies to work there first needed to be an adequate, affordable housing supply with reasonable security of tenure (Pleace 2018). Cooperation and targeted measures in implementation also led to the Finnish success (Homelessness Australia 2017b: 11). The success in Finland is attributed to the following (Thredgold et al. 2019):

(a) An intensive focus on reducing long-term homelessness.

(b) A comprehensive national strategy with substantial resources devoted to establishing new housing units.

(c) Converting shelters into permanent housing for long-term homeless people (Benjaminsen and Knutagård 2016: 50).

152 Finland offers a sound case for Housing First, but a coherent homelessness services system needs 'prevention, rapid rehousing, lower intensity services, high intensity supported housing … and sufficient homes' (Pleace 2018).

153 According to European Union researchers (FEANTSA and Abbé Pierre Foundation 2018: 23– 29) there are five factors to note in developing integrated strategies to reduce and end homelessness:

(a) 'The needs and the rights of the individual should be the starting point for any strategy to fight homelessness.'

(b) 'Housing First', noting that Finland and Norway offer successful examples of using this model. The construction of affordable housing is fundamental to this policy.

(c) 'Funding the strategy' is key, for without adequate and long-term investment the strategy to end homelessness is destined to fail.

(d) 'The importance of a continuous and constant strategy.' Once again, Finland serves as an example. For over 20 years Finland has had an integrated strategy and has built new permanent housing, converted emergency housing into supported units and developed new service models—all based on Housing First principles.

(e) Multi-level governance: 'A convergence of stakeholders in the fight against homelessness is necessary to invest all efforts on moving together towards the same objectives.' The Finnish success would not have occurred without political will (regardless of political affiliation or level of government) to put an end to homelessness.

154 There are four common pitfalls to avoid in developing integrated strategies to reduce and end homelessness:

(a) National governments having 'light-touch' policies, including not taking on a coordination and facilitation role; little evaluation of the causes of increased homelessness; lack of funding; and no subsequent programs after action plans for certain time periods.

(b) 'Paper policies' with good intentions that are not implemented and with insufficient funding for programs.

(c) Having an ambitious policy to end homelessness, but penalising some categories of homeless people—for example, moving on homeless people to reduce 'public nuisance'.

(d) 'Policy silos' and lacking an integrated approach that includes housing, health, employment, social inclusion, regional, urban, and justice. (FEANTSA and Abbé Pierre Foundation 2018: 30–33). As Benjaminsen and Knutagård (2016: 61) argue, reforms of welfare and housing policies—in combination with structural factors, such as the increasing shortage of affordable housing— create new

exclusion mechanisms that cannot be resolved within the domain of homelessness policies but, rather, require wider societal responses. Differing welfare states, housing systems and civil society are all key contributors to homelessness responses (Anderson, Dyb et al. 2016: 110). Finland and Norway provide exemplars of effective policy responses to homelessness. Scotland, which has had success in the past, recently released the Ending Homelessness Together: High Level Action Plan, highlighting how extensive coproduction processes can build networks for collaboration to end homelessness.

STRATEGIES TO SUPPORT HOUSING FOR PEOPLE LIVING WITH MENTAL ILLNESS

The role of the National Disability Insurance Scheme in providing housing for people with severe mental illness

155 The *National Disability Insurance Scheme Act 2013 (Cth)* outlines the disability eligibility criteria for access to NDIS supports, including psychosocial support packages (Australian Government 2013). While many severe mental illnesses are permanent, their symptoms can be episodic in nature, and there remains uncertainty whether NDIS criteria are appropriate for people with psychosocial disability. In 2019, 27,974 people with a primary (severe) psychological disability received NDIS funding, representing 9.1 per cent of all active participants across the scheme (National Disability Insurance Agency [NDIA] 2019).

156 Packages for NDIS for eligible people with psychosocial disability may include a Supported Independent Living (SIL) component, which provides funding specifically for managing domestic and independent-living tasks in the home, including overnight support. SIL is delivered in the home, typically in a shared accommodation environment, and is available to people with evidence of a functional impairment who can live on their own with support. Approximately one-third of the NDIS total budget is expected to be allocated toward SIL (NDIA 2018). SIL packages can be quite substantial and therefore provided people with the choice and financial resources to access the services they need (Brackertz et al. 2020a).[14]

The extent to which people with severe mental illness in the National Disability Insurance Scheme are benefiting from Specialist Disability Accommodation

157 The Special Disability Accommodation (SDA) is currently meeting approximately 6 percent of demand across the range of disabilities it provides for. In the event that mental health and severe mental health were prioritised within the 6 percent, it would still not be adequate to meet the need.

[14] *Ibid, page* 26

158 However, those who are receiving SDA are receiving good services that address their needs. The issue is that the SDA is not able to meet the needs of the vast majority of people who need it. Further, it is a difficult system to navigate that is arduous and not user-friendly

Coordination between housing and mental health services to facilitate access to services

159 System coordination remains a challenge between the mental health and housing systems. One of the difficulties is that when system coordination is addressed, it is done at the expense of additional services and costs, which does not resolve the overarching problem of lack of supply. Resources are given to system coordination, however the lack of supply remains.

160 As outlined above in paragraphs 52 to 54, the Housing First Model is an evidenced-based model that demonstrates effective system coordination by prioritising housing and "wrap-around" services. The Victorian housing and mental health systems require a significant increase in funding because providing support for homelessness (whether in housing or 'wrap-around' services) saves costs in the long term in other systems, such as Corrections. This approach also enables people to have contributing lives. A person struggling with homelessness and mental health challenges is not likely to obtain good employment or participate in the economy constructively. Therefore, the Housing First Model benefits both families and greater society.

161 Research undertaken by AHURI for the National Mental Health commission included a comprehensive analysis of housing and mental health policy systems (Brackertz et al. 2018a; 2018b). Policies at national and state levels recognise the need for greater integration and coordination across housing and mental health, but they rarely make systematic connections.

162 Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration (Brackertz et al. 2018b). This contributes to poor housing and health outcomes for people with lived experience of mental ill health.

163 There is a need for greater integration of the housing, mental health and health systems to facilitate better access to services.

164 Australian mental health policies are underpinned by a model that is intended to assist policy-makers to develop policy, supports and services that provide interventions according to a cohort's needs (Brackertz et al. 2020a).

165 All state and territory mental health policies and plans align (to varying degrees) with the Commonwealth priorities and policy direction described in *The Fifth National Mental*

Health and Suicide Prevention Plan (the Fifth Plan) (DoH 2017). These policies prioritise: integrated service delivery and coordinated access; person-centred and recovery-based approaches; suicide prevention; Aboriginal and Torres Strait Islander mental health; workforce capability; community education and stigma reduction; and the social determinants of health.

166 Although several plans (SA, NSW, NT, Queensland, WA) include actions or strategies, most provide limited detail on how policy may be implemented in practice. The policy rhetoric aims for clearly defined care pathways to positive mental health and wellbeing. However, it is acknowledged that these aspirations are stymied by a fragmented service system and disjointed care coordination (DoH 2017). The achievement of a linear pathway to optimal mental health is further challenged by: (a) managing complex needs (AOD use, dual intellectual and psychiatric disability, and involvement in the criminal justice system); (b) the episodic nature of mental illness; and (c) a personal recovery trajectory that is non-linear and emphasises recovery as a process, as distinct from a clinical (absence of symptoms) outcome. Despite these challenges, federal government policy claims that a range of reform interventions will create 'real improvement in the lives of people with mental illness, their families, carers and communities' (Coalition of Australian Governments [COAG] 2012).

167 Australia provides both public and private access points to mental health care. The Commonwealth Government distributes funding to the jurisdictions, each of which oversees the delivery of its own mental health service system. States and territories provide hospital-based, specialised, clinical and community-based mental health services, both directly and through partnerships with non-government organisations. Private mental health providers also deliver in-hospital and community support. Rebates under the Medicare Better Access initiative or an individual's private health insurance may be available for people seeking support from private mental health practitioners (COAG 2012). Each state/territory has its own Mental Health Act which has provisions for involuntary inpatient or outpatient treatment where there is a deemed risk to self or others. Although state-run voluntary hospital services and community services available to the public share some similarities, they are not consistent and limited resources restrict these services to people with serious mental illness or those at risk of suicide (Gee, McGarty et al. 2016).

168 Several Australian state and territory governments have achieved a degree of system integration in housing and mental health service provision. However, this is a recent phenomenon and has occurred in an ad hoc manner, with significant differences between states and territories in the scope of system integration.

169 The Housing and Mental Health Agreement (Agreement), which commenced in 2011, is an example of collaboration between the housing and mental health systems in Australia.

The Agreement replaces the Joint Guarantee of Service (JGOS) for People with Mental Health Problems and Disorders Living in Public Housing, Community Housing and Aboriginal Housing.

170 The Agreement is between NSW Health and the NSW Department of Family and Community Services encompassing all its agencies: Housing NSW; Aboriginal Housing Office; Ageing, Disability and Home Care, and Community Services. It recognises that NGOs are key providers of services to people with mental ill health and signatory departments are committed to working in partnership with NGOs, and their peak organisations to improve outcomes for this group of people.

171 The Agreement provides the overarching framework for planning, coordinating and delivering mental health, accommodation support and social housing services for people with mental ill health who are living in social housing or who are homeless or at risk of homelessness. It includes a high level action plan to support the implementation of the Agreement.

172 Commitments within the JGOS and the Agreement have enabled the implementation of programs such as HASI. The success of HASI shows that high level system integration and the support of interagency collaboration can lead to the establishment and long term sustainment of an effective housing and mental health program in Australia.

173 The Memorandum of Understanding between Housing SA and SA Health, Mental Health and Substance Abuse is another example of system integration in mental health and housing provision. It was established in 2007 and updated in 2012 to 'guide the coordinated delivery of mental health services, psychosocial support and general housing services' (South Australian Government 2012). The agreement provides management guidelines for information sharing; timely pro-active, early intervention and preventative approaches; sensitive tenancy monitoring approaches, and collaborative and flexible arrangements between housing agencies (South Australian Government 2012).

174 Historically, in Victoria, well established non-government agencies have been the primary drivers of 'joined-up' mental health service provision approaches at the local level. This was shown in the implementation of the Psychiatric Disability Rehabilitation and Support Service (PDRSS) framework (Bleasdale 2007), which has since been replaced by NDIS psychosocial supports. While the PDRSS highlighted effective integration in the mental health system, the housing system was a peripheral concern in the framework, with only 3 per cent of PDRSS framework funding dedicated to housing and homelessness (DoH 2012).

175 Current housing and mental health programs in Victoria, such as Doorways, demonstrate program level integration involving hospitals, the peak industry bodies and mental health

service providers. Government system level integration with the purpose of mandating the long term, large-scale provision of housing and mental health programs in Victoria is not yet evident.

176 Opportunities exist to scale up successful models of consumer and recovery-oriented housing to meet demand. The evidence shows that existing programs that integrate housing and mental health supports are effective in generating government cost savings (especially in health) and reduce hospital admissions and length of hospital stay. They also contribute to tenancy stability, improve consumer mental health and wellbeing, social connectedness and lead to modest improvements in involvement in education and work (Brackertz et al. 2018a).

177 The evidence does not point towards one particular program approach that is suitable for all circumstances or consumers (one size fits all); there is a place for a variety of programs accommodating specific needs.

178 Successful initiatives have in common certain factors and principles that are essential to facilitating good outcomes. Critical success factors include effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, immediate access to housing (social housing or private rental), and integrated person-centred support work (Brackertz et al. 2018a).

179 Successful programs could be promulgated at a national level through national frameworks and formal interagency agreements, together with clear guarantees given by parties around outcomes. Policy and stakeholder coordination at the local and state levels could be achieved via formal agreements, Memoranda of Understanding (MOUs), cross sector collaboration, and local coordination.

180 Reform frameworks around mental health already have good potential to integrate housing related support and housing provision at a national level using an integrated, person centred approach.

181 A lack of appropriate, affordable and sustainable housing is an impediment to scaling up successful programs nationally. However, coordination with the private rental sector can facilitate access to an immediate and greater supply of established homes, potentially enabling program providers to readily scale up in response to increased program demand.

182 Barriers to scaling up successful programs nationally include the lack of a national framework, a lack of commitment to innovative funding models, a lack of formalised agreements for collaboration between housing and mental health providers at the local level, and constraints on organisational capacity in the housing sector around mental

illness and mental health provision.[15] Continual reorganisation and reform in both the mental health and housing sectors has interrupted personal links and advocacy networks.

Stabilising existing tenancies is a key mechanism for early intervention and prevention.

183 Early intervention and prevention can reduce housing insecurity and improve prospects for mental health recovery and wellbeing. Numerous early intervention strategies could be implemented quickly and cost effectively to provide more secure housing and better mental health outcomes for people with lived experience of mental ill health. This includes greater use of existing tenancy sustainment services and capacity building in the housing sector (tenancy managers, real estate agents, social housing providers) to recognise and effectively and appropriately respond to the early warning signs of a mental health crisis (Brackertz et al. 2018a)

PANEL QUESTIONS

Question 1: For Victorians experiencing severe mental illness and housing insecurity or homelessness, please describe:

a) The current supply of housing and supports in Victoria.

184 Generally, the current supply is inadequate, whether or not the person has challenges to their mental health.

185 While Victoria has around 81,200 social housing dwellings (the second highest number per state or territory in Australia), as a proportion of the state's dwelling stock, this is low by comparison to other states and territories. In 2016, social housing dwellings represented around 3.4 per cent of all dwelling stock in Victoria (occupied and unoccupied).

186 This proportion has not changed substantially since 2011 when AHURI researchers found that Victoria had the lowest proportion of social housing compared to total housing stock out of all states and territories (see Figure 2, Attachment MF-2).

187 A recent report by the Victorian government found that Victoria's social housing supply requirements will increase until 2036 and suggested that 1,700 more social housing dwellings are required each year over the next 20 years to maintain social housing at 3.5 per cent of all homes in Victoria (requiring an additional 30,000 social housing dwellings over this period) (Victorian Government 2019).

[15] Brackertz and Badenhorst 2015.

188 The level of social housing in Victoria (and Australia more generally) is much lower than overseas. Table 3 (Attachment MF-2) shows the level of social housing as a proportion of all dwellings across a number of countries. This shows that the proportion of total housing stock that is social housing is relatively low in Australia (4.8%) and Canada (5%), but high in countries like Scotland (24.2%), England (17.1%), Denmark (22%) and Finland (16%).

b) The extent and nature of unmet demand.

189 I am not aware of any comprehensive data that would cover the extent of Victorians with severe mental illness experiencing homelessness, but they are over-represented within the homeless population.

190 AHURI has developed a method of estimating the need for social housing and private rent assistance and has used statistical methods to estimate current and projected housing need in Victoria and other states and territories across Australia (Rowley et al. 2017). Housing need is defined as the 'aggregate of households unable to access market provided housing or requiring some form of housing assistance in the private rental market to avoid a position of rental stress'. (Rowley et al. 2017:1)

191 Table 4 (Attachment MF-2) shows that, in 2017, Victoria had around 291,000 persons in housing need, with 110,400 being households unable to enter the market (effectively homeless) and another 181,000 that were housed but required rent assistance to avoid rental stress. This represented around 12 per cent of all Victorian households. By 2020, this was projected to be around 116,500 persons unable to enter the market and 193,200 requiring rent assistance (total need of 309,700).

192 By 2025, this is expected to increase markedly and around 171,700 persons are expected to be unable to enter the market and 290,200 needing rental assistance (summing to a total housing need of 461,900, or 17 per cent of all households).

193 The modelling used five interlocking models of: housing market, labour market status, labour market earnings, household formation and tenure choice. A number of assumptions were made at the time of the analysis, and the authors stressed that the projections were 'greatly dependent on assumptions around national and regional economic conditions' and needed to be recalculated every 2-3 years. These may be altered now due to the changed economic circumstances due to the COVID-19 pandemic, but it is likely that there will be continued and increased high calls on our social housing system.

194 Housing need was most acute in New South Wales (where 13% of all households were estimated to be in housing need as at 2020 and 21% were projected to be in need in 2025), but Victoria was the second in terms of acute housing need.

c) The cause/s of unmet demand.

195 The fundamental cause is the lack of housing supply.

196 Homelessness is caused by a combination of structural factors (e.g. housing markets and labour markets) and individual risk factors. A person's eligibility for, and ability to access, housing and homelessness supports is also a factor.

197 A person experiences homelessness because they are exposed to a range of risks, including the risk of losing housing and their incapacity to exit homelessness. The experience of homelessness itself can lead to negative outcomes including issues around mental health and substance abuse that in turn can prolong the experience of homelessness.

198 Many people draw on a range of strengths and resources that can protect them when they are at risk of losing housing, provide resilience and assist in exiting from homelessness. These include relationships with spouses or children, mental and physical health, and access to financial, family and government support. However, for many in, or at risk of, homelessness these strengths and resources are depleted.

199 The risk of becoming homeless is profoundly affected by social and economic ('structural') factors like poverty, gender inequity, inequitable housing or labour markets or inequitable access to homelessness services (e.g. Batterham 2012; Wood et al. 2015; Parkinson et al. 2019). However, individuals may also face risks. Risk of homelessness is heightened for:

(a) those in middle age (especially men) are at risk of longer-term homelessness

(b) older women are a fast growing group for homelessness

(c) indigenous and Culturally and Linguistically Diverse (CALD) communities are at higher risk of homelessness and overcrowding because of poverty, mobility and cultural practices.

(d) those who have experienced domestic or family violence, physical, emotional or sexual abuse or losing a partner.

(e) those who have experienced mental ill-health and substance abuse

(f) people exiting prison, foster or state care or the military.

(g) those with previous experiences of homelessness

(h) those with low education and unemployment (see for example, Johnson et al. 2015b)

200 In many cases, multiple risk factors will intersect, creating an even greater chance of experiencing homelessness.

d) The most critical unmet demand.

201 Homelessness data from the ABS Census (2011 and 2016) gives an indication of the groups most in need of assistance. This includes people who are housed or utilising temporary accommodation in the specialist homelessness system, but for all intents and purposes, have not had their demands for adequate, affordable and secure tenure housing met since they are homeless.

202 Table 5 (Attachment MF-2) shows that, in general, homeless persons in Victoria are less likely to be rough sleeping (living in improvised dwellings, tents or sleeping out) or couch surfing (staying temporarily with other households), and severely overcrowded dwellings, but are more likely to be in supported accommodation or boarding houses compared to homeless persons in Australia more generally. Even so, there was a dramatic increase in the number in severely overcrowded dwellings from 2011 to 2016 (almost 50%) and a small increase in rough sleeping.

203 All of these groups are important for policy makers to address. However certain groups such as rough sleepers are of high importance because they are also more likely to experience persistent homelessness or cycle in and out of homelessness (AIHW 2018b).

e) The impact of unmet demand on other service systems, including hospitals, sub-acute services, and judicial settings.

204 People who experience homelessness are significant users of services such as health (including ambulance and emergency departments of hospitals), welfare (e.g. receipt of welfare benefits because they are out of work) and justice (e.g. nights in prison, victims of robbery, being apprehended in street, court appearances).

205 A national study by AHURI (Zaretzky and Flatau 2013) examined the way Specialist Homelessness Services (SHS) improve outcomes for clients such that this leads to reductions in usage of other government services, leading to reductions in costs in these non-homelessness government programs. The study was conducted across four states – New South Wales, South Australia, Western Australia and Victoria. The study found that homelessness programs save money in government programs related to justice, health and welfare. For example, after people became housed (or were stabilised in their present housing) this led to:

(a) small increases in employment for single men and women (though in most cases they were so modest they did not substantially reduce calls on income support);

(b) significantly reduced health service usage for women;

(c) reduced contacts with the justice system overall (especially for single men and women) reducing requirement for expensive justice related costs.

206 However, there was an increase in health service usage for men and those in tenancy support. These increases in health service usage reflected engagement with mental health, drug and alcohol, ambulance services and hospital usage. While this represented an increase in costs, this may be a positive development in that homeless men often do not engage in health services but when housed this can change and lead to longer term health improvements.

207 Table 6 (Attachment MF-2) below shows that across all these states, there are reductions in non-homelessness related costs related to access to supported housing (for single men and single women) and tenancy support. Reductions in costs associated with non-homelessness programs are apparent for single men ($1,389 per client per year) and also for those put in tenancy support programs ($1,934 per client per year). These offsets mean the effective costs of the homelessness programs are lower.

208 Cost savings are especially apparent for housing single women – on average there was a reduction of $8,920 per client, driven mainly by reductions in health-related expenditures. Even after the costs of the program are taken into account, there is a net saving to government from providing supported housing to this client group of over $4,000 (Zaretzky and Flatau 2013).

209 Many of those placed into housing receive private rental housing, but there has been interest in understanding the benefit of placement in public housing. More recent AHURI research also found significant cost savings associated with reduction in health service usage for those who were placed into public housing and received tenancy support. Government health care cost savings associated with reduced health service use was nearly $16.4 million in the first year ($4,800 per person/year) These savings were even more pronounced for those not in priority housing (homelessness) clients ($13,300) and especially for people housed who were exiting mental health programs ($84,100), more than justifying the average cost of such tenancy support program costs of $6,500 per person per year (Wood et al. 2016). This study included looking at the Victorian Social Housing Advocacy and Support Program (SHASP) which was the fore-runner to the present Tenancy Plus program. However separate estimates for cost offsets were not calculated for Victoria.

210 Given the not inconsiderable whole-of-government savings resulting from SHS provision to formerly homeless people, and given that the cost savings in many instances outweigh the costs of providing SHS, it stands to reason that ceasing funding for homelessness services will in fact incur costs to government once considered on a whole-of-government basis (Brackertz et al. 2016).

211 A national study by MacKenzie, Flatau et al. (2016) examined the cost to government of youth homelessness. The study, which covered 60 programs in Victoria, Western

Australia, New South Wales, the ACT, SA and QLD, was undertaken over a period of four years and followed more than 400 young people who were either homeless or at a very high risk of homelessness. The study provides the main results on the economic costs of youth homelessness in comparison to another group of disadvantaged young people who were not homeless but who were unemployed. This comparison provides a net average cost difference that can be attributed to homelessness.

212 The study found that the costs associated with young homeless people's use of services such as health and the justice system were much higher than for the comparison group.

213 The costs to the Australia economy of health services associated with young people experiencing homelessness is an average of $8,505 per person per year or $355 million across all young people aged 15–24 accessing SHS. This is $6,744 per person per year more than for long-term unemployed youth (another key group of disadvantaged youth).

214 Homeless young people are much more likely to have contact with the criminal justice system than the general population or other disadvantaged young people, who are long-term unemployed but not homeless. The cost to the Australian economy is an average of $9,363 per person per year or $391 million across all young people aged 15–24 accessing the SHS system. This is $8,242 per person per year more than for long-term unemployed youth.

215 The total cost to the health and the justice systems due to young homeless people is an average of $17,868 per person per year ($14,986 more per person per year than for unemployed youth). These costs do not include the additional lifetime impact of early school leaving and low engagement with employment.

216 On the basis of 41,780 young people aged 15–24 years who were clients of SHS in 2014–2015 and present alone rather than in a family group, the total cost to the Australian economy of additional health and justice services is an estimated $747 million annually. This exceeds that total cost (approx. $619 million) of providing SHS to the 256,000 (young and old) assisted by the system over the same period.

Question 2: The Commonwealth and Victorian governments are both involved in housing and homelessness policies and funding agreements. Please describe the strengths and weaknesses of the current intergovernmental arrangements in meeting the housing and homelessness needs of Victorians?

217 There is a 70-year history of the Commonwealth and the States shifting roles within housing policy broadly. It has constantly changed. Historically, there have been strong and productive periods between the Commonwealth and States, such as post-World War II and through the 1950's where housing was a national priority. More recently, housing has become less of a priority at a national level, which is visible in the lack of housing policy from the Commonwealth.

218 Currently, the way in which the Commonwealth and the States work together in relation to housing is complex. At a central level, the Commonwealth provides funding to the states and territories to support their work in housing and homelessness through the National Affordable Housing Agreement, which is a 10-year agreement with a five-year review point. Essentially, each jurisdiction, through that agreement, provides the Commonwealth with a copy of their housing and homelessness strategy. At the moment, there are diverse strategies amongst the jurisdictions.

219 One of the weaknesses of the arrangement is the absence of a national housing strategy. There is funding provided by the Commonwealth to the States for housing and homelessness, however, the funding is not adequate to cover all expenditure by the States and Territories on housing and homelessness. The State is solely responsible for providing public housing.

220 Another weakness is the lack of a consistent national regulatory system for the community housing system across all jurisdictions. All jurisdictions have adopted the New South Wales legislation, except for Western Australia and Victoria.

221 However, one of the strengths in the intergovernmental relationships has been the appointment for a Federal Minister for Housing and an Assistant Minister for Community Housing, Homelessness and Community Services. The presence of a Housing Minister creates a forum for high-level policy discussion and coordination that has been absent for the last six years. It is also a strength that we have the Commonwealth and all the States and Territories involved in housing and homelessness, the only issue being that we need better coordination between them.

222 Local Governments should also have strong involvement. Councils are increasingly becoming involved, particularly in relation to homelessness and the supply of housing, which is positive. Local Governments can assist by implementing inclusionary zoning - a mechanism that requires developments at a certain scale to have a proportion of properties that are affordable or social. Local Governments can also partner with community housing providers to ensure that when there are new developments that are affordable or social housing, they can supply land or waive rates for land to make it available for social housing and they can help coordinate and support homelessness services. Melbourne City Council is a good example. However, one disadvantage is that when neighbouring councils have contradictory policies, whether vulnerable people have access to services will be dependent on their location.

223 It is important that Local Governments coordinate with each other and also the States. In some circumstances, City Councils have strategies on housing and homelessness that do not leverage into State strategies.

224 Involvement from the private sector is also needed. There have already been positive developments in the form of real estate agents that manage rental properties at less than full market rates as a result of owners who are willing to charge less rent in order to create more affordable housing. Home Ground Real Estate is a good example of this. It is run by Launch Housing, which is a combined homelessness and community housing service in Melbourne. Home Ground Real Estate owns and manages a number of properties across Melbourne. They provide tax incentives to allow landlords to provide more affordable housing. This approach has been replicated in a number of states across the country in a number of services and has real promise. Such initiatives in the development sector is needed in the provision of affordable housing.

Greater integration and coordination across housing and mental health

225 Research undertaken by AHURI for the National Mental Health commission included a comprehensive analysis of housing and mental health policy systems (Brackertz et al. 2018a; 2018b). It found that policies at national and state levels recognise the need for greater integration and coordination across housing and mental health, but they rarely make systematic connections.

226 Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration (Brackertz et al. 2018b). This contributes to poor housing and health outcomes for people with lived experience of mental ill health. The report notes regarding *Victoria's 10-Year Mental Health Plan* (DHHS 2015) that the 'plan associates mental illness with homelessness (p. 7) but stops short of making linkages with other systems.' (Brackertz et al. 2018b: 13)

227 AHURI research examining Australia's multi-level governance arrangements found housing policy development and implementation is dispersed and uncoordinated across and within levels of government, undermining accountability and leading to policy fragmentation and politicisation (Dodson et al. 2017). There is no systematic coordination of policy settings at different levels of the governance system.

228 That means that one cannot speak of a 'homelessness system' (Brackertz et al. 2016) or mental health system (Brackertz et al. 2018a; 2018b) and consequently the policy architecture is weak and fragmented and struggles to effectively address complex problems such as housing supply, housing affordability and access to appropriate housing, homelessness and mental health services (Brackertz et al. 2020a).

229 At the intergovernmental level, the capacity to coordinate efforts across state and federal jurisdictions was weakened in 2013 when the COAG Ministerial Council on Housing was disbanded. Ministers can, and still do, meet in special circumstances, but not as part of a regular or ongoing decision-making forum. Without institutionalised mechanisms to

ensure regular meetings and agreement on key matters, reforms have stagnated. Related cross-jurisdictional forums, such as the Housing Ministers' Advisory Committee, have met intermittently or not at all (Lawson et al. 2016).

230 Despite the undeniable importance of housing and its cross-portfolio dimensions, there has been a trend in both federal and state and territory governments to relegate housing to the welfare portfolio, thereby limiting the scope of policy expertise and the capacity for an integrated and coordinated approach to policy making and implementation (Dodson et al. 2017).

231 The abolition of the National Housing Supply Council (NHSC) has contributed to the demise of policy capability and evidence-based policy development and oversight. Prior to its abolition in 2013, the NHSC provided specialist advice and information to governments, including housing supply and demand estimates, projections and analysis. It also investigated the influence of wider policy settings such as infrastructure investment, housing-related taxation and urban planning. When the Government announced it would dissolve the NHSC, it stated that specialist housing policy advice would be provided by the relevant COAG Ministerial Council and Commonwealth departments. However, the Ministerial Council on Housing and Homelessness was disbanded shortly after the NHSC, and a 2015 Senate Inquiry into affordable housing found that the NHSC's functions were not subsequently absorbed into Treasury (Parliament of Australia 2015).

232 In summary, the current intergovernmental arrangements are not well suited to effectively meeting the housing and homelessness needs of Victorians.

Question 3: If housing availability and supports for people living with severe mental illness and housing insecurity or homelessness in Victoria were to increase, which cohorts should be prioritised? In your response please describe:

a) The key characteristic of each cohort.

b) Why you consider them to be a priority cohort.

233 Prioritising a particular cohort is problematic because there may be people who move in and out of severe mental illness and there are also people who move through the system in different ways. For example, the latter group may move from boarding houses, squats, parks, emergency shelters and/or social housing.

234 However, it should be noted that different approaches to providing support are needed, depending on the cohort (e.g. young people or rough sleepers).

235 Early intervention approaches that ameliorate housing insecurity and prevent homelessness from occurring in the first place should be prioritised, as they have the

capacity to cost effectively prevent many of the problems that occur downstream if a crisis happens.

236 Prevention and early intervention strategies aim to re-orientate the service system away from crisis management and include offering post-crisis support where necessary. They also aim to ensure successful transitions for people exiting institutional settings such as psychiatric care facilities and prisons.

237 The national and international evidence base has firmly established that the longer someone is homeless, the more difficult it is to assist them to stabilise their life. The responses and resources required are therefore substantively different for someone who is homeless compared to someone at risk of homelessness.

238 Prevention strategies operate at the structural level (Chamberlain and Johnson 2003) and occur before a person has become homeless. They aim to:

(a) address the underlying political, economic and social causes that place people at risk of homelessness (e.g. increasing the supply of affordable housing, improving labour markets);

(b) identify people who are most at risk of homelessness and build up their protective factors and decrease their risk factors;

(c) focus on people who are at risk but not actually homeless (e.g. sustain tenancies); and

(d) use broad population wide strategies that target the general population and at-risk groups; these interventions are not solely in the domain of Specialist Homelessness Services (SHS), but include mainstream services, such as housing, health, education, employment and family welfare services (Culhane et al. 2011).

239 Early intervention strategies are targeted at individuals who have recently become homeless and aim to ensure that short periods of homelessness do not become chronic.

240 Stabilising existing tenancies is a key mechanism for early intervention and prevention (Brackertz et al. 2018a). Early intervention and prevention can reduce housing insecurity and improve prospects for mental health recovery and wellbeing. Numerous early intervention strategies could be implemented quickly and cost effectively to provide more secure housing and better mental health outcomes for people with lived experience of mental ill health. This includes greater use of existing tenancy sustainment services and capacity building in the housing sector (tenancy managers, real estate agents, social housing providers) to recognise and effectively and appropriately respond to the early warning signs of a mental health crisis.

241 Tenancy sustainment programs are prevention and early intervention initiatives aimed at preventing people at risk of eviction from losing their tenancy and becoming homeless. These programs are usually short term. They encompass Private Rental Assistance programs, which operate in all jurisdictions and typically provide financial relief in the form of bond loans and rental grants, subsidies and relief (AIHW 2018b; Tually et al. 2016). Private Rental Brokerage Programs are tenant advice schemes that frequently adopt a case management model and provide targeted early intervention and assistance in the form of information, advice and brokerage services designed to build tenancy capacity. They also aim to establish links with the local private rental industry.

242 Many early intervention strategies can be implemented quickly and cost effectively to provide more secure housing and better mental health outcomes for people with lived experience of mental ill health.

243 The goal of early intervention should be to stabilise people in their existing tenancy and to avoid evictions. The evidence and the investigative panels show that early intervention is an important mechanism to prevent housing instability and homelessness and that there is considerable scope to increase and improve early intervention.

244 Mainstream tenancy sustainment services, which exist in all jurisdictions and typically provide financial relief in the form of bond loans and rental grants and subsidies, have been shown to be effective and cost effective in managing short term crises, sustaining tenancies and preventing homelessness. They provide a model that could be more widely used to assist people with lived experience of mental ill health.

245 There is scope to expand the use of, and tailor, tenancy support programs to assist people with lived experience of mental ill health to maintain their existing tenancies.

246 Therefore, while prioritisation of any group is problematic, if there is a group that is to be prioritised, it should be the chronically homeless. They experience particularly difficult journeys and are in most need of support. The concern with this cohort is how long they have been moving through the system, unable to escape the cycle of homelessness and the ultimate impact that this has on mental health.

c) Characteristics of housing and support models and support that you consider would effectively meet the needs of each cohort.

247 The Housing First Model is the ideal approach for all groups of people, including those who are chronically homeless. Housing First is discussed in detail at paragraphs 52 to 54. If it cannot be applied to everyone, those who are chronically homeless should be prioritised.

Question 4: What key changes and/or reforms do you consider would effectively reduce the rates of people being discharged from mental health services into homelessness?

248 AHURI research found that the following contribute to reducing the rates of people being discharged from mental health services into homelessness (Brackertz et al. 2018a):

(a) Developing a national discharge policy and a nationally consistent definition of 'no exit into homelessness'.

(b) Resourcing hospitals to make thorough discharge assessments and develop appropriate discharge plans.

(c) Increasing knowledge and capability in the acute sector to enable officers to better identify people who are in precarious housing or at risk of homelessness.

(d) Ensuring timely and assertive follow up after discharge.

(e) Investigating the feasibility of a national roll out of transitional housing treatment programs for homeless people with mental ill health.

249 Transitional housing programs aim to improve living skills and housing stability for tenuously housed patients with mental illness. Queensland established a Transitional Housing Team (THT) in 2005 as part of a government response to homelessness among people with mental illness. The team provided time limited housing and intensive living skills training and support to clinically case managed patients.

250 In this sample, the THT averted 22.42 psychiatric inpatient bed-days per THT participant after adjustment for age and Health of the Nation Outcome Scales **(HoNOS)** score, while the program also resulted in a greater improvement in living conditions. The costs saved on bed-days-averted more than eclipsed the cost of the THT in this case (Siskind et al. 2014). This suggests that post-discharge integrated mental health and housing supports can significantly improve outcomes for people with lived experience of mental ill health and produce downstream savings for government.

251 Examples of THT currently operating in Australia are the Housing and Mental Health Pathway Program delivered by HomeGround and St Vincent's Inpatient Mental Health Service in Victoria. This program targets consumers at St Vincent's and The Alfred Hospital psychiatric wards who are not currently case managed, and who are experiencing or at risk of homelessness after being discharged (Launch Housing 2018).

Question 5: Funding, property and asset management, tenant selection and tenancy support are key functions in the delivery of housing for people with severe mental illness. If more housing was provided for people with severe mental illness:

a) what approach to the above roles would maximise the benefit of any new housing for people with severe mental illness?

252 Tenancy support is a specialist skill. Public housing tenancy support workers have significant caseloads, with 300 tenants per worker. Community housing tenancy support

workers will have approximately 80 or less tenants per worker. This is the reason why the general feedback from workers in the community sector is that tenants feel that community housing sector manage tenancy better.

b) do you have a view on the benefits or risks of particular types of organisations performing the above roles (e.g. the mental health system, Director of Housing, community housing providers, mental health specialist not for profit organisations etc)?

253 The coordination between the housing provider, whether it be state or community, and the mental health system and particular providers is crucial. Tenancy support tends to be about supporting the tenancy, that is, supporting the ability of a person to stay in a place and stay well in that place. Case management, by comparison, deals with more complex needs that includes tenancy support goals, but also coordination of services that are needed. It would be extremely beneficial if community housing providers were funded for case management, however, currently they are not.

254 Tenancy managers and real estate agents in both social and private housing have a role to play in early intervention and prevention and tenancy sustainment as they are often the first to notice early warning signs. The evidence suggests that the social housing system does not adequately identify, monitor and consider the mental health of its tenants. There is a lack of knowledge in the profession about what actions to take in response to early warning signs and to avoid a tenancy reaching crisis point (Brackertz et al. 2018a).

255 There is scope to:

(a) educate social housing providers, real estate agents and tenancy managers about how to identify early warning signs of a mental health crisis and the need for early intervention if early warning signs are detected;

(b) develop materials and work with social housing providers, real estate agents and tenancy managers on how to take appropriate action to link tenants to service providers and supports to assist in sustaining their tenancy; and

(c) better implement procedures in public housing authorities to identify and monitor people with lived experience of mental ill health and link them with the required supports and services when needed.

Question 6: For young people who have an onset of a severe mental illness and are at risk of housing insecurity or homelessness:

a) What is the size and characteristics of this cohort, and the nature of unmet demand (to the best of your knowledge)?

256 I am not in a position to answer this question.

b) What are the characteristics of effective models of housing and support that would assist this cohort?

257 Young people experience a unique set of circumstances related to their developmental life stage. The factors that lead to youth homelessness differ from those for adults, and many serious mental illnesses first emerge when people are in their mid-teens to mid-twenties. Young people often have not yet developed the life skills to access and successfully maintain a tenancy without help, and tend to have fewer financial resources, which limits their options. In addition, the service system is designed such that age limitations and age transitions impact on young people's ability to access and sustain services. This places young people at a particular risk (Brackertz et al. 2020a).

258 The evidence supports that if youth homelessness is not prevented or effectively addressed early on, this can lead to a life of insecure housing and homelessness. The evidence shows that if a first episode of psychosis is effectively addressed, chances of functional recovery are high; however, if it is not addressed, the person may not achieve functional recovery even over the long term (Brackertz et al. 2020a).

259 Family conflict is one of the most common pathways to youth homelessness (Chamberlain and Johnson 2011).

260 Many young people only seek formal support when all other avenues have been exhausted, at which time their resources and social supports are depleted, and their mental health is poor, which makes it difficult for them to access and sustain housing.

261 Young people with complex needs often find it difficult to successfully access housing. The idea of 'housing readiness' is particularly challenging for young people, as they often have not yet developed the necessary skills to maintain a tenancy.

262 Young people access the housing and homelessness systems from a number of points. Some seek support to navigate their way into housing prior to reaching a crisis point; some are discharged direct from hospital into the homelessness system following an admission for mental health; some enter the homelessness system upon the expiry of their out-of-home care order, with the department or child protection contacting the support service directly as a viable exit-from-care pathway; others enter the homelessness system after exiting from youth justice detention or correctional institutions.

263 Young people's ability to access social housing depends on various eligibility criteria related to age—for example, the legal age at which they are eligible for support, the legal age at which they can have their own public housing tenancy, and the age at which they are no longer eligible for services targeting youth and therefore have to transition to the adult service system.

264 Service providers stressed the importance of effective early intervention for young people, including addressing trauma, to prevent them from accumulating disadvantage and cycling through the service system on a downward spiral (Brackertz et al. 2020a).

265 The key research finding for youth trajectories is that effective early interventions coupled with social inclusion supports housing security for youth in mental health recovery by opening up access to a raft of informal community resources. Indeed, we conclude that access to informal community resources is the primary mechanism by which social inclusion bolsters housing security for youth recovering from mental illness (as argued by Duff, Murray et al. 2013). In summary:

(a) housing security is an 'anchor' for recovery;

(b) feelings of housing security grow with community attachment;

(c) formal supports can help young people access informal resources;

(d) coordination of formal and informal resources is important.[16]

c) Are there models, approaches, or programs in other jurisdictions (either in Australia or internationally) that Victoria could learn from to better support this cohort?

266 I am not in a position to answer this question.

d) What is working well and what could be improved in Victoria's current approach to the supply of mental health accommodation options for this cohort?

267 I am not in a position to answer this question.

Question 7: How could people experiencing severe mental illness and housing insecurity, or homelessness be better supported by Specialist Disability Accommodation under the National Disability Insurance Scheme?

268 The NDIS provides housing support via Specialist Disability Accommodation (SDA) packages. SDA is currently only available to people with a psychosocial disability who also have a severe physical or intellectual disability. However, home modifications are available for many NDIS-eligible people with a psychosocial disability through the Capital Supports budget, which is used for the 'design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home' (NDIA 2018: 40).[17]

[16] *Ibid, pages* 81-82

[17] *Ibid, page* 27

269 The NDIS is a significant disruptor to the mental health system and is changing the way people can access mental health services, how services are provided, what services are available, and how funding is made available to service providers and consumers.[18]

270 AHURI research indicated the following in relation to the NDIS (Brackertz et al. 2020a):

(a) in most states and territories, funds that were previously allocated to community-based mental health services are now being funnelled into the NDIS, which is reducing the capacity of services that were traditionally funded to provide these supports, and in many instances this threatens the viability of those services;

(b) service providers can struggle to engage with and keep abreast of the many changes introduced by the NDIS, and many have difficulties obtaining information and advice from the NDIS;

(c) housing providers reported that a lack of responsiveness and a lack of coordinating capacity from the NDIS can lead to dwellings remaining unoccupied for long periods and the increased number of access points for support created by the NDIS made it more difficult for them to get help for their tenants;

(d) consumers reported being unable to afford psychosocial support if they were not eligible under the NDIS;

(e) while consumer choice is a key principle underpinning the NDIS, consumers' choices can be constrained by the availability of services in some locations (e.g. rural and remote locations);

(f) attracting and retaining skilled workers under the NDIS is a challenge for many mental health providers; and

(g) the NDIS works well in instances where there is a dedicated resource for support coordination.

Access to the NDIS as a barrier

271 Access to the NDIS is a significant barrier for people living with mental health issues. This is because the NDIS was not designed with consideration of the complex and differing needs of people with psychosocial disability. To access the NDIS, a person must 'have a permanent and significant disability that affects [their] ability to take part in everyday activities' (Department of Social Services [DSS] 2019). However, the NDIS definition of a 'permanent and significant disability' is at odds with a recovery-oriented approach and does not accord with the episodic nature of mental illness.[19] This creates barriers to

[18] *Ibid, page* 59

[19] According to the NDIS website (https://www.ndis.gov.au/understanding/what-ndis): 'A permanent disability means your disability is likely to be lifelong. A significant disability has a substantial impact on your ability to complete everyday activities.'

access in the application process as it makes it challenging for people to meet eligibility criteria. In 2019, the National Disability Insurance Agency **(NDIA)** reported that one-third of the applications by people with a primary psychological disability did not satisfy access requirements, mostly because of not meeting disability criteria (Brackertz et al. 2020a).

272 The complexity and length of the application process and the amount of documentation required excludes many people from the NDIS. Consumers and service providers reported that it can take many months to complete the application process and then many more months before a decision about the application is made (Brackertz et al. 2020a).

273 While some agencies assist clients to apply for the NDIS, most are not funded to provide the intensive one-on-one support needed to lead applicants through every step of the application process. Many applicants do not receive help to apply. Applicants face additional barriers if they are homeless, as they generally do not have the required medical and other documentation, have no address at which to receive communication about the status of their application, and face barriers in accessing the application documents (Brackertz et al. 2020a).

Review of eligibility criteria

274 Diagnosis is a prerequisite for the NDIS application. It is possible to qualify for 'early intervention' support, which is intended 'to alleviate the impact of a person's impairment upon their functional capacity by providing support at the earliest possible stage' and 'to benefit a person by reducing their future needs for supports' (NDIS 2019a). However, most people with a primary psychological disability receiving NDIS support qualify because they are in the 'disability' cohort (i.e. they have a diagnosed psychological disability); only 2 per cent are in the 'early intervention' cohort (NDIA 2019). Eligibility for early intervention depends on the type of mental health diagnosis: for example, it is easier for people on the autism spectrum to successfully apply, but more difficult for those with a diagnosis of borderline personality disorder. The cost of providing the medical reports (e.g. from a psychiatrist) to support the application is a further barrier that contributes to exclusion.[20]

Education of consumers and service providers about the NDIS

275 Many consumers do not fully understand how the NDIS operates. For example, some were assessed as eligible for the NDIS but did not know what to do once they were accepted, while others were rejected and did not understand why. Consumers and service providers were unclear on how decisions about NDIS eligibility are made, as in

[20] n, 1, page 59

some instances people with similar needs were judged eligible and ineligible for the NDIS (Brackertz et al. 2020a).[21]

Better access to psychosocial support

276 The ways in which the NDIS is reshaping the service system also contributes to the exclusion of some people from services. Many community-based and psychosocial support services are being subsumed into the NDIS, which changes the access pathways to these services, their funding base, and the ways in which they deliver services. To build capacity among providers and deliver more consistent support services for people with a disability, initiatives such as those delivered by the Pathways Program and the Disability Reform Council, are aiming to improve the NDIS (NDIS 2018).[22]

Better coordination and case management

277 The NDIS is also impacting the way support coordination is carried out, which particularly affects people with high and complex needs who need specialist programs. For example, the support coordination function under the NDIS differs from the case management support that was previously provided by Mind's Partners in Recovery (PIR) program. Local Area Coordinators (LACs) for the NDIS are supposed to help people navigate and connect with the system. However, LACs have limited capacity to do so and often do not have the skills, expertise or training to address the needs of people with very complex needs, who require an assertive approach to service engagement (in the way PIRs did) (Brackertz et al. 2020a). [23]

Better integration of housing and support

278 Housing and support are not well integrated under the NDIS. This creates challenges in terms of providing support for a client in a way that respects their ability to choose what they want to disclose to their housing provider. It also makes it difficult to put arrangements in place so supports can be accessed if the person's mental health deteriorates. [24]

[21] *Ibid*

[22] *Ibid*

[23] *Ibid*

[24] *Ibid,* page 60

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print name Dr Michael Fotheringham

date

15 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT MF-1

This is the attachment marked 'MF-1' referred to in the witness statement of Dr Michael Fotheringham dated 15/05/2020

Curriculum Vitae of Dr Michael Fotheringham

NAME

Michael John FOTHERINGHAM

CURRENT POSITION
Executive Director, Australian Housing and Urban Research Institute (AHURI)

TERTIARY QUALIFICATIONS
Doctor of Philosophy (Psychology) University of Adelaide (Australia), 1998

Bachelor of Arts with Honours (Psychology) University of Adelaide, 1993

RELEVANT EXPERIENCE

Dr Michael Fotheringham is the Executive Director of the Australian Housing and Urban Research Institute—AHURI.

Michael is a research and policy development specialist with experience in a wide range of areas including housing and homelessness, urban policy, public health, and community services planning.

After joining the Australian Housing and Urban Research Institute in 2014, he was appointed Executive Director in 2017 and is now responsible for setting the strategic direction of the Institute and leading the national research agenda through development of a contemporary and policy relevant evidence-base on housing, homelessness, urban policy and Australian cities issues.

Michael has expertise in building research programs and policy agendas with not-for-profit, government and academic organisations. He has authored numerous peer reviewed journal articles, book chapters, research monographs, reports and policy framework documents.

Michael currently serves on a variety of expert advisory panels including the Australian Government's Cities Reference Group, the Housing Supply Expert Panel, the Queensland Housing and Homelessness Research Alliance, The Urban Futures and Sustainable Living Expert Research Advisory Group, and the Homes for Homes Housing Advisory Group. He has provided expert advice to Commonwealth and State Ministers and provided testimony and guidance to numerous senate, parliamentary and government inquiries and Royal Commissions.

Michael is a past president of the Australasian Society for Behavioural Health and Medicine, and for many years has served on various Human Research Ethics Committees as a representative of the research community.

Michael is an in-demand facilitator and conference speaker, and an experienced media spokesperson.

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CITIZENSHIP	Australian
CURRENT POSITION	**Executive Director** **Australian Housing and Urban Research Institute**
CURRENT ADVISORY COMMITTEES	Cities Reference Group (Australian Government Minister for Urban Infrastructure and Cities) Housing Supply Expert Panel (Qld Minister for Minister for State Development, Infrastructure & Planning) Housing and Homelessness Research Alliance (Qld Minister for Housing and Public Works) Aged Care Diversity Committee – Homelessness Sub-Group (Australian Government Minister for Aged Care) Australian Academy of Science Urban Strategy Expert Group NHHA Data Improvement Working Group Aged Care Reform and Housing Policy Reference Group Urban Futures and Sustainable Living Expert Research Advisory Group Homes for Homes Housing Advisory Group
TERTIARY QUALIFICATIONS	Doctor of Philosophy (Health Psychology) University of Adelaide, 1998 Bachelor of Arts with Honours (Psychology) University of Adelaide, 1993

EMPLOYMENT HISTORY SUMMARY

2017	Executive Director Australian Housing and Urban Research Institute
2014	Deputy Executive Director and Head of Research Services Australian Housing and Urban Research Institute
2011	Director of Research Baptcare
2007	General Manager Strategy Arthritis Victoria
2004	Senior Manager, Program Design and Implementation Unit Department of Human Services (Victoria)
2003	Independent Research Consultant Fotheringham Research Solutions
1999	NHMRC Public Health Research Fellow Deakin University
	Visiting Research Fellow The Cancer Council Victoria
	Research Associate Brown University, Rhode Island, USA
1998	Post-Doctoral Research Fellow Deakin University

KEY VOLUNTARY ROLES

2020 —	Non-Executive Director Homelessness Australia
2013 – 2017	Royal Women's Hospital Human Research Ethics Committee Member Research sector representative
2014 – 2018	Anglicare Victoria Human Research Ethics Committee Member Research sector representative
2001 – 2004	Executive Committee Member International Society of Behavioural Medicine
2002 – 2003	President Australasian Society for Behavioural Health and Medicine
1999 – 2001	Treasurer & Secretary Australasian Society for Behavioural Health and Medicine

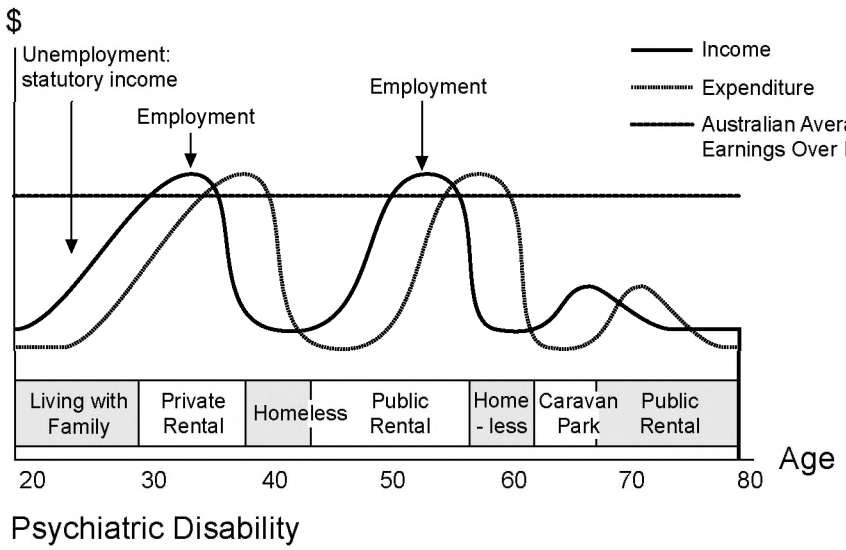
Royal Commission into Victoria's Mental Health System

ATTACHMENT MF-2

This is the attachment marked 'MF-2' referred to in the witness statement of Dr Michael Fotheringham dated 15/05/2020

Figures and tables

Figure 1: Indicative housing career for a person with a psychiatric disability



Source: Beer and Faulkner (2009:158).

Source: Groenhart and Burke (2014:17)

Figure 2: Proportion of all dwelling stock that is social housing, states and territories and Australia, 2011

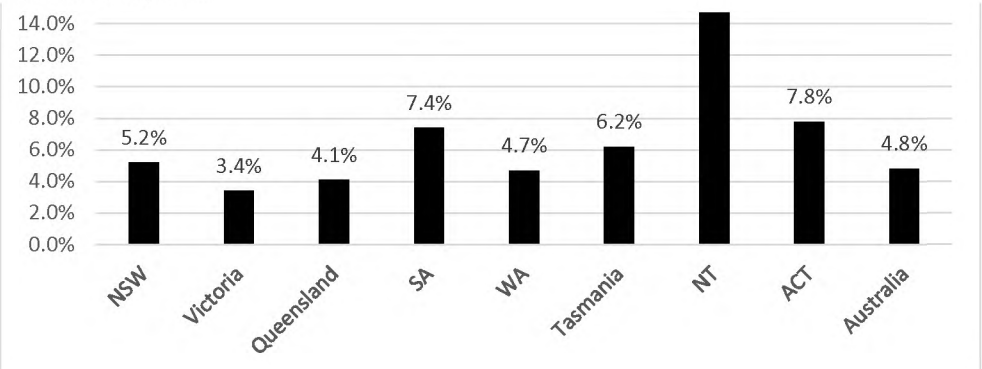


Table 1: Brisbane Common Ground cost offsets summary

N=41	12 months pre-tenancy commencement	12 months post-tenancy commencement	Difference between pre and post
Admitted patients	$1,064,167	$472,673	-$591,495
Mental Health	$372,498	$129,958	-$242,540
Emergency	$102,510	$104,860	+$2,350
Ambulance	$41,600	$40,950	-$650
Subtotal Health difference	$1,580,775	$748,441	-$832,335
Corrective Services	$32,296	$1,452	-$30,844
Court	$23,400	$13,217	-$10,183
Police	$165,832	$83,955	-$81,877
Subtotal Criminal Justice difference	$221,528	$98,624	-$122,904
Specialist Homelessness Services	$174,613	$5,249	-$169,364
Total cost difference	$1,976,916	$852,314	-$1,124,603

Source: Parsell et al. (2016)

Table 2: Baseline and 12 month outcomes of the J2SI (Phase 2) evaluation

Domain	Indicator	Group	Baseline	12 months
Housing	Proportion permanently housed	J2SI	8.3%	60%
		Comparison group	9.5%	31%
Mental health	Psychological stress (mean score K10)	J2SI	29.0	24.6
		Comparison group	29.3	26.7
Drug use	Proportion with high risk use of: amphetamines			
		J2SI	21.6%	12.7%
	Opiods	J2SI	23.9%	11.9%
	Proportion in methodone treatment:	J2SI	17.2%	25.4%
	Mean number of drug rehab nights over previous 12 months	J2SI	11.4	0.8
		Comparison group	6.5	4.6
Health	Mean number of hospital nights over previous 12 months	J2SI	7.97	2.87
		Comparison group	3.23	7.24
	Mean health care costs	J2SI	$27,898	$12,480
		Comparison group	$14,426	$24,478

Source: Flatau et al. (2018)

Table 3: Proportion of all dwellings that are social housing by country

Country	Proportion of all dwellings in social housing
Australia	4.8%
England	17.1%
Scotland	24.2%
Finland	16%
Canada	5%
Denmark	22%

Source: ABS Census (2011); UK Ministry of Housing, Communities and Local Government (2018); Scottish Government (2018); OECD (2016).

Table 4: Projections of households in housing need, Victoria and Australia

Year	Victoria				Australia	
	Households unable to enter market	Households needing rent assistance to avoid rental stress	Total housing need	% of all house-holds	Households unable to enter market	% of all house-holds
2017	110,400	181,000	291,400	12%	1,333,500	14%
2020	116,500	193,200	309,700	12%	1,313,300	13%
2025	171,700	290,200	461,900	17%	1,748,400	16%

Source: Rowley et al. (2017: 35).

Table 5: Numbers of homeless persons and rate of homelessness: Victoria and Australia, 2016, change from 2011 to 2016

	2016		Percentage share of homeless population		Percentage change 2011 to 2016	
	Vic (N)	*Aust (N)*	*Vic (N)*	*Aust (N)*	*Vic*	*Aust*
Persons living in improvised dwellings, tents, or sleeping out	1,119	8,200	4.5	7.0	2%	20%
Persons in supported accommodation for the homeless	7,172	21,235	28.8	18.2	-8%	0%
Persons staying temporarily with other households	3,080	17,725	12.4	15.2	-7%	2%
Persons living in boarding houses	4,413	17,503	17.8	15.0	13%	17%
Persons in other temporary lodgings	108	678	0.0	0.0	19%	-1%
Persons living in severely crowded dwellings	8,930	51,088	36.0	43.9	48%	23%
Total homeless persons	**24,828**	**116,427**	100	100	**12%**	**14%**
Total Population (000s)	**5,926.6**	**23,401.9**				
Incidence (per 10,000 population)	**41.9**	**49.8**	**41.6**	**47.6**		

Source: Census 2011 and 2016 (ABS 2018).

Table 6: Reductions in non-homelessness related service costs per client per year

	Reduction (addition) in costs of non-homelessness costs per client per year	Cost of program/client (including opportunity cost of capital)	Net cost (saving)
Single men	$1,389	$4,890	$3,501
Single women	$8,920	$4,890	($4,030)
Tenancy Support	($1,934)	$2,027	$3,961

Source: Zaretzky and Flatau (2013)

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ATTACHMENT MF-3

This is the attachment marked 'MF-3' referred to in the witness statement of Dr Michael Fotheringham dated 15/05/2020

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