Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF CATHERINE HUMPHREY

I, Catherine (Cathy) Humphrey, Chief Executive Officer, Sacred Heart Mission and Chair of the Board of the Council to Homeless Persons of 87 Grey St, St Kilda in the State of Victoria say as follows:

1 I am giving evidence to the Royal Commission on behalf of the Sacred Heart Mission and the Council to Homeless Persons and confirm that I am authorised to do so.

2 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.

Background

3 I have the following qualifications:

(a) Certificate IV in Training and Assessment;

(b) Certificate IV in Life Coaching;

(c) Associate Diploma Social Science (Welfare); and

(d) Advanced Certificate in Residential and Community Services.

4 I have been working in areas specifically focused on people experiencing homelessness in government and not for profit organisations since 1996. This includes organisations such as Bethany Family Support (Geelong), Wesley Central Mission (Ringwood) and the Department of Health and Human Services **(DHHS).**

5 I began working at the Sacred Heart Mission in 2002. Since 2002, I have worked in various service areas within the Sacred Heart Mission including Aged Care, Sacred Heart Central, Women's Services and the Rooming House Program. I became the Chief Executive Officer of the Sacred Heart Mission in 2011.

6 I am also currently the Chair of the Board of the Council to Homeless Persons, the peak body representing organisations and individuals in Victoria with a commitment to ending homelessness in Victoria.

7 Attached to this statement and marked 'CH-1' is a copy of my current curriculum vitae.

8 The Chief Executive Officer is responsible for ensuring Sacred Heart Mission provides high quality services in accordance with its Vision, Mission and Values, is a respected stakeholder in relation to homelessness and housing issues and remains a sustainable and innovative organisation.

9 The key role of the Board of the Council to Homeless Persons is to set, revise and monitor the Council's culture, strategy, and risk management approach and to appoint the CEO. Directors are elected by the members and tend to be drawn from the specialist homelessness sector, academia and specialist areas such as law and accounting.

MENTAL HEALTH, HOUSING AND HOMELESSNESS

Definitions of homelessness and housing insecurity

10 Homelessness is about the *absence* of the critical elements of a home. This can be an absence of safety, security, and stability, privacy and connection with community or significant others. Homelessness is multifaceted in the way it is experienced.

11 An absence of safety and security refers to people experiencing a level of safety or security that is below community standards. The following are examples of an absence of safety and security: a lack of access to a bathroom or toilet with a door that can be locked in a boarding house; sleeping rough with no physical structure to provide you protection form physical assault; a woman who lives with her husband and children but is not safe in the house due to family violence.

12 Homelessness can also manifest through an absence of connection with community or significant others. For example, a person may be housed, but still be at risk of homelessness, because they feel isolated and disconnected from the community, and when a crisis hits, their ability to recover is hampered by the lack of supports to overcome the crisis.

The link between mental health and housing and homelessness

13 In 2012 Sacred Heart Mission undertook research in conjunction with Mind Australia, VincentCare, Star Health and the Australian Centre for Post-Traumatic Mental Health, known as the Trauma and Homelessness Initiative **(THI).**[1] The THI found that the

[1] O'Donnell, M., Varker, T., Cash, R., Armstrong, R., Di Censo, L., Zanatta, P., Murnane, A., Brophy, L., and Phelps, A., 2014, *The Trauma and Homelessness Initiative. Report* prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria, Melbourne.

relationship between trauma, mental health and homelessness is significant. Key findings from the THI show:

(a) **Trauma drives homelessness**: Traumatic events often occur as a precursor to becoming homeless. The research showed that, many people left home to avoid ongoing trauma in the form of assault, child abuse and other forms of interpersonal violence.

(b) **Homelessness drives trauma exposure**: being homeless is a risk for experiencing further trauma. In the study, the frequency of trauma exposure escalated when people lost their housing.

(c) **Trauma drives social difficulties**: it impacts on an individual's sense of safety and connection with other people, especially when caused by a primary caregiver.

(d) **Trauma drives mental health problems**: exposure to traumatic events in both childhood and adulthood are associated with mental health problems. The research showed that not only was the prevalence of mental health disorders high, but other mental health experiences were reported.

14 In my experience, people with complex mental illnesses often have a history of trauma. It is not uncommon for a person's first experience of homelessness to be around the age of 13, usually because of a family breakdown, often involving an assault by a primary care giver. If the person remains in that experience, then experiences multiple and prolonged periods of homelessness, whether that be sleeping rough, in transitional housing or an unsafe rooming house, they can be exposed to multiple trauma and develop mental health conditions. This situation is quite prevalent, as evidenced in the THI research. Experiencing homelessness over an extended period of time can also impact on health and wellbeing that, in turn, leads to the development of significant physical and psychosocial conditions.

15 An important link between mental health and homelessness is that mental health issues can lead to the homelessness experience. For example, a person's family and social networks break down as a result of the behaviour associated with their mental health condition. Consequently, their housing stability is affected and eventually the housing breakdowns causing them to enter and remain in the homelessness experience. As a result of the homelessness experience, they also experience traumatic events which in turn, exacerbate their mental health condition. Being able to prevent a breakdown of a persons' housing is critical, so having the ability to identify when this risk is occurring and intervening early is critical.

16 The role that chronic drug and alcohol use plays in the interaction between mental health and homelessness cannot be underestimated, it prevents people's recovery and

ability to sustain housing. In these situations, long term intensive wrap around services such as our Journey to Social Inclusion **(J2SI)** program have shown that people can sustain a housing outcome, manage their mental health and significantly reduce their problematic drug and alcohol use. I describe the J2SI program in paragraph 37 below.

The proportion of people who experience both severe mental illness and housing insecurity or homelessness

17 There is a gap in the evidence base in relation to those experiencing housing insecurity or homelessness and severe mental illness. There are those people with low prevalence disorders such as bi-polar, schizophrenia, and clinical depression, however, it should be noted that other mental health conditions can cause significant functional impairment and substantially limit major life activities.

18 Currently there is no data that estimates across Victoria how many people are experiencing long term or chronic homelessness, and of this group how many also experience severe mental illness. The J2SI longitudinal randomised control trial study indicated that 60 per cent of the total cohort group (both intervention and control) reported a mental health condition; five times higher than the rate amongst the general population accessing homelessness services at the time the program commenced. Mood disorders, such as depression (21%) and schizophrenia (18%) and were the most common, and the proportion of people with schizophrenia, in particular, is much higher than the general population.[2]

19 In our engagement hubs in St Kilda, we see approximately 7,000 people who come to our hubs for meals, social connection and for pathways to more formalised services. In the period 2017-18, 878 people who came to the hubs engaged with our case management support. Of those, 36 per cent reported having a mental health issue and another 50 per cent were unclear about their mental health status.

20 We are of the opinion that there is under-reporting of mental health issues as the capturing of such data is reliant on self-reporting. We also hold the view that the reason there is a high proportion who are unclear about their mental health status is due to a lack of a diagnosis, rather than the absence of mental health issues. We believe the associated stigma and discrimination causes people to not disclose their mental health condition, alongside the loss of personal agency and control as people become subject to involuntary orders and treatments. As a result, people's mental health conditions are often unmanaged, undiagnosed and likely to impact on their ability to sustain or even acquire housing.

[2] Johnson, G., Parkinson., S, Tseng, Y., & Kuehnle, D., 2011, *Long-term homelessness: Understanding the challenge - 12 months outcomes from the Journey to Social Inclusion pilot program*, Sacred Heart Mission, St Kilda.

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

21 The Interim Report of the Royal Commission into Victoria's Mental Health Services found that 17.3 per cent of people who accessed a public specialist mental health service in 2017-18, also utilised homelessness services in that year.[3] This problem is only growing. The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13. The number of people accessing Victorian homelessness services who report having a mental health issue has increased by 84 per cent in this same period.

22 Meanwhile, acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.[4] There is a lack of social housing, and of temporary accommodation options, as places of last resort have been gentrified.

23 The period of transition from a psychiatric hospital into the community is marked by instability and stress. Compounding this stress, a lack of housing, poorly coordinated supports, and a lack of assertive outreach mean that many people exiting such facilities do not have their needs adequately met during this time.[5]

24 The person is then left to languish in the homelessness service system, which severely impacts their prospect for improved mental health and wellbeing, and likelihood of prolonged and repeated periods of homelessness.

25 The absence of adequate social housing supply is a significant barrier to ensuring outcomes for people experiencing homelessness and even more so for people who also have a mental health condition. There is a risk that people with chronic mental health conditions will continue to be exposed to homelessness where there is an absence of a strongly managed housing supply.

26 When someone is housed and receiving treatment, and we are able to wrap around the person the necessary supports to ensure that discharge planning is in place, advocacy can be undertaken with the landlord to prevent housing breakdown and engagement with their GP to manage their recovery. Research has shown that those discharged from mental health hospitals who received social housing and in-reach support required 22 fewer psychiatric in-patient bed days per participant, with the related financial

[3] Royal Commission into Victoria's Mental Health System, 2019, *Interim report*, p. 369.
[4] Council to Homeless Persons, discussion in meetings between clinical mental health and homelessness services, 2018.
[5] Brackertz, N., Wilkinson, A., and Davison, J., 2018, *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, p.43.

savings eclipsing the cost of providing this support. The living conditions of consumers also improved.[6]

27 We have experience with this through the J2SI model. We undertook a randomised controlled trial study of the participants in the J2SI pilot program. In the pilot study, baseline data showed 27% of intervention participants had used emergency psychiatric services in the previous six months, and 24% had been admitted to psychiatric units.[7] Over a 48 month period, 36 months of support and a 12-month follow up, this declined to 7% for both use of services, and admissions. Intensity of usage also decreased: the number of times the intervention participants presented at hospital emergency departments declined by 75%, from 4.6 at baseline to 1.1 at the 48-month follow up.[8]

28 With the cost of providing an acute bed in Victoria at $917 per patient per day, supporting people to transition successfully out of psychiatric hospitals is both cost-effective, and achieves better outcomes for consumers.[9]

HOUSING NEEDS AND HOUSING STOCK

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

29 There is a shortage of 106,300 affordable and available homes in Victoria.[10] Critically, it is important to note that some of this shortage exists due to properties in that private rental market that *are* affordable being leased to households on higher incomes. It is clear that in order to ensure that people on low incomes with mental ill-health are able to obtain homes that they can afford, the Commission must consider not only housing *provision*, but housing *access.*

30 At Sacred Heart Mission, approximately 30% of our clients require at least two periods of support, which is an amount of time we can support them that is funded by the government. Some clients receive five or more support periods over a 12-month period; and the experience of mental health issues is one of the key drivers of this need. The other main reason is that when people present to us without housing, it is much more difficult to house them without available and appropriate stock. Unison Housing, a large homelessness provider had a similar experience – in a six-year study of their Initial Assessment and Planning (IAP) services, 21 per cent of service users either returned

[6] Siskind, D., et al, 2014, *A retrospective quasi-experimental study of transitional housing programs for patients with severe and persistent mental illness*, Community Mental Health Journal, vol. 50, no. 5, pp.538–547.
[7] Johnson, G., Kuehnle, D., Parkinson, S., Sesa, S., & Tseng, Y., 2014, *Sustaining exits from long-term homelessness: A randomised controlled trial examining the 48-month social outcomes from the Journey to Social Inclusion pilot program*, Sacred Heart Mission, St Kilda.
[8] Ibid.
[9] Productivity Commission, 2019, *Report on Government Services; Chapter 13 Attachment Tables, Table 13A.36.*
[10] Hulse, K, Reynolds, M., Nygaard, C., Parkinson, S., Yates, J., 2019, *The supply of affordable private rental housing in Australian cities: short-term and longer-term changes*, Australian Housing and Urban Research Institute, Melbourne, pp.105-110.

multiple times in one year, or over several years and consumed nearly half of the available support periods (41 per cent) and support days (43 per cent).[11]

31 These consumers require support for longer durations than are available through mainstream specialist homelessness services. There is a clear need for further homelessness support programs that can work with consumers for as long as they need; we have talked about this as a continuum of care model. Sacred Heart Mission's J2SI program, and the GreenLight Supportive Housing program that was funded under the State Government's Rough Sleeper Action Plan, are positive examples of rapid housing programs, but these types of programs currently have limited geographic reach in Victoria, and need to be invested in across the state.

HOUSING FOR PEOPLE WITH SEVERE MENTAL ILLNESS

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

32 Currently, the homelessness service system is an inflexible system that is largely crisis orientated, responding to homelessness as a short-term experience, which is often not the case for people who have multiple and complex needs such as severe mental illness.

33 A more effective service model would be a continuum of care model that provides a tailored response to people according to their needs and is not limited by duration and targets, but is focused on achieving five outcomes of sustained housing, health and wellbeing, social inclusion, economic participation and independence. A model that works across a continuum of need: from people who at risk, or experiencing homelessness for the first time, to people who have moderate needs, to people who have experienced long term/chronic homelessness.

34 The ultimate goal of the program over time is that the experience of homelessness is a temporary event that is not repeated.

35 It should involve an evidence-based assessment that determines the right level of support required to assist the person to meet their goals and manage their recovery and sustain their housing.

36 Diverse communities also need tailored responses that suit them and meet their needs. For example, Aboriginal and Torres Strait Islander people need a tailored response and culturally safe understandings of mental illness and what that means in that community. This also applies to lesbian, gay, bisexual, trans*, intersex and queer (LGBTIQ+)

[11] Taylor, S. and Johnson, G. (2019) Service use patterns at a high-volume homelessness service: A longitudinal analysis of six years of administrative data. Unison Housing, Melbourne.

communities, culturally and linguistically diverse (CALD) communities, young people and people with a disability. We need to ensure that the system can support people with diverse needs.

37 An example of an effective wrap-around service response at the high end of the continuum of care model is Sacred Heart Mission's J2SI program, which works intensively with people who have experienced chronic homelessness for three years. It builds rapport, finds rapid pathways into housing and concentrates on five outcomes, being social inclusion, economic participation, household well-being, housing sustainability and independence. Independence is the ultimate goal after three years of support. The program targets people with a chronic experience of homelessness; for J2SI this means people who have a history of rough sleeping for 12 months continuously and/or at least three episodes of homelessness in the last 3 years. As stated above, 60 per cent of pilot participants reported having a mental health issue. The researchers also recognised that certain conditions, such as personality disorders that require more intensive treatment were likely to have been under-reported as they are less likely to be diagnosed or disclosed by the individual.[12]

38 The essential building block for a continuum of care model are general practitioners. We know that if there is a good relationship between the general practitioner and the client, then their mental health is more likely to be managed, rather than a crisis, episodic experience (that is, presenting in an emergency department or psychiatric ward). The ability of general practitioners to work with this cohort is essential; the involvement of general practitioners keeps people out of the clinical system. When we can provide long term intensive support such as J2SI we are able to coach the client to manage their circumstances - whether it be mental health, social interactions or conflict resolution skills.

39 There are, however, significant barriers to Sacred Heart Mission's clients accessing general practitioners in the first place. These include not being able to get in to see the general practitioner, not having a Medicare card, not being able to access a bulk billing practice or being suspicious of medical professionals due to trauma or being unable to afford a psychologist and psychiatrist, which is not often bulk billed.

40 Sacred Heart Mission has its own general practitioner clinic. It is currently funded by DHHS, however, the funding is soon to be withdrawn and without philanthropic funding will close. General practitioners embedded onsite in a service environment is ideal for swift access and placing people on mental health plans. Currently, there is no incentive in the general practitioners' system to take part in such programs, because the business system does not support it. The State needs to intervene in a Commonwealth funded

[12] Johnson et al., 2011

program to create better pathways to good general practitioner services for those with severe mental illness experiencing homelessness.

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

41 A good example of what Victoria is doing well is Sacred Heart Mission's Queens Road Rooming House. This is a supported accommodation model, providing long-term housing alongside individualised and tailored support and social inclusion activities. Sacred Heart Mission is the onsite support provider and the property is managed by Community Housing Limited Victoria. The service provides "wrap around" support through individualised case management, that enables early identification of someone who is becoming unwell or not managing. We have a strong relationship with the Alfred Hospital Psychiatric Services who can intervene early and provide more intensive support quickly when someone does become unwell. Our staff are available onsite and have a good knowledge of the residents, so they quickly become aware if something is not going well for a particular resident and can support them. A key feature of this program is that the housing and support are managed separately; housing is not conditional on the resident engaging with individualised support if they do not want it.

42 The Queens Road Rooming House has a communal dining room where residents can eat meals together and participate in social inclusion activities, a community discussion group, a lifestyle program, medication management, an art room and a gym. It is a home for its residents. It is operated on a harm minimisation framework; meaning that residents can consume alcohol in private spaces providing they are not causing harm to other people as an example. We do not attempt to control this in any coercive way. We give residents the ability to live their lives the way that they want to.

43 The Queens Road Rooming House is funded by DHHS and is not part of the National Disability Insurance Scheme (**NDIS)**. Though a number of residents have a mental illness, many are not eligible for the NDIS. These residents still require assistance to live independently; and find the communal living environment a positive experience. Ensuring that these services can continue to operate for people who need it is essential, as without a supported environment, many of these residents would be at risk of falling back into homelessness. These types of environments need to be maintained through the Victorian mental health system, as they serve the needs of a specific cohort of people who would not be able to receive this level of support through another system.

Examples of successful housing approaches in other jurisdictions

44 The Housing First Model provides a great evidence base that providing safe, affordable, long term housing as quickly as possible is the key to resolving the experience of homelessness and recovery from their range of conditions, which includes mental

health. Providing a person with housing and a sense of home is fundamental to good mental health.

45 We do not have a Housing First system in Australia as we do not have the housing supply available. In Australia, we have a "pathways model", where a person steps through from a crisis to temporary transitional housing. If you are fortunate, you may have transitional housing until being placed in long term housing. The difficulty is that housing providers often require "housing readiness" before housing is provided. For people who have been without a home for an extensive period, being able to live within four walls can be difficult They also need to understand the importance of paying rent, maintaining a clean environment etc. Housing providers need to know the person is actually ready to go into a property before offering one. The Housing First Model does not require "housing readiness" - the first step is always settlement support into tailored and long-term housing, and then the supports come in to assist that person to maintain the tenancy and build life skills to sustain housing .

46 The J2SI program uses a "rapid housing" approach because it attempts to secure housing more quickly than the service system. However, it still takes six to nine months to secure housing, which is still inadequate.

47 The Australian Housing and Urban Research Institute **(AHURI)** conducted research entitled "Supportive housing to address homelessness" in 2015 about single site housing with onsite support, which is what our Queens Road Rooming House provides.[13] The research found that people who are living in such supportive housing are highly vulnerable, and supportive housing allows them to overcome disadvantage, to become good tenants, and empowers them to create positive change. This highlights that supportive housing models reduce homelessness and improve the ability of people with mental illness and substance use issues to stay in the community over time and present less at hospitals. Further, consumers consistently prefer such models over more restrictive forms of care. If support is voluntary, integrated and tenant directed, a person's quality of life improves.[14]

STRATEGIES TO SUPPORT HOUSING FOR PEOPLE LIVING WITH MENTAL ILLNESS

The role of the NDIS in providing housing for people with severe mental illness

48 There is not any specialised and targeted housing attached to the NDIS for people with complex mental illness and an experience of homelessness. For people on very low incomes (Centrelink payments), their main housing options are public and community

[13] Parsell, C., Moutou, O., Lucio, E., and Parkinson, S., 2015, *Supportive housing to address homelessness*, AHURI Final Report No. 240. Melbourne: Australian Housing and Urban Research Institute, Melbourne.
[14] Rog, D, Marshall, T, Dougherty, R, George, P, Daniels, A, Ghose, S and Delphin-Rittmon, M (2014) 'Permanent supportive housing: Assessing the evidence', Psychiatric Services, vol. 65, no. 3, pp. 287–94.

housing, of which there is very little as we have discussed. Sacred Heart Mission provides either service coordination or personal care by reaching out to people in their housing. For people with more complex needs, their ability to navigate access into an NDIS package and utilise the package after they are deemed eligible is challenging. In our J2SI Program, we put a lot of effort in working with the NDIS provider, to ensure the NDIS can be valuable and meaningful to those deemed eligible. That is a current gap in the system, because we require two intensive services working together to get an effective delivery response.

49 The NDIS is not the ideal response for providing supports to address people's recovery from severe mental illness as it is inconsistent with the recovery model and implies a lifelong disability, that there will never be improvement in a person's mental health. As a result, it is our experience that not many people end up qualifying for NDIS packages who have mental health conditions.

50 By nature, people will experience periods where they do not need as much support and other periods when they do. That is very difficult to estimate when preparing a NDIS plan as it requires a prediction of future mental health needs. As a result, many applications are rejected on the grounds that the condition is not permanent and significant.

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

51 As a result of the Commonwealth funded programs being decommissioned in Victoria, such as Personal Helpers and Mentors **(PHaMs)** and Partners in Recovery **(PIR)** , only 10 per cent of people with mental illness are eligible for the NDIS. PHaMs and PIR were effective programs and their absence has led to many not receiving assistance because of waiting periods to be assessed for a NDIS package, as well as a lack of eligibility for the NDIS at all. Consequently, there is a need to fund community-based programs for people with a psychosocial condition who are not eligible for the NDIS and who do not meet the permanent and significant criteria. Without support, such people will be at risk of homelessness and more likely to present in an emergency department to manage their mental health. If we invest in community mental health programs, we can prevent future costs related to crisis and costly treatment.

52 For NDIS to be an effective response for people experiencing homelessness who have a mental health condition, several modifications or enhancements are required. Firstly, service navigation support that supports the person to navigate the pathway of eligibility into a NDIS package. Secondly, once allocated a package, support is required to ensure package utilisation management, so the person gets value and benefit from the

package. It is not uncommon to see significant package underutilisation for people with multiple and complex needs.

53 Many people with psychosocial disabilities struggle to know whether they are eligible for the NDIS, as well as what evidence they need to apply. Many people with a psychosocial condition as their primary disability are rejected, often due to documents from specialists that are not worded to highlight the permanency and significance of conditions.

54 Currently, I am not aware of any Specialist Disability Accommodation **(SDA)** that is specifically targeted to people who have experienced homelessness and who have a severe mental illness. It is an area that appears largely underdeveloped and further investigation of accommodation modelling is required.

55 Supported Accommodation is also provided in other settings outside SDA, such as specialist residential aged care services. In this case, people who are under 65 are provided with aged care services due to the prevalence of age-related conditions associated with histories of chronic homelessness, and who also have enduring mental health conditions. At Sacred Heart Mission, we operate a 97-bed aged care facility where 25 per cent of the residents are under 64 years old, in comparison to 1 in 25 within the general population. These residents are housed in the facility because they experience age related conditions as a result of homelessness and complex mental illness. Our residents have almost twice the number of diagnosed mental health conditions per resident than the combined Victorian data (1.9 compared to 1 incident per resident).

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.

b) The extent and nature of unmet demand.

c) The cause/s of unmet demand.

d) The most critical unmet demand.

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

56 Outside of those linked to the clinical system, there is not any housing in the mainstream housing supply dedicated to Victorians experiencing severe mental illness. Housing is under-resourced and under-supplied. Victoria has an overstretched housing

system which attempts to meet the needs of many, including those with severe mental illness.

57 According to the DHHS Victorian Housing Register Transition Report from December 2019, there are 41,725 current applications to the Victoria Housing Register – this is presented as applications on behalf of households, and therefore includes people across a wide variety of circumstances and household types.

58 A starting point in understanding the need for this cohort is the DHHS linked dataset used by the RCVMHS in its' Interim Report - that 17.3 per cent of acute mental healthcare users are exited into homelessness. These people have evident acute mental illness, and evident acute housing need.

59 However, there is likely to be more unmet demand, and we need to find out more about the nature, cause/s of unmet demand, the most critical unmet demand and its impact. It is difficult to capture such information as the Victorian Housing Register is only required to know whether people meet the eligibility criteria, such as homelessness, but not mental illness. However, if mental health challenges were to be captured by the Victorian Housing Register, it would rely on self-identification and a known diagnosis – this is a difficulty amongst this cohort. Tailoring the priority waiting list to include a mental illness identifier as a subcategory of prioritisation may assist but is not the only mechanism that will enable us to better understand that demand.

60 For people with low prevalence, high severity illnesses, the risk of poverty and of homelessness is particularly high. Centrelink is the main source of income for 85 per cent of people with psychotic illnesses. A 2010 study found that the vast majority of people with psychotic illnesses had incomes of less than $400 per week.[15] Only 21.8 per cent of people with psychotic illnesses live in private rental, while 25.9 per cent live in rent-controlled social housing. Shockingly, 5.2 per cent of people with psychotic illnesses are homeless, while 12.8 per cent experience homelessness across the course of a year. The duration of that homelessness averages 155 days,[16] whereas across the broader population 57 per cent of people experiencing homelessness are without a home for fewer than three months.[17]

61 The private rental market provides very few options for people living in poverty, including many people whose poverty results from mental ill-health. Across all of metropolitan Melbourne there were just 35 rental properties left in the March 2019 quarter that would have been affordable to a single person on Newstart (now known as

[15] Morgan, V., et al, 2010, *People living with psychotic illness 2010*, National Mental Health Commission, Canberra, p.53
[16] Ibid, pp. 60-61.
[17] Australian Bureau of Statistics, 2015, *4159.0 - General Social Survey: Summary Results, Australia, 2014, Table 17. Homelessness.*

the JobSeeker payment),[18] and just 148 affordable rentals available across the entire state. This continues a prolonged downward trend in the availability of housing affordable to those on our lowest incomes.[19]

62 Even those few properties that are affordable to a person on a Centrelink income are likely to be leased to households on higher incomes.[20] Ensuring that housing is available and affordable to those who need it most will require Governments to invest directly in housing. Given that there are already 75,000 – 100,000 at-risk households who do not have access to affordable housing, an immediate investment in social housing is required, as well as strategies to provide a pipeline of affordable housing into the future.[21] The enhanced security of tenure in social housing also provides greater ontological security, which has a positive impact on mental health.[22]

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?

63 The existence of a Commonwealth-State agreement is a strength because it gives dedicated oversight of both the Commonwealth and Victoria through the National Affordable Housing Agreement. In the absence of such an agreement, identifying where various responsibilities lie would be unclear.

64 However, one of the weaknesses is that it leads to housing and homelessness being perceived as solely a State issue. Historically, this division has led to a lack of investment by the Commonwealth of growing and improving housing stock. As a result, the States are solely responsible for improving or growing investment in housing.

65 Another weakness is that Commonwealth Rent Assistance, the JobSeeker payment (formerly Newstart), and the Disability Support Pension are inadequate. They do not meet market conditions, consider a person's ability to pay rent or allow for maintenance of quality of life and wellbeing.

66 We recognise that the Jobseeker payment has been increased temporarily due to the COVID-19 pandemic, and many income support recipients received COVID-19 stimulus payments. These changes are temporary and at this stage, Centrelink payments will

[18] Victorian Government Department of Health and Human Services, 2019, *Rental Report March Quarter 2019*, p.19
[19] Victorian Government Department of Health and Human Services, 2019, *Rental Report March Quarter 2019; Affordable lettings by local government area – March quarter 2019* available at <https://dhhs.vic.gov.au/publications/rental-report>
[20] Hulse, K., Reynolds, M., Stone, W. and Yates, J., 2015, *Supply shortages and affordability outcomes in the private rental sector: short and longer term trends*, AHURI Final Report No.241. Melbourne: Australian Housing and Urban Research Institute, p.26
[21] Infrastructure Victoria, 2016, Victoria's 30-Year Infrastructure Strategy, p.104
[22] Rebecca J. Bentley, David Pevalin, Emma Baker, Kate Mason, Aaron Reeves & Andrew Beer (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, Housing Studies.

revert to their prior arrangements in September 2020; and we know that this will be unsustainable for recipients.

67 There needs to be greater focus on growing affordable housing with the assumption that social housing is a subset of that.

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.

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

68 Those with chronic homelessness and mental health conditions should be prioritised. From a cost perspective, this cohort costs the most in a crisis-oriented system, which includes hospital bed days, psychiatric wards, police, ambulance, courts and prisons. Use of these systems is expensive, and ultimately, prevention through the provision of affordable long-term housing and community support is the best return on investment. Focusing investment into this cohort would free resources and allow others to get better mainstream service responses.

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?

69 There needs to be a range of housing options available within the service system, that meets people's needs in relation to locality, size and type. It cannot be a "one size fits all" model. Public and community housing are essential when private rental is largely unaffordable. Segregated housing (standalone properties in the community) and supported accommodation that has on-site support, both have a role to play, with the latter option being effective for people with complex and multiple needs.

70 It is essential that people who are exiting the mental health system are not discharged into homelessness. We need more housing, particularly social housing, and supports as well as discharge planning prior to an exit from a clinical setting. These are critical to support recovery. This is severely lacking in the current system and needs to be addressed in order to break the cycle of inpatient mental health services exiting people into homelessness, which then results in re-admissions back into mental health services.

71 The State Government has implemented an integrated waiting list for both public and community housing, with priority given to certain groups of the Victorian Housing Register. This helps house those deemed as priority sooner. However, people with

severe mental illness are not identified within these priority groups, as they are considered within the group of homelessness with support. There may be merit in considering if the priority groups can be extended to mental illness, as well as homelessness with support.

72 Sacred Heart Mission with Alfred Health has effectively addressed the issue of people being at risk of homelessness with our 'Early Intervention Psychosocial Response' program. The program employs mental health case managers who provide advocacy and support to clients where their behaviour (related to their mental health) puts their tenancy at risk. Staff liaise with tenancy managers to sustain the tenancy and identify how we can support the client to address tenancy issues. For example, a client may respond to auditory hallucinations during the night, and therefore not maintain a quiet environment, or they may be unable to maintain a level of cleanliness due to amotivation or suffer from hoarding disorder. This advocacy supports that person to sustain their tenancy, and prevent a homelessness experience, but the property itself may not be fit for purpose for that particular individual. For example, a rooming house, or high-density property may be inappropriate due to their mental health and ability to live with others. In these cases, staff will assist clients to complete housing applications for accommodation that is better suited to their needs, such as self-contained and low-density accommodation.

73 However, there is a lack of available social housing of this nature and securing this type of housing may require a long wait time. It is important that the client sustains their tenancy in the interim, so this advocacy is essential. More generally, there needs to be more flexibility and choice in the supply of social housing, to accommodate people with a diverse range of needs, including mental illness. In order to understand this diversity of needs, experts in mental health and consumers should be consulted to ensure that future social housing is more appropriate.

74 Securing housing in a location that keeps people connected with their community and services is important to sustaining good mental health and staying out of homelessness, and independent of the crisis service system. When a person with mental health issues is housed in a different area to their supports and services, it disconnects them from the supports that keep them well. This kind of disconnection is a significant barrier to maintaining good mental health and can lead to social isolation. If there is no investment in social inclusion or 'soft' services that keep people connected to family, friends and community, and into a community of services that sustains them, then people will call on the crisis-oriented system when a life shock occurs, and will become at risk or experience homelessness.

75 Further, housing needs to be tailored to place, taking into consideration what is effective in Melbourne may not be effective in a rural area, because access to systems in Melbourne are not necessarily replicated in rural regions in Victoria.

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?

76 Community Housing Providers are essential as property owners and tenancy managers because they understand the needs of the clients. Community Housing Providers are business entities that can use Commonwealth or State assistance to grow housing supply.

77 The key role of specialist homelessness support is assisting people to get housing, settle into that housing, and to sustain their housing.

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)?

78 The separation of landlord and support is really important. When it is the same organisation, it can compromise the decisions that are made in relation to good quality care and service provision versus tenancy risks. It allows the support provider to work in tandem with the community housing provider to manage risky tenancies and avoid tenancy breakdowns.

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)?

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

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

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?

79 This is not applicable to Sacred Heart Mission. Sacred Heart Mission does not work with young people so I cannot 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?

80 The use of the SDA activity under the NDIS for people with severe mental illness who are experiencing homelessness has seen very little uptake so far. It is clear that consumers and providers alike have not found this mechanism easy to use, despite the great need for SDA for these consumers.

81 If the SDA market is to develop in a way that meets the specific needs of people with severe mental illness and housing insecurity or homelessness, a model of SDAs needs to be developed that meet a variety of needs and is based on evidenced based research, with further investigation of how models such as Supported Individual Living in various community settings might better support people.

sign here ►

print name Catherine Humphrey

date 30 April 2020

Royal Commission into Victoria's Mental Health System

ATTACHMENT CH-1

This is the attachment marked CH-1-1' referred to in the witness statement of Catherine Humphrey dated 30 April 2020.

CV

NAME: Ms Cathy Humphrey

POST SECONDARY EDUCATION:

2010 – Certificate IV Training and Assessment

2008 – Certificate IV Life Coaching & NLP Practitioner

1995 – Diploma Social Science - Welfare Studies

1992 – Advanced Certificate in Residential and Community Services

SECONDARY EDUCATION:

1984 - H.S.C

BOARDS

Dec 2018 to current

Chair – Council to Homeless Persons

2011 – to current

Board of Governance –Council to Homeless Persons

2002 – 2011

Deputy Chair, Board of Governance –St Kilda Community Housing

WORK EXPERIENCE

NOVEMBER 2011 – CURRENT

CEO, Sacred Heart Mission

JANUARY 2011 – NOVEMBER 2011

General Manager, Aged Care Services, Sacred Heart Mission

JULY 2009 – DECEMBER 2010

General Manager, Client Services, Sacred Heart Mission

JANUARY 2002 – JULY 2009

Operations Manager, Services Division, Sacred Heart Mission.

JULY 2000 – JANUARY 2002

Manager, Community Programs

Southern Metropolitan Region, Complex Care Unit.

Victorian Department of Human services

OCTOBER 1999 – JULY 2000

Contract Manager - Community and Family Services

Victorian Department of Human Services- Eastern Metropolitan Region

MAY 1999 – OCTOBER 1999

SAAP Regional Network Coordinator - Eastern Region

The position was auspiced by Wesley Central Mission.

SEPTEMBER 1998 to MAY 1999

Program Advisor – Access & Coordination,

Homelessness & Family Violence Services Unit.

Victorian Department of Human Services

APRIL 1996 to SEPTEMBER 1998

Team Leader Case Management Services

Bethany Family Support.

JULY 1995 to MARCH 1996

Programs Manager

Central Highlands Regional Residential Association (C.H.R.R.A)

C.H.R.R.A was a federally funded Disability Service, which provided supported accommodation through Community Residential Units and an Independent Living Program.

JULY 1994 - JULY 1995

Intellectual Disability Services Officer (Part time)

Central Highlands Regional Residential Association, Independent Living Program.

APRIL 1994 - JULY 1994

Intellectual Disability Services Officer (casual)

Department of Human Services, Ballarat Community Living Support Service.

SEPTEMBER 1993 - FEBRUARY 1994

Intellectual Disability Services Officer Grade 2,

Melbourne City Mission, North/Eastern Region Independent Living Program.

JUNE 1993 - SEPTEMBER 1993

Residential Support Worker

Jewish Welfare Society.

JULY 1992 - APRIL 1993

Intellectual Disability Services Officer (Casual)

Central Highlands Regional Residential Association, Ballarat.

1985 - 1991

Ministry of Education and during this period worked in the following Departmental Units, School Library Support Services, Teacher Leave and Payroll Unit, Workcare Unit, Payroll Review Unit.