Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR SARAH POLLOCK

I, Sarah Pollock, Executive Director in Research and Advocacy of 86-92 Mount Street, Heidelberg, in the State of Victoria, 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 I make this statement in my professional capacity as the Executive Director in Research and Advocacy at Mind Australia Limited (**Mind**).

Professional background

3 I have been the Executive Director in Research and Advocacy at Mind since 2017. My current role and responsibilities include establishing and leading Mind's policy advocacy function. This is aimed at advocating for social conditions in which people impacted by serious and complex mental health issues will have more equitable opportunities and a better quality of life. I also provide strategic oversight of Mind's research program.

4 I have previously held the following roles at Mind: Senior Advisor: Policy and Strategy (2014-2015); General Manager, Research Development and Advocacy (2013-2014); and, Manager Strategic Projects (2012 to 2013).

5 Prior to my work at Mind, I worked for Wesley Mission Victoria in the role of Executive Manager, Research, Social Policy and Advocacy (2005-2011). I worked at URCOT (Union Research Centre on Organisation and Technology), in the role of Researcher (2002-2005), and at RMIT University in the roles of Manager, Research and Curriculum Unit, Faculty of Business (from 1998-2002) and Senior Project Manager, Education Programs Improvement Group (from 1995 to 1998).

6 I hold the following qualifications:

(a) Doctor of Philosophy (PhD) in Public Health (2016) from Deakin University;

(b) Master of Business (2002) from RMIT University;

(c) Graduate Diploma in Education (1991) at La Trobe University; and

(d) Bachelor's Degree (Hons) in English Literature and Psychology (1983) at University of Newcastle-Upon-Tyne, UK.

7 Attached to this statement and marked ‘SP-1’ is a copy of current curriculum vitae.

MENTAL HEALTH, HOUSING AND HOMELESSNESS

Definitions of Homelessness and Housing Insecurity

Homelessness

8 My definition of homelessness includes the technical definitions of homelessness that cover primary, secondary and tertiary homelessness, based on the work of Chamberlain and Mackenzie (2008)[1]. These are:

(a) **Primary homelessness**: this is rough or street sleeping. Rough sleeping refers to a person sleeping out, for instance on the street, in doorways, bus shelters, sheds, under boats and any other place not intended for regular human habitation. Street sleeping, on the other hand, is a more encompassing term that refers to a person who lives on the streets during the day and has nowhere to go at night, other than to find shelter outside somewhere. I note that the two terms are generally used without distinction in Australia, although I am aware that, for instance, the Salvation Army’s National Homelessness team makes this distinction in their service delivery and advocacy.

(b) **Secondary homelessness**: includes various forms of temporary accommodation, such as couch surfing, staying with family members or multiple transitional or emergency housing placements.

(c) **Tertiary homelessness**: people living in single rooms in boarding houses without their own bathroom or kitchen, and with little security of tenure.

9 I would add to the above three categories, marginal accommodation, meaning any form of accommodation that falls below acceptable community standards, which is also often associated with insecure tenure.

The Trajectories Research Project and homelessness

10 I would add to the technical definition of homelessness the findings from the *‘Trajectories: the interplay between mental health and housing pathways’* Research Project **(Trajectories)** that Mind Australia recently conducted with the Australian Housing Urban

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[1] Chamberlain, C. and MacKenzie, D. (2008) Australian census analytic program: counting the homeless 2006, cat. no. 2050.0, ABS, Canberra, https://www.abs.gov.au/ausstats/abs@.nsf/mf/2050.0.

Research Institute **(AHURI).**[2] Trajectories is a program of research work that we have been conducting with AHURI over the last two years.

11 The research project aimed to identify typical housing and mental health pathways, the intersection of these pathways, and potential points of intervention. It comprises:

(a) a review of existing evidence on the intersections between mental health and housing;

(b) a quantitative study using the Household Income and Labour-market Dynamics Australia **(HILDA)** and Journeys Home **(JH)** surveys;

(c) a qualitative study involving 16 sets of community interviews in 14 locations across Australia, involving 130 people who had experienced intersecting difficulties with their mental health and housing (consumers) and carers/family members;

(d) focus groups in each of the eight Australian capital cities with 109 service providers from the mental health, housing and homelessness sectors; and

(e) a synthesis of findings across the different strands of the program of work, reported in the final research report for the program. [3]

12 The final piece of work, a series of policy transfer workshops with key decision-makers and other stakeholders in the mental health, housing and homelessness sectors, has been delayed because of COVID 19, and will take place later this year.

13 The research found:

(a) that housing is foundational for mental health recovery, and the basis for accessing appropriate services and supports, including informal support;

(b) a persistent shortage of appropriate housing for people whose lives are impacted by serious and complex mental health issues. Housing affordability, shortages of social housing and a lack of housing plus support all contribute to this;

(c) that housing, homelessness and mental health systems are crisis-driven and lack integration, with the consequence that people are not able to access the help they need when they need it, nor for long enough. [4]

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[2] Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S. and Davis, E. (2020) *Trajectories: the interplay between mental health and housing pathways*, AHURI Research Paper, Mind Australia, Australian Housing and Urban Research Institute Limited, Melbourne, (**Trajectories Report**) https://www.ahuri.edu.au/research/research-papers/trajectories-report.

[3] Trajectories Report, page 1, 11, 13, 51-54.

[4] Trajectories Report, page 1.

14 The research was also able to identify in the various data available to the research team some mediating factors that can reduce the likelihood of housing instability and homelessness and promote better mental health outcomes. These include: access to social support (support from families, friends and neighbours); good general health; and good access to mental health and other health services.[5] When these mediating factors are absent, there is a consequent negative impact on people's mental health and on their housing situation. [6]

15 From the synthesis across the different strands of this program of work we were able to identify five, non-linear pathways that we have used to conceptualise how people travel through the mental health, housing and homelessness systems. These have a basis in data, and differ markedly from the more linear, theoretical pathways described in policy documents. The five pathways are:

(a) excluded from help for either mental health or housing issues, or both;

(b) stuck in inappropriate housing, institutions or services because of a lack of adequate support;

(c) cycling in and out of service systems: where each turn reflects a downward spiral that progressively erodes the person's resources;

(d) stabilising: where people have access to secure, safe, appropriate and affordable housing, ongoing support to help them get well and stay well, and help to facilitate meaningful social connections and activities and sufficient financial security; and

(e) well-supported: where the person has the type of housing and support that aligns with their needs, capabilities and goals and which enables them to develop independence and achieve their wider life ambitions.[7]

16 From the research findings, we put forward a number of key policy implications. Policies need to ensure that people have:

(a) access to safe, secure, affordable and appropriate housing in a meaningful location;

(b) connection to a trusted worker who can help them navigate service systems;

(c) funded support co-ordination, and assistance and advocacy to navigate service systems;

(d) greater access to psychosocial support for day-to-day tasks and to take part in meaningful activities;

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[5] Trajectories Report, pages 1, 30, 31, 84.
[6] Trajectories Report, pages 1, 30, 31, 84.
[7] Trajectories Report, pages 2, 51-53, 83, Appendix 2.

(e) financial security that provides for a reasonable standard of living;

(f) holistic support that meets the level and duration of need, and timely access to support;

(g) expanded access to trauma-counselling and culturally appropriate services.[8]

17 The evidence from Trajectories suggests that when a combination of these supports are in place, they act as a circuit-breaker, with the effect of shifting a person from one of the three negative trajectories to the positive stabilising or well-supported ones, thus enabling them to focus on things beyond mental health and housing.[9]

18 From the Trajectories research, it is my view that homelessness is about lacking a place to live that is safe, secure and meaningful to the person. Homelessness is about much more than not having a roof over somebody's head – it is about lacking a place that you can build a life from.

Housing Insecurity

19 Housing insecurity is when somebody does not have secure tenure, and/or lacks control over their living arrangements. As a consequence, they are likely to experience multiple forced moves or, otherwise, live in fear of forced moves.

20 During the Trajectories community interviews, we spoke to people who didn't know what sort of housing they were in. For example, we spoke to people who thought they were in permanent housing, but then discovered that they were actually in transitional housing, and thus lacked the security of tenure they thought they had. We spoke to people who didn’t know whether their housing was permanent, or only for weeks or months. People’s accounts made clear how the lack of certainty about tenure had a negative impact on their mental health, and acted as a barrier to recovery.

21 As well as uncertainty and lack of control over tenure, we found that people lacked control in the processes for applying for housing, and then, once housed, how they maintained and lived in their house. In public and private rental properties, people gave accounts of having to maintain the house to someone else’s standards and timeframes, often placing great stress on them at times when they had a lot of other things they needed to attend to. People experienced the landlord/tenant relationship as an unequal one, with further consequent negative impact on their mental health.

22 Mind is particularly concerned about the impact of lack of control and unequal relationships on the mental health of people who are already marginalised because they are impacted by severe and complex mental health issues. These are people who need

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[8] Trajectories Report, pages 2, 84, Appendix 2.

[9] Trajectories Report, pages 30-31, 51, 76-77, 84,

more support because that insecurity has a very negative impact on their mental health. This lack of control has a compounding effect on their health and wellbeing, and points to the need for specialised responses that combine housing and support in ways that enhance people's wellbeing and dignity, rather than diminish them.

The link between mental health, housing and homelessness

23 The Trajectories research demonstrated a very clear link between mental health or mental illness and housing and homelessness. This was evidenced in the quantitative data and in the data obtained through community interviews.

24 It is a complicated relationship because it is bidirectional: poor mental health impacts on housing stability and can lead to forced moves, whilst housing instability impacts on mental health and drives mental health downwards. Financial hardship – or poverty – makes the relationship more complicated. The research found that financial hardship experienced in the past 12 and 24 months elevates the likelihood that people will experience deteriorating mental health to the point where they experience symptoms by 23 and 21 per cent respectively. When people experience poor mental health, without accessing health/mental health services, they are more likely to experience financial hardship in the next 12 and 24 months. They are also more likely to experience forced moves. However, the effect or impact is more pronounced when there is no access to mental health services.

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

25 When thinking about the interrelationship between housing and mental health, we need to ensure our understanding of what 'severe mental illness' looks like is broad enough to encompass experiences that may stretch outside clinical and diagnostic frames for understanding the life impacts of severe and complex mental health issues.

26 One of the things that really struck me during the community interviews for the Trajectories research was the contrast between the narrowness of clinical definitions of severe mental illness and how people spoke about their experience. For example, of the 130 people we spoke to, 44 of them were Aboriginal. The Aboriginal respondents, in particular, didn't speak in terms of diagnosis - they spoke about 'stress' or 'worries', or more generally about feeling down or depressed. On the surface, these seem like relatively minor impacts. But, when we drilled down in the interviews we found that they were talking about very serious stress, worry and suicidality, often sustained over many months and years.

27 The interviews indicated high to very high levels of trauma amongst people living with severe and complex mental health issues. This was particularly the case with the

interviews with Aboriginal people, where experiencing and/or witnessing traumatic events was ubiquitous. In my lay view, I wonder about the levels of undiagnosed Post-Traumatic Stress Disorder (as well as other mental health diagnoses that people may have received) in Aboriginal communities, and amongst people living with severe and complex mental illness more generally. Throughout the interviews, there was a disconnect between the specificity of clinical understandings of severe mental illness, and how interviewees talked about their experiences of terrible mental health, with little reference to diagnostic labels. In considering the extent of intersecting mental illness and housing insecurity or homelessness, I have taken this more inclusive meaning offered in people's accounts in the Trajectories research.

28 In order to reach a view on the proportion of people experiencing both 'severe mental illness' and housing insecurity or homelessness in Victoria, I drew on:

(a) the National Mental Health Commission's "2014 Contributing Lives Review"[10] in order to determine figures for severe mental illness. I reviewed the population percentages for 'severe, persistent mental illness with complex multi-agency needs' (0.45%), 'severe, persistent' (1%) and 'severe episodic' (2%) (totalling 3.45% of the population), and calculated what prevalence that would yield in Victoria; and

(b) the "People Living with Psychotic Illness" report on the 2010 Survey of High Impact Psychosis (**SHIP study**).[11] I took into account the prevalence of people who were homeless at the time of interview (5.2%) and people who would have been homeless in the 12 months prior to the interview (12.8%).

29 I took as my base an estimated Victorian population of 6.36 million people. I used the National Mental Health Commission's population prevalence for the first two groups of people (ie 1.45%) to derive an estimate of the number of Victorians living with complex, severe and persistent and severe and persistent mental illness, arriving at 92,220 people. I then applied the percentages for homeless at time of interview, and homeless at some point in preceding 12 months from the SHIP study. This gave me a range of 4,795-11,804 people living with severe and complex mental illness who were homeless at any point in time (lower end of the range) or who had been homeless sometime in the preceding 12 months (upper end). When I performed the same calculations including those with severe episodic illness, the range moved to 6,512 to 16,030 people. I discussed this approach,

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[10] https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports/2014-contributing-lives-review

[11] https://www1.health.gov.au/internet/main/publishing.nsf/Content/717137A2F9B9FCC2CA257BF0001C118F/$File/psych10.pdf

and these figures, with colleagues with on-ground knowledge, and came up with a 'best guess' for what seems right.

30 Based on this approach, I estimate there are, at any point in time, around 6000 people who are homeless with severe mental illness and complex mental illness in Victoria (all forms of homelessness, but not including marginal accommodation). This is higher than the lower end of the range for the people in the most severe and complex categories, because the SHIP survey is specific to psychotic illness – not the full cohort of those who might be deemed to have severe and complex mental illness. Trajectories made clear the importance of framing mental health in wider, more inclusive ways than specific diagnostic framings. When I added in people who have episodic mental illness, my estimate rises to around 11,000 people.

31 In addition to people who were homeless, the SHIP study identifies people who live in supported accommodation or with family, but do so because they (the individual and/or their families) have no other option. The study does not offer a definition of 'supported accommodation' but given that it does make a distinction between this and all forms of homelessness (primary, secondary and tertiary), I have assumed this does not include people in boarding housed or rooming houses, although I have assumed it would include Supported Residential Service **(SRS)** residents. In other words, there is a cohort of people who, because of their mental health, are in forms of non-preferred accommodation, and find themselves in supported accommodation or with their family because they do not have a choice. This lack of choice is important when we consider the findings from Trajectories of the impact of lack of choice and control over housing on mental health. Also from Trajectories interviews with family/carers, people gave accounts of having an adult son or daughter living at home because there were no other options (of housing and support), despite the arrangement not meeting the family's preferences, or even being unsafe.

32 Therefore, in addition to the figures I referred to in paragraph 30, I estimate there are around a further 10,000 people with complex/severe or severe mental illness living in forms of supported accommodation and around another 10,000 living with family in Victoria, who would live independently if they could access appropriate housing and support.

33 I have also considered the number of active psychosocial Supported Independent Living packages **(SIL)**. Although, the Council of Australian Governments Disability Reform Council quarterly data[12] does not provide disability per state, my best guess is that there are currently around 500-530 active psychosocial SIL packages in Victoria. However, we

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[12] https://www.ndis.gov.au/about-us/publications/quarterly-reports

know from the quarterly reports that SIL uptake for psychosocial is running at about 10 per cent, lower than the modelling that the Productivity Commission did in 2011, which suggested it should run at 13 per cent for psychosocial disability. As far as I am aware, the figures in Victoria for SIL are markedly lower than the figures for New South Wales **(NSW),** where there are around 800 SIL packages for people with psychosocial disability.

34 This difference between NSW and Victoria is partly explained by system differences. New South Wales deinstitutionalised later than Victoria and as a result, it still has psychiatric institutions which it is slowly closing and moving people to live in the community where they receive supports through the National Disability Insurance Scheme **(NDIS),** including SIL, and in some cases, the Specialist Disability Accommodation (**SDA**). In Victoria, people with psychosocial disability have been living in the community for longer, in various forms of shared supported accommodation – including private and state-funded. Given the greater chance that people with significant impairments relating to psychosocial disability are already living in the community in Victoria, this makes the difference between NSW and Victoria quite surprising (in other words, I would have expected to see more SIL packages in Victoria, supporting people who already live in community to exercise control and choice in their living arrangements).

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

35 I note that the SHIP study identifies the proportions of people discharged from hospital following a psychiatric admission who reported being able to remember discussing their housing needs with a staff member prior to leaving (52.8%). Around two-thirds (64.2%) reported not needing help because they already had somewhere to live, whilst 21% received help for their accommodation needs. However, the study reports that 6.9% of respondents could not remember being asked about their housing needs, nor had somewhere to live on discharge. This study was reported in 2011, so these figures may not reflect the current position. Moreover, they are national, rather than Victorian specific. I am not able to quantify any further the extent to which Victorians with mental illness exiting mental health services into homelessness. The community interviews and provider focus groups that we undertook as part of the Trajectories study, however, make it clear that discharge into homelessness and/or the lack of inquiry into and assistance with housing needs, remains a widespread problem for people.

36 During the Trajectories research, we found that there were a number of drivers behind people exiting mental health services into homelessness:

(a) the lack of suitable accommodation options;

(b) a lack of awareness by mental health staff that people might have housing needs, or how to ask about housing in ways that were effective; and

(c) the failure to meaningfully involve family and friends in discharge planning.

37 We also know, from our work with area mental health services and hospitals, that it is difficult for clinical services to control the discharge process. For instance, someone may supply an address when they are admitted to an inpatient ward, but sometimes people don't return to the address they give when they are discharged – and in this case, the hospital has no way of knowing what has happened. We also heard accounts of exactly this, but from the family perspective in the community interviews for Trajectories. Families talked about discovering that their relative had been discharged without the family being informed and then had disappeared for a period of time. I understand that, in Victoria, clinical services were given additional brokerage funding to facilitate rapid discharge (as a means of countering bed block). The funding could be used to put someone without an address into a motel on discharge, but only for a short period of time.

Lack of suitable accommodation options and intensive support

38 The Trajectories study included an analysis of state mental health and housing policies, using the empirical findings to identify system/policy gaps, to identify options for policy development and system reform. A major gap appears to be the lack of options that combine suitable accommodation and intensive support in the medium term following a period of acute mental illness and incapacity.

39 Medium term support following an episode of illness and associated significant impairment, provided for a period of two years at a minimum and ideally up to five years, recognises that rehabilitation can be slow for some people. However, when adequate supports are put in place, and the person is housed in a safe, suitable and sustainable home, gains back to independence can be made. The former Adult Residential Rehabilitation model was a Victorian example of an effective medium term support. However, our critique of this program is two-fold: firstly, the two-year period was not long enough for some people; and secondly, at the end of their period of service (or two years), they had no guaranteed access to affordable and appropriate housing. The cycle of service exit into homelessness is never far below the surface.

40 Mind is interested in the option of developing a medium term approach that combines sustainable housing with intensive, flexible supports (see further paragraph 49 below). The interface with the NDIS is a major consideration in relation to the length of 'medium term'. Although the Tune Review[13] recommended greater clarity on the permanence clause in the NDIS Act and associated rules, there is no defined period that someone has

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[13] 2019 Review of the National Disability Insurance Scheme Act 2013 report by Mr David Tune AO PSM (https://www.dss.gov.au/sites/default/files/documents/01_2020/ndis-act-review-final-accessibility-and-prepared-publishing1.pdf)

to be 'ill' for before they meet the permanence criteria (as there is with other disability support and/or compensation schemes).

41 People who exit mental health services and end up being homeless, do so partly because they need a considerable amount of support to maintain any kind of secure or stable living. People who exit mental health services with insecure housing or who are homeless are likely to have a whole range of needs, requiring a response from multiple service systems. But currently there is not sufficient, formal and funded service navigation and/or care co-ordination to ensure that people are connected to the full range of services and supports that they need. For example, a person might have a clinical case manager, but the clinical caseloads are so high that clinical case managers cannot do the follow up that they need to do.

Families or friends not sufficiently involved in discharge planning:

42 As mentioned above, interviews with family members/carers in the Trajectories study indicate that there is a greater role for families and friends in discharge planning. During the Trajectories research family members and/or carers gave accounts of discharge of the person they were in a care relationship with, where they were not informed, or were informed but their advice or point of view was ignored. This is particularly concerning when what is being ignored is family concerns about personal safety, if the person is discharged back to the family home, or the person's safety, if they are discharged to somewhere else without adequate support. In the Trajectories interviews, we heard how families inadvertently became a 'provider of last resort' when the only other options were prison or homelessness.

43 Whilst hospitals and area mental health services may have clear standards and protocols in place to guide discharge planning and support, these alone do not guarantee discharge into appropriate housing, with required support. In 2017, the Western Australian Mental Health Advocacy Service conducted an inquiry into treatment, support and discharge of people under the WA Mental Health Act[14]. This was led by the Chief Mental Health Advocate, Debora Colvin. The inquiry found that none of the WA health service providers were compliant with prescribed standards discharge planning and support. Mind understands that this is partly because the people who receive treatment in hospital facilities under the provisions of the WA Mental Health Act are unlikely to have good access to primary and secondary mental health care that is essential for continuity of care across service boundaries. I suggest, from what we know from the Trajectories interviews, that the situation is largely similar across jurisdictions. This is not to place blame on the

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[14] https://mhas.wa.gov.au/assets/documents/TSD-PLANS-final-report-19-March-2018.pdf

hospital and health services, but merely to indicate that this is point of particular weakness in the system – and as such, is also a point for possible intervention.

HOUSING NEEDS AND HOUSING STOCK

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

44 I am unable to comment on the broader need for housing and homelessness services, but reiterate my 'best guess' in paragraph 30 above. There are between 6,000 and 11,000 people who are homeless with severe mental health issues, and up to a further 20,000 people with severe mental health issues who are living in non-preferred housing arrangements.

HOUSING FOR PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

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

45 The characteristics of effective service models for people experiencing severe mental illness and housing insecurity or homelessness are flexible and holistic support. The first step is housing people in secure and ongoing housing that is in a place that they actually want to live in or can come to terms with living in. Such housing should not be predicated on an absence of alcohol and drug use - alcohol and drug use has to be accommodated as part of the person's needs, which need to be worked through.

46 After housing, the next step is to ensure that a person has holistic support that deals with a whole range of needs, not just mental health, such as comorbid physical health or social isolation. People with mental health challenges are usually disengaged from friends, community and employment. Support in such areas should be able to flex up and down depending on the level of wellness.

47 In the Trajectories research, we found that when people were able to build a trusting relationship with the worker, whether a clinical mental health worker, from the community sector, an Aboriginal agency or a housing agency - they could start accessing services from a range of sectors that they needed. They just needed a relationship with someone in the service system that they trusted. Therefore, a trusted relationship is really important.

48 We also need to address more than a person's symptomatic mental illness. Often people who end up with both sustained poor mental health and housing problems have really deep experiences of trauma. Therefore, we need to provide supports to deal with previous trauma, including both trauma-informed psychosocial supports, and specific trauma counselling.

49 Finally, again drawing on Trajectories but specific to the Victorian context, I contend that the biggest gap in the system relates to medium term supportive housing. We need policy options that deliver secure, sustainable and suitable housing, along with flexible, person-centred supports for people who are rehabilitating from mental illness that has destabilised their lives in multiple ways. Whilst housing could be provided by the private rental market, we note the findings from Trajectories that emphasise the protective factor offered by public housing equal to home ownership. Specifically, the analysis of JH data found that public housing tenants were 10 per cent less likely to enter homelessness compared to private renters. There is not enough stock in Victoria to provide public housing for all those who need it. The Trajectories findings did not indicate the same degree of protection from community housing, but I would suggest that this is probably related to capability and capacity amongst housing providers, and can therefore be ameliorated by mechanisms to ensure appropriate workforce capabilities.

50 We also need to ensure that we have solutions that prevent families, prisons or homelessness services becoming the de facto provider of last resort. I refer to paragraph 60 below where I discuss the Community Recovery Program (**CRP**). We need specialised residential solutions for people whose behaviours, when unwell or distressed, can be scary or dangerous, particularly to others. Whilst we can manage these behaviours in regular SIL environments, it is very difficult for other residents in congregate care settings when someone who, because of their distress or illness, becomes violent and scary. The CRP is one example of an effective medium term solution for people in this cohort.

Examples of successful housing approaches in other jurisdictions

Housing First

51 The Housing First approach is an example of an international approach that Victoria could learn from to better support people experiencing severe mental illness and housing insecurity or homelessness. The Housing First model provides safe and permanent housing as the first priority for people experiencing homelessness, regardless of their enrolment in, or continuation of, any other forms of intervention (for instance mental health and/or addictions treatments). Once housing is secured, a team of support workers can address complex needs including mental ill-health. I believe the model was developed and trialled in New York by Pathways[15], and is based on five principles: immediate access to housing, with no readiness conditions; consumer choice and self-determination; recovery orientation; individualised and person-driven supports; and, social and community integration.

The Rehabilitation in the Community of Persons with Mental Disabilities Law, Israel

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[15] https://www.pathwayshousingfirst.org

52 I have also recently become aware of the '*Rehabilitation in the Community of Persons with Mental Disabilities'* legislation enacted in Israel in 2000 to shift the focus of treatment and support from inpatient psychiatric beds to care in the community.[16] As far as I understand, the law establishes an entitlement to rehabilitation support following a period of mental illness with resulting impairments deemed sufficient to qualify for support by a psychiatrist. I am interested in this because it establishes a legal framework for rehabilitation for mental illness. I understand supports can be provided in residential settings, selected from a continuum of housing options including supportive hostel/co-located apartments and supportive housing in the community. As far as I understand, the hostel settings are designed as 'supportive communities', where people live in co-located apartments in the community, with access to 24/7 support.[17] I draw attention to the hostel component of the rehabilitation program because, on the surface, it appears to share some characteristics with the Haven model that Mind operates, which I discuss at paragraphs 68 to 69 below.

HASP and HASI

53 Further examples of programs that are relevant to people with complex and severe mental illness are the HASP model in South Australia, and the HASI model in NSW. Each of these combines ongoing housing and support, including mental health support, with linkages to clinical care as required.

Many Rivers Aboriginal Housing Co-Operative

54 Many Rivers Aboriginal Housing Co-Operative provides a supported approach to tenancy management that balances the needs of the landlord and tenant well, with a culturally capable housing support workforce who intervene early and appropriately to help people maintain their tenancies. This model brings to mind for me the potential for a peer workforce in mental health tenancy support.

55 The characteristics of these models include: the provision of stable, secure housing, combined with support for mental health and wider social determinants or life domains; delivered by a workforce with diverse capabilities that cover the full range of people's clinical, psychosocial and practical support needs; unconditional access to housing and support; funding that is consistent and sufficient to maintain programs over time (not time limited, or 'trial' phase).

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[16] https://www.researchgate.net/publication/295860339_Israel's_Rehabilitation_in_the_Community_of_Persons_with_Mental_Disabilities_Law_Challenges_and_Opportunities

[17] https://www.health.gov.il/English/Topics/Mental_Health/rehabilitation/rehab_sub/housing/Pages/default.aspx

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

56 Some of the approaches to chronic homelessness in Victoria that include Housing First models have been good, including Sacred Heart Mission[18] and Launch Housing.[19] A randomised controlled trial of the Housing First program, Common Ground showed a significant decrease in inpatient admissions, including mental health admissions, without an increase in people's use of community mental health care services.[20] Although these are excellent examples of what can be done, there is no systematically implemented approach to ongoing housing plus support (referred to as supportive housing) for people with severe and ongoing mental illness, particularly where this is associated with complex support needs.

57 The mental health system has no medium or longer term offerings that combine housing and support for this cohort of people. The facility-based rehabilitation support that is available in Victoria through Prevention and Recovery Centres **(PARC),** including the extended PARC, is good. But, there is still a significant gap between acute and sub-acute inpatient care and access to, and availability of, long-term supportive housing and/or other support for housing and tenancy management available through the NDIS.

58 The Wellways Doorway program[21] provides support to people to maintain private rental tenancies, and in my opinion is a good program. The program works by providing a minimum of weekly support by a qualified housing and recovery worker. This worker leads a collaborative approach to ensure the clinical case manager, property manager, DES - employment consultant and other formal supports are working holistically to support the individual live sustainably and well in the private rental market.

59 However, one of the really big problems with private rental is that as soon as a person takes a private rental property, they lose their place from the public housing register. Therefore, it is not really even in their interests to try private rental. Changing how the register works so that more people would be encouraged to try private rental properties would be beneficial. I am aware that organisations are exploring ways of working with NDIS participants to support people in private rental tenancies – either through SIL or other price items designed for tenancy support. This is something that Mind has also investigated, but we have not been able to progress this much because of the issue of

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[18] https://www.sacredheartmission.org/seek-help/housing-support/journey-to-social-inclusion-program

[19] https://www.launchhousing.org.au/housing-support/housing-initiatives/

[20] Johnson, G., Kuehnle, D., Parkinson, S., Sesa, S.s & Tsang, 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

[21] https://www.wellways.org/our-services/doorway

people losing their place on the Victorian Housing Register once they enter the private rental market.

60 Mind, in partnership with Austin Health, runs the CRP in Heidelberg. The CRP is a 2-year residential service. The service aims to enhance peoples' ability to successfully live in the community and help people recover from the disability and social disadvantage resulting from psychiatric ill-health. A combination of clinical and recovery-focussed mental health supports are provided to residents living with severe and long-term mental ill-health. Seven of the twenty-two places in the service are allocated to forensic clients to support their community re-integration post-exit from Thomas Embling Hospital. The resident cohort comprises people with complex support needs, including behaviours when distressed/unwell that may be hard to manage and difficult for the individual and those around them.

61 In 2019, we undertook an evaluation of the CRP.[22] The evaluation demonstrated that people's mental illness symptoms decreased progressively over their time living in the CRP, they had less difficulty with family and social relationships, and in developing independence and autonomy. Residents also reported feeling much better about themselves and their lives. These are particularly encouraging results when we consider that many of the residents would be expected to have lived with mental illness for a number of years and dramatic changes in symptoms would not be predicted. Therefore, improvement in mental health given the persevering and severe nature of the mental health concerns in this resident group are significant in this context.

62 Importantly, the only negatives were related to the feelings of stress around service exit, especially if housing had not been secured. Both residents and carers were concerned about discharge occurring when a resident did not feel ready or was not able to arrange suitable accommodation. Residents and carers felt concerned that service exit could be dependent on "KPI's" and not true readiness. Transitions were seen as a stressful time that risked recovery gains made throughout the service. Given the history of trauma and developmental challenges for some residents, it is possible that attachment and developmental issues may be precipitating unhelpful reactions in some residents.

63 Carers and residents both wondered if the stress of discharge could be reduced and the timing of service exit could be re-negotiated if necessary. Carers also wondered if a "step-down" service could be available, providing stable accommodation and ready access to supports but less intensive than CRP. These suggestions indicate there is a great deal of anxiety about discharge in both residents and families.

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[22] Hayes, L., Shackleton, F., Davis, E. Murphy, C., & Karapolous, V., 2020, *Community Recovery Program: evaluation report,* Mind Australia, Melbourne

64 I describe these findings in some detail, because they are an excellent example of the need to ensure continuity in people's housing, as well as access to flexible and ongoing supports. When these are provided (as they are in other models, for instance, Housing First), then we begin to see really good life outcomes for people.

STRATEGIES TO SUPPORT HOUSING FOR PEOPLE LIVING WITH MENTAL ILLNESS

The role of the National Disability Insurance Scheme and Specialist Disability Accommodation in the provision of housing for people with severe mental illness

65 To date, the application of SDA for people with psychosocial disabilities has been limited. Our understanding is the SDA was established to ensure a supply of specialist designed housing stock that otherwise would not have been available in a general housing market. In other words, it houses or accommodates housing that was built to specific standards around inclusive design.

66 There has been insufficient or inadequate consideration of SDA's application to psychosocial disability. Based on National Disability Insurance Agency **(NDIA)** data from June 2019, it appears that around 300 people across Australia have been approved for SDA on the basis of primary psychosocial disability, whereas the figures in the original Productivity Commission report into disability care and support suggest that around 1200 people should have SDA in their plans by now.

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

67 The NDIA projected that about 6% of participants were intended to receive SDA funding. Using the Productivity Commission's estimation that there would be around 64,000 people with primary psychosocial disability in the Scheme once it reached capacity, we would expect to see around 4,000 people with primary psychosocial disability in SDA funded homes. Given that Victoria accounts for around 25% of the Australian population, it is reasonable to assume that around 1,500 of these people would live in Victoria. The figures we are currently seeing from the NDIA fall far short of this. As far as we know, there have only been 348 people across Australia who have SDA on the basis of psychosocial disability and the majority of those have come from one institution in New South Wales.

68 I have some ideas about why this is, but no hard evidence to support my conjectures. In part, I think it may rest in the lack of understanding of what constitutes the psychosocial support need within the NDIA, combined with a view that SDA is for people with high physical support needs. What I can say for certain is that there are problems with SDA regulations as they might apply to people with primary psychosocial disability. At present, the SDA regulations prevent builds that accommodate more than five people. This makes

it difficult to apply for SDA for models that rely on some shared or co-located living, even where there is evidence that these are suitable for a cohort of people with psychosocial disability. For instance, Mind runs the Haven model which provides congregate accommodation for 14-16 people, and where residents live in single apartments (similar to modern apartment living) but with access to mental health staff on a 24/7 basis. Each person has their own apartment, with everything that a regular apartment would normally comprise (bathroom, toilet, living area, bedroom), and access to their own outdoor area. Each Haven is located in desirable areas, with access to community facilities as well as services. Currently, all Haven residents have a SIL package, and the property component sits with the Haven Foundation, which is a registered Community Housing Provider in Victoria.

69 For people who have quite unstable mental health, having staff on site 24/7 can often help to de-escalate an impending mental health crisis, and consequently stop us from having to call an ambulance and/or take the person into ED.

70 Our view is that a congregate arrangement is also financially sustainable from a government funding point of view. It is extremely expensive to house people in separate dwellings to acceptable community standards. We are of the view that the Haven model is one option that does this really well in a shared or co-located environment. I also note that Haven provides a home for life. A resident only has to move out if they choose to.

GOVERNANCE

The contribution of people with lived experience to the development of policy, practice and research

71 Consumer, family and carer participation in all aspects of a recovery-oriented mental health system is essential. Without participation, there is no recovery orientation. Recovery is – in my mind – a concept framed by notions of social justice and human rights. Self-determination is at the heart of recovery, and participation is the best means to achieve this. Participation has to be central whilst we still have mental health legislation that can deprive people of their liberty on the basis of illness status. It is a means to shore up people's humanity, dignity and right to decide for themselves about how they live their lives. It is a means of achieving systems that are anti-oppressive and just in the ways in which they achieve outcomes and benefits for all – consumers, families, workers, the general public.

72 Here I draw on my experience of working with people in participatory processes over the last twenty years, and my PhD research which looked at the enhancement of service user autonomy through inclusive service development in different community service settings. On this basis, I contend that it is essential that people with lived experience have a say in what it means to experience mental distress (or illness, if that is the preferred term) and

recovery, where that say – or way of knowing – is equal to that of professionals and professionalised ways of knowing. My research found that when there is authentic co-production for service development (or participatory practice), services are more efficient, safer, and more humane.[23] When we involve people with lived experience of mental distress and recovery in service design, development and delivery, and treat their knowledge and input as equal to other ways of knowing, then we understand things about what we are trying to do that we cannot find out any other way. I note too, that there were identifiable health and wellbeing benefits to the service users and family members who took part in the co-produced service development activities that formed the basis of the research study. In other words, user involvement is good for people's mental health.

73 In my view, lived experience needs to be present at every single level of decision-making from policy down to individual service decisions. The problem is that it is difficult to achieve. It is relatively straightforward for an organisation to put in place practices that ensure that people have a say in their own service mixture and delivery. It is also possible for organisations to embed lived experienced ways of knowing in service development and service governance decisions – including implementing roles for people with lived experience. There is lived experience co-design at a local level, and there are governance structures that enable people with lived experience to have input into broad system reform processes. But to get all of those levels linked up is very difficult. In my view, it is not recognised sufficiently in our funding formulas. Resourcing is required to ensure proper involvement of people with lived experience. However, the more we move to transactional models of funding within marketised service systems, which promote a focus on an efficient price for delivery of support to an individual, the harder it becomes to ensure the proper involvement of people with lived experience particularly at the meso (whole of service) and macro (whole of system) levels.

74 My experience of working with inclusive or co-produced structures and systems has been in the social care/psychosocial NGO setting. However, I argue that there is a strong interface between co-production and recovery, and gains to be made in clinical settings particularly in relation to: reduction or elimination of restraint in inpatient settings; shared decision-making around medication; developing advanced directives and joint crisis plans (something that could well be taken up by the NDIA for people with NDIS packages); and the development of co-produced clinical governance and service delivery, with strong user involvement.

Mechanisms and structures that ensure people with lived experience to have a meaningful and enduring voice in decision-making at all levels of system design, policy planning and setting, and service delivery

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[23] Pollock, S., 2016, *Power and participation: enhancing service user agency in social care*, PhD thesis, School of Health and Social Development, Deakin University

75 From my PhD research, I can identify requirements for an organisational framework for ensuring that people who use services, and their families and carers, have a meaningful say in decision-making, as follows.

(a) First, put in place measures to ensure that there is organisational commitment to user involvement at all levels of the organisation.

(b) Second, find ways to value and utilise diverse ways of knowing, with a particular focus on the equal validity of lived experience knowledge – even where this challenges dominant and/or professionalised ways of knowing.

(c) Third, build relationships that intentionally challenge professional-client discourses (where power relations marginalise people who are clients, and their ways of knowing).

(d) Fourth, build systems to support organisational capacity to generate knowledge through participatory and inclusive processes (in other words, this is a specialised capability that needs intentional design and implementation). This includes developing models of leadership that are facilitative, responsive and transformative.

(e) Fifth, hold the organisation to account for its practice.[24]

76 I think it is also essential that there are designated roles for people with lived experience at all stages and levels of implementation of these processes.

77 The best outcomes will be achieved when people with lived expertise work alongside those with learned expertise. If we were able to implement approaches built on these principles in each and every organisation involved in the identification of need, and design, development and implementation of mental health policy and programs, then we would be going a long way towards having authentically co-produced services. I note that this framework is founded on principles that can be adapted to different organisational conditions and priorities.

Reforms that have given greater voice to people with lived experience in relation to service delivery

78 There is a program, 'Stretch to Engage,' which the Mental Health Commission in Queensland promotes as its preferred model to support user engagement and

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[24] Pollock, S., & Taket, A. 2014, *Inclusive service development: exploring a whole-of organisation approach in the community services sector.* In A. R. Taket, B. R. Crisp, M. Graham, L. Hanna, S. Goldingay, & L. Wilson (Eds.), *Practising social inclusion* (pp. 77-90). Oxford: Routledge

Pollock, S., In Press, Socially inclusive service development: a new expression of democracy for non-government organisations delivering social care, In A. R. Taket, B. R. Crisp, M. Graham, L. Hanna, S. Goldingay, & L. Wilson (Eds.), *Sustaining social inclusion,* Oxford: Routledge involvement.[25] It comprises seven principles that align well to the five principles that I have outlined above, and offers a values-based approach to changing culture in order to foster authentic engagement. I think that the approach of tackling engagement as an exercise in cultural development provides a practical way forward for organisations looking to achieve practice change. Rather than starting with policy and practice, it tackles culture, values and mindset, and asks what is required to have a more inclusive way of working.

79 Clearly, the NDIS is a major reform with a major objective of enhancing control and choice for people living with disability, in terms of how they are supported. Eighteen months ago, we undertook a research study, working with Deakin University, to explore people's experience of choice and choice-making in the NDIS (**the 'Choices' project**).[26] That research found that while the NDIS is good at giving a greater voice to the values and preferences of people with lived experience in choices relating to their individual service experience, there are some significant limitations on control and choice. We found that while the NDIS gives people choice on support for basic needs, it is much harder to have a choice around higher order needs that relate to their lifestyle and how they express their identity through the activities they want to engage in. These might include choices about education, employment, and personal development activities.

80 Access to information and support for choice-making at multiple stages of the NDIS process also emerged as problematic. People also found that the choices they wanted to make at times were not available (ie not on the 'approved list), or were deemed inappropriate in some way (not matching the professional assessment of need). For people with histories of trauma, and experiences of feeling voiceless and/or being ignored or being subjected to coercive interventions (denial of choice), even making simple choices can be very difficult. Reaching a point of feeling empowered to have a say and make one's own choices – including speaking against other powerful voices – is a journey of development for some people, and where support is not always available or obvious. When people become voiceless, it takes intentional work to understand what it means to have a choice and to feel safe exercising that choice.

81 The research also found that poverty and lack of access to financial resources remains a barrier to the choices that people have available to them. Many people in the NDIS who have a psychosocial disability are quite poor. The NDIS is blind to poverty or financial resources. One area where this plays out is in relation to housing. At present, people are unable to use any part of their package to support a rental tenancy, despite there being a widespread and acknowledged crisis in terms of housing affordability. This limits

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[25] https://www.qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/stretch2engage

[26] Wilson, E. Campain, R., Pollock, S., Stratford, A. & Brophy, L., 2018, *Understanding people with psychosocial disability as choice-makers in the context of the National Disability Insurance Scheme,* Mind Australia, Melbourne

people's choices in terms of where and how they live, but the constant pressure of maintaining a tenancy, and living with the fear of eviction, are deleterious to people's mental health, in turn deleterious to people's general functioning. The effects of poverty are cumulative: the longer people live in poverty (for instance, on a DSP or worse, NewStart) the harder it is for them to achieve and maintain a contributing life.

82 Therefore, while individualised, marketised systems like the NDIS offer some benefits in relation to personal choice, we need to understand the limitations on choice by learning from people with lived experience about what it is actually like having a choice for them. The 'Choices' research clearly demonstrated that choice, for people in positions of marginality, exclusion of disadvantage is very different to having a choice for people who are used to having a degree of voice in all parts of life.

83 The notion of a personalised plan that is responsive to a person's life circumstances, personal preferences and desires, and which the person has control over is an important facet of tailored and responsive services. However, individualised funding is only one way of achieving this kind of personalisation – and there are many problems for the so-called market (ie service system) that have arisen in the implementation of the NDIS. Greater attention on what resourcing is required to ensure a thriving service system, and funded work to build inclusive communities (rather than the current assumption that appears to be that communities will become more inclusive if people with disabilities are 'out there' with money to spend) would go a long way to optimising the opportunities for control and choice for individuals that systems like the NDIS offer.

COMMISSIONING

Ideal objectives and features of a commissioning strategy

84 A central objective for a commissioning strategy is to promote recovery through an approach that recognises the relationships and community connections that are essential to good mental health – including connection to formal services from diverse sectors, rather than a narrower focus on clinical symptom management. Commissioning should be informed by transparent identification of population need and service planning, where local people with lived experience have been involved. Commissioning should be informed by evidence of what works, specific to need and tailored to local conditions. Given the multifaceted nature of supporting recovery, we also believe a feature of commissioning should be clinical/psychosocial partnership models, and models that intentionally connect to other service sectors, for instance housing and homelessness, family violence, and employment support.

85 A redesigned commissioning strategy should also take account of the impact of commissioning models on workforce development and capability. Strategies which offer short term contracts through competitive processes are burdensome for organisations in

terms of response costs, and often fail to facilitate the development of a stable, high performing workforce. Strong forward planning would facilitate the delivery of commissioning strategies based on longer term contracts, and perhaps, in some instances, through block grants rather than competitive tendering. Pricing should ensure a sustainable and vibrant service delivery sector, where quality can be assured and safeguarded, through a workforce strategy that encompasses clinical, psychosocial and peer workforces, and recognises the additional components that go into making for high quality service delivery and good outcomes for people and communities. Effective commissioning also needs to consider the costs of contractual compliance. Mind's current compliance and accreditation costs sit at over one million dollars on an $80 million turnover.

a) Changes to current commissioning strategies required to realise these objectives

86 **There needs to be greater recognition of the cost of a skilled psychosocial workforce.** Pricing is a critical enabler of maintaining a skilled psychosocial workforce. NGO providers in Victoria are delivering services under multiple funding streams – NDIS, PHN and state funded services. Reflecting this, there could be economic modelling of the costs associated with a stratified staffing model, including higher skilled staff who can intervene to prevent and respond to mental health crises and suicide risk. This would also allow providers to build in career progression into their staffing model.

87 **There needs to be greater flexibility to respond to a mental health crisis.** This could be achieved by having models for crisis response that are based in the community, rather than located within hospitals and accessed through ED. Ensuring thorough clinical and medical assessment remains important during a mental health crisis; thus, new models lend themselves to clinical-NGO partnerships, with a strong focus on the role that peer support workers could play. In addition to commissioning innovative and community-based solutions to mental health crises, we suggest that some amendments to the operation of the NDIS would deliver better outcomes. We recommend modifying pricing arrangements to allow providers greater flexibility to respond to a mental health crisis. Options include creating greater flexibility in NDIS plans as recommended by the Tune Review, and likely to be implemented as part of the 2020/21 Annual Price Review. In addition, we would like to see contingency built into plans of participants with a psychosocial disability which can be used flexibly by providers when someone is in a crisis. For example, implementing dual staffing and additional costs related to coordinating with clinical services. If accepted in principle, the Victorian Government could advocate to the NDIA on this basis, and include this thinking in its own system design, through this Royal Commission process.

Responding and valuing the preference and needs of consumers in commissioning

88 Choice and control should be central principles of service delivery in a consumer-centred system. However, it must be recognised that with a great deal of choice and greater competition in markets, comes added responsibility. For people who have severe and complex mental illness, including dual disability with impaired cognitive function, they may require support to be able to exercise choice. Without it, the onus will fall on carers and families to assist them to make decisions about which provider they want to receive services from. Victoria's mental health system should have system navigators and clear system maps to help people navigate the system. The obvious choice would be to employ peer workers and family peer workers to perform these roles.

89 Furthermore, we know from our interactions with families and carers that helping people navigate marketised systems can be time-consuming, stressful and require particular capabilities that people may not have. Not all families and/or carers are in a position to help people to navigate systems – even where they are in a care relationship with someone who needs that kind of assistance. On this basis, we would suggest that commissioning strategies need to take into account the need for funded co-ordination/facilitation in service models where 'administration and management' involved in accessing support falls to the individual service user. Commissioning strategies should identify the navigational, administrative and management aspects of accessing and using services, and ensure that service models include provision for these elements of individualised delivery.

90 There must be an expansion of the peer workforce, including the family/carer peer workforce, noting that the Commission has already identified this in its Interim Report. Including peer support as a requirement in all commissioned services would be one way to achieve this. Where services are focussed on the consumer, the inclusion of a family engagement worker in the service model could be made a requirement. A family engagement worker is included in each of our services in Queensland: this has generated strong engagement with benefits to the consumer, their family and service delivery staff.

91 In addition to the provision of peer support in commissioned services, we recommend that resourcing includes an amount to facilitate co-design and user involvement at all stage of service planning, design, delivery and evaluation – recognising that authentic lived experience involvement is not cost neutral for service system enterprises.

92 In addition, the funding of a lived experience advisory body and secretariat to advise government and commissioning agencies on mental health policy, strategy and service design would support the development of a system that is responsive to the needs and preferences of consumers and their families/carers.

Benefits of greater market competition in mental health service delivery

a) Approaches to enable market competition in mental health service delivery

93 Improved consumer choice would be advantageous, particularly for those consumers who are subject to conditions in the *Mental Health Act 2014* **(the Act).** I note that the revised Act contains a number of provisions to enhance consumer control and recovery (for instance advanced directives, and supported decision making), but it appears that more attention is required in relation to implementation to really extract best advantage for consumers. I also note my previous comments about choice (in paragraph 79 above), based on our Choices research study. Choice-making is not a level playing field for people with significant histories of marginalisation, exclusion and trauma, and people need support to make choices, and to learn that they can indeed be efficacious choice makers.

94 In addition, we would welcome sector benchmarking, based on good systems to collect and analyse data, including client-driven outcomes data. Investment at the organisational level is required to achieve this.

b) The benefits and risks of the above approaches

95 It is my view that greater market competition in mental health service delivery, on its own, will create more risk than benefit. The system as it currently stands is not working in anywhere near an optimal sense. This is particularly the case for people who use tertiary mental health services. We have seen in the NDIS (with particular reference to people with disability associated with mental illness) how the introduction of market competition into an already floundering system has been problematic and has not brought about the intended improvement in experience or outcomes for participants. I argue that moving to market competition before some of the essential design features of an effective mental health service system are sorted out will be similarly problematic.

96 Greater competition may be of value in some sections of the system, or for certain needs or cohorts, but introducing it as a central principle for system delivery is, in my view, an error. However, opening up delivery, for instance to enable NGOs to provide clinical case management or to provide alternatives to ED for mental health crises, may offer opportunities for innovation and improved outcomes.

c) Protections that may be required to respond to thin markets and prevent market failures

97 Market stewards need to understand what thin market looks like. In the NDIS context, from a provider perspective, we could actually argue that the whole of provision for people with psychosocial disability and/or severe and complex mental illness is a thin market because of the requirement for a specialised workforce capability.

98 A workforce development strategy that incorporates clinical and medical provision, psychosocial rehabilitation and support, and peer support is essential for good market functioning. Workforce capability is a critical enabler of recovery-oriented, quality and safe supports for people with a psychosocial disability. This requires a more highly skilled workforce able to practice in ways that promote recovery, including competencies in skilled judgement, self-awareness, relationship building, problem solving, goal setting, motivational interviewing and coaching. We maintain that the psychosocial workforce requires a minimum Certificate IV in Mental Health qualification, SCHADS[27] 2 level worker. These requirements are consistent with what has been established under the Fifth National Mental Health and Suicide Prevention Plan, the National Mental Health Workforce Strategy and Industrial Law. We note that this is not supported by what is feasible under the NDIS, and we are concerned that state commissioned services continue to provide for a Cert IV minimum.

99 I note that NGO psychosocial providers face a range of unique cost drivers associated with hiring and retaining a skilled psychosocial disability workforce in an environment where the capabilities of this workforce are not well understood. The costs of staffing to minimum standards, as well as providing the workforce with adequate supervision and professional development translate into safety issues for clients and for the workforce. Further, there are costs associated with providing assertive outreach and coordination with other services and supports to maintain engagement and prevent/respond to a mental health crisis. As a result, a large proportion of providers are cross-subsidising across multiple funding streams, drawing on their reserves and are providing unpaid support due to their moral responsibility and duty of care. Insufficient pricing is the primary driver impacting on the financial viability of providers. We argue that it is essential moving forward that NGOs are funded for the full cost of service delivery.

Protections required to ensure high quality and safe services

100 A good understanding of the non-direct service delivery components of what goes into making that direct service delivery high quality and safe is needed. With our experience of the NDIS, what is funded is the interaction between the individual service provider and the individual participants. This is important as for people with psychosocial disabilities, much of what they need is embedded in that relationship. The care they need is relational and cognitive.

101 If you want consumers to participate and flourish, there needs to be more support for support workers and that is not sufficiently accommodated in the pricing structure.

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[27] Social, Community, Home Care and Disability Service

Approaches to grow and diversify the mental health service provider market

102 My view is that now is an opportune time to consider an expanded role for NGOs, in our own right and through partnerships with clinical services and potentially private providers. Over the last decade, we have developed capability in working with people with more complex needs and higher acuity. We have capacity in provision of support and in co-ordination, facilitation and navigation work. Many NGOs now have strong service governance frameworks, and some (including Mind) apply these to the delivery of supports in sub-acute and clinical settings. Our workforce now includes allied health professionals who can undertake assessments and planning and deliver a wide range of technical interventions, as well as the core of our workforce who provide psychosocial rehabilitation and disability supports. I believe that the opportunities to leverage the NGO workforce – with suitable standards and controls in place – far outweigh the risks.

COVID-19

Emerging changes in health service delivery as a consequence of COVID-19

103 Mental Health Services, including Mind, have changed the nature of their service delivery to comply with physical distancing requirements. Telehealth and phone services have replaced many face-to-face client contacts, including one to one supports, and formal group activities.

104 As many of our clients have severe and complex mental health issues, we have undertaken a process to determine the type and frequency of support provided to people throughout the pandemic. We have recorded the outputs from this process on 'vulnerability maps' (per state). Key workers regularly update these, and they are reviewed by managers to identify any situations that may require escalation or a change to current support arrangements.

105 The process captures information related to living arrangements, current mental state, type of support required and connection to services, including access to telephone and telehealth services. A risk analysis for each person was completed in close consultation with the person themselves, and their families/carers where appropriate.

106 This has meant that we have increased the frequency of support provided to some of our clients, while also continuing to offer face to face support where telehealth/phone options are not appropriate.

107 As we have responded to the changing conditions under the COVID outbreak, we have found that many of our clients are not able to access video conferencing facilities because: they do not have access to suitable equipment; they have low technical literacy; they cannot afford access to large data packages; and/or the internet connection is

patchy, especially in our regional areas. Therefore, we are offering many of our psychosocial supports via phone meetings. However, our staff report that it is difficult to make a full assessment of the client's mental health as visual clues are not available.

108 Furthermore, it is evident there has been care deferral, with reductions in all presentations, including mental health, to EDs, low inpatient unit admissions and low PARC occupancy. Community mental health services staff require further support to service the increased need that is being experienced both now, and likely well into the future.

109 A rapid scale up of the Community Mental Health System was needed before COVID-19, and now is required even more to assist in the surge of demand once immediate threat of COVID-19 is over. The mental health response will need to consider the social determinants of health and how they interact with mental health to provide a complete response to address both future and ongoing mental health needs. It is psychosocial support which provides this wrap-around support and helps people to build and meet the goals and aims that are important to them.

The potential for recent changes to emerge into longer term opportunities for new approaches to service delivery, for the benefit of mental health consumers and carers

110 Some of our clients have indicated that they have enjoyed the added flexibility and comfort of receiving supports by virtual means and therefore this should continue to be offered as a blended model once restrictions are lifted.

111 If telehealth services are going to continue to be offered beyond the pandemic, organisations need support to implement these services in the long-term. Whilst our staff have moved willingly to telehealth modes of delivery, we note that the skills in delivering mental health support via phone and video platforms are not the same as face to face, and some assistance for capability development is required: there is a risk that skill is being assumed.

112 Furthermore, Mind incurred significant costs to continue providing services through COVID-19. We have purchased phones with data for our clients, laptops for our staff to work remotely, essential Personal Protective Equipment in bulk to continue safely providing face to face services where necessary, videoconferencing licences and other essential items.

113 The impact that the pandemic has had on carers cannot be underestimated. We remain significantly concerned that carers' needs are not often considered a priority when government policy is implemented. An example of this, is that the Coronavirus Supplement was not extended to people receiving the Carer Payment.

114 Caring Fairly, which is a national campaigning coalition of carer organisations and coordinated by Mind, has undertaken a survey to understand the impact of COVID-19 on carers in their own words.

115 The survey ran for two weeks and aimed to assess the impact of the pandemic on carers' work and income, expenses, health and wellbeing and access to services and supports. The findings draw on 471 responses, collected from carers across Australia. Overall the results demonstrate the considerable impact the COVID-19 pandemic has had on unpaid carers.

116 Some key findings are:

(a) A majority (60%) of carers said they had lost some or all of the supports for the person they care for and almost half reported losing supports for themselves. Only 10 per cent said they had received extra support for either themselves or the person they care for since COVID-19.

(b) Almost half of the respondents said they had increased the amount of time spent on care tasks.

(c) The vast majority (81%) of carers said their mental health had deteriorated since the COVID-19 pandemic. Almost all carers (88%) had experienced increased stress in their role as a carer, with over half (52%) responding that their stress had increased by 'a lot' or 'an extreme amount'.

Longer-term opportunities for new approaches to service delivery, for the benefit of mental health consumers and carers

117 I believe there is great value to be gained for consumers and family members from alternative approaches to mental health crises, including models of care and support that take place outside the ED setting. Some that come to mind are: the Open Dialogue model;[28] peer-run crisis and respite centres, for instance the one run by Hafal in Wales[29] or the service run by Flourish in Hervey Bay, Queensland; recovery colleges (including those in Australia, of which Mind's was the first, and was evaluated in its early implementation[30]); peer navigators, peer engagement specialists, peer bridges,

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[28] https://opendialogue.org.au/

[29] https://www.hafal.org/gellinudd/

[30] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-mental-health/news-and-events/recovery-college-evaluation

networked peer workforces and other peer mechanisms that have been developed as party of the Yale Program for Recovery and Community Health.[31]

118 In addition, to be able to understand and optimise opportunities and developments over the long-term, we need an approach to data that centres on the outcomes that are meaningful to people. One excellent example is the Citizenship Outcome Measure, developed by Michael Rowe at Yale[32]. Unless we have outcomes data that is truly person-centric, the data we have available to us will not be sufficient to understand what creates value for mental health consumers and carers.

119 However, the best people to determine what is of value to consumers and families are those people themselves, working co-productively with other stakeholders who bring other forms of knowledge to the shared endeavour of a more hopeful future for all.

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

120 I offer a picture of the complex situation that Victorians who are impacted by severe and complex mental illness face in relation to finding and keeping a home.

121 Housing supply consists of different components: a highly rationed and limited supply of public housing, accessed through a central registry with a long, segmented waitlist; social housing provided by community housing providers; private rental; and home ownership. None of these forms of housing are specific to people with severe mental illness, and also have to meet the needs of other marginalised, disadvantaged and excluded groups. In addition, there are various forms of congregate accommodation, including rooming and boarding houses, SRSs, some congregate NDIS SIL properties and residential aged care (Including services with specialism in caring for elders with histories of mental illness and/or substance abuse).

122 With the exception of rooming and boarding houses, these forms of housing offer varying degrees of support with personal care, activities of daily living, health and mental health. Once again, they are not specific to the needs of people with severe mental illness. We know from the Trajectories research that people may wait years to get a public housing place – waits of more than five years were not infrequent, and people even waited up to

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[31] https://medicine.yale.edu/psychiatry/prch/

[32] https://medicine.yale.edu/psychiatry/prch/research/citizenshipmeasure/

eight years. People gave accounts of the stress and anxiety of waiting, the uncertainty, and associated feelings of hopelessness and worthlessness.

123 I note that the SRSs grew out of the deinstitutionalisation process in the 1980s to early 1990s, they are privately owned and often accommodate as many as 80 people per residence, including people with high mental health needs, with very limited support. Stays can be long or short term. Evidence emerging from the Trajectories study underlines that SRSs and other forms of private congregate care are an extremely poor accommodation option for individual dealing with complex mental health issues. Issues include unqualified staff, the complete absence of appropriate supports, including psychosocial supports, and significant social isolation. Many residents are essentially warehoused on medication, without access to services and no exit options, while others cycle through SRSs and Primary Care Connects (**PCC**) as part of a long history of unstable accommodation. In addition to this being a social justice issue, the SRS/PCC cohort also represents a potential business opportunity as a potential pipeline of clients into SIL, which some PCC operators are now taking advantage of.

124 In addition to these forms of housing – either with or without some built-in or integrated support, there are mental health supports designed to help people live independently that are delivered through outreach models. Since the implementation of the NDIS, these are largely accessed through the NDIS, with the consequence that people who are deemed ineligible for the NDIS have a very limited range of support for independent living – including support to maintain housing – outside of the NDIS. This is a departure to the period prior to the NDIS implementation, when there was a range of programs that provided support to people with serve mental illness, some of which were funded by the State Government (for instance, Individual Client Support Service, and the Adult Residential Rehabilitation program) and other by the Commonwealth (for instance, Personal Helpers and Mentors Scheme and Partners in Recovery). Under the prior arrangements, some form of community mental health support was provided to more than 290,000 people nationally – including 180,000 people who received individual support. This figure will be reduced to somewhere in the region of 70,000 people (ie DSS projections for participants with primary psychosocial disability at full NDIS roll out), leaving a shortfall in support for around 180,000 people across Australia – or an estimated 45,000 adults in Victoria.

125 There is a significant shortfall in the demand for options that combine housing and support, for those people who are not able to access the NDIS or do not get SIL in their packages. At a system level, the gap between supply and demand is particularly apparent in relation to housing and support for the medium-term period, say, up to five years, after which time if someone still needed housing and support, it would be reasonable to

assume that they should be able to access this via the NDIS (having fulfilled the nebulous 'permanence' criteria).

b) The extent and nature of unmet demand

126 I am not able to comment on the question of supply against unmet need. The RCVMHS Interim Report found that there are around 205,000 Victorians who, each year are likely to experience severe mental illness and may benefit from housing support. I note that the 'People living with psychotic illness 2010' study (SHIP) found that 12.8% of people interviewed had experienced homelessness at some point in the previous 12 months, and 5.2% were homeless at the time of interview. These figures correspond to around 28,000 and 11,500 Victorians with severe and complex mental illness and with experiences of homelessness – a total of 39,500 unwell people homeless in any one year.

127 Using the figures in the SHIP study, in combination with population prevalence figures in the National Mental Health Commission's 2014 report, I estimate that there are a further 10,000 people living in forms of supported accommodation and 10,000 living with family who, if they had the choice, would live independently if they could access housing plus support. I explain how I reached these estimates at paragraph 30 above.

128 At present, and to the best of my knowledge, only around 530 Victorian NDIS participants with primary psychosocial disability have SIL in their packages (which facilitates independent living that the participant has a degree of choice and control over). The original Productivity Commission projections for 'psychosocial SIL' put the need at 13%, or around 9,100 people (using the 70,000 DSS figure). This translates to 2,275 Victorians – a long way off the current figure. This is also a long way off the 39,500 people with severe mental illness who are homeless in any given year, many of whom will never enter the NDIS nor be eligible.

129 To the best of my knowledge, there are only a handful of Victorian NDIS participants with primary psychosocial disability who have access to SDA housing (if any).

130 In relation to housing supply, the Productivity Commission reports that there was a shortfall in social housing places nationally of 190,000 (2017 figures) – or an estimated 47,500 places in Victoria. Likewise, they note a shortfall of 8,000-12,000 supported housing places for people with severe mental illness (2016-17) – translating to around 2,500-4,000 Victorians. The report also notes shortfalls in availability of tenancy support, and growing numbers of people accessing homelessness services, with around a third experiencing mental illness. Finally, the report identifies around 2,000 people who are currently long-term inpatients in psychiatric facilities. Whilst it might be tempting to assume that none of these people are in Victoria, I have heard informally that there are people who are long term inpatients, and others stuck in forms of secure welfare because

it has not been possible to provide the level of support they need, and a place for them to live in the community.

c) The cause/s of unmet demand.

131 From the housing side of the equation, the lack of affordable, secure and appropriate (in terms of design and location) housing is the primary cause of unmet demand. There is simply not enough housing for people who are marginalised in the labour market, who are poor and who are continuously or periodically unwell and lacking capacity, to maintain a tenancy. This is compounded by the combination of inadequate rent assistance and low rates of payment for people on pensions or benefits (particularly for those on Newstart) – particularly for those who live in Melbourne where private rental remains out of reach for most people on low income.

132 On the mental health side, since de-institutionalisation, there has not been enough attention paid to – or resourcing put into – the housing needs of people who are rehabilitating from period/s of severe mental illness/distress. This is a predominant pattern in western economies: when care and support was shifted to the community, the question of where people would live was largely overlooked or assumed.

133 This has been exacerbated by chronic underfunding of our mental health system and continued contestation over what constitutes ‘mental illness’ and the ‘mental health need’ (put crudely, to what extent is it a biological illness suited to a clinical/medical remedy, all the way through to an individually and socially experienced variation from what is deemed ‘normal’ suited to a range of social and psychosocial supports). Our inability to reconcile the biomedical needs of people who experience extreme distress with their human rights, impacts on policy, resourcing and programs. In the Trajectories community interviews, we heard account after account where people spoke about only being able to get help (with either mental health or housing) when they had reached absolute rock bottom, and then, were largely only able to access short-term assistance with the most immediate and pressing problems.

d) The most critical unmet demand

134 The most critical area of unmet demand is the supply of affordable, secure and appropriate housing. However, as the Trajectories research makes clear, housing on its own is insufficient for people who live with the impacts of complex and severe mental illness.

135 If I consider unmet mental health and housing needs for these people, some patterns of unmet need emerge. There is unmet demand for:

(a) housing and support for people who are currently homeless, including those who are living in sub-standard accommodation such as rooming and boarding houses.

(b) extended rehabilitation support for people who have been unwell, including those who have been unwell in the past, but who didn't receive the support they needed to rehabilitate at the time.

(c) support for people who generally manage their tenancies well (and other aspects of their lives), but who need extra assistance – including assistance to manage their housing – either side of a period of acute illness.

(d) long-term housing and support for people who have received all the rehabilitation support that is available, but still require ongoing assistance. This cohort would ideally meet NDIS eligibility requirements, including access to SIL or SDA, but as I have made clear, this is not currently the case.

(e) housing and support for young people (potentially up to the age or 25, or even 30), whose needs differ somewhat to those of older adults.

136 For each of these cohorts, the unmet mental health need includes flexible access to services for a sufficient duration to achieve desired individual outcomes on a range of life dimensions that cover physical and mental health, personal safety including sense of self, social relations, community connections and activities, education and employment. The current service system response comprises elements of what is required, but not in sufficient volume, duration, accessibility or flexibility to meet need.

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

137 There are very clear impacts when people are not housed properly nor supported around their mental health. They end up coming into contact with the criminal justice system and may end up in prison. They use EDs more frequently – including being taken there by police. And in some cases, the family becomes the de facto 'provider of last resort'. We heard accounts from family members in the Trajectories study of the toll taken on the family unit when all other options have run out or been used up: the impacts are financial, on health and wellbeing and on family relationships.

138 What we saw clearly in the community interviews in the Trajectories research was how this was driven by a lack of early intervention, and by a service system that only responds once things have reached crisis levels. We heard repeatedly that people were not able to get assistance either with their mental health or housing until they had reached an absolute crisis point. It is then possible to receive assistance from costly tertiary services that only last for the period of the crisis. For example, someone's mental health may start to deteriorate but they are not be able to get help at this stage. They then may jeopardise their living arrangements or become homeless, end up spending some time in the ED or

even an acute inpatient unit until their mental health is stabilised, then be discharged with minimal supports only for the whole cycle to start again.

139 One of the three negative trajectories in our recent research showed this pattern of cycling in and out of the system because of the focus on crisis management. We found that through each round of the cycle, they lost a bit more capability, such as social connections, confidence in navigating the systems of support, and trusting professionals, thus creating a downward spiral.

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?

140 I have little detailed knowledge of the intergovernmental arrangements that relate to housing and homelessness in Victoria. However, I make my observations based on my experiences in the mental health sector – which is also subject to complex intergovernmental arrangements.

141 When multiple layers of government are involved in the delivery of services to the community, it can make it difficult to track vital aspects of system delivery, in particular expenditure and outcomes (at both policy and program levels). Setting strategy that takes account of and integrates Commonwealth and state responsibilities is also problematic, with the attendant risk of lack of accountability.

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;***

142 The following comprise priority cohorts (in all cases, severe and complex mental illness/distress is assumed):

(a) People who are currently chronically homeless, or at risk of becoming chronically homeless. These may be people who are street sleeping, living temporarily with families or friends, or living in boarding or rooming houses, either repeatedly or likely to be repeatedly.

(b) People who are currently living in supported accommodation or with families, where this is not a preferred option and where the situation is not sustainable, unsafe or in other ways deleterious for the person and those they live with.

(c) People in private rental tenancies or home-owners whose tenure is at risk, particularly where there is a pattern of tenancies breaking down. This may be associated with income poverty and financial insecurity, family violence and personal safety, inadequate social support, lack of access to services or some combination of these.

(d) Young people who are at risk of becoming chronically homeless (all forms).

b) why you consider them to be a priority cohort

143 In the first case, other than the clear equity issue that there are people without a home in a country as wealthy as Australia, people who are homeless are clearly unable to get their needs met within their current resources. Moreover, when they access services, this tends to be at the more costly, tertiary end of the service system. The complexity of their needs requires a multi-dimensional, cross-sectoral and specialised response that is not widely available in current service offerings.

144 In the second case, whilst these people may not be as visible to the service system or the public eye, they nevertheless represent significant need that has not been appropriately met. Although they may be 'out of sight, out of mind', in many cases their care and support places greater demands on their families, due to their financial, personal and wellbeing costs. Moreover, without alternate supports, this group will not go on to lead a contributing life.

145 In the third case, timely and sufficient intervention could easily prevent an escalation of distress and forced moves and enable the person to return to a contributing life as soon as possible.

146 Young people must be seen as a priority to change the trajectory of their lives to one of flourishing and contribution. As with the previous cohort, if sufficient, appropriate and timely supports are put in place, young people can go on to life fulfilling lives.

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

147 Many of the features of what is needed are common to all groups. The Trajectories research enabled us to identify features of a service system, which, if in place, would likely flip the switch on the negative trajectories of being excluded, being stuck or cycling so that people moved through a more positive stabilising or doing well trajectory. These essential elements are often missing, not accessible, or available in sufficient

combination, duration in our current system configurations (and can thus be understood in terms of unmet demand). These are (as I outlined in paragraph 16 above):

(a) access to safe, secure, affordable and appropriate housing in a meaningful location;

(b) connection to a trusted worker who can help them navigate service systems;

(c) funded support co-ordination, and assistance and advocacy to navigate service systems;

(d) greater access to psychosocial support for day-to-day tasks and to take part in meaningful activities;

(e) financial security that provides for a reasonable standard of living;

(f) holistic and flexible support (clinical and psychosocial) that meets the level and duration of need, and timely access to support; and

(g) expanded access to trauma-counselling and culturally appropriate services.[33]

148 The above elements could be delivered through a schema that understands need in relation to short-, medium- and long-term support, as follows:

(a) A comprehensive program response for **people who currently have housing, but need help to maintain a tenancy when they are unwel**l, and in the period following acute illness/distress when they may still be functioning at less than par. This would focus on regaining mental wellness and improving functioning, tenancy support, including the possibility of short-term financial assistance, financial counselling, linkage to other community services and assistance to enter, re-enter or maintain paid work and/or education.

(b) A comprehensive program response for **people who need a medium-term intensive housing response that combines accommodation and support.** A key distinction between this and the previous programmic response relates to the mental health status of individuals – in this case with more unstable mental health and needing a longer and more intense mental health response than in the previous group. This would focus on stabilising mental health and building or rebuilding life skills. In some cases, the best outcomes may be achieved if support is provided in a residential setting for a period of time (for instance the Austin Health CRP (see paragraph 60 above), or modified and extended versions of Community Care Units). For others, the support can be delivered through a

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[33] Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S. and Davis, E. (2020) *Trajectories: the interplay between mental health and housing pathways*, AHURI Research Paper, Mind Australia, Australian Housing and Urban Research Institute Limited, Melbourne, p 2, 84. https://www.ahuri.edu.au/research/research-papers/trajectories-report.

community-based program such as Early Intervention Psychosocial Support Response (which could be considered for ongoing funding, following evaluation and review). However, it is essential that a goal of the program is to transition people to ongoing housing (with support) once their period of tenure in the residential setting is completed.

(c) A comprehensive program response for **people who need specialised long-term housing and support**. In an ideal world, this cohort would be the NDIS participants, whose needs would be met by appropriately constructed and sufficiently resourced packages, including SIL and/or SDA where appropriate.

(d) A comprehensive program response for **young people** with significant mental health challenges. This is explored in paragraphs 162 to 167 below.

149 I have considered these responses as a mental health responsibility, although the responsibility to ensure a supply of housing sits in Victoria with the Director of Housing. There is some cross-over in the medium and long-term groups with people who are chronically homeless and who have, or are at risk of severe a complex mental illness. The needs of this group are currently met through the housing and homelessness systems through models like Common Ground. Whilst these may be seen to be outside the remit of the Royal Commission, the Trajectories research clearly demonstrates that environmental exposure to stress, such as housing instability and financial insecurity or poverty, can lead to mental illness and exacerbated distress. Once we accept the role played by social determinants in mental health, then the scale-up of housing first based solutions to homelessness must be part of the solution.

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

150 While improved discharge planning and service integration at the service level, and enhanced and extended holistic support, service navigation and/or care co-ordination at the individual level are part of the solution, on their own (even in sufficient supply) they will not deal with this problem.

151 An increased supply of housing and support is essential. People need to be discharged to somewhere that they can live for an ongoing period of time, with the support that they need, and a guarantee of further housing at the end of intensive support. Moreover, the housing component of service responses must operate on a ‘housing first’ principle. Whilst integrated housing and mental health supports work well, for instance the housing first models, continuum of care approaches and combined hybrid models such as assertive outreach focussing on street sleepers or on discharge post-institutional care, there is insufficient volume to meet demand.

152 In order to reduce rates of discharge into homelessness the following are required:

(a) better identification and more sophisticated understanding of people's housing needs at some point during the hospital stay – including for ED presentations. In part this relates to policy and protocol, and in part to workforce capability and resourcing. Better data capture would facilitate more effective discharge planning that is inclusive of the person's housing needs, and family/community context.

(b) rapid access to secure, sustainable and affordable housing, and the capacity to place the person somewhere that they are likely to want to live. This means addressing administrative barriers around geography and eligibility.

(c) extended and effective follow-up post-discharge, to ensure that the individual's mental health needs are being met, and the tenancy is being sustained.

(d) effective policy and stakeholder co-ordination at local levels, via formal agreements, MoU and local collaboration arrangements.

153 These measures will only work if there are high-level policy and agreements to enable delivery at scale. This will require funding to develop innovative models that are properly evaluated prior to roll out. Service delivery funding must be sufficient to cover local collaboration and co-ordination, and to enable organisations to recruit retain and support appropriately skilled workforces across mental health and housing sectors.

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?

154 Trajectories demonstrated that the nature and quality of tenancy management has an impact on people's mental health and sense of dignity, and on tenancy outcomes. A good tenancy manager can be the difference between a successful tenancy, or an eviction. We were able to identify features of effective tenancy management: an empathic and caring tenancy manager who listened to people respectively and worked with them to generate solutions that suited both parties. Knowledge of mental health, triggers for deterioration and early intervention when problems arise, how to work in ways that are supportive, and when to escalate to specialised support can all be implied from the study. Conversely, the research demonstrated that when people are treated badly by tenancy managers, through rude behaviour and/or administrative incompetence, this has a negative impact on mental health and is not effective in helping people manage their tenancy.

155 I note that larger community housing providers who are able to include housing workers with mental health specialism seems to be effective. The Victorian Aboriginal Housing Trust has recently implemented a program to support tenants through a life coaching, peer support model. This program is being evaluated throughout implementation, and I

believe that the model would work well for people with severe and complex mental illness. In NSW, the Many Rivers Aboriginal Housing Co-operative (referred to at paragraph 54 above) has a model that balances the needs of the landlord with the needs of the tenant, and includes a large Aboriginal workforce (equivalent to the peer workforce in mental health). Housing workers were proactive in helping people early who were struggling with their tenancy, worked in culturally appropriate ways because understood the sorts of problems that Aboriginal families had in managing their tenancies.

156 The quantitative data from Trajectories found that public housing provided a protective response equalled only by home ownership – and more than was found for community housing. Our view is that this is because of the security of tenure that public housing offers, and a lack of capability in the community housing workforce at large (although we note there are community housing providers who work really well with people with severe and complex mental illness). Having a housing workforce with mental health capability and support is critical. This could be achieved through specialist roles within housing providers or through partnership models and mechanisms.

157 On the tenant side, I would argue that there is a need for mental health literacy as it relates to maintaining a tenancy – and this includes financial counselling and developing financial management skills.

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)?***

158 What we saw in the Trajectories study was that the public housing bureaucracies are, by and large, not as well placed to offer positive tenancy support. The better examples were where NGOs were operating as community housing providers, in some cases because of their specialised knowledge of the needs of tenants with mental health issues (for instance, Mind's Haven model). We also saw good results where generic housing/homelessness organisations can employ specialised mental health skills or develop partnership models so they can access these skills (for instance, Launch Housing, or Mind's work with various community housing providers in our congregate SIL properties). Where community housing providers are able to draw their staff largely from the community in which they were working, tenancy managers and support staff then understand the pressures tenants experience, and what constitute acceptable and effective ways of working (in particular, in the Aboriginal housing sector).

159 There are a number of community-managed mental health organisations who take on tenancy support work. They do this by employing staff with skills in mental health and tenancy management, including in some cases, skills in working with the private rental market – for example, real estate agents and landlords.

160 The key point here is that mental health support and tenancy support are specialised capabilities within broader community supports, and this should be reflected in models of provision and resourcing to ensure an appropriately skilled and regulated workforce. My current understanding of the situation leads me to believe that the better role of the Director of Housing is in ensuring supply of housing, whilst tenancy support is facilitated by organisations who are closer to the worlds and lives of the tenants.

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)?

161 I am not able to comment on the size of cohorts.

162 The Productivity Commission's report into mental health describes young people with more moderate to severe and complex mental health issues who are in danger of slipping through the gaps of the mental health and housing/homelessness systems – potentially a wider population groups than adults, because of the particular developmental needs of young people. These come about because young people have not developed the life skills that they need to maintain a tenancy. They also have access to fewer financial resources.

163 Groups who are particularly at risk include:

(a) Young people who are existing residential (including out-of-home care) services or coming out of juvenile justice.

(b) Young people living in private congregate care with minimal other supports.

(c) Young people who are at risk of becoming homeless and who are not connected to any services.

164 I agree with the Productivity Commission's assessment of need, that young people need more specialised, intensive and extended care than is currently available in the primary sector. The Productivity Commission notes that many of the young people who need assistance fall below the threshold for access to state-funded and/or continuing care.

165 The findings from Trajectories reinforce the importance in intervening in a comprehensive way for young people, before the impacts of early experiences of homelessness and/or housing instability set a template for later life. Young people – especially those aged 16-24 – face major barriers in accessing NDIS assistance because of the difficulties of establishing a diagnosis and evidence of permanency. Mustering the bureaucratic stamina and knowledge required to access the scheme and accommodation options attached to it is also beyond the capabilities of young people whose lives are already

disrupted. Young people with mental health issues have not been factored into SIL or SDA provisions, and both medium term residential mental health and youth housing and support options are limited.

166 Based on our service delivery experience, we note the following unmet demand in terms of housing and accommodation for young people exiting residential services:

(a) The removal of block-funded outreach services for young people, limiting outreach post-discharge from a youth residential rehabilitation service, to six weeks. Ongoing service provisions is crucial not only in terms of getting young people exiting residential services into accommodation, but also tracking their progress with a view to helping to make sure it is sustainable. The role of an ongoing and consistent advocate is particularly important in terms of helping young people access accommodation options such as private rental (and related to this engage with education, employment, training, medication regimes and service engagement generally, including getting into the NDIS). A family member usually fulfils this advocate role, but many young people don't have access to this due to family breakdown. Linked to this are the shortfalls of the headspace model, the dominant model in the mental health space for young people, particularly as it relates to housing and employment.

(b) Private rental is a key exit option but is expensive and often of poor quality. Young people are massively disadvantaged in terms of the private rental market. Shared housing is often the only private rental option. However, this is not suitable for all, and often the young person might achieve better mental health outcomes by living alone (this highlights a potential youth specific element to the question of what the components are of a mental health housing intervention for young people dealing with mental ill-health).

(c) Another accommodation option is transitional housing. Mind has nomination rights into a number of transitional housing units, managed variously by Housing Choices Australia, Active Housing and Unison. Complications arise from the fact that the state government mandates these transitional housing applicants have outreach support, i.e., in an NDIS plan, which potentially excludes young people. At the moment, Mind is funding this outreach support for some young people. We also understand that nomination rights may disappear once we transition to the Victorian Housing Register.

167 Private congregate care accommodations, in particular SRS, are one default option for people exiting mental health services, including, young people. I am are aware that this is the destination for some young people existing Mind's youth residential rehabilitation services, because there is no other viable option. Young people generally do not fare well

in these forms of accommodation because of the high risk of abuse and neglect, which occur under minimal support conditions.

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

168 One of the things we know about young people is that they often do not use tertiary services like mental health and housing until things are quite bad. They tend to rely on their informal networks until things get so bad that those informal networks cannot support them. At this point, they may end up in ED, sometimes taken in by the police who have been called out by family, school or a member of the public because things have escalated significantly and rapidly.

169 We need models that identify early that a young person is vulnerable in relation to their mental health and housing. Early identification may best be done by non-mental health sectors – for instance schools, family services welfare agencies, out-of-home care providers or other community services and resources. Once identified, models need to include formal supports that focus on helping them build informal support networks. These have been found to be effective because young people do not operate in entrenched in patterns that can be seen once people reach their mid-thirties and beyond. The research evidence indicates that young people do very well when they are helped to build informal community resources, noting that co-ordination of formal and informal resources is important, and needs to be resourced as part of a service response.[34]

170 Early intervention should also take a family focused view. Once identified, we need models that support young people to stay at home, where it is the preferred for the young person and their family. This means understanding risk and safety in the family context, and what would support safe shared living. Whilst systems may identify vulnerable young people, supports must in these cases be aimed at the family group as a whole. When it is not appropriate or safe for the young person to stay at home, then there must be immediately available youth specific housing and support, with a focus on stabilising and maintaining mental health and connection to education, training and or employment.

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?

171 One model that interests me in terms of its potential application to young people with mental health issues is the Youth Foyer. These provide supports to enable young people who are at risk of extended marginalisation, disadvantage and exclusion to develop and achieve educational and employment pathways, to avoid long-term welfare dependence.

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[34] Duff, C., Murray, S., Loo, S. & Jacobs, S., 2013, *What is the role of informal community resources in supporting young people recovering from mental illness?*, AHURI Research and Policy Bulletin No. 165, AHURI ltd., Melbourne

Currently the program is run as an integrated approach by homelessness and education agencies. Central to the model is the provision of stable accommodation for up to two years in a supported, congregate living environment. The support model is personalised and goal oriented and focuses on the individual young person and their specific capabilities, talents and hopes for the future.

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?

172 There are various local examples of services that do great work with young people who are at risk of, or homeless with mental health issues. Hope Street and Melbourne City Mission are two that I am aware of. The Youth Residential Rehabilitation **(YRR)** services that operate here in Victoria and in Queensland also do excellent intensive work in supporting young people with significant mental health issues to develop the skills they need for adult life. However, there is no systemic response ready for them once they complete their time in a YRR. Poor housing, following a period of rehabilitation, can quickly undo the good work done in the previous service – particularly if the young person has a background involving trauma. This is consistent with case studies of youth clients from our YRR service staff, and with the findings from Trajectories. I believe there is a clear policy and service development opportunity here.

173 This indicates that we don't have a fully-fledged, systematic approach to addressing the housing and mental health needs of young people at risk. There is no developed youth housing first approach, nor commitment to attend to the needs of young people whose futures are at risk because of their combined mental health and housing challenges.

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?

174 To date, the application of SDA for people with psychosocial disabilities has been limited. There has been insufficient or inadequate consideration of SDA's application to psychosocial disability. As discussed in paragraph 67 above, the NDIA modelling indicates that around 6% of participants should be eligible for SDA funding. For Victorians with primary psychosocial disability, this translates into around 1,500 people. This is far short of the current national total for this disability category, which I understand is about 300 people, 250 or so of whom have come from the closure of one institution in NSW.

175 Mind would like to see an expansion of existing SDA strategies and policies to support SDA for people with complex, severe and persistent mental illness. We are of the view that this is entirely consistent with NDIS objectives around independence and enhanced social and economic participation. Our view is that the majority of thinking about SDA up until now has been about how to accommodate people with high physical needs, including

ramps, hoists and high-end technologies. However, there has been little attention and understanding of the built environment needs that people with psychosocial disability might have, including soundproofing, natural light, designs that connect the interior living environment with the natural environment/nature, and access to individual, private bathroom and toilet.

176 The Trajectories research demonstrated how the built environment has a significant and important impact on people's mental health and recovery, including the size of dwellings, the light, ambience and aspect, and the neighbourhood. These are not universal design features and can therefore be understood as requiring special builds to meet need under the SDA scheme.

177 We also recommend that SDA builds need to conform to trauma-informed design principles so that people feel safe in their homes. As well as the features I have already mentioned, these principles take into account lines of sight in/out of windows and doorways, orientation of the dwelling in relation to surrounding buildings and so forth. These specific built environment needs are generally not considered in regular builds, or if they are, place the dwelling out of financial reach of people with psychosocial disability.

178 In summary, for people experiencing severe mental illness and housing insecurity to be better supported by the SDA part of the NDIS, the following are required:

(a) consideration of evidence of the nature of the SDA psychosocial disability need, and development within the NDIA of capability (including cultural acceptance of the existence of the need) to respond to this need via SDA.

(b) design criteria that focus specifically on these needs, including soundproofing, natural light, designs that connect the interior living environment with the natural environment/nature, and access to individual, private bathroom and toilet. Standards should also conform to trauma-informed design.

(c) greater flexibility with the SDA rules to allow the development of apartment-style congregate living for up to 20 people (as discussed in paragraphs 68 to 70 above). This would allow the provision of financially sustainable 24/7 onsite support to de-escalate mental health crises and divert away from ambulance call outs and ED presentations. Moreover, it would allow the development of intentional communities of peer and family support – something that is seen as desirable by some people living with severe and complex mental illness, and by their families.

179 I note, however, in making these points that SDA will not meet the ongoing housing and support needs of all Victorians who live with severe and complex mental illness. There

remains a role for state governments to play in the provision of medium and longer-term housing and support options.

sign here ►

print name Dr Sarah Pollock

date 14th May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SP-1

This is the attachment marked 'SP-1' referred to in the witness statement of Dr Sarah Pollock dated 14 May 2020.

Curriculum Vitae

Sarah Pollock

Qualifications

Doctor of Philosophy, *Power and participation: enhancing service user agency in social care,* School of Health and Social Development, Deakin University (2016)

Master of Business (Organisation Change and Consulting), RMIT University, Melbourne (2002)

Graduate Diploma in Education, La Trobe University, Melbourne (1991)

Bachelor of Arts (Hons) in English Literature/Psychology, University of Newcastle-Upon-Tyne, U.K. (1983)

Summary of employment

Jan 2017 – current	Executive Director, Research and Advocacy, **Mind Australia**
Nov 2014 – Dec 2016	Senior Advisor, Policy and Strategy, **Mind Australia**
Feb 2013 - Oct 2014	General Manager, Research Development Advocacy, **Mind Australia**
Jan 2012 - Jan 2013	Manager, Strategic Projects, **Mind Australia**
Jan 2012 - Dec 2013	Research and development consultancy (concurrent with above)
Dec 2005 - Dec 2011	Executive Manager, Research and Social Policy, **Wesley Mission Victoria**
Feb 2002 - Nov 2005	Researcher, **URCOT (Union Research Centre on Organisation & Technology)**
July 1998 - Jan 2002	Manager, Research & Curriculum Unit, Faculty of Business, **RMIT University**
June 1995 - June 1998	Senior Project Officer, Education Programs Improvement Group, **RMIT University**
Jan 1992 - May 1995	Co-ordinator, Communication Skills, and Consultant, Industry Training Unit **Melbourne College of Textiles (TAFE)**
Prior to 1995	Teaching roles in various adult and further education institutions in UK & Australia

Detailed employment history

Feb 2012 – current Mind Australia

Jan 2017 – current Executive Director, Research and Advocacy, Mind Australia

Key responsibilities

- Establish, develop and manage Mind's policy advocacy function, including identifying priorities for advocacy, and leading campaigns and other influencing strategies
- Monitor the external policy and systems environment to identify opportunities relevant to Mind's focus on mental health and the participation of people with mental illness, develop positions and position Mind centrally in key debates
- Lead Mind's investment in research and evaluation, ensuring it is strategically aligned, and delivers value to the organisation

Achievements

- Rapidly established the advocacy function and developed a five-year program of work that is now being implemented; integrated this into the research and evaluation program
- Developed and launched 'Caring Fairly', a national campaign with over thirty coalition partners, focused on securing economic, social and cultural rights for unpaid carers
- Led a major research program on mental health and housing, undertaken with AHURI; translating this for policy service development advocacy
- Led the development of an organisation-wide approach to managing client outcomes, facilitated by a digital platform for outcomes measurement

Nov 2014 – Dec 2016 Senior Advisor, Public Policy and Strategy, Mind Australia

Key responsibilities

- Provide high level advice to CEO, Board and Executive on the state/national health and social care policy and service systems, to facilitate development and implementation of organisational strategy
- Work with the CEO to identify priorities and opportunities in the external environment, and scope business and service development initiatives for the whole organisation (delivery in four states)
- Commission, lead and manage organisation-wide projects related to strategy and business development, including working in collaboration with relevant organisational stakeholders to undertake change initiatives and projects

Achievements

- Rapidly established this new role, so that it produces clear, accessible and timely outputs (advice and project outputs) that the Executive and Board rely on, trust and utilise
- Rapidly synthesised a large amount of material (including policy documents, existing research, organisational data and project outputs) and provided succinct but comprehensive briefings on key issues for Board and Executive to consider in relation to Mind's new strategy plan
- Created good engagement of a broad range of organisational stakeholders, including consumers, families and carers, staff, managers and Board in the development of the new strategy plan
- Currently leading a range of cutting-edge projects that will assist Mind transition into a 'marketised' service delivery system whilst retaining its core values and practice excellence in working with people significantly impacted by mental illness

April 2013 – Oct 2014 General Manager, Research Development and Advocacy, Mind Australia

Key responsibilities

- Provide direction and strategic leadership to the Research Development and Advocacy Division (RDA), comprising eight organisational units covering diverse functions (34 staff, with an operating budget of approx. $3m)
- Lead and provide support to staff in the division, develop and support the divisional leadership team and ensure that structures, communication and processes are in place to guide the division's work
- Lead the development of frameworks and systems to support: quality service delivery and quality assurance; service development; organisational learning and practice development; consumer, family and carer engagement; and the provision of policy, program and strategic planning advice to the organisation

Achievements

- Managed a large, complex and evolving division during a period of uncertainty and change in the external and internal environments. Significant and ongoing restructuring work meant that the composition of RDA changed frequently, and, in collaboration with senior colleagues, I successfully managed transition of organisational units in and out of the division
- Undertook an internal review of the role of and value provided by RDA to the organisation. On the basis of this, I identified opportunities for improvement, including alignment to strategic and operational priorities and the delivery of outcomes, and then put in place activities to enhance RDA's value and utility to the organisation (see below)
- Strengthened the RDA leadership team by focusing on our role as leaders within RDA and across the organisation, and further developed this through individual supervision
- Improved project performance and outcomes by improving project management capabilities through staff-to-staff mentoring and in-house skill building activities
- Strengthened the alignment of the RDA work units' activities to Mind's strategic priorities through the implementation of a divisional planning process that linked to unit and individual workplans, and embedded the workplans within our team meeting and individual supervision processes

- Led and oversaw a number of major organisational initiatives, including:
    - The establishment of the Recovery College, Mind's flagship service innovation project
    - A major focus on peer work, including an organisation-wide project to expand the peer workforce, the integration the Centre of Excellence in Peer Support into RDA operations and managed a commissioned project to assist with the development a peer workforce across the Frankston-Mornington Peninsula Mental Health Alliance (included a literature review and workforce development plan)
    - Review and redesign of the organisational approach to outcome measurement to ensure better integration into existing client management and quality systems
    - Development of an organisation-wide capability framework for service delivery staff

Feb 2012 – March 2013 Manager Strategic Projects, Mind Australia

Key responsibilities

- Manage and implement strategic development projects for the organisation, including establishing and maintaining relationships with key internal and external stakeholders
- Provide strategic advice to the Mind Australia Executive and Board related to emerging policy issues and the development of new services and supports

Achievements

- Brought project management and stakeholder engagement disciplines and applied these effectively to project tasks, as well as assisting colleagues in other units develop and apply similar capabilities to their own activities
- Assisted the General Manager, Research Development and Advocacy with a range of organisation-wide tasks, and acted in her role in her absence: I was permanently appointed to the General Manager role following an organisational restructure
- Developed the service concept and business case for the Mind Recovery College: this was the first recovery college in Australia, adapted to Australian conditions and service systems based on models in the US and UK
- Successfully completed a project looking at system and service development options for people ageing with psychosocial disability, commissioned by the Victorian Department of Health

Jan 2012- Mar 2014 Research & development consultancy (concurrent with above)

Completed a range of research and development projects for various clients:

- *Mental health impacts on injured workers of their involvement in the Victorian WorkCover system*, research project undertaken for Creative Ministries Network, completed December 2013
- *Graduate Diploma in Vocational Leadership in Community Services Organisations*, course development project undertaken for the Melbourne College of Divinity-University of Divinity, completed June 2013

- *Work value reviews (3)*, undertaken for specific technical support functions for Victoria Police, Jan 2012

Dec 2005-Dec 2011 Executive Manager, Research and Social Policy, Wesley Mission Victoria

Key responsibilities

- Lead and manage the Research and Social Policy Unit and maximise the contribution of its staff to the organisation (five staff and an operating budget of approx. $700k, operating across aged care, disability, children, youth and families, housing and homelessness and crisis services)
- Identify opportunities for innovation and service development; manage and undertake research and service evaluation that fulfils the needs of the organisation, including collaborating with operational staff and managers and external organisations where appropriate and/or beneficial
- Develop the capacity of the organisation to advocate with and on behalf of disadvantaged, marginalised and excluded people and communities

Achievements

- Established and successfully developed the research, development and advocacy function in the organisation, including the establishment of the Research and Social Policy Unit (RSPU)
- Provided high quality supervision to RSPU staff, maximising their strengths and interests. I combined this with a systematic approach to planning and built a high-functioning, flexible team whose work was strategically aligned and responsive to organisational directions and priorities
- Developed Wesley's Social Inclusion and Belonging Policy. This became the central policy guiding all the organisation's activities and shaping service development and delivery
- Identified the need for and developed Wesley's Service Delivery Framework (later named 'Evidence-Informed Practice Framework'), an organisation-wide approach to client outcome measurement and service evaluation, integrated into the organisation's existing quality systems and aligned with other legislative and contractual obligations
- Designed, trialled and implemented a coproductive approach to service evaluation, planning and development, involving service users and families/carers collaborating with service delivery staff, managers and government agency officers to design evaluations and guide service development
- Introduced consumer participation to the organisation, conducted a consumer participation audit in all areas across the organisation and developed an action plan to implement consumer participation in service delivery and development activities
- Established a formal partnership with Deakin University (School of Health and Social Development), focussing on a range of social inclusion activities aligned to Wesley's strategic direction. As part of this partnership, I initiated two community-led research projects on Aboriginal health, undertaken in collaboration with Maya Healing Centre (now part of Victorian Aboriginal Health Service) and Deakin University
- Developed the reputation of the RSPU outside the organisation. We were successful in seeking external funding for two research projects conducted within the organisation from Helen Macpherson Smith Trust (disability and ageing) and VicHealth (Aboriginal health), and were commissioned by DHS to

undertake research into the service development needs of people who were repeat users of homelessness services in Eastern Metro Region

- Initiated and/or led various research and service development partnerships, including: '*Who Am I?*' - ARC project with Australian Catholic University, Melbourne University, Centre for Excellence in Child and Family Welfare, Victorian Aboriginal Child Care Association and DHS; partnered with Anglicare Victoria to undertake the *CIAO* project (care-system impacts on academic achievement for young people in out-of-home care), which led to the development of Anglicare's flagship *Teach* program, to support educational engagement and achievement of young people in care

Feb 2002 – Nov 2005 Researcher, URCOT (Union Research Centre on Organisation & Technology)

Key responsibilities

- Identify and actively pursue research and development opportunities, and initiate and develop research proposals in response to tenders or identified business opportunities
- Design and execute research and organisation development projects, and analyse findings, prepare and present project reports
- Contribute to the organisation's teaching programs at RMIT University, including co-ordination of work placement program for B. Soc Sci students and taught Organisation Studies to undergraduates in the social work, youth work and social science degrees

Achievements

- Balanced developing tenders and seeking new work at the same time as completing projects to ensure the continuance of this small, self-funded research centre. Maintained a high success rate in getting new work (around 70% of tenders applied for)
- Successfully completed multiple projects in the areas of work and education, including:
  - Identified the workplace needs and outcomes for applied design for the vocational education sector in Victoria. This included the design and development of a framework to integrate new design qualifications into existing vocational qualifications across industry sectors and at a range of qualification levels (Victorian Registration & Qualifications Authority)
  - Secured and undertook commissioned research into workplace violence against women (Office of Women's Policy), and evaluated the Bullying Guidance Note (WorkSafe Victorian)
  - Secured and undertook commissioned research to investigate success factors in school education for Aboriginal children (Department of Education and Early Childhood Development)
  - Developed a strategic plan for continuing professional education for all categories of the public dental sector workforce (Dental Health Services Victoria)
  - Developed a classification framework for employees at the Victorian Trades Hall (VCTU)
  - Developed consultative processes and structures with DHS and HACSU representatives as part of the implementation of the 2002 Disability Services EBA (DHS)
  - Developed a capability framework for senior management at AMCOR Paper
  - Chaired tripartite Work Value Review Committees restructure of classifications for the Victorian Public Sector, involving the CSPU and Departmental staff, esp Vic Police, DEECD, DHS and DIIRD

July 1998 – Jan 2002 Manager, Research & Curriculum Unit, Faculty of Business, RMIT University

Key responsibilities

- Manage the staff, resources and operations of the Research and Curriculum Unit (RCU) (four staff)
- Undertake industry research to inform new program develop in the Faculty, and design and manage educational development projects (internal and commissioned external projects)
- Design and professional development to support ongoing educational change in the Faculty

Achievements

- Reviewed and re-aligned the RCU following the integration of Vocational Education and Training (VET) and Higher Education within the Faculty of Business. This was a major change project, which impacted on staff roles and on the output of the Unit, but ensured the continued relevance of the Unit to the new direction of and opportunities presented by the restructured Faculty
- Established the Unit as a thought-leader for vocational education within the Faculty and externally, gaining the trust of teaching staff and VET Program Managers, the Faculty leadership and external stakeholders (industry partners, government and other providers). This enabled us to work well with teaching staff in practice development activities, with senior staff on strategic development activities and with external stakeholders in new course developments
- Managed a review of the external and internal operating environments for vocational education in business and made recommendations in relation to the integration of VET 'seamless' Faculty structure
- Led the development of a flagship program, the Diploma of Business for online delivery in China, where I managed a multi-disciplinary team of teachers and educational technologists to develop both the curriculum and online learning resources
- Developed, in collaboration with colleagues from VET and Higher Ed, the Work-Integrated Learning framework, a strategy and action plan for developing work-integrated learning activities across the university

Jun 1995 – Jun 1998 Senior Project Officer, Ed. Programs Improvement Group, RMIT University

I worked in a unit that supported the development of teaching and learning in the VET sector of the University. I undertook various teaching and learning development projects and related staff development initiatives, and provided advice and support to Faculty curriculum units on all curriculum and related matters. I also successfully tendered for and managed a range of educational development projects for external parties, including the Australian National Training Authority, Office of Training & Further Education, other government departments and private industry.

Jan 1994 – May 1995 Industry Training Consultant, Melbourne College of Textiles

I worked in an industry consultancy unit that provided skills development and training services to companies in the Textiles, Clothing and Footwear sectors (TCF). My work including marketing the services of the unit and the broader college, identifying and responding to client needs though the design and implementation of work-based projects and providing staff development to ensure that college staff were able to adequately respond to industry and student needs. Projects included training needs analysis, skills audits, design and management of on- and off-job learning strategies and programs and assisting companies develop innovative approaches to quality management.

Jan 1992 – Dec 1994 Co-coordinator, Communication Skills Unit, Melbourne College of Textiles

Melbourne College of Textiles was a mono-industry TAFE college serving the TCF sector. It has since merged with RMIT University. Communication, supervision and management skills were taught into all programs across the college by teaching staff from a specialised unit. I taught within a range of programs, largely apprenticeships and labour market programs aimed at people who were long-term unemployed or had complex barriers to employment. As well as teaching, I managed the functions of the unit and its staff and ensured that teaching programs provided high quality learning experiences that were relevant to the industry contexts in which they were delivered.

1984 - 1991 Various teaching positions in London and Melbourne

During this time I was employed on a series of short-term contracts teaching English as a Second Language to adults. I worked in the public education sector in London, teaching at Westminster College and the Central London Polytechnic. In Melbourne, I taught at International College of English, a private college which has since been absorbed into Holmes Colleges. I was responsible for the design, development and delivery of suitable programs for classes across a range of language proficiencies from basic to advanced. This included preparing students for language exams, such as the Cambridge and IELTS exams.

Other professional activities

- Epworth Healthcare, Human Research Ethics Committee, 2013-2018
- DEECD-VCOSS Partnering Agreement Research Committee, inaugural co-chair, 2010 - 2012
- Insight (VCOSS magazine) Editorial Committee, 2010 - 2012
- UnitingCare Australia Disability Interest Group, 2009 - 2012
- VCOSS Community Sector Futures Task Group, 2006 - 2012
- VicHealth Healthy Eating Advisory Panel, 2007 – 2010
- Victorian Health Inequalities Network Management Group, 2007 – 2009

In 2016, I was awarded the Yungaburra Foundation Award for my PhD research. This award is given by the School of Health and Social Development to the student who shows the greatest potential for leadership in the disability field.

Publication information

Book chapters

Pollock, S. (2020), *Socially inclusive service development: a new expression of democracy for non-government organisations delivering social care*, in Sustaining Social Inclusion, Taket, A. and Crisp, B. (eds), Routeldge (forthcoming)

Pollock, S. and Taket, A. (2013), *Inclusive service development: exploring a whole-of-organisation approach in the community service sector*, in Practising Social Inclusion, Taket, A. et al. (eds), Routledge

Barter-Godfrey, S., Pollock, S. and Taket, A. (2013), *inclusion in participatory research – what were the whitefellas doing in an aboriginal health project?*, in Practising Social Inclusion, Taket, A. et al. (eds), Routledge

Taket, A., Pollock, S., Hanna, L., Learmonth, E., Farquhar, P. (2013), *Promoting social inclusion of frail older people living in the community*, in Practising Social Inclusion, Taket, A. et al. (eds), Routledge

Journal articles

Pollock, S. (2016), *Shifting the power...are we ready to embrace the potential of co-production?*, Insight, VCOSS, Melbourne

Pollock, S., Taket, A. (2014), *Achieving socially inclusive practice: analysing power dynamics in a participatory approach to service development*, Journal of Interdisciplinary Social and Community Studies

(d)

Selected commissioned research and development project reports

Trajectories: the interplay between housing and mental health pathways – report for national consumer and carer consultations (2020), Mind Australia (lead author)

Understanding people with psychosocial disabilities as choice-makers in the context of the NDIS (2018), Mind Australia (co-author)

Mental health and the NDIS: a literature review (2014), commissioned by Mind Australia for NDIA Independent Advisory Council, undertaken with Centre for Mental Health, Melbourne University (co-author)

Establishing and effective peer workforce: a literature review (2014), commissioned by the Frankston-Mornington Peninsula Mental Health Alliance (lead author)

Workers compensation and mental health: examining the mental health impacts of involvement in the Victorian WorkCover system from the perspective of long-term injured workers (2014), Creative Ministries Network (sole author)

Ageing with enduring psychosocial disability: service development options (2013), Victorian Department of Health (sole author)

Healing Stories (2010), Maya Healing Centre, Wesley Mission Victoria and Deakin University (co-author)

CIAO: care-system impacts on academic outcomes for young people in out-of-home care (2010), Wesley Mission Victoria and Anglicare Victoria (co-author)

Talking It Up: aboriginal voices in the formulation of health policy that works (2009), Maya Healing Centre, Wesley Mission Victoria and Deakin University, (co-author)

Evaluation of the Bullying Guidance Note: a case study analysis (2005), WorkSafe Victoria (sole author)