ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Tuesday, 2 June 2020 at 10am

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

THE CHAIR: Welcome to the Royal Commission's discussion on enabling a contributing life.

I'm Penny Armytage, the Chair of the Royal Commission into Victoria's Mental Health System, and I'm joined by my fellow Commissioners, Professor Allan Fels, Alex Cockram and Professor Bernadette McSherry.

On behalf of the Commission I acknowledge Aboriginal peoples as the traditional owners across all of the lands on which we locate for today's panel discussion, and I pay my respects to their Elders past, present and emerging.

Firstly, I would like to extend my sincerest thanks to Dr Sarah Pollock, Dr Michael Fotheringham and Ms Catherine Humphrey for taking the time to participate in today's panel discussion.

I know that you have dedicated a significant amount of time and effort into developing your comprehensive witness statements and preparing for today's discussion.

The Commission recognises that a contributing life can mean many things to different people. During last year's hearings the Commission heard from Janet Meagher AM who was actively engaged in the development of the National Mental Health Commission's Contributing Life Framework. Janet defines a contributing life as:

A life that is fulfilling, enriched by close connections to family, friends and our communities of choice.

In her witness statement, Janet highlighted a range of factors that can assist people to live contributing lives including:

Having a home, having something meaningful to do, improving opportunities, obtaining good personal health, having healthy relationships and having adequate mental health and social supports.

Given the complexity and enormity of the issues in Victoria, today's discussion will have a particular focus on the topic of housing and homelessness for people living with mental illness.

The Commission is aware of the scale of housing and homelessness issues in Victoria. The statistics about the lack of safe, secure and affordable housing stock in Victoria are particularly striking, as is the heightened impact of these issues for people with mental illness.

The Commission understands that there are, according to the Australian Bureau of Statistics, currently an estimated more than 24,000 Victorians experiencing homelessness and, according to the Parliament and Victoria's Legal and Social Issues Committee, more than 80,000 Victorians on the waiting list for social housing.

The Australian Institute of Health and Welfare also estimates that more than 30,000 Victorians who were Homeless Support Service clients in 2018 were recorded as having a current mental health issue.

We understand that this issue impacts many Victorians. We are also acutely aware of the complex bidirectional relationship that exists between poor mental health and housing and security.

Existing evidence tells us that people with mental health issues are significantly more likely to experience housing challenges or homelessness and vice versa.

The Commission has consistently heard that, while housing alone is not sufficient to effectively and fully support someone with mental illness, access to secure and appropriate accommodation is a fundamental component of recovery.

One individual who attended our community consultations in St Kilda noted that:

I don't understand how you can have stable mental health if you don't have stable housing.

We also understand that this issue is experienced differently by different people, affecting consumers, their families, carers and loved ones.

While we acknowledge that there is a critical need for stable housing for all Victorians, our terms of reference

are clear that our inquiry is to focus on Victoria's mental health system.

As a Commission, we understand that we cannot resolve all issues in the housing and homelessness sectors, including the current shortage of social housing stock in our state. But to the extent to which it is possible within our remit we are considering opportunities to drive meaningful reform for Victorians experiencing both mental illness and housing and homelessness issues.

We are particularly interested in exploring the supported accommodation needs of people living with mental illness who have experienced homelessness or unstable housing, that is, housing that is accompanied by care, treatment and support for an individual with mental illness to support them to live a contributing life.

We're considering a wide range of approaches to such supported accommodation within Victoria, around Australia and internationally, including those funded by the National Disability Insurance Scheme.

In addition, we're interested in opportunities to address homelessness in young people experiencing mental illness. The Commission is aware of the potential lifelong impacts of mental illness and homelessness at a young age and of the evidence of the significant cost of youth homelessness in Australia.

We are interested to understand opportunities for early intervention for young people with mental illness who are homeless that includes housing support.

To quote an individual that attended our community consultation in Box Hill, "The one-size-fits-all model doesn't work", and I believe this remains particularly pertinent for any reform that we are to pursue.

It is clear that across your statements there are broad areas of consensus, including the insufficient supply of social housing stock in Victoria, unmet demand for supported accommodation options for people with mental illness, and opportunities to improve and better leverage the National Disability Insurance Scheme specialist disability accommodation.

Today's discussion will seek to explore reform directions proposed in your witness statements. This will support us as a Commission to better understand our windows of opportunity to drive meaningful reform and change in this area.

I would like to emphasise that today's deliberation is just one way that the Commission will obtain information on this issue.

We remain committed to placing the views and experiences of people with lived experience at the centre of all of our inquiries. Insights and recommendations will continue to be sought from consumers, carers and families on this issue, as well as representatives from the mental health and housing sectors.

Finally, before I hand over to Counsel Assisting, Fiona Batten, who will facilitate today's discussion, I would like to once again thank you for your time in assisting the Commission with our inquiry. We look forward to a robust and insightful discussion on a difficult but very important topic.

MS BATTEN: Thank you, Chair. I will first introduce our three panel members for today's discussion and then I will outline the main areas proposed to be discussed. This is in no particular order.

Dr Sarah Pollock is the Executive Director in research and advocacy at Mind Australia. In that role Dr Pollock advocates 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.

Over the last two years Mind Australia, together with the Australian Housing and Urban Research Institute, where Dr Fotheringham is from, has conducted a national research project called Trajectories. That project explores the interplay between mental health and housing pathways.

Ms Cathy Humphrey is the Chief Executive Officer of Sacred Heart Mission and the Chairperson of the Council of Homeless Persons. Ms Humphrey has been working in government and not-for-profit organisations in areas specifically focused on people who are homeless since 1996.

Sacred Heart Mission delivers the Journey to Social Inclusion program, amongst other programs, and that program supports people to exit long-term homelessness.

Finally, Dr Michael Fotheringham is the Executive Director of the Australian Housing and Urban Research Institute (AHURI). Dr Fotheringham is a research and policy development specialist with experience in housing and homelessness, public health and urban and community services planning.

As I mentioned, AHURI was the partner with Mind Australia to conduct the Trajectories research.

As the Chair mentioned, each panel member has provided the Royal Commission with a witness statement and they will be uploaded onto the Commission's website in due course. We are grateful for the considerable time and energy each witness has put into their statement and this panel process, particularly with the additional challenges of COVID-19.

As the Chair also highlighted, there is broad agreement amongst the panel members on key issues relating to homelessness and mental health, and in particular the lack of secure appropriate affordable housing.

But to assist the Commission consider the needs of people with mental illness, the panel discussion will focus on six areas. First, the nature of support people with mental illness need in different housing contexts; second, which group should be prioritised for additional support; third, the options for enabling consumer choice and control; fourth, increasing access to accommodation support through NDIS; fifth, considering innovative models for increasing the volume of housing stock and maintaining tenancies; and finally, examining the workforce capabilities that are needed.

I will now turn to ask our panel members questions and the first topic is the nature of support for people with mental illness need in the context of housing.

The first question seeks to explore the nature of support needed in four housing contexts. I will outline the question in full and then ask Dr Pollock to respond first.

Dr Pollock, for people with severe and complex mental illness, what is the nature of support needed for people, first, who generally manage their tenancy well but who can become unwell; second, who need a medium term response that combines housing and supports; third, who need long-term specialised accommodation support; and fourth, who are chronically homeless? Dr Pollock, could you respond to that?

DR POLLOCK: Thank you, yes. In starting, I thought about this question, I think in fact the types of supports that are needed across those four groups are actually the same supports, but I think what there is, is the intensity and duration and the balance of the mix of the types of supports, and particularly the supports across clinical psychosocial and tenancy support.

I think there's also variation in the extent to which people need formal funded support coordination or system navigation, and the difference between the extent to which those supports need to be delivered assertively.

So, in general the supports that are needed are the supports you've noted, so first of all access to secure housing in a meaningful location. People need financial security as well. They need support to manage their tenancy, they need connection to a trusted worker somewhere, someone who they can believe and who they feel believes them and can help them navigate the system.

Help to manage the symptoms of distress and illness, but also help beyond that, so the sort of practical and emotional support that they can get through psychosocial services, help to deal with trauma and early intervention when things go wrong.

In relation to the specific groups, I would say that the people who are in a tenancy but need help when they go wrong, I think the really important thing there is that there's early identification that things are going wrong and an ability of services to - and a clear escalation pathway and services that then can flex up to support that person through their period of illness. I wouldn't expect that those people would need care coordination, but they might.

During a period of illness they need help with practical matters that are related to their tenancy, like paying bills and keeping the house clean, and they need someone to help them to possibly liaise with the tenancy manager or certainly to help them liaise with the tenancy manager.

They need ramped up access to clinical support, and then, especially if there's a period of hospitalisation, they need ongoing support after that.

I think for the second group, again, the housing tenure is the sort of precursor, and I think they need similar supports to the first group, but they need them probably at a higher intensity and for longer.

I think we can assume that people in the second group, the people who need the medium term supports, have less stable mental health, so it's really important that clinical support can be there for them over a duration of time, flexing up and down as they need it.

I think also one of the very important things for this group is helping them build community connections and supports in their community so that they're not only reliant on formal support services.

I also think that there needs to be some consideration given to support to get them into education and employment in the long-term.

And I think that, as the support period comes to an end, if they still need support, then they should automatically be NDIS eligible. So, if after a period of say 5 years you still need pretty much regular support, then that indicates to me that that's an NDIS need.

The third group I think is the NDIS cohort, people who need long-term supportive accommodation, so the full range of supports to help them live independently; quick, rapid access to clinical support when they need it, help to build relationships with primary health providers. And I think for this group too, support to access education and possibly employment, whether that's voluntary or paid.

I think for the fourth group, the real focus there has to be on understanding the underlying causes of the chronic

homelessness, not necessarily what drove them into homelessness in the first place, but what has contributed to the chronic nature of their homelessness and then support to deal with that, and I would suggest that that's likely to be support to help them deal with underlying trauma and quite possibly AOD support, as well as the full range of supports that I've mentioned for the previous groups.

MS BATTEN: Thank you, Dr Pollock. Ms Humphrey, could you outline to the Commission the nature of the support that you think people with mental illness need, and just to clarify which cohort you're talking about, thank you.

MS HUMPHREY: You can hear me?

MS BATTEN: Yes, thank you.

MS HUMPHREY: That's better. So, if we can talk to the first group of those who have become unwell. I use the term "sustaining tenancy support" and that does capture a whole lot of kind of ongoing enduring support that can flex up and down as needed, and it's about keeping people housed.

It's a practice that's probably very underdeveloped by the sector because we tend to have a set and forget mentality of getting someone housed and our job is done and our belief is that it's actually not done; that's when the hard work starts about keeping people housed, so that practice development around sustaining tenancy support is really critical.

Also is early identification and prevention of risk, and that's that risk of tenancy breakdown, and I think that's - the sustaining tenancies' role should pick that up early and avoid people's housing breaking down.

Alongside that is self-management, so that's the development of kind of the personal social, capital to keep well and manage a crisis. In my statement I talk about a GP being really central to that.

Alongside that is re-connection with family and friends, so building that social capital of others who have a care or concern for someone's life and what's happening in their world and with their health, so that development

of self-management strategies is really critical.

Alongside social inclusion activities, like having a meaningful opportunity and purposeful activity, so whether that be through volunteering, education, workforce participation that keep people engaged in community. So, that's kind of the first group about what keeps people well and keeping them housed.

If I then look at the medium term group, I think it is all of the above, but I would add in assertive outreach and that's home visits; it's a sense of connecting with people in their home and making sure that they're managing their tenancy and their care needs well, and that support needs to be tailored, flexible and responsive and can flex up and down as needed.

Then if I look at the long-term group who are in specialised accommodation, that's when I think, you know, you're in that congregate care model where on-site support including sleepover staff is required; you would have medication management, you make sure that there's wrapped around coordinator supports and visiting services, and that's both specialist and mainstream supports.

Then I think where it is a congregate care facility, you need to manage community, so that's the community living in the facility so there's a sense of how you navigate living with others is really critical in that environment.

If I go to the fourth group which is chronically homelessness, I have a huge slopping list, so bear with me.

MS BATTEN: I won't cut you off, Cathy.

MS HUMPHREY: I'll be succinct. So, a housing pathway plan is really important because, you know, there's no silver bullet for this group; they are chronically homelessness for a reason, but it needs to be a rapid housing response. So, if we can't deliver housing first, we need to make sure we can get someone into permanent housing quickly, and then do that settlement support to help them set up and establish a home which might be the first home that they've had for their lifetime.

We then need that wrap-around coordinated support,

including service navigation through very complex systems. We need to help people develop the independent living skills of managing a home because often they've not had to do that, whether that's paying bills, cleaning, whether that's establishing a tenancy, all those things that you and I can take for granted are really important.

Then there's that coaching to self-management, so what does that look like in managing a crisis or managing a conflict, or recognising the signs of when I'm becoming unwell is really critical.

Then those social inclusion activities that keep people connected to community and to that personal social capital that keeps them well.

Trauma-informed care is really important because with this group there's often been an associated traumatic event that's led to their homelessness, but also the trauma of experiencing homelessness, so it's really essential that trauma-informed care is fundamental to the nature of the needs that's provided.

Outreach assertive treatment is really important. And I kind of talk about the duration being something like a 2 to 5 year that allows that kind of intensity, flexibility and responsiveness, because once people are housed that's when the real work starts. I'll stop there.

MS BATTEN: Thank you, Cathy. Dr Fotheringham, we've had a very comprehensive outline of services, is there any other support that you would add that hasn't been covered?

DR FOTHERINGHAM: I'm grateful to my fellow panellists for really answering the question for me, but I guess just to provide a little bit of complementary perspective: I think it's worth just stepping back and thinking about tenure in this. So, from a housing perspective, you know, mental health problems occur for people in all types of tenure, that includes homeowners as well as those in private rental, the social housing system whether it's community housing or public housing, and those experiencing or at risk of homelessness, and there are different supports needed for each of those tenure groups, if you like.

So, for homeowners that support often comes through the medical system, but in terms of the housing impact can

be around loss of income which can affect mortgage payments, so that's where the banking system tends to be needed to support, mortgage holidays and various other mechanisms, which have waxed and waned over the years, but I think in our current COVID pandemic we're seeing a new wave of accommodating behaviour by the banking system.

For private rental, there's probably less support systems around; there are some, but there is not as much tenure support for people in the private rental system. Community housing and public housing, the social housing system is where that's perhaps best shown.

The housing first principle, which I know I think all three witness statements address in different ways, is an important principle; that people need to be housed to be able to progress their wider complex needs. You can't address people's complex needs while their housing is insecure and unsafe, and so I'll probably stop there.

MS BATTEN: Thank you. The next question is directed to the support needed for youth and young people.

It has been suggested to the Commission that the characteristics of effective housing and housing support for young people with mental illness are similar to those needed for adults, except there is a greater emphasis on family-based housing and support that is needed.

The question is, do you agree with that position, and is a different approach needed in relation to young people? Dr Pollock, can I turn to you first.

DR POLLOCK: Sure. So, I agree with the position to the extent that young people need housing, they need support, they need connection to communities, they need connection to meaningful activity, and for young people I think particularly connection to education, training and employment. But I think that there needs to be sufficient recognition and response to the developmental stage that young people - you know, that they're young people, they're not adults.

I think too, the age that a young person ticks over into being an adult in service systems tends to get set in an arbitrary way, you know, we have to pick an age. But I think for young people who are trying to establish a life

at the same time as coming to terms with potentially having a significant mental illness, when that tipping point of young person into adult occurs will depend on when things first started to go wrong for them.

So, if you're a young person whose life started to go off the rails when you're in primary school or early secondary school, by the time you reach your late teens or early 20s your life is likely to be in a pretty - you know, the risk is that, without appropriate supports, your life will be in a pretty parlous state and you will have missed out an awful lot of the development that your peers will have had.

If, on the other hand, you first become ill in your late teens or early 20s, especially in your early 20s, if you've got some reasonable education under your belt the point at which you're starting from is very different and consequently, the sorts of supports you need are very different.

So, I guess what I'm saying is, I think we need possibly to allow that notion of being a young person certainly, to extend into the mid-20s, and possibly even up to 30 for some young people because of their early - or their adolescence being disrupted.

I also agree that attention to the family situation is a good idea, but I think it needs to be undertaken with a prevention framework. If we wait to do family focused work at the point when the young person is already in trouble and homelessness it's a very different kind of work from the family focus work that you might do when the young person is at home and possibly exhibiting the first signs of possible mental illness; often exhibits in behavioural issues at home or at school, and I think that's the point at which the family focus work needs to kick in.

So, it's really important that, for young people, we actually have early identification of things going wrong to try and not get to the point where the young person is unwell and homelessness.

So, youth appropriate housing needs to take account of the young person's relationship with their family, and that for some young people it's too difficult to reconnect with family at that point, at the point at which you're trying

to actually put some housing together for them; that may occur in the passage of time, but it may not be appropriate in the first place, so I think it's a sensitivity around when a family focus approach is appropriate and when it isn't.

Do you want me to talk as well about what I think about the approach that is needed for young people?

MS BATTEN: Yes, if you can briefly, I'm going to move you all along, but I will let you say this.

DR POLLOCK: Alright, I'll go as quickly as I can. The evidence suggests, and we put this evidence in our Trajectories research report, the evidence suggests that young people tend to be better in congregate care than adults, and that in that case housing first models actually do need some adaptation for young people, and Dr Fotheringham may be able to talk to that more than I can.

I think the supports provided need to respond to the likelihood that the young person who's experienced trauma either prior to becoming homelessness or through their homelessness experience, I think it's likely that support will need to deal with the issue of substance use, quite often as a form of self-medication or self-management of their mental distress.

Quite often young people have been involved in the criminal justice system, so sort of helping them sort out any outlying criminal justice issues, and then helping them to build - so kind of sorting out the worst of the mess or the difficulties, but in one sense helping them to build connections in a community that will sustain them and support them.

I know with the young people that we've worked with in residential settings, when the periods of time, whether that's short residential like the step-up/step-downs for PARCs or the longer residential youth ready rehab models, young people are quite fearful when it comes to the end of their period in the residential support; they're fearful that they're going to go back to the same group of friends, the same set of circumstances that actually drove them into the difficulties that are the combination of mental distress and no housing in the first place, so building

those informal networks, those community connections that are sustaining and nourishing is really, really important.

I think young people also need at least assessment of the extent to which they need to develop skills for daily living; the sorts of skills that, you know, my kids developed at home, living at home with me for stuff like managing a house, budgeting shopping, cooking, taking care of yourself, taking care of a house and doing that with other people who might be living with you in that house.

I think too young people need care coordination; it's too much to ask them to sort out all the different parts of their life where they will require help from different service systems without having some sort of formal coordination and formal service system navigation support.

MS BATTEN: Thank you, Dr Pollock. Dr Fotheringham, I might turn to you next, could you tell us about the nature of supports that you think young people need.

DR FOTHERINGHAM: Happy to, and I'd like to endorse the comments that Dr Pollock has made, and perhaps just expand a little bit specifically on the approaches to housing support for young people.

I think there's probably two forms of that that I would like to put forward to the Royal Commission and some Victorian examples that demonstrate how that can be done well.

The first is, as Sarah alluded to, the congregate care model, sort of congregate care version of the housing first principle which we see in the Foyer model, which is an internationally recognised approach to the congregate housing for young people where there is wrap-around support provided, often with someone living within a complex to provide 24-hour support, and with some expectations that residents engage in education or employment in some way.

It's a fairly well developed model and the Drill Hall in Melbourne run by Housing Choices is a really good example of that model. There's many others as well, it's been adapted in different ways, but as an approach takes the housing first principles and adapts them to a young people cohort.

The other group that I think it's worth acknowledging is those who have come through out-of-home care systems, whether it's foster care or kinship care or other versions of that type, and one of the challenges we've seen across the country is transition from those care environments into the wider housing ecosystem and that transition from being supported in that way to graduating from it when you reach a certain age. Different states across the country have different ages at which young people graduate from those programs, and the general pattern appears to be that, the later that is the better. So, that ranges from 18, 21, 25 years old, and the longer the support generally the better. But a transition program can be a really important way to help people move from that supported environment to one where they're perhaps more independent.

The Springboard program in Victoria has been a good example of that sort of approach run by DHHS.

MS BATTEN: Thank you, Dr Fotheringham. Ms Humphrey, do you agree with the proposition that the characteristics of effective housing and housing support for young people with mental illness is the same as what's needed for adults?

MS HUMPHREY: Yes, I do, and not being an expert in terms of support services for young people, but I would just like to probably note that it is really important that we prevent the trajectory of young people into adult homelessness, and so, I think I'd really support the comments made by Michael and Sarah in that respect.

MS BATTEN: Thank you. This leads to the next question: of people who have severe and complex mental illness and housing support needs, are there particular cohorts who have more challenging support needs?

Ms Humphrey, I might stay with you and see, in your view are there particular cohorts who have more challenging support needs?

MS HUMPHREY: Yeah, the group that we tend to see are single adults who have really been experiencing long-term cycles of chronic homelessness, often with untreated mental health issues and that's exacerbated by being in and out of homelessness. Because of the lack of continuity of care, the person's kind of engaging and disengaging with the service system. Also, crossing regional boundaries, so

that kind of continuity of care really gets lost over time and it's almost like you're starting again with the person as they're crossing boundaries.

On top of this is kind of that multilayered factors of the impact of trauma alongside problematic drug and alcohol use, and often a cognitive impairment and they're the kind of groups that we really see who are difficult to engage and difficult to sustain their engagement in support services.

I'm talking I guess from the 18 years of experience at Sacred Heart Mission of seeing this cohort cycling round and round and round the homeless services in the mental health service system.

MS BATTEN: Dr Pollock, are there particular cohorts in your experience who have more challenging needs?

DR POLLOCK: In the Trajectories research we were able to identify some of the risk factors or factors that really amplify the sort of nexus of housing instability or homelessness and deteriorating mental health, and I think these factors are all the things that Ms Humphrey has just referred to.

So, substance abuse, history of abuse and/or being a victim of violence; history in detention; history in state care, and I think, too, long-term financial hardship.

We also know from the Trajectories research that serious injury or serious illness amplifies the effects of housing homelessness, mental health interface and family violence, or rather, family breakdown.

I think, as Ms Humphrey said, it's the people who are difficult to engage and difficult to keep in services, and they are often people whose behaviours are scary; they're scary for the people who work with them, they're scary for the public, and they're scary often for the individual themselves.

I think that issue of chronicity, the longer the problems have gone on, the harder it is to engage and the harder it is to address and remediate the issues.

I think then there's the issue of impaired cognition,

whether it's from an ABI or from an undiagnosed intellectual disability, or developmental delay, or simply the impacts of having led a really tough life for a long time with a serious mental health issue

MS BATTEN: Thank you. Dr Fotheringham, in your experience of people with severe and complex mental illness and housing support needs, are there particular cohorts who have more challenging support needs?

DR FOTHERINGHAM: This was a question that I was troubled by in initially looking at it, because I think I interpreted it as a question about diagnostic categories, you know, are there particular diagnoses that should be prioritised over others, and that was an idea that I found quite risky, in that, it could impact on the diagnoses given. If a person presents with a mental illness and is known to be at risk of homelessness or homeless, that their diagnosis might be impacted by that situation which could then compromise their care: I think that's a high risk with a sort of diagnostic approach.

What I do think is important, and it's a similar concept to what Dr Pollock has talked about, is their experience of homelessness or risk of homelessness, of trauma that I think concerns me most. I think what we know about homelessness risk, is the biggest predictor of becoming homeless is having been previously homeless. So, if we can address people whose housing is most vulnerable, that's the priority from my perspective.

MS BATTEN: I will come back to that priority question, but before we get there I would like to ask about the support needs for people who are living with a carer.

We've touched on this briefly with family focused work. But, Dr Pollock, if I can ask you first, where a person with mental illness is living with a carer, what support can help both the person and the carer to maintain that living arrangement, assuming it's an appropriate living arrangement?

DR POLLOCK: And I think that's a really important clarification, because I actually think it's important to challenge this assumption that everyone who lives with a carer, especially where they're living - with mainly a family member, that they as the individual or the family,

either party or both parties want that.

I think the SHIP survey of high impact psychosis, the 2010 study, makes very clear that in 2010 there were 10,000 Victorians with high impact psychosis who were living with families for whom that wasn't their preferred option. That's a lot of people.

If I think about the carer interviews that we did in the Trajectories, there are some things that all families need, and whether the person lives with them or not, and then there's a sort of subset of things that families need, that have someone living with them who has a serious mental illness, all families - so there's this broad category and then the specific category. The broad category, so that includes the people who have got someone living with them who's got a mental illness, people need greater control over their housing situation than they currently have and that means, particularly for family members, they want to have better information about the choices available to them for the person they're caring for and the options and how to access those.

They need interactions with tenancy managers who are knowledgeable about the impacts of mental illness, particularly around the stress points of things like inspections or coming to the end of a tenancy.

I think they need help managing - carers live on payments, often live on payments that are quite minimal, so I think attention needs to be given to their financial planning, financial counselling and their financial security.

Carers need psychoeducation, particularly for somebody who, when they've got somebody living in their house with a complex mental illness, so psychoeducation around recognising the sorts of things that trigger episodes that are difficult for everybody to handle in the family and what to do to actually manage family relationships.

Family members need really good involvement in treatment and discharge planning when somebody's admitted to hospital so that the person only returns home when it's safe for everyone, for everyone concerned, and to make sure that people aren't discharged too early or, if they are, if they're discharged from acute, that they have an

opportunity to go into a step down before they go straight home.

I think carers absolutely need respite and I think, with the introduction of the NDIS and the rollover of the Mental Health Carer Support Respite Program into the NDIS, it's actually quite fraught for carers to make sure that the individual gets the sort of support in their package that is the carer respite, and I think it's too soon to know whether the integrated carer support system will provide mental health carers with the access to respite that they need. I think that that is something that needs to be monitored by the State Government to see whether there is actually a state responsibility in there to supplement the respite arrangements that are available through those two Federal schemes.

I think carers, certainly carers who have got somebody living at home, they need support, they need carer support too. Again, will the ICSS deliver that? I think it's a situation that needs to be monitored and we need to make sure that carers are supported to manage their own mental health and their own physical health.

The other thing that Mind has a particular interest in is carers' access to employment and their support, their support to access employment in the first place and stay in employment. So, if you're a carer and you've got somebody living at home with a - an adult with a complex mental illness, it's really important that if you're employed you've got an employer who actually understands that you may need to really quickly and suddenly and unpredictably take some time off.

So I think there needs to be some consideration of the sorts of programs that might help carers access and stay in work given the importance of financial security, and also, given the importance to carers of having an identity that isn't solely around being somebody's carer.

There's a couple of programs in New South Wales that I think are very good in this space: the Care2Work, which is a Recovery College program that's specifically for carers to help them with skill matching, goal setting and resumé development. There's a Carer to Career program which is run through New South Wales TAFE, and there's a Carers + Employer program, which is actually aimed at assisting

employers develop flexible workplace practices to support carers and actually provide accreditation.

So I note that those programs are not mental health carer-specific, but certainly I think they're of value to carers.

MS BATTEN: Thank you. Ms Humphrey, can I turn to you next. In your experience, what kind of support would assist a person with mental illness and their carer maintain that living relationship?

MS HUMPHREY: I think in addition to what Sarah has said I think that engagement of the carer in a co-care plan is really important, so with consent; so, both the carer and the person with the mental illness are supported to create a, whether it's a co-plan or a living plan, where there's agreement about how they work together to sustain that care arrangement.

I think in addition to that is probably access to kind of brokerage and information and education is also fundamental for the carer.

MS BATTEN: Okay, thank you. Dr Fotheringham, is there anything you would like to add on what can support carers and people with mental illness living with carers?

DR FOTHERINGHAM: No, I would support and endorse the comments of the other two members of the panel but probably have nothing additional.

MS BATTEN: Thank you. The second topic that I wish to address is the issue of prioritising which we've touched on briefly and I would like to ask you all directly.

In the context of this Royal Commission into Victoria's mental health system, and considering the reality of rationed resources, of Victorians experiencing mental illness and homelessness or housing insecurity, which group would you prioritise for additional support? Ms Humphrey, can I ask you first, who would you prioritise?

MS HUMPHREY: Look, I'd use a number of indicators to kind of direct me to the answer that I'll give you.

One is around the group that's having the most impact

on the service system in terms of costs and service usage. A kind of theory is that, if you can meet the needs of this group, then you can free up the service system to meet others' needs. This is really an approach that we took to the Journey to Social Inclusion program which works with people who are experiencing chronic homelessness who a high portion of them have diagnosed mental illness but also mental health challenges.

I think the other interesting thing is also the lives lost. We've seen through now two cohorts going through the Journey to Social Inclusion program, that lives lost to suicide and unmanaged mental health is quite significant. For me it points to that direction of, that adults who are experiencing long-term chronic homelessness who really have untreated mental health exacerbated by their homelessness experience.

Equally, I'd also say we need to stop the trajectory of young people into adult homelessness alongside that.

MS BATTEN: Thank you. Dr Pollock, can I turn to you next. Which group would you prioritise?

DR POLLOCK: I think this is really difficult because, like my two colleagues, it depends on how you want to understand priority.

I think, if we look at the greatest immediate need, people who are chronically homeless. If we look at the people who are at greatest risk of becoming the people of greatest need, it's the people in tenancies who become unwell without support and, I would add, I think that they are relatively cheap to support too. You know, if you get in quickly and get in with sufficient intensity, you can actually avert longer and costlier and potentially less efficient or less effective supports.

The other group who are at greatest risk if their support needs are left unattended are those people in the medium term intensive support. Again, they're your next chronically homelessness group in the wings.

I think, if we take an investment lens, then it's young people. Invest sufficiently and invest early for the greatest chance for those young people to lead contributing and meaningful lives.

I think, as I said before, I think those people in tenancies also give good return on investment. So, you know, people who things are going along, go along most of the time they go along well; when they don't go well, they don't go well quite quickly; get the supports in, because quite often it's intensive but it's for a temporary period of time and, you know, people have a good return to being able to make a contribution.

Having said all that, I just - I feel really uncomfortable about ignoring those people who are less visible because they're sitting at home with mum and dad - whether mum and dad want that or not, whether they want that or not - or they're in an SRS, or they're in a boarding house or they're in a rooming house, so in those forms of sort of privatised, loosely regulated and minorly supported forms of accommodation, it's easy to ignore them because their needs are - at a very minimal level their needs are being met but they're not leading very contributing lives.

So, I find this question difficult and slightly uncomfortable because I think there are very good arguments for the needs of all of those people for different reasons.

MS BATTEN: Thank you for addressing it. Dr Fotheringham, who would you prioritise given the focus of the Mental Health Royal Commission and the limited resources?

DR FOTHERINGHAM: I guess I should apologise for jumping the gun and answering this question while addressing the previous question.

MS BATTEN: No, no, not at all, they're linked, you're ahead of us.

DR FOTHERINGHAM: But, yes, there's a flow to the discussion there that I think is important.

As I said earlier, I think a diagnostic lens on that is a potentially very risky one, I do think people's history and trajectory of housing and homelessness and related trauma, or housing insecurity to put it another way, is a really significant dimension to this.

You know, for young people who experience homelessness

in their childhood their future pathway in terms of housing, their housing careers, can be incredibly damaged and the interaction with that with mental health, I think, is something we're only just starting to understand but it's very significant.

So for me, it's really about understanding people who are most at risk of homelessness and intervening early, as early as possible.

MS BATTEN: Thank you. I'll move now to the third topic which is options for enabling consumer choice and control.

I understand the difficulties with the lack of housing staff, but I still would like to ask, and I'll direct this to you first, Dr Pollock, what are the options for enabling consumers choice of housing, including the location of the housing and proximity to connections that are meaningful to the person?

DR POLLOCK: I think, you know, you've pointed out the limitations: it's limitations of supply, it's limitations of diversity, of types of housing and it's limitations of where that supply actually is. People are also limited by having often very, very restricted financial resources, and limited choice over the supports they get and how those supports are delivered to them, and all of those things contribute to further limiting people's choices around housing.

In the Trajectories research, in the community interviews that we did, people talked a lot about having a lack of control, and they talked about lacking control in the process of applying for housing. Some of that was the enormous sort of delays in formal processes around accessing social housing, particularly public housing; inefficiencies in the process, errors made, people's files being lost.

And then basically having to talk to tenancy administrators and wait list administrators who were rude and unhelpful and lacking in understanding of people's situations, and all of those contributed to people feeling like they had no control over the process of trying to get a house, that they were just a number, that they as a human being weren't important and, you know, the very worst, that they were actually some sort of burden on a system that

they had believed was there to help them.

People also talked about this same lack of control and lack of choice once they were housed over the things they needed to do to maintain their housing, maintain their tenancy: so being forced into inspections at times that didn't suit them. A family member talked about being really, really hassled by the public housing tenancy manager to do an inspection at a time when - her sister who lived with her - at a time when her sister was really, really unwell, and for her, her priority was her sister's health and helping her sister as she kind of gets things back together, and yet she had this tenancy manager on her back who just would not let up on this issue of, we're going to do the inspection, we're going to do it now, and if you fail the inspection you'll lose your tenancy. Those things contributed to really feeling like you've got no control and no choice over how you manage your housing.

People also talked about an imbalance in this, you've got to respond to this inspection now, but when you put a maintenance request in it could be months before there's a response. Not always, some people have had really good experiences of tenancy managers. And when people did have good experiences of tenancy managers they felt like they had more control over their housing; they felt like they had greater choice over, you know, over the things that they needed to do to maintain their housing.

And then, one of the very specific issues was not being able to have pets in rental properties. For many people with complex mental illness pets are a lifeline, you know, they're a really important part of their support. The connection between a person and their animal is really important in terms of that person's emotional health, but also for a lot of people, especially when it's a dog, the dog is your means of accessing community. For people with social anxiety, quite often the dog is the thing that gets you out of the house; the dog is the thing that enables you to go down to the shops; the dog is the thing that enables you to go out for a walk and actually maintain your physical health. And, when there are prohibition on pets in rental properties it's a real problem, and I think, as somebody who isn't in this position, it seems minor, but when we hear it from people who use our services, but we certainly heard it in the Trajectories interviews, it's a big issue.

MS BATTEN: Ms Humphrey, can I turn to you: what are the options for enabling consumers' choice of housing, location and proximity to meaningful connections?

MS HUMPHREY: I think one of the recent improvements in Victoria is the development of the Victorian Housing Register, so that's a combined wait list for both community and public housing, and they have moved to more of an online system that hopefully will cover off on some of those challenges that Sarah spoke to around, you know, efficiencies and losing applicants' details, et cetera, so that process of applying for housing should be now more streamlined, although there are challenges for a community that doesn't have the IT literacy and that requires a service system to enable that IT access.

I think one of the possibilities that could come out of the Victorian Housing Register is that an ability to release data in local areas in which there are vacancies. What that means as a support provider that's supporting someone through the application process, there's no point choosing a local area in which there is no vacancies and will be no vacancies for the next 10 years. But if there are areas of vacancy turnover, it can then give people some choice of communities within those limitations. So, I think, if that data can be made available in the application process, it might help people's pathway through the wait time to be somewhat accelerated than it currently is.

I think one of the things that's really important is for the service system, whether it's the homelessness service system or mental health service system, is to have good housing and support planning. It is really fundamental for the workforce in both those sectors to understand housing pathways and the options to navigate those service systems on behalf of their clients. So, whether that's the NDIS service system, whether that's a housing service system, whether that's a private service system, we really need skilled staff that can help navigate that application and getting housing is really important.

I think the other opportunity is around DHHS staff that manage public housing. I think skilling up that workforce so that they can do that sustaining tenancy practices is really fundamental. So, if we can stop that

kind of exchange between their tenancy support workers that contributes to possible breakdown of the tenancies in public housing, I think that would be a great result.

MS BATTEN: Thank you. Dr Fotheringham, can I ask the question to you, what are the options for enabling consumers' choice of housing, location and connections?

DR FOTHERINGHAM: Again, a tenure focus to this is probably worth considering, because the degree to which you have choice of your housing is greatly influenced by what tenure form you take. For a homeowner there's obviously a very significant amount of choice, with a price caveat; for private rental similar but a slightly more constrained market. But for social housing and community housing choice is a lovely concept but not a reality at the moment.

You know, the opening remarks this morning spoke of an 80,000 person waiting list in Victoria: that's not an environment in which choice really exists, and most public housing systems, or most waiting lists across the country, if you refuse a property that's offered to you, you don't get a lot of other choices. You might get one other offer and then you go to the bottom of the list is a typical outcome. So, the notion of choice there is an artifice that the current supply of affordable and social housing just doesn't allow for. It should.

The principle is really important, we've seen that in NDIS, and we'll talk about that shortly I think, but the concept that people can have some say in the built form of the house they live in, which could be quite significant from a mental health perspective, as is the surrounding environment and their connection to community are really important dimensions of how people live, and I think that's something that's been really demonstrated in the last few months as people have spent far more time than they're used to perhaps in their homes, and the role of local community in shaping that environment is really significant, so that's a dimension of choice that perhaps is lacking in the system generally.

MS BATTEN: Dr Pollock, I'll address the next question to you, and very conscious of what Dr Fotheringham has just said, so potentially looking more towards an ideal system. What are the options for increasing consumer and carer co-design of housing and housing support?

DR POLLOCK: I think, the more we can build co-production capability into the mental health system, the better. I would say that, to do that, that requires actually building co-production capability into every single organisation that comprises the mental health system.

I think that at the moment we have a tendency to rely on advisory panels that are kind of slotted into the system at various points and advise Government decision making, and then we rely on NGOs doing their best around co-design and co-production, so we end up with sort of centralised mechanisms for co-production through advisory committees and then some grassroots, and patchy - some better than others - some grassroots co-designed services or developments.

And this is noted in the literature on co-production, that there's a real problem bringing together - getting co-production to actually have any impact outside of the immediate location in which people are co-producing something, and particularly forming links between where co-production happens at a grassroots level and where it happens centrally, which is why I think it's really important to actually build that capability into all of the organisations that comprise the service system and to understand that it takes some resourcing to do that.

Beyond that, I would say we probably don't have the evidence base that we need to actually understand what are the sorts of design principles that might apply to housing for people with complex mental illness. I note that there's some work going on at the moment - various bits of work, I know because we're involved in it - on thinking about the physical design of emergency departments.

In mental health research there's beginning to be recognition that actually we need to pay attention to the design of the built environment in which various kinds of mental health interactions take place; I think that applies to people's housing as well and I think it would be great to see some research, some participatory research go on that really looks at what constitutes good design for people with complex mental illness.

In the Trajectories interviews, one of our researchers actually, one of our lived experience, our peer researchers

actually is an architect by background, and when she looks at - it's fascinating, because when she looked at the interview transcript she said, ah, this is really interesting, there's all this stuff in here about design which I don't think we would have picked up on because we didn't come to it with this dual lens of lived experience and the eye of an architect. So we've done some work together, so the research team, we've done some work and we've looked at some of the things that came out very clearly in terms of the sort of lived experience way of knowing about the design principles: so natural light, sound proofing, lines of sight into and within the building, particularly placement of windows and doors so that people feel safe inside their house. So that, when you open your front door, you're not looking directly into somebody's living space, or you can see the shower from the front door, and in fact there's another unit dead opposite yours with a front door right in front of it so that, you know, when you have your door open - in Australia especially in the summer with your screen door open quite often for long periods of time you're visible when you're inside the house.

So that question of aspect and physical relationship to other nearby dwellings. Own garden or own private external space, very, very important. I think safety and privacy are really important. Now, those are some of the things that have come out from the interviews we've done. I think, given the reality of increasing consumer and carer co-design in the construction of actual dwellings is really limited. I think investing in some research to understand trauma-informed design in particular, but also what makes sense for consumers and carers would be really good.

MS BATTEN: Thank you. Ms Humphrey, can I turn to you next to ask about the options for increasing consumer and carer co-design.

MS HUMPHREY: Look, I'd like to follow on I guess and say, where there is an opportunity within the build environment, so where Government is providing grants to build new facilities or new properties or new housing, I think that engagement of the lived experience in the co-design alongside the architectural eye is really fundamental.

We've seen that in our new facility called Sacred Heart Community, and it's a prime example of a co-designed

building for people who are ageing early as a result of, you know, the lived experience of being in disadvantage and homelessness who also have a mental health issue.

What we're able to do is co-design a facility with those residents alongside the architect consulting with them and providing them examples of other facilities.

If we take in a very mainstream aged care service we wouldn't have met the needs of the community which looks very different to an older cohort who are often bed-bound, where we're dealing with a younger cohort whose life experience is vastly different to that of mainstream aged care.

So, for us, I think it meant that we developed a facility that really meets the needs of a very specialised cohort, so I think those principles of the build environment of building in principles of co-design alongside the architectural eye is really critical.

Then, if I think of the support needs, I really think that the basic building block of effective assessment and good individualised service planning is fundamental, and we need to make sure that that's consistently practised across the service system, whether that's housing, homelessness, mental health service system, because I can tell you it's not, and I think that's the problem of that co-design at the beginning of identifying need and with the individual identifying a plan that will meet their needs; there is some gaps across the service system.

MS BATTEN: Thank you. Dr Fotheringham, noting your comments earlier, do you have anything to add on the options for increasing consumer and carer co-design?

DR FOTHERINGHAM: Yes, I do. Yes, within that context I alluded to of a shortfall of social housing supply, I guess it's worth recognising that Victoria currently has the lowest market share across the country of social housing, so the proportion of the overall housing stock that is social and affordable housing in Victoria is lower in Victoria than it is in any other States and Territories.

But there are some really positive signs with the Victorian Government's announcements over the last couple of years, and in fact the last couple of weeks, for social

housing development and some positive moves as well in rental reforms in the private rental system addressing the pets dimension that Sarah talked about earlier which has a really important housing focus as well as on mental illness.

Some of the recent reforms or announcements look at a significant build of social housing, and the disability sector I think are engaging quite strongly with that and I think it's quite important that the mental health sector does too.

A good example of what that can look like, I guess, comes across the border in New South Wales, the SAHF, the Social and Affordable Housing Fund, which last year went into its second round of large-scale long-term funding. It's an approach that involves partnerships between social housing providers, developers and various landholders, which often are faith groups, church groups that own significant land, but not necessarily.

Public/private partnerships involved in the community sector to co-design and co-deliver precincts of mixed tenure development, so the Ivanhoe development in Sydney is probably the best known example of that, where a really significant housing development that was situated close to a train station or around a train station, so good access to public transport which is an important dimension to many, with some private housing within that, some affordable housing within that, and some social housing within that, in a mixed model, so it wasn't sort of segregated housing within those and separate entrances for social housing dwellers and so on but actually much more integrated and comprehensive within a sort of precinct development approach. That model is less cost intensive to Government because it involves partnerships with developers and community sector and provides really good outcomes.

I guess the contrasting journey for Victoria in the last three or four or five years while that's been happening in New South Wales is public housing redevelopment has become highly politicised, where redevelopment of public housing sites that have needed to be redeveloped because they've ceased to be really habitable have been approached with that sort of partnership in mind and the politics of it has been difficult, significant opposition to the approach, where

the net number of public housing dwellings has increased and other social housing and affordable housing as well, with private housing within it, but it has had a difficult journey in this state so that's something we would hope to see stronger bilateral support for going forward.

MS BATTEN: I might ask one more question and then give you all a break. We'll turn to the fourth topic which is increasing access to accommodation support through NDIS.

The first question is, what are the requirements of the NDIS for people with mental illness seeking specialist disability accommodation or supported independent living? Dr Pollock, can I ask you that question first?

DR POLLOCK: Sure. I think, before I answer the question specifically, I think there's a problem with the conceptualisation of disability that the scheme currently relies on. I think it still relies on quite a diagnostic frame for understanding disability, i.e. there's got to be diagnosis that underlies people's functional impairment.

Getting into the NDIS does require for people with psychosocial disability, it does require them to prove a diagnosis and to prove permanence, or the likelihood of permanence of the diagnosis and of likely long-term or lifelong support need; rather than relying on evidence of significant and ongoing functional impairment and need for support around functional impairment. What this does is, I think, is separates people with a so-called disability from people with debility.

So, I think the NDIS is particularly poor at responding to significant levels of debility that have often been poor. So, if we think about the various cohorts that Cathy Humphrey has described today, the people who have had multiple experiences, multiple systems fail them over a long period of time to the extent that they carry significant debility, there are problems for them getting into the NDIS because it doesn't recognise debility as a kind continuum within disability.

So, having said that - and I think it's a major problem for people who have got complex support needs - having said that, the general requirements are set out in s.24 of the Act and they relate to permanent impairment associated with substantially reduced functional capacity

to undertake one of a number of core activities, and where that impacts on capacity also limits a person's social and economic participation.

The NDIA then identifies six criteria for having SIL in your package, but these I think are quite vague criteria, and I haven't got them in front of me I'm afraid but they're on the NDIA website, but they're very broad, they're things like goal setting, engagement and planning; that sort of thing.

At Mind, we've developed our own process. We have a customer service centre, so people ring up and they say, you know, I'm interested in accessing the NDIS and we have developed a particular set of inclusion criteria for advising somebody to ask for SIL in their package, and we have about a 98 per cent success rate for people who ask for SIL and get it, so I think that indicates our inclusion criteria works quite well.

A history of housing insecurity and/or homelessness and evidence to support that, a long-term reliance on clinical support, so that might be a period of time in a CCU, repeated use of PARCs or step-up/step-down, and multiple inpatient stays over a 24-month period. Again, ability to evidence that.

Then the ability to provide evidence that shows how their mental illness impacts on their day-to-day living and on their social and economic participation. And, if people are able to do that, they are likely to get SIL in their packages.

I think that the NDIA are going to tighten up their criteria around SIL, I think coming out of both TUNE and the recent joint standing committee look at SIL, I think these will get tightened up. But in reality what actually happens is - and this goes to Ms Humphrey's points about how vacancies are managed - in reality what happens is, people ring us and say, "I see you've got a vacancy in a SIL property. I've got somebody who would like that but they don't have SIL in their package." So, most of the time a support coordinator or a planner, or sometimes a family member, will identify that we have a SIL vacancy and that will kick off somebody then asking for a plan review and asking to get SIL into their package through the plan review. And at the moment there's quite a considerable

time lag of between three to six months for that plan review to happen and the person to get SIL in their package, so I think it's quite an inefficient process.

In terms of SDA, even more difficult. SDA is really a specialist housing solution that I think has been predicated on the notion of physical disability where what you need is ramps and hoists and wide doorways and, you know, walls that don't fall apart if you bump your wheelchair into them. So, the criteria to get SDA in your package is associated with extreme functional impairment and very high support needs.

At the present time I think there are around 468 people with SDA approved in their plan, on the basis of primary psychosocial disability. But I guess that only around 300 people actually have SDA properties. I would say this notion of primary psychosocial disability often, to the extent that we know about this, those people who have SDA with primary psychosocial actually either have long-term histories of institutionalisation, so all of the sorts of developmental delay issues that you have if you've lived in an institution for 20 years, or my guess is they will have considerable cognitive impairment. Now, whether that's identified or not and included as part of their package, I don't know, but I suspect there's quite a bit of unrecognised or unassessed/non-assessed cognitive impairment. Really difficult to get SDA for psychosocial.

MS BATTEN: Thank you, Dr Pollock. Ms Humphrey, can I turn to you, is there anything else that you can add on the requirements to access the SDA or the SIL for NDIS for people with psychosocial disability?

MS HUMPHREY: I think following on from Sarah's comments, I really think it points to that workforce capability development that's required and the need for service navigators. I think it's a complex system and, in terms of NDIS, and then on top of that access to SDAs and SILs is quite complex as well.

I am very interested to hear Mind's approach around their customer assessment process around SILs, and I think that sounds like a great example of something that should be replicated more broadly across the service system.

MS BATTEN: Thank you. Dr Fotheringham, is there anything

you can add about the requirements for NDIS first accessing the SDA and SIL?

DR FOTHERINGHAM: Nothing of substance. I think Dr Pollock has answered the question very thoroughly and very well and I agree with all her comments. I think she can add to them.

MS BATTEN: I'll come back to you, Dr Pollock.

DR FOTHERINGHAM: So no, I'll sit aside.

DR POLLOCK: So, SDA and SIL are not the only housing supports available through the NDIS. Do you want me to say a little bit about the other supports because I think they're greatly under-utilised?

MS BATTEN: Yes, if you can say those briefly and then after the break I'll come back to each of you and ask what can be done by NDIA to better access all of these supports and then what the state can do to help people better access these supports. Thank you, Dr Pollock.

DR POLLOCK: So, there's two specific items in the NDIS price guide: the first is a capacity building item called Improved Living Arrangements, and that is really designed to help people with any activities that relate to their accommodation. So, that may be helping them to apply for a rental tenancy or undertaking tenancy obligations, but it's very specific around helping them to secure and maintain a tenancy.

The second one which I've actually only just found out about, and I think that fascinates me, it's only in the last couple of weeks because I've been digging around in the NDIS because of this panel, I discovered there's a thing called capital support for home modifications, which I guess I knew about, I knew about it in relation to physical disability, but potentially it's there to be applied to people with psychosocial disability; for instance, soundproofing.

So, sound disturbance, particularly at night, for a lot of people with a complex mental illness can be a significant stressor, and then lack of sleep can be one of the things that tips people from going along really, really well into being very, very unwell.

Potentially the home mods, it's called capital improvements to a building, I am not aware that this has been used at all for the sorts of things that people with psychosocial disability might need modified in their building. I also think there may be a barrier for people living in social housing making certain kinds of home modifications.

This has come up because I've got a friend who's actually in this position of wanting some soundproofing but, (a) not being able to get it through the NDIS, and (b) whether she can actually make the modifications to her property or not is another matter, but it's kind of opened up this whole kind of area and whole kind of question for me about what is an appropriate application of that home modification for people with psychosocial disability.

MS BATTEN: Thank you very much. I will give everyone a break, so I'll give you all 10 minutes. I have five more questions for you and then I will hand over to the Commissioners after that. Thank you very much everyone.

SHORT ADJOURNMENT

MS BATTEN: Thank you everyone. As I mentioned before the break, I just have five more questions for you and then I will hand over to the Commissioners.

We're still in the topic of trying to increase access to accommodation support through NDIS. Dr Pollock, you just very helpfully outlined the different sources of potential NDIS funding.

My question, and I'll direct this first to you, Dr Pollock: how can the NDIA improve the ability of people with mental illness to access those supports?

DR POLLOCK: I think that's a very good question. I think some of this actually goes back to the sort of original design of the NDIA and the NDIA's own understanding of what psychosocial disability actually kind of looks like and consequently what sorts of things support people with psychosocial disability, and particularly how - the role that housing plays in improving the lives and the outcomes of people with psychosocial disability. So, I think it's about the NDIA's own understanding of the intersection

between housing, mental health and mental illness and disability, and in the context of trying to achieve a contributing life.

I think that, if the NDIA - so some of it, kind of speaks to the NDIA's own understanding of these things and their own workforce capability, particularly planners, particularly planners and LACs, but probably also people who make decisions that impact on what goes into people - you know, make eligibility related decisions and package size decisions.

I think generally if the NDIA want to improve the ability of people with mental illness to access SDA and SIL and other housing supports, I think the NDIA needs to improve its own understanding of what those things look like and why they matter.

I think more consideration needs to be given to the possibility of having congregate care, congregate models as one option. I know that, in the NGO sector, and amongst consumers, there's some opposition to anything congregate because it's seen as, you know, that's not how other people live. Well, actually it is. If I think about modern urban apartment living that's exactly what we're talking about.

So, we're talking about high quality congregate models, where people have their own apartments and have access to their own private space, but they also have access to the 24/7 support that they might need. And I would say that probably up to a maximum of 15 people; once you get beyond 15 people then you move into some sort of different notion of congregate care. At the moment there are rules and regulations that prohibit that or certainly make it much more difficult.

I think some of the NDIA workforce capability, and then looking at the NDIA's own rules and regulations to see where it presents options like congregate living, would certainly enable people to access more housing support.

MS BATTEN: Thank you. Ms Humphrey, can I turn to you next. Are there things that you think the NDIA could do to help people with mental illness access better accommodation supports?

MS HUMPHREY: I think the role of the local area

coordinator is something that should be examined, and the clarity about where housing risk is identified in the support plan, what is there in the role around considering SILs and SDAs within that context. I mean, I guess that's what I would add to what Sarah's already outlined.

MS BATTEN: Thank you. Dr Fotheringham, is there anything that you would like to add on what NDIA can do?

DR FOTHERINGHAM: I guess I want to make the remark that, you know, the NDIS has been a really rapid rollout of a very comprehensive and wide-ranging system reform, and that has led to a number of challenges around information dissemination, clear guidelines, and consistent understandings of the system across the country.

And, as Dr Pollock mentioned, the understanding of that system of psychosocial issues is still developing, which means that determination of understandings of guidelines and protocols is a constantly evolving piece. It's not a static system at this point and not even close to it, so it's very early days for the whole system, and I think just as a communication exercise that's a really difficult challenge. So, if people who are working within the system are struggling to understand how the system works, how can consumers understand how the system works and know what to ask for?

And that's a profound challenge still, and that's a challenge for physical disabilities as well. I mean, it's not as though that's all clear and completed.

Sarah mentioned capital improvements and some of the work AHURI's done in terms of disability housing in relation to physical disability has shown that the capital improvements side or stream of funds is a really difficult one to access and a difficult one to use, so it's useful for mental illness, I think. It's certainly worth exploring and worth supporting, but by no means simple.

I just wanted to, I guess, touch on Dr Pollock's comments around congregate housing and I think it's worth just making a distinction between two forms of that. She talked about apartment complex living and, you know, studio apartments and the like where one of the apartments is occupied by a carer of some form, versus some of the other congregate housing that's been used in the disability space

over the years which tends to be more like a share house, where you have your own room, but it's shared kitchen, shared land facilities and so on, but you don't actually have a choice about who your housemates are, and that's quite a different scenario and probably a different set of outcomes, and I think the more we're moving towards that apartment complex version rather than the forced share house version, then I think that's a positive.

MS BATTEN: Thank you. The last question related to NDIS is the role of the State Government, so the question specifically is, how could the State Government better support people with mental illness to access SDA and SIL and the other supports that have been mentioned funded by the NDIS?

Ms Humphrey, I might turn to you first to see what you have to say about what the state can do.

MS HUMPHREY: Look, I think there is a gap between connecting people into the NDIS in totality, whether that's then leading to SDA or SIL access, and I think that really points to the need to fund the systems advocacy and service navigation role. There's a real gap in the service system with, you know, now the loss of the PDRSS system in Victoria of kind of what we need to do prior to the NDIA in order to get someone into that service system. So, I think there's a kind of functional gap within the service system that the State Government needs to fill in the absence of the PDRSS program.

MS BATTEN: Dr Pollock, can I turn to you next, what do you think the State Government could do to enable people to better access the supports under NDIS?

DR POLLOCK: Look, I fully concur with what Cathy's just said about system navigation and care coordination. People need the support coordination within the NDIS to be sufficient; it's kind of underdone I think, in terms of actually helping. It's underdone in terms of how the role's conceptualised and how it plays out. I think anyone with complex needs, some State Government funded coordination and navigation would be really, really helpful.

I think there's some workforce issues. Just upskilling the mental health workforce in the most general

sense around the role that housing plays in people's wellness and illness. Both the clinical programs that actually interface with the NDIS, so the EIPRS, the Early Intervention, Prevention and Recovery Support program, which is really an NDIS gateway, it's really important for the people, the NGOs and clinical partners who are providing that to have good housing capability.

I think beyond having a housing aware mental health workforce that can then help people either access NDIS, or who are within the NDIS to actually access the housing supports that are available; I think that would be helpful.

MS BATTEN: Dr Fotheringham, is there anything that you can add on what the state could do to support people to better access the NDIS?

DR FOTHERINGHAM: My understanding is that New South Wales has done a bit of work and I believe this connects through to the social and affordable housing fund that I talked to earlier that has prioritised disability housing in some parts of the program.

I guess it's also worth making the point that there is a supply issue here as well and it sort of echoes some of my earlier remarks about the social housing system and the size of the waiting list. The sense that there is sufficient SDA funds to meet those needs, you know, in a physical disability space: it's clearly not, it's a very small proportion that's met. So, again, we have a really significant gap between the size of the demand and the size of the available funds, the available supply. And I think that's the context that, as much as it is repetitive to keep reinforcing, it is a really important part of the context.

MS BATTEN: Thank you. This leads on to where I'm going to direct my questions to you, Dr Fotheringham, about innovative models. You mentioned the SAHF fund before. Can I ask you this question and maybe if you need to return and expand on this on what your comments were in relation to the SAHF fund please do so.

Are there innovative ways the State Government could increase the volume of appropriate affordable housing stock for people with mental illness?

DR FOTHERINGHAM: Thank you, yes. And look, I think SAHF is a really good example of that so I will perhaps draw on that example again. And again, a bit of context setting, it's worth recognising that housing policy in Australia is split across levels of Government. A lovely Federation means that the Federal Government has some responsibilities for housing policy, and the states and territories have other responsibilities, and for that matter so does Local Government, and that creates, I guess, a division or a less accountable sense because of that dispersion of responsibility.

But the states clearly have a key role and a lead role in many respects, including the supply of social and affordable housing through the public housing system and support of the community housing system.

There is, I think, a need for much greater emphasis on disability accommodation generally, physical and mental health included. I think the way in which the continuing evolution of a multi-provider system; I guess, going back many decades there was a public housing system and that was essentially the offering for affordable housing, it was largely targeted to key workers, and that's sort of the very early history of public housing in this country.

But over recent decades that's shifted to become more of a multi-provider system where the state-owned and run public housing sits amongst a combination of community owned and operated social and affordable housing, and housing that is perhaps formerly owned by the state or still owned by the state but managed by the community sector. So, there's a complex system of suppliers there and it is entirely possible for the state to prioritise funding towards particular cohorts and, to my knowledge, mental health has not been amongst the cohorts of particular attention in that space, in Victoria's recent history, but certainly there is opportunity for that.

That probably needs to be pragmatically built into other programs. So, recent announcements by the Victorian Government of significant building of social and public housing could be fine-tuned to have particular emphasis on mental health. That would be a really positive step.

Programs like the SAHF fund which harness private sector engagement, community sector as well as Government

to effectively a multiplier effect through that partnership. Again, an emphasis on mental health within the design of those programs would be incredibly beneficial.

MS BATTEN: You also mentioned stock transfer. Could you just explain how that works, the stock transfer arrangement works, and then also if I can ask you to maybe go into more detail with the SAHF fund with the Ivanhoe example, what the partnership arrangement was exactly and the roles of the different players.

DR FOTHERINGHAM: Sure. So, stock transfer, there's two forms of stock transfer which is really the movement of housing stock from the public housing system, for the state-owned and run housing system, to the community sector. And that's done for a range of reasons but there are two key forms of it: one is title transfer where not just the management of the property but the ownership of the property is transferred to a community organisation, often through a tender process. And the other is management transfer, where the state retains ownership of the property and the land beneath it, but a community housing provider will take over the management of the property itself and of the tenancy within it.

The motivations for that process are complex, there are a whole lot of sort of funding implications for that, and one of which is access to Commonwealth rent assistance, so tenants who need rent assistance because their income is not sufficient or adequate for the rental.

That's not available to public housing tenants but it is available to community housing tenants, so that switch has an impact on the cost sharing between state and Commonwealth.

But, more significantly perhaps, the transfer of management of stock to the community sector is believed to have better outcomes for the tenant. There is a perception that the caseloads that are typical of a community housing provider are lower than for a public housing tenancy manager.

I've recently heard someone in Victoria say that as a public housing tenancy manager they had 300 tenants on their books as a tenancy manager and they moved to a role

in the community sector where they had 80 and that was considered a high load in that sector. So, you know, there are different approaches to tenancy management in those systems and different emphases.

And there is a bit of a prevailing assumption that the community sector provide better outcomes for tenants and for the management of the properties. Now, that's not necessarily evidence based but that is an assumption underlying that transfer.

In terms of the SAHF program and the Ivanhoe example in particular: well, I'm not privy to the contract, unfortunately, but what I can say is that, look, it involved a significant developer, one of the sort of names that you see all over the town, you know, on construction sites; major development. I'm not sure how many apartments, a couple of hundred I think overall, or at least a hundred, and a community housing provider, I believe it was Mission Australia in this particular example but there have been many involved; the bidding process for that fund was exhaustive. And use of Government land as well, so there was a complex arrangement involving Government assets and the private sector and community sector coming together in a really complex partnership.

There have been two rounds of that fund so far, really significant investment of funds in I believe the billions of dollars for long-term housing outcomes.

MS BATTEN: Thank you. Ms Humphrey, can I turn to you and ask you about innovative models, and particularly some of the work that Sacred Heart's been involved in.

MS HUMPHREY: I think there are opportunities for that private sector investment to be explored. We certainly began some conversations with private sector investors about their interest in developing accommodation options, but it is a piece of work that's underdeveloped.

I think the other area of opportunity, you know, there is the affordable housing social impact bond money sitting with - where Hesta has made available funds through superannuation to Social Ventures Australia which I don't think the uptake has been significant. So, I think there are those kind of options that ring in that kind of

investor environment into creating housing options, you know, alongside access to the NHFIC fund for community housing providers to get low cost debt.

I think there's ways of kind of massaging the available mechanisms to create some opportunities, and I think, you know, really it's got to be led through community housing providers that want to provide particularly options for this cohort group.

I think Michael's outlined a couple of examples of those. I couldn't add to that detail. From a support provider perspective I think, having payment by results contracts really drives a support provider to really focus on outcomes in a supported accommodation environment, so that alongside the capability of investing into housing, alongside support models that are outcomes-driven, I think get great results.

MS BATTEN: Dr Pollock, can I direct this question to you, about innovation and opportunities to increase the housing stock.

DR POLLOCK: You can direct me, but I actually don't have anything to add to what my colleagues have already said.

MS BATTEN: Okay, thank you. Dr Fotheringham, I'll come back to you, would you like to add something else?

DR FOTHERINGHAM: Dr Pollock and I are running a good tag team, I think.

I would actually like to expand a little bit and thank you, Cathy, for mentioning NHFIC. The National Housing Finance Investment Corporation is a Commonwealth initiative that I think provides a really interesting angle on the question you're asking.

It has several functions now, but one of its core functions is the bond aggregator which is a mechanism through which financiers, often superannuation funds or large-scale investors, can make contributions to social bonds that are backed by Government guarantee, you know, for a reasonable rate of return but with a social impact purpose to them, and those bonds are aggregated by NHFIC, collected by NHFIC, and then awarded to community housing providers through an incredibly detailed, effectively

tender process, bidding process, for development of affordable housing, of social housing. In its very short history that's already channelled billions of dollars worth of money into the community housing sector, and that's starting to form direct relationships between the large-scale investors, the financiers and superannuation funds who historically have invested in social housing in the UK and US but not in Australia, and we're talking about Australian entities; is building connections between those financiers and the community housing sector which will start to build a life of their own and that's one of the knock-on effects of that system.

Victoria has also announced a bond aggregation, but the uptake I think is probably less. The volume of funds available are smaller, the ambition is smaller, it's not a national scheme, but there would be an opportunity for the Victorian Government to re-tool that mechanism to focus specifically on areas of need, and so that could housing for mental health. Part of this is about the impact, the social impact that those investors can point to and that's significant for them in a range of ways.

I would have thought that this is an area that has real potential for them. In terms of how bond aggregation works, there's a long history of AHURI research that has built this model and examined the international evidence over the years in coming together to do this that informed the development of NHFIC and I'm happy to share those (indistinct words).

MS BATTEN: The next question is still on innovative models, and, Dr Fotheringham, I direct this to you first again. What could be done to better support people with mental illness to maintain private rental tenancies?

You touched on this earlier, but what needs to be done? You mentioned that this was a cohort that's undersupported, but what supports or what can be done to maintain those tenancies?

DR FOTHERINGHAM: Thank you. My understanding is, there are fairly limited programs, and I think even more limited awareness of programs that are available to support tenants in the private rental system through the sorts of challenges we're talking about today. Awareness of them would be a first step.

Part of the complexity of the private rental system which is, and I should acknowledge, is the growing tenure form in this country. So, more people are renting and more people are renting for very long periods of time. I mean, the sort of more traditional sense of an Australian housing career was that you lived with your parents, then you moved out and rented for a year or two and then you bought your own place and settled down. That's shifted dramatically.

There are very significant numbers of the population renting for 10 years or more, either in one place or sequentially, more often sequentially, and increasingly we're seeing people who are retiring while renting in the private system, and that's financially very challenging.

There are also two ways in which people can be involved in rental in the private system. One is renting directly with a landlord, often the mum and dad investor, a small-scale investor with just a few properties often close to their own home, and the other is through a real estate agent, and the dynamics there are incredibly different, and I think this is probably an unappreciated aspect to this.

One of the responses to the COVID pandemic and impacts on employment in this country, across the country we've seen state governments put forward models of negotiation between tenants and landlords, and well, that's not an even negotiation in that case, there is a power differential there automatically.

But also, in many of those there is a third party with a different set of interests in the situation, so there's the outcome for the landlord, there's also the outcome for the real estate agent.

Similarly, the information that can be made available to a tenant, a real estate agent actually might have better access to that information, be more aware of the programs that are around than an individual who's invested in a property as their nest egg that is then renting it out will probably not be aware of some of those programs, so just the awareness of them, let alone the scale of them and availability of them is a really significant area for improvement.

MS BATTEN: Thank you. Ms Humphrey, can I turn to you

next. In your view, are there things that can be done to better support people with mental illness maintaining private tenancies?

MS HUMPHREY: There's an example within the Victorian Homelessness Service System, a program called PRAP, which is Private Rental Access Program which has taken a focus on homelessness and family violence, and I think there's an opportunity to expand that program into responding to people with mental illness.

So that works to both secure and sustain housing in the private rental market. There is a program called PRAP Plus that does a little bit more than that, but I think there's an opportunity to kind of look at how that's working in the homelessness system and whether that can be replicated in the mental health service system.

The other program that I've seen work well is head leasing programs where a community housing provider holds the lease and then subleases that to a person with a mental illness. But what's important with that program, there needs to be a subsidy that bridges the gap between market rental CRA and Newstart. I think when someone's on a disability support pension that subsidy's not as deep, but I think that requires some Government funding alongside the head leasing program to make that effective.

We've seen people over time successfully manage those head leasing properties and eventually have the lease transferred to them away from the community housing provider and lead into more independent management of the private rental, so they're two options that are worth exploring in this space.

MS BATTEN: Dr Pollock, did you have anything to add about how people with mental illness can be maintained in private rental tenancies?

DR POLLOCK: I think what I would add is that, if we're serious about this, we actually have to do something about people's financial security and their ability to access employment. And I know that's kind of a long stretch for what might help support people in private rental tenancies, but having a decent income is really important. People cannot, they simply cannot, manage a private rental tenancy particularly in metro Melbourne on Newstart: it's just not

possible. And I would say even the DSP in metro Melbourne is actually very, very difficult. So there's a big issue about financial security and income that I actually think has to be addressed.

In terms of specific supports or specific ways in which people could be supported to maintain private rental: a lot of the people with complex mental illness will have some kind of service contact or service system contact, so just making sure that tenancy, the role - it's what I said before, the role that housing plays and the need to support people through tenancies when they're not very well is well understood in the mental health workforce most broadly, so there's early identification and available supports been put in place, and that will suffice for quite a lot of people.

I think if we look at specific programs, one of the ones that I've been interested in is the Doorway program that Wellways has run, and that provides interlinked tenancy support, psychosocial support, and delivered in partnership with an Area Mental Health Service so that the person has a clinical case manager and has their clinical mental health needs met by the Area Mental Health Service, and the program has the ability so sort of flex up and down and to support people through periods of relative wellness and illness, specifically focused on people in private rental tenancies.

I would say that it requires focused, high quality support coordination which is, you know, something that Cathy mentioned before, it's absolutely essential.

Then I think beyond that I think, yes, definitely looking at arrangements that facilitate head leasing and lead tenant arrangements, and thinking about the ways in which risk - that there could be some risk sharing between the State Government and a community housing provider or an NGO who's willing to take on a lease for somebody with a complex mental illness. So, it's something that we've looked at, and particularly with the application of SIL in private rental, but have stepped away from it because of the risk of carrying the lease.

Then I think it would be great to see some advocacy for people who are private rental tenants who have an NDIS package to just be able to use some of their package to pay

for their rent during periods of illness.

So, if I think about what - well, not necessarily what typically happens, but what can happen to people; they can be going along all right, everything fine, working, paying their rent. Then they get unwell, they can't work, they stop looking at their mail, they stop notice, they see the red envelope, they ignore the fact that they haven't paid their rent for three months because it's just been beyond what they can do, they get an eviction notice, that will be enough to tip them into significant illness and a period in hospital.

The stress around maintaining a tenancy, paying the rent, is massive and it's a massive driver of deteriorating mental health. If people with packages could actually use some of that package to tide them through really difficult times I think it would be great. They can't at the moment, but it would be good to really test that with the NDIA.

And likewise, considering some sort of short-term brokerage funds that pays people's rent during a period of illness so that they don't come out of hospital trying to get themselves back together and then immediately hit a huge great big, you know, unpaid rent bill.

MS BATTEN: Thank you. Dr Fotheringham, I'll come back to you.

DR FOTHERINGHAM: Just very briefly, thank you. I just wanted to pick up on one mechanism that both Cathy and Sarah mentioned, head leasing, which I think their comments are really framed as something that a community provider or a community organisation might do, and it's a very positive mechanism, but it's not just the community sector that can do that.

So the Queensland Government, for example, through the Department of Housing and Public Works have for a number of years now, for 20 years or so, run a head leasing program where they will lease properties for particular vulnerable clients as a head leasing arrangement. That was originally designed as a crisis accommodation set-up when there was a shortfall of available social housing, but over the last couple of decades has really evolved into a head leasing arrangement that has operated for people to give stability and safety for, well, typically about two years

now rather than the initial framing as a crisis response. That's called the Community Rent Scheme up in Queensland and that's something that the Victorian Government could certainly look at as a model.

MS BATTEN: Thank you. Thank you for adding that. My final question before I hand over to the Commissioners for their questions is workforce capabilities.

All of you have touched on this briefly as you've gone through in your comments, but I would just like to wrap it up in a final place.

The question is, what is needed to ensure the workforce has the capability to provide the support needed for people with mental illness to maintain housing and to live a contributing life?

Ms Humphrey, I'll come to you first.

MS HUMPHREY: Look, for me front of mind is sustaining tenancies practices. I think making inroads to kind of defining that and articulating that in a practised way across the various workforces, both in mental health and in homelessness.

Trauma-informed care practices is really fundamental and what that means both from an organisational perspective as a support provider, but what does it mean for individualised care as well.

I think increasing knowledge of the NDIS and its systems and navigating that is really fundamental, both in mental health services and in non-mental health services.

I think somehow within the kind of mainstream service system is creating information about where to go for supports. There's kind of that first responder principle, and this certainly was highlighted in the Family Violence Royal Commission around, what are the touch points in which a woman might touch the system and identify that family violence is a factor for her.

In the same respects, how does the mainstream service system identify when someone is at risk of becoming unwell or at risk of their housing breaking down, where can we kind of intercept into that system early, and whether

that's with estate agents or GPs or other kind of first points of contact for people.

I think we need to kind of rethink that prevention activities of keeping people housed and what that means for workforce development and practices.

MS BATTEN: Thank you. Dr Pollock, can I come to you next.

DR POLLOCK: Absolutely agree with what Cathy's just said. I think that we need systems that actually - we've got a terrible lack of data, terrible lack of systems that generate useful data. So, early identification is both a skills issue, but it's a system issue. It's a, what do you do once you've identified that somebody's housing is falling apart? There needs to be systems for actually collecting that data and multiple points of visibility, I suppose, for providers to actually see who's vulnerable, who's at risk.

I think we need systems around, not just early identification when things go wrong, but ways of knowing who's vulnerable, and I think that applies both to the specialised systems but also mainstream services.

So, if I think about young people, what's the role of schools, because schools know an awful lot about the young people and their family circumstances. So, what's the role of schools in being part of an identification and kind of early warning for children and young people who might be vulnerable.

I think, when we think about workforce capability, I think we're talking about multiple workforces, we're talking about the mental health skills, the mental health awareness and basic skills of the housing and homelessness workforce. The mental health workforce, we're talking about their awareness of the role that housing plays and knowledge of the housing and homelessness system.

Then I think we've got the disability workforce too that I don't think, you know, as I've said in a number of different ways already this morning, I don't think the disability workforce, neither planners, nor LACs, nor the NGO components of the workforce, I don't think we are particularly housing aware.

So I think it's a question of understanding the different workforces that kind of come to bear on this question of housing and mental illness and the different kind of skills that they need.

And there is a very particular and rather difficult question of what you do about private landlords and real estate agents and their skills and understanding of the role that mental illness in particular plays in people's ability to sustain their tenancies.

MS BATTEN: Thank you. Dr Fotheringham, is there anything else that you want to add to the skills that are needed or the workforce capability?

DR FOTHERINGHAM: I guess I was intending to make some of the same remarks that Sarah has already expressed very well, but look, the point of this is, there is not a workforce, there's a multitude of workforces involved in this issue as part of the problem, and as much as there is a challenge for the mental health workforce to be housing aware, there is equally a challenge for the housing workforces to be mental health aware.

I guess there's a number of sort of key providers or key elements of the system to consider. There's DHHS as the public housing provider and the training of public housing tenancy management and so on in mental health matters. There's the community housing sector and the role of CHIAVIC, the Community Housing Industry Association for Victoria as their peak in disseminating information in that space, and there are a number of training providers relevant to both community and public housing through the Australasian Housing Institute and through Swinburne's graduate courses, for example.

I'm less aware of what training is provided for real estate agents by the REIV or other leading agencies in the real estate space, though I think there is probably a workforce there where training and so on is highly relevant.

Then again, also in terms of the mortgage markets, for homeowners, it's entirely possible for someone to go from home ownership to homelessness for mental health reasons, and so, the extent to which the mortgage holders have good

systems and good understandings of those challenges and good ways of supporting is an area to consider as well, so it's many different workforces to bring in.

MS BATTEN: Thank you very much for answering all of my questions, I'll now hand to the Chair to ask you the Commissioner's questions.

THE CHAIR: Thank you very much, all of you, for your contribution today, and I'm going to try and just keep my one question short because I know this is an area of particular interest for Professor Fels, and then I'll hand over to him and other Commissioners.

I think what's become evident both from your witness statements and the conversation today, we've got two very complex service systems: so the mental health service system, the housing and homeless service system, running in parallel, and we know about the bidirectional relationship between mental health and housing and homelessness and what we need to try and deal with, and your witness statements do really highlight what we need to do both in terms of rapid housing responses but also long-term housing for people with severe mental illness.

And so, the challenge I guess for me is probably to the last point you raised about, has anyone - and maybe starting with you, Dr Fotheringham - do you have a view about what is a way we can keep this discourse about the mental health housing homelessness interface dynamic so that we - because both service systems have very high levels of unmet demand, probably haven't had enough planning for the longer term requirements, and we're trying to future proof the mental health system. Do you have any suggestions about what might be done to ensure there's a better planning arrangement in place between mental health and housing and homelessness services?

DR FOTHERINGHAM: Thank you for that question. Look, yes, it is a really profound and complex space, and I'm glad that you also acknowledge Professor Fels' interest in this matter because I think it's important to point out that the work that AHURI's been doing in this space over a number of years now with Mind Australia, but also with the National Mental Health Commission before that, and Professor Fels was instrumental in triggering that body of work, so I wanted to acknowledge that as a really important

foundation for the work that Sarah and I have been doing since.

They are quite different systems. This is one of the spaces in which the way in which governments operate with policy portfolios starts to run into trouble because, as issues work across portfolios, the coordination can be really difficult. I mean, this is a whole-of-government issue rather than an area for a specific department, a specific minister, it's one that bridges portfolios and those are always the most complex: the wicked problems, if you like.

It needs a dedicated focus, is my short answer.

THE CHAIR: I think that whole thing about whole-of-government responses and how do we actually translate it into practice is an ongoing challenge for us.

Professor Fels, can I hand over to you because I know it is an area of great interest for you.

COMMISSIONER FELS: Thank you, Chair, and also like you, I'd like to thank the three witnesses for their excellent papers and their contribution this morning, they've all been most informative and helpful.

I had three questions. The first one is to Dr Fotheringham, and in a sense he's partly answered it already: when we were discussing the question of the NDIA not really making much room for SDA funding, I just wanted to sort of remind everyone, or have us reminded, that while we need to pursue that question, we shouldn't let the State Government off the hook. They have a really important responsibility, do they not? I'm trying to make this a question, Chair.

Do they not? Do you agree, or do you agree that the state has got important responsibilities, and I acknowledge you have actually covered off several of those points already.

And also slightly related to that, about the specific SDA issue, I'd like to comment that I believe one of the reasons for the limited SDA funding is that there was a major conflict between the Commonwealth and the states about who would be responsible and who was responsible for

housing, particularly for housing for people with a disability.

The final outcome was a standoff with neither really being willing to step into the space but with the fact that previously the State Government spent about $700 million on their own disability housing, so that kind of funding got lobbed into the NDIA and is used for SDA. So, a lot of it, the problems arise from a lack of Commonwealth and state agreement on who's responsible for funding for housing for people with a disability, including people with a mental health problem.

So, do you agree or do you agree that the state has got pretty significant responsibilities in this area and along the lines that you've actually indicated, including making mental health a bit of a higher priority in their own housing allocations and decisions?

THE CHAIR: Well, go for that, Dr Fotheringham.

DR FOTHERINGHAM: Thank you for those questions, slightly leading though they may be.

I guess, look, there's a few different things to unpack there, but the broad theme of what you're talking about, whether it's NDIA or more broadly, is really about the Commonwealth State division responsibility for housing policy, and look, that is a significant issue.

It's worth acknowledging actually the changing relationships or the changing responsibilities over the last 10 years or so - further, if you like, but really fundamentally over the last 10 years or so - so really the life course of the NDIA has operated in two different contexts in terms of housing policy.

So, when NDIA was first formulated we had a National Affordable Housing Agreement and a National Partnership Agreement on Homelessness. The NAHA, the National Affordable Housing Agreement, was a 10-year agreement that was towards the end of its 10-year lifecycle.

The National Partnership Agreement on Homelessness was much more short-term, typically one year of funding at a time, and had led to significant uncertainty within the homelessness sector.

So, as the housing agreement approached its end and a new agreement was being negotiated between Commonwealth and states, one of the shifts that was undertaken was to roll the homelessness agreement into the housing agreement to have a single agreement that was longer term providing more certainty for the homelessness systems and homelessness funding.

We have that through the National Housing and Homelessness Agreement, it is a different agreement to the previous one in a range of ways and therefore a different policy context to sit alongside the NDIA.

The Commonwealth Government, it's fair to say, has had waxing and waning interests in housing policy and its role in housing policy. Under Prime Minister Abbott there was a very clear declaration that housing and homelessness was not the Commonwealth's remit and they would be stepping back from it. With a change in leadership, the Commonwealth has returned to the space, and quite significantly so. We now have a national housing minister which we haven't had for a number of years, and we have much stronger engagement in both housing and homelessness, both through the Department of Social Services and through Treasury, as well as through the investment in NHFIC as a bond aggregator and distributor of first home buyer loan guarantees and a range of other matters as they've taken responsibility.

So, there was a period in which the Commonwealth was less interested in housing that has now fortunately turned to a much stronger engagement. But the challenge remains that Commonwealth-state negotiations are always fraught and the responsibilities are not necessarily completely clear, nor are the approaches to it consistent from state to state which makes that negotiation more complex.

Look, this happens in a number of policy domains but certainly happens in housing.

AHURI led a policy, a group of senior officials on a study tour of Canada in 2018 where we looked at how their system works for housing and homelessness and they have similar challenges, in that, they have a Federal Government that has moved in and out of housing policy over the last three or four decades. The states or the provinces and

territories there have significant roles but have taken divergent approaches. They have the additional complexity that their municipal governments, their city governments or local councils, have taken really active roles as housing providers which is something we've not seen in this country that I would like us to see.

But to answer your broad question, yes, the Commonwealth-state complexity there is a significant impact.

THE CHAIR: Thank you. If we can now go to Dr Cockram.

COMMISSIONER COCKRAM: Thank you. My question is to Ms Humphrey, but before I start the question, just again to say thank you to everyone for the wonderful submissions and the capacity of this group to better inform the Commission, so thank you for that.

But, Ms Humphrey, you highlighted in your witness statement issues related to trauma and the importance of a system that maintains a strong focus on being trauma-informed.

In the context of this Commission's work related to people living with mental illness I wanted to ask you about the connection, trauma, substance misuse and abuse, and the acknowledgment in your submission around increased rates of personality disorders in groups of people at risk of housing instability.

I'm asking this question because throughout the Commission's work we have been regularly informed about the mental health system's challenges in fully supporting people in a trauma-informed practice, supporting people with comorbid alcohol and other drug problems, and supporting people with a diagnosis of personality disorders.

So, I was wondering if you could give us some directions about how we might think about the interconnection of those issues for service system design and service response.

MS HUMPHREY: Thank you, Commissioner, for that question, I think it's a complex response and I probably won't do it justice in this short timeframe.

But I think essentially, in order to understand trauma and its impacts on an the individual and then what does that mean from a service system design or an individualised support plan design, you have to understand trauma and what trauma-informed care means, and so, I think fundamentally the service system needs that workforce capability and organisational capability developed to understand what trauma-informed care actually really means.

For us, it's kind of taking that view that we're not necessarily assessing everyone for the impact of trauma, but we take a trauma-informed view that people have been exposed to trauma in some form throughout their lives.

We have data that provides evidence of its prevalence, so we work from the assumption that trauma impact is evident in people's lives. I think for people with personality disorders often that's developed as a result of that traumatic experience often as a child and often in the family home that leads to that particular mental illness challenge for people.

So, you know, there's behavioural contexts and, you know, Sarah spoke about people who can be scary, scary to themselves, scary to the service system, and scary to their support workers, and that's often the people we'll see with personality disorders alongside, you know, really problematic and chaotic substance abuse issues. They're often the group that we're seeing really cycling around and in and out of homelessness and in and out of engagement with the service system.

So, it requires a really thorough understanding of what trauma means in terms of the way the person thinks about their world and how they navigate their world.

I think, when you think about young people and their stages of development, often for someone who's had their first traumatic experience as a young person, that kind of development as an individual is really impacted, and often there's that impact of the brain and what that means; that they're often emotional, still functioning as a 7-year-old, rather than as the adult that's in front of you and what does that mean in the way that we respond to their needs.

I know that's a very short answer but it is quite a

complex and multilayered issue, but I think we need as a service system to understand what it means both from an organisational perspective and what that means when we are dealing with people with complex behaviours, that we don't want a service system that gets scared of them and therefore bans them from the service system; we need to understand about regulation, about responsibilities around, I think, coaching the people to understand the impact of trauma in their lives and how they navigate their worlds and the service systems that they come across.

THE CHAIR: Thank you very much. I think that point that you all made about the issue of trauma and the link between trauma and mental illness, housing, insecurity and homelessness was very strongly put, as was the fact that it's very challenging to find safety in those environments if you don't have stable or secure housing.

Professor McSherry, can we go to you.

COMMISSIONER McSHERRY: My question was actually on trauma-informed care too, so I think that's been well covered. So, again, I just want to thank everyone for such comprehensive statements and I've certainly learned a lot today. Thank you.

THE CHAIR: Thank you. I think you've also given us lots of examples of where you think better practice exists and ideas of where there is the different service delivery models, different ideas of where we can, together in the mental health system and the housing and homelessness sector, have a better response, so we'll certainly be following up a number of those.

I was particularly interested, Ms Humphrey, in your GreenLight Supportive Housing Program, the rapid housing responses that you think are important to have within the system and what that might mean for people with mental illness.

Professor Fels, I think you wanted the last question before we wrap up, so a question not a statement.

COMMISSIONER FELS: Okay, I just wanted to ask Dr Pollock if she would mind briefly summarising her conclusions, around about paragraph 30 and following, about the extent or the numbers needing housing support; that might feed

into our general assessment of kind of general needs in mental health. You've got some numbers there which are very interesting, could you just briefly summarise them.

DR POLLOCK: I'll do my best. So, these are absolutely estimations, they're a kind of best guess, and I used largely the SHIP study, the 2010 study, and then figures, the prevalence figures that are used by the National Mental Health Commission around severe and persistent - and severe and persistent episodic.

In Victoria I estimate that there are potentially around 6,000 people who are homeless at any given time with complex mental illness. But when I added in the prevalence for people whose complex mental illness was also episodic, that figure rises to about 11,000. So, we've got somewhere between 6,000 and 11,000 people who are currently homeless with mental illness.

I think then - and this actually concerned me quite a lot, was the figures that I estimated around the people who are currently housed, but they're either housed - they're either living with family and they don't want to be, or they're in some form of supported accommodation and that wouldn't be SIL; the numbers for SIL in Victoria are quite small.

So, there are around 10,000 people who are currently living in some form of supported accommodation, so SRS or boarding house or rooming house, and potentially another 10,000 who are living with family where that is not the desired outcome for either the individual or their family.

In terms of what I could work out in terms of who's actually housed through SIL, somewhere between 500 and 530 people with primary psychosocial disability in Victoria at the moment. And SDA, I think I said previously, I think it's about 468 people who have got SDA approved in their plan, but - I can't remember - somewhere around 250 or 300 people who actually have an SDA property and the majority of those are in New South Wales and they've come from the closure of a single psychiatric institution, Morisset.

Is that sufficient, Professor Fels?

THE CHAIR: Thank you, and I think that was a very important acknowledgment also in that response that, in

addition to those who are homeless, you have a large number of people who are living really in circumstances that are not conducive to their mental health, wellbeing and recovery, nor to those that they're living with, and we've certainly heard that from both consumers with lived experience and carers about how stressful sometimes those circumstances are simply because there's no other choice and the other choice is possibly homelessness.

So, thank you all very much for underscoring the importance of this issue for us as a Royal Commission, it's one of our very challenging areas to try and think through what do we focus on, where do we think there'd be the greatest impact for improving outcomes for those with mental illness and housing instability or homelessness, and that's something that we'll certainly be looking at further and today's panel discussion has been very helpful in focusing us on those four directions.

Ms Batten, thank you also for facilitating our discussions today and for leading us through the witness statements and the materials that were coming through that.

Thank you all for your participation and, as I said at the beginning, I might just in concluding re-record my introduction after everyone else leaves. So, thank you all again, it was fabulous, and thank you especially panel members for putting the effort in during this Covid environment where everyone's working in such a different environment but your witness statements are such an important part of our deliberative process, so thank you again on our collective behalf.

AT 12.48PM THE COMMISSION WAS ADJOURNED

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