Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF JENNY SMITH

I, Jenny Smith, Chief Executive Officer, of 2 Stanley Street, Collingwood in the State of Victoria, say as follows:

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

2 I am giving evidence to the Royal Commission in my professional capacity as the Chief Executive Officer of the Council to Homeless Persons **(CHP)**.

BACKGROUND

3 I am the Chief Executive Officer of the CHP, which is the peak body representing organisations and individuals in Victoria with a commitment to ending homelessness. I have held this position since 2011. The responsibilities of my role include:

(a) Leading the implementation of CHP's strategic plan to achieve CHP's goals and targets;

(b) Managing CHP's operations and performance in a sustainable manner; and

(c) Representing the views of CHP's members in public debate and discussions.

4 I am also currently the Chair of Homelessness Australia and have been since 2016.

5 Prior to my current role with the CHP, I was the General Manager of Medical Services at St Vincent's Hospital in Fitzroy from 2009 to 2011.

6 I hold the following qualifications:

(a) Bachelor of Arts, University of Melbourne, 1977

(b) Bachelor of Social Work, University of Melbourne, 1979

(c) Masters in Social Work (Honours,) University of Melbourne, 1991

(d) Masters in Public Policy and Management, University of Melbourne, 2006.

7 I completed the Company's Directors Course from the Australian Institute of Company Directors in 2012.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

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

MENTAL HEALTH, HOUSING AND HOMELESSNESS

Definitions of homelessness and housing insecurity

Homelessness

9 The Australian Bureau of Statistics **(ABS)** has adopted a definition of homelessness that has evolved over time. At present, according to the ABS, a person is homeless if they do not have suitable accommodation in their current living arrangement. This can include a dwelling:

(a) that is inadequate;

(b) where there is no tenure, or where the tenure is short and not extendable; or

(c) where there is no control over, or access to, space for social relations.

10 Tenure brings together two components. Firstly, tenure can be about people being kicked out of their circumstances quite easily, because there is only an informal arrangement in place. Secondly, tenure can be about the accommodation being unsustainable. Examples of unsustainable accommodation include where a person is on a Centrelink income and pays more than 30 per cent of that income on rent; or a young person who leaves residential care and attempts returning home, when conflict at home is inevitable.

11 Adequacy of a dwelling is about whether the place is fit for human habitation. As a baseline, a home must have access to basic facilities such as a kitchen and bathroom, and be soundly built so as to not cause a fire, building collapse, hygiene or other safety issue. In short, if an occupied dwelling is not a real home, a person is considered to be homeless.

Housing insecurity

12 Housing insecurity includes issues of tenure and sustainability discussed in paragraph 10, but also includes housing stress. Housing stress is experienced by those in the lowest 40 per cent of incomes, who pay more than 30 per cent of their income on rent; then do not have enough left to live on. The stress that this causes is called "housing stress".

13 Housing stress, and indeed, all forms of housing insecurity are common precursors to homelessness, and indicate that a person is at risk of homelessness.

14 The ABS Census in 2016 found that 24,817 Victorians were homeless.[1] Approximately 5% were rough sleeping and the rest (95%) were in temporary accommodation that did not meet the ABS standards of adequacy, tenure and control, such as severely overcrowded dwellings.

Rooming houses

15 Residents of rooming houses are often homeless under the ABS definition of homeless because they lack tenure and/or because they do not have a space for social relations, which is a key feature in a home being adequate. Residents of rooming houses often lack secure tenure because they do not have a written contract stating they can stay for a period of time. This means their housing security is at the whim of the proprietor. There is also often not any space for social relations. A rooming house is really just a bed in a room, with a shared bathroom, kitchen and lounge.

16 A person can stay at a rooming house, but they are not a viable place to live long-term. While rooming houses provide a roof over a person's head, the amenity of the accommodation is often extremely poor. It is common in informal or illegal rooming houses, for a three-bedroom dwelling to be divided up with flimsy dividers to create 'rooms' for seven or eight people, by sub-dividing the lounge, sub-dividing bedrooms, and even utilising balcony or garage spaces. Some rooming houses even rent out multiple beds to unrelated tenants in each room. With many highly vulnerable people living in close proximity to each other, tenants are also often at risk of their safety from other tenants or visitors, or at risk of being exploited by unscrupulous operators. Poor standards, lack of safety, unsuitability for many of the purposes for which we use housing, and next-to-no security of tenure, make many rooming houses living situations well below any acceptable community standard, such that few such residences could be considered stable housing.

17 There is a cycle of housing insecurity for many people who stay in rooming houses: 25 per cent of rooming house residents were previously rough sleeping,[2] and 25 per cent of rough sleepers were last housed in a rooming house.[3] These people are not settling, but rather are caught in a cycle of homelessness and marginal housing. This becomes a poverty trap, because not only do rooming houses provide a very poor standard of accommodation, they are also expensive, often costing more than 50 per cent of a person's Centrelink income. It is common for a tenant to leave because of conflict or violence, or fear of violence in the rooming house, to return to rough sleeping; and then to return to rooming houses when the risks or privations of rough sleeping make it appear

[1] Australian Bureau of Statistics, 2019, *2049.0 – Census of Population and Housing: Estimating homelessness, 2016*, Australian Government, Canberra.
[2] The Salvation Army Adult Services, 2011, 'No room to move? Report of the Outer West Rooming House Project', p.15
[3] Bevitt, A., et al., 2015, 'Journeys Home Research Report No.6; Complete findings from Waves 1 to 6', p.19

to be a better option, at least for a while. There is rarely a pathway into stable housing for people on the lowest incomes because there is simply not affordable housing available that they can afford.

The link between mental health and housing and homelessness

18 Poor mental health is strongly associated with reduced employment.[4] This means that a person is more likely to be poor if they have poor mental health. In that way, mental illness causes poverty.

19 Social housing makes up a very small portion of available housing, which increases the need to rely on the private rental market for housing. However, the way that our private rental market is currently structured does not provide for people who are living in poverty. There is nothing in the market-based approach that considers vulnerable people - it is purely economically driven. Poverty alone can mean that a person is unable to compete in the private rental market. Poverty combined with the challenges of competing in the private rental market while also living with a psychosocial disability can be insurmountable. Therefore, in that very simple way, mental illness can lead to poverty and homelessness.

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

20 People with severe mental illness are experiencing homelessness at extraordinarily high rates. If we take people with psychotic illnesses (which is a much smaller group within those with severe mental illness) as a proxy, less than 22 per cent of people with psychotic illnesses live in private rental and less than 26 per cent live in rent controlled social housing. It is a shock to find that 5.2 per cent of people with psychotic illnesses are homeless and that 12.8 per cent of people with psychotic illnesses experience homelessness across the course of one year.[5] While data isn't available across the range of severe mental illnesses, the extremely high rate of homelessness among those with psychotic illness is nevertheless instructive.

21 When people become homeless in the general population, that homelessness is usually for a period of less than three months on average. Whereas when someone with a

[4] Frijters, P., Johnston, D.W. and Shields, M.A., 2014, *The effect of mental health on employment: evidence from Australian panel data*, Health Economics, vol. 23, no. 9, pp. 1058–1071
[5] Morgan, V., et al, 2010, *People living with psychotic illness 2010,* National Mental Health Commission, Canberra, pp. 60-61

psychotic illness becomes homeless, the average duration of that homelessness is 155 days.[6] This clearly adds to that challenge of breaking the cycle of homelessness.

22 About 116,000 different people come to homelessness services in Victoria every year.[7] Research has shown that around 30 per cent of homeless people have experienced mental illness *before* experiencing homelessness and half experienced mental health issues *after* they became homeless.[8]

23 CHP analysis of homelessness data suggests that around 4,000 people using homelessness services would meet the access requirements for the National Disability Insurance Scheme (**NDIS**).[9] Given the specific requirements of Specialist Disability Accommodation **(SDA)** eligibility, only a small proportion of these will be eligible for SDA.

24 Among the chronically homeless, studies have found the incidence of chronic mental illness to be very high: 60 per cent[10] (20 per cent high prevalence disorders and 40 per cent low prevalence disorders). We accept that there is significant under-diagnosing of mental illness among the chronically homeless. People whose housing situations are transient rarely have sufficiently long relationships with their medical professionals to obtain diagnoses, which commonly require extensive treatment histories. There is also a large trauma loading in that group. Almost all people with long term or persistent experiences of homelessness (95 per cent) have histories of trauma, most commonly physical injury and sexual assault.[11]

25 The Australian Institute of Health and Welfare Specialist Homelessness Services Collection data from 2014-2015, collected by our homelessness workers, identified 8,250 people in Victoria who were homeless and who needed mental health or disability assistance. The data identified that 5,440 of these people were not receiving that assistance.[12]

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[6] Morgan, V., et al, 2010, *People living with psychotic illness 2010,* National Mental Health Commission, Canberra, pp. 60-61
[7] Australian Institute of Health and Welfare, 2019, *Specialist Homelessness Services Collection,* Australian Government, Canberra
[8] Johnson, G., and Chamberlain, C., 2011, *Are the homeless mentally ill?*, Australian Journal of Social Issues, Volume 46, Issue 1, p.36.
[9] Paterson, K., for Council to Homeless Persons, 2017, *Homelessness and the National Disability Insurance Scheme; Challenges and Solutions*
[10] Johnson, G., Parkinson., S, Tseng, Y., & Kuehnle, D., 2011, *Long-term homelessness: Understanding the challenge - 12 months outcomes from the Journey to Social Inclusion pilot program.* Sacred Heart Mission, St Kilda, p.13; Melbourne Institute for Applied Economic & Social Research, *Journeys Home*, cited in Australian Housing and Urban Research Institute, 2019, *AHURI Brief: Understanding the links between mental health, housing and homelessness*
[11] Johnson, G., Parkinson., S, Tseng, Y., & Kuehnle, D., 2011, *Long-term homelessness: Understanding the challenge - 12 months outcomes from the Journey to Social Inclusion pilot program.* Sacred Heart Mission, St Kilda, p.14
[12] Australian Institute of Health and Welfare, 2016, *Specialist Homelessness Services Collection*, Australian Government, Canberra.

Primary cause of homelessness – lack of access to affordable housing

26 The primary cause of homelessness for people with mental illness is lack of access to housing options that they can afford.

27 When there is low prevalence, high severity mental illnesses, the risk of poverty and homelessness is very high.[13] The National Mental Health Commission found that Centrelink is the main source of income for 85 per cent of a people with psychotic disorders in the community.

28 The Disability Support Pension is just 28 per cent of average adult full-time income. The NewStart allowance, pre COVID-19, was only 17 per cent of the average adult full-time income. As a community sector, we have advocated over a long period of time, that those allowances be increased, because people are living in abject poverty.

29 From January to March 2019, there were just 148 rentals across the whole state of Victoria that would be affordable to a single person on Newstart.

30 In a competitive environment, just because those rentals are affordable does not mean those who need them will get them. There are many other groups competing for those low-priced rentals. This only makes it more difficult for those with lower incomes and psychosocial disability.

31 In addition, psychosocial disability can impact on the way people are able to present themselves in the world, particularly when they are acutely mentally unwell. In a competitive rental market, where real estate agents have multiple applicants for rental properties, this very commonly leads to discrimination. Real estate agents select the preferred tenant using objective criteria such as income, as well as subjective criteria, such as appearing to be someone who may be a 'good tenant'.

32 The other dimension is that even if someone in those circumstances obtains an affordable housing option, the impact of the psychosocial disability can cause difficulty in sustaining that housing. For example, depression can lead to low motivation to perform the tasks required to successfully sustain a private rental property, while agitation can lead people to behave in ways that contravene standard rental agreements.

33 One Victorian homelessness service found that people who enter social housing from psychiatric inpatient units often don't sustain that housing past 18 months;[14] 72 per cent of people leaving psychiatric inpatient units into social housing were no longer housed

[13] Morgan, V., et al, 2010, *People living with psychotic illness 2010,* National Mental Health Commission, Canberra, p.53
[14] Johnson, G., McCallum, S., Watson, J.,, 2009, *Who stays, who leaves and why; Occupancy patterns at Unison Housing between 2014 and 2016*, p.4

after 18 months. This is far higher than the 45 per cent of people who enter social housing from homelessness who are no longer housed after 18 months. This highlights the current lack of effective support models to assist people with mental illness to keep housing once they do obtain it.

HOUSING NEEDS AND HOUSING STOCK

The strengths and weaknesses of the current arrangements in meeting the housing needs and the needs of people experiencing homelessness

34 The funding for housing and homelessness is a shared responsibility of both Commonwealth and State and Territory governments. The funding is provided by the Federal Government to States and Territories under the National Housing and Homelessness Agreement (**the NHHA**), which was made under the Federal Financial Relations Reforms of 2009. The NHHA apportions funding on the basis of a state or territory's proportion of the national population. This funding is then used to meet the costs of maintaining and operating the state's social housing portfolio, to build new social housing, and to fund homelessness services. The States and Territories then add additional resources to that funding.

35 One of the weaknesses with this agreement is that funding has remained static for nearly a decade with very minimal indexation.

36 Victoria's contribution to the funding pool has increased over the past 9 years, but it is still significantly less than that of the other states and territories. Victoria has the lowest proportion of social housing, compared to any other state and territory. To illustrate, Victoria is at 3.2 per cent and the national average is around 4.5 per cent. It is a relatively small difference, but it reflects a large amount of housing.

37 Another weakness of the Federal Financial Relations system is that additional spending by one party, either the Federal or State government, does not necessarily trigger an accompanying increase from the other party. The arrangement leaves the Federal Government to argue that if they provide additional funding, then a State or Territory might reduce its contribution. Funding contributions from the States are not binding.

38 CHP is keen to see a conditional special purchase agreement, which would, for example, bind each party to contribute a fixed proportion of the total sum. Further, in the context of having clear targets across the portfolio, such an agreement would see both parties locked together in achieving those targets. This is not what we have at the moment.

39 A further weakness is that funding is not proportional to the number of properties. This means that a State or Territory can reduce the amount of social housing stock it has and still retain the federal funding that it receives. If a State increases social housing, they are choosing to spend the same amount of funding over more property.

40 Because Victoria has less social housing proportionally than any other state, Victoria gets more federal funding per unit of housing than other states and territories, because we are not spreading the funding across as many properties as other states and territories. Therefore, we have seen increased effort from the State Government, but that increased effort is still not stopping our inexorable decline of social housing, as a proportion of all housing, as our population grows.

HOUSING FOR PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

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

41 There are many effective models for people experiencing severe mental illness and housing insecurity or homelessness. They have been well demonstrated internationally, in Australia and in Victoria. The issue is that we do not have enough of them.

42 There is enormous international evidence that affirms that Housing First approaches are the most effective models for people with serious mental illnesses. That is people whose income means that they are not going to get by without subsidised housing; and who also require intermittent support to keep that housing, sometimes with enormous intensity. As the cycles of acute mental illness manifest on top of people's psychosocial disability, they will need support to sustain their housing.

43 The Housing First models require access to permanent housing that a person can afford. Time limited housing is not helpful because people spend the whole time worrying about what they will do after the time limit runs out. People need somewhere to settle.

44 This is important because routines play an important role in managing a psychosocial disability. People in these circumstances need things in their life to stop changing; they need stability by settling down in permanent housing, with the support they need. The housing and the support need to be long term. Because, as an example, a person may be well for nine months of the year in most years. But at various points, that person could be off medication, having fights with the neighbours or having money troubles. That person will need support to help sort those issues out, pretty proximal to when they start to unravel, otherwise they are going to end up back in an acute inpatient unit. The support needs to be ongoing because that person might be like that for the rest of their life.

45 We need clinical mental health specialist support and disability support that have that expertise. This is different from housing support to retain housing. There are some programs that provide them expertly together, as evidenced by Victoria's former community mental health support services operated by providers such as Neami National **(Neami)**, WellWays, Mind and CoHealth. But, clinical support and support to get and keep housing are different jobs. They need to be separate so that if people engage in challenging behaviours in housing, their clinical support will not be threatened. Or, if people are having a bad time with their clinical support provider, it will not affect the tenure of their housing.

46 This is what is needed for successful Housing First. We have known that in Australia since the early 1990s. We know how to do it. We have very fine examples of it all over the country and the state. The problem is that we do not do enough of it.

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

47 Victoria led the country in psychosocial disability support up until the advent of the NDIS. It was not fully taken to scale, but we have a long history of knowing how to provide psychosocial disability support well. Some of our providers, like Neami, Mind and Wellways, have done it very well since it was invented back in the 1970s and 1980s. The mental health community support services operated by NGO's across Victoria prior to the advent of the NDIS were funded to and provided effective housing and support for people with psychosocial disability.

48 In 2007-2010 (the Rudd era), funding became available through the National Partnership Agreement on Homelessness, which funded many best practice homelessness projects. However, many best practice projects have not since been taken to scale, and so remain as small pilot projects.

49 In Brisbane, Micah Projects use the Housing First model to great effect. There are examples across the country.

50 However, in Victoria, we have services that engage people, many of whom have mental illness, and get them into housing. Examples of what Victoria is doing well, include:

(a) The Rough Sleeping Initiative and Streets to Home by Launch Housing, Salvation Army and VincentCare, particularly in central Melbourne. From the Rough Sleeping Action Plan, Victoria funded permanent supportive housing teams and recently funded assertive outreach services across the state, although only in selected areas;

(b) Sacred Heart Mission's Journey to Social Inclusion – a full Housing First program;

(c) The Wellways Doorway program adopted a Housing First approach to private rental. The only problem was that the program was time limited, and many participants with Centrelink incomes in the context of their psychiatric disability, were unable to sustain full market rents when the program concluded;

(d) The Elizabeth Street Common Ground by Launch Housing and Unison: while not very many people need to live in congregate care, there are some people who do well in rooming houses and that type of large Housing First facility where there is a concierge and around the clock support staffing with in-reach medical and psychiatric services.

(e) Aboriginal specific programs that are partnerships between homelessness and mental health services like Wadamba Wilam, an initiative by Neami and partners, or Towards Home, another partnership that include Neami for clinical mental healthcare.

(f) Bolton Clark, formerly the Royal District Nursing Service and the trailblazing Homelessness Health services they provide to bring health services to those who would otherwise not access such services complementing the work of homelessness support workers.

51 There are three principles in common across all of those services: housing, mental health care and housing focused support.

52 Where the services all struggle, is when they can't get the housing stock. In those circumstances, having support to maintain housing is better than nothing. That is why CHP supported the funding of support projects. Recent initiatives such as the Rough Sleeper Initiative, and other programs funded under the Victorian Homelessness and Rough Sleeping Action Plan, bring together the essential support elements of Housing First, although they require greater access to housing. The assertive outreach services and permanent supportive housing workers play a similar role to that of the community mental health support worker roles lost with the advent of the NDIS. Governments find it easier to fund support because it is cheaper than providing the housing. Essentially, you cannot obtain upwards of 90 per cent sustainment of housing for people with enormous complexities in their lives unless there is secure affordable housing. In the current environment, this is effectively social housing or a permanent private rental subsidy.

Examples of successful housing approaches in other jurisdictions

53 The tension is always the amount of congregate care that you need in housing approaches. My view is that most people do well, or are likely to do better, in their own

place that is integrated into the community. Where they are supported by a team of people based in the community, who can support them as needed.

54 This is to be preferred to a big edifice with many residents who have significant challenges in their lives, which can lead to a need for increased security. Everyone finds it difficult getting on with neighbours at times, but if you have mental health challenges and your neighbours also have challenges, you may not be the best equipped person to deal with any difficulties between neighbours. Other than for a small group of people with incredible challenges in their lives who need a permanent on-site staff presence, big apartment blocks are not the most sustainable form of housing. It is also incredibly expensive to provide the level of support needed, and so often it is not provided to that level. It is also probably not the most effective model of care.

55 Whereas if a person has a flat in a neighbourhood, where everyone has their own lives, and where support can come to people regularly, stay in touch with them and only intrude when they need it - they have a much better chance of sustaining tenancies and remaining well.

The characteristics of those approaches, strategies or programs

56 I have commented on the necessity of permanent housing to support people's ongoing recovery from mental illness at paragraphs 41 to 52. I have also referred to the built form of that housing, the need for clinical mental health, health and housing focused supports, and for ensuring that housing and support are provided irrespective of continued uptake of the other. Lastly, I would emphasise my earlier comment at paragraph 44 that it is critical that support should be available for as long as needed and titrated with a person's fluctuating needs – and that this might extend to a lifetime of support. Very long duration supports are rarely provided in mental health or housing support, and they need to be expanded.

The supply and extent of unmet demand for Victorians experiencing severe mental illness and housing insecurity or homelessness

57 In Victoria, we are spending just over half the national average on social housing. The Victorian Social Housing Waiting List currently has 44,379 households on it, which is more than 80,000 people.

58 There are 23,459 households on the priority list. Where mental health issues lead to homelessness, this can make a person eligible for the priority list. That is alongside other vulnerabilities, such as family violence, disability, chronic homelessness and age. While these factors define priority access, even if on the priority access list, the average wait is 10.5 months for housing.

59 There is an enormous challenge in the situation where people are admitted to an acute inpatient unit, where they only need to be there for two or three weeks clinically, their housing has fallen over, or they didn't have housing to begin with. They will not be able to obtain a housing outcome that they can afford during the inpatient stay.

60 Further, the longest wait times are for single bedroom accommodation for people under 55 years of age. The biggest demand is for singles, which is true for people with severe mental illness as well. The 10.5 months priority list wait includes many family homes, which singles will not have allocated to them. It is a very, very long wait.

61 When I was Chairing the Family Violence Housing Assistance Implementation Task Force, Dr Judy Yates from New South Wales showed that Victoria needs at least 1,700 long-term social housing dwellings a year for 20 years just to sustain the around 3 per cent bottom of the league table position in relation to social housing.

62 The Government has made welcome investments in social housing, but since 2015-16, the stock has only grown by 638 properties a year. This is far less than the 1,700 that Dr Yates recommended. The Government committed a further 1,000 new properties over three years in 2019-20, which is still not meeting the recommended 1,700.

The most critical unmet demand

63 The most critical unmet need should be considered in terms of chronicity and complexity. That is, how long-term a person has been homeless with unmet mental health support needs. When Victoria deinstitutionalised and moved to a community mental health model, we assumed that people would be able to move out of an institution and live in community in a place that they could afford. Deinstitutionalisation was predicated on the assumption that social housing would be available or that there would be a rental market that was friendlier to people on low incomes, which is not the case.

64 The Royal Commission has already found in its Interim Report that 205,000 Victorians each year are likely to experience severe mental illness and may benefit from housing support.[15]

65 If we take as a proxy[16] the 12.8 per cent of people with psychotic illnesses experiencing homelessness in the course of a year, we are short about 26,240 additional properties each year. Alternatively, there are 17.3 per cent of people who exit public specialist mental health services in Victoria each year, who also use homeless services within the

[15] State of Victoria, *Royal Commission into Victoria's Mental Health System, Interim Report*, Parl Paper No. 87 (2018–19) p.27

[16] A smaller subset of people with severe mental illness who experience homelessness. This group is used because there is data available for this group, but not the larger group.

same year.[17] That would demonstrate a need for 35,465 additional properties for people with severe mental illness.

66 Regardless of which proxy is chosen, it is clear there is a significant shortage in suitable, affordable housing. These shortages should not be regarded as static, one-off shortages. The numbers will continue to grow.

The impact of unmet demand on other service systems, including hospitals, subacute services, and judicial settings

67 In Victoria, one in four people using acute mental health services is also experiencing homelessness. A lack of suitable housing prevents discharge. People stay in acute psychiatric beds (at a premium cost) much longer than they need to because there is nowhere for them to go.

68 People are also discharged into inappropriate environments. While health staff know that they should not be exiting people into homelessness, they do so because of the demands of the emergency department and because they cannot find an alternative.

69 One study found that if mental health hospital dischargees obtained social housing and support with a Housing First approach, they required 22 fewer psychiatric inpatient bed days per participant.[18] There are obviously financial savings there, but, there is the opportunity for psychiatric beds to be used more appropriately, which is a better living circumstance for the person involved.

70 We have to recognise that in the absence of appropriate housing, prisons have also become an alternative institution for many people with mental ill health and comorbid homelessness. Those who are homeless and have mental ill health are 40 times more likely to be arrested and 20 times more likely to be in prison than those with stable accommodation.[19]

71 In terms of the pressure on acute psychiatric services, the New South Wales Ombudsman recognised that the lack of appropriate accommodation options is a key factor in preventing the discharge of mental health patients, which has led to reduced availability

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[17] State of Victoria, 2019, *Royal Commission into Victoria's Mental Health System; Interim Report*, Parl Paper No. 87 (2018-19), p.369

[18] Siskind, D., et al, 2014, *A retrospective quasi-experimental study of transitional housing programs for patients with severe and persistent mental illness,* Community Mental Health Journal, vol. 50, no. 5, pp.538–547.

[19] NSW Department of Corrective Services, 2004, *Submission to Experiences of Injustice and Despair in Mental Health Care in Australia consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission,* cited in Mental Health Council of Australia, 2014, *Not for Service,* p.220

of acute-care beds and mental health staff referring patients to inappropriate housing options.[20]

72 When CHP talk to acute mental health services, they tell us that about a quarter of patients are homeless prior to admission. This data is not collected very well, but that is consistent with what our staff say - that most people are discharged back into homelessness because of a lack of suitable accommodation options. This is broadly consistent with the finding that 17.3 per cent of people who exit public specialist mental health services in Victoria use homelessness services within that same year.[21]

73 Exiting people from acute psychiatric care into homelessness is self-defeating because people are not going to maintain the treatment regime on which they are discharged. It introduces a whole additional set of pressures to maintaining your mental health and is unsustainable. All the good work that was done during the acute inpatient admission is very quickly undone when the homeless patient needs to deal with their day to day survival.

74 The number of Victorians who have exited mental health facilities into homelessness has grown 55 per cent since 2012-13 and the number of people accessing our services telling our staff that they have a mental health issue has increased by 84 per cent since 2012-13.

The cohorts that should be prioritised if housing availability and supports for people living with severe mental illness and housing insecurity or homelessness in Victoria were to increase

75 The priority has to be the people with the greatest support needs that are least likely to have their needs met within the broader service system. That means people with long-term homelessness, sometimes called chronic homelessness, and severe mental illness. These people are also likely to have other complexities in their lives, such as drug and alcohol misuse, physical disability or other chronic health conditions as homelessness can often lead to people having chronic health conditions, due to lifestyle factors, poor treatment histories, and high levels of exposure to disease transmission.

76 Young people as a cohort can be a hidden in the data. Some of the assessment tools that we use in homelessness like VI-SPDAT are good at assessing vulnerability, but they privilege the duration of the homelessness. Therefore, we need to think about young people differently and also consider them a priority cohort.

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[20] NSW Ombudsman, 2012, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability,* p.55

[21] State of Victoria, 2019, *Royal Commission into Victoria's Mental Health System; Interim report*, Parl Paper No. 87 (2018-19), p.369

77 The studies tell us is that the earlier a young person experiences homelessness, which can happen to many young people in the context of family violence, the more likely they are to experience homelessness later in life and the longer the duration of that homelessness.[22] Therefore, the people who should be prioritised are those who are least likely to be able to meet their needs with their own personal resources; and who are least likely to be able to access specialist mental health service offerings without support.

78 There is no question that Housing First is the evidence-based model for responding to that. If you accept that homelessness is about poverty and lack of access to housing and support to keep it, mental illness doesn't mean that you can't live in a house. Mental illness doesn't mean you can't live independently or among the community.

Approaches to funding, property and asset management, tenant selection and tenancy support that would maximise the benefit of any new housing for people with severe mental illness

79 The research makes it clear that government provision of social housing is the best means of ensuring that housing is affordable and available to vulnerable people on low incomes.[23] The evidence suggests that the property management and the mental health support need to be separate so they are not contingent on each other. It is clear that tenants with severe mental illness might benefit from including their support workers in all discussions with their property managers. That is something that has happened fairly routinely over the years. However, under the NDIS rollout we have seen less adherence to this important principle, resulting in enormous power imbalances between the NDIS participant and the agency providing them with housing and support.

80 In terms of tenant selection, the greatest priority needs to be given to those with the greatest needs. I would emphasise that with scattered site housing in ordinary communities, you don't have to think about tenant selection as much as you do with a congregate situation. In a congregate situation it is necessary to consider tenant mix, such as who might get on well together or be able to cope with some of the challenges that another tenant might bring.

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[22] Johnson, G., and Chamberlain, C., 2008, From Youth to Adult Homelessness, Australian Journal of Social Issues, Vol.43, No.4, 2008.

[23] Johnson, G., Scutella, R., Tseng, Y., & Wood., G., 2018, *How do housing and labour markets affect individual homelessness?,* in Housing Studies, 34:7, p. 1099

The benefits or risks of particular types of organisations performing the above roles (e.g. the mental health system, Director of Housing, community housing providers, mental health specialists, not for profit organisations etc)

81 Where not-for-profit community housing providers have borrowed to build or buy, the related servicing of debt makes it challenging for them to be able to afford to house people on the lowest Centrelink payments such as the pre COVID-19 Newstart and Youth Allowance. Community housing provides tenancy management but the available funding does not provide support for resident complexity. These circumstances can reduce access to this housing for people with severe mental illness, particularly if they are on the JobSeeker (Newstart) or Youth Allowance payments and/or have behaviours that create financial risk, or pose challenges for other tenants. In these circumstances, the experience of the Specialist Homelessness Services is that some community housing providers may not select people with serious mental illness, and/or can be quick to evict them when problems emerge in the tenancy. This is not the case with all providers, but where it occurs reflects the additional unmet costs – including for ongoing support - that accompany highly vulnerable tenants.

82 Research has shown that the most effective factor in promoting sustained housing exits from homelessness is public housing, while community housing has higher rates of exit into homelessness.[24] A balance must be achieved between government provided public housing, and not-for-profit community housing.

HOUSING FOR YOUNG PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

Young people who have an onset of a severe mental illness and are at risk of housing insecurity or homelessness

83 Young people with severe mental illness are a very big proportion of the homeless population. Most people still think about a middle-aged man with an alcohol or drug problem being the average homeless person. However, in 2018-19, 19,253 young people aged between 15 and 24 sought assistance from our services. Our services report that 80 per cent of those young people say they have a co-occurring mental illness or mental health problem at the very least. An analysis by Melbourne City Mission, Victoria's largest provider of support to young people without a home, found that 64 per cent of their youth homelessness service users had a mental health concern flagged by a worker. Further, 44 per cent of their youth homelessness service users had already received a diagnosis,[25]

[24] Johnson, G., Scutella, R., Tseng, Y., & Wood., G., 2018, *How do housing and labour markets affect individual homelessness?,* in Housing Studies, 34:7, p. 1099
[25] Melbourne City Mission, 2019, *Submission to the Royal Commission into Victoria's Mental Health System*

which is an extremely high proportion given the difficulty young people face in obtaining diagnoses.

The characteristics of effective models of housing and support that would assist this cohort

84 The Housing First model can work with this cohort, but it requires some modification. Of particular concern is that Housing First models support a consumer's independence, whereas young people may not be developmentally ready to be fully independent and need a support model that provides adult support and guidance. [26] This includes support across many domains of life, including to encourage continuation in education, and where possible to strengthen relationships with family or other community supports. While generally adults do better in scatter site housing options, research indicates that many young people are more comfortable and achieve better outcomes in congregate care. [27] So, Housing First *can* work for young people experiencing homelessness and mental illness, but in a context where the support delivered is commensurate with their needs, which are likely to be both greater and different from that of the adult population.

Models, approaches, or programs in other jurisdictions that Victoria could learn from to better support this cohort

85 Canada has developed specific homelessness and mental health models to work with young people called, Chez Soi – At Home. Of particular note from Chez Soi is their proven ability to achieve strong outcomes across a range of different communities, whether they be different cities' housing markets, different housing ownership models, different mental health symptoms, or different racial identities.[28]

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

86 Victoria has a lot of good services in our community, but none are complete Housing First for youth services. We have a great front door through Frontyard, Melbourne City Mission. We have great youth refuges and we have refuge providers moving people into shared homes with in-reach support. Frontyard works well because it provides streamlined access to a range of supports that young people need, such as family reconciliation or mental health support. However, Victoria has not had the policy grunt or the funding to turn that into a systemic model, and many refuges operate on a strict 6 week residency,

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[26] Gaetz, S., 2014, *Can Housing First Work for Youth,* European Journal of Homelessness, Volume 8. No. 2, December 2014, p.164

[27] Ibid, p.167; Gaetz, S, 2017, THIS is Housing First for Youth: A Program Model Guide. Toronto: Canadian Observatory on Homelessness Press, p.7.

[28] Mental Health Commission of Canada, 2014, *National Final Report; Cross-Site At Home/Chez Soi Project,* p.5

without any appropriate housing exits available for young people at the conclusion of their stay.

87 In the youth space we have Youth Foyers, which are essentially like a college style residence with education support and expectation, as well as a community. There is one operated by Berry Street in Shepparton that has a mental health focus. The benefit of youth foyers is that they support young people with important and affirming goals, like education. The challenge is that Foyer accommodation is not always appropriate for the most vulnerable young people – due in part to its congregate model and requirement that young people be engaged with formal education.

STRATEGIES TO SUPPORT HOUSING FOR PEOPLE LIVING WITH MENTAL ILLNESS

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

88 In the last few years, the homelessness sector has been focused on trying to get people experiencing homelessness that you would expect would be eligible to realise NDIS eligibility. We have focused on educating ourselves about how to do that, providing input to the NDIA about how to improve the systems and assisting people to get their packages. Our experience would be that most of those people who are eligible are not getting housing as part of their package.

89 The more we find out about the SDA, it should be playing a role in providing that. It is clear that it is not realising its potential as yet. While the NDIS is providing a funding mechanism for SDA, this has not seen widespread growth in the number of properties.

Improving the support for people experiencing severe mental illness and housing insecurity, or homelessness, through the Specialist Disability Accommodation under the National Disability Insurance Scheme

90 The overarching question here is: what do we all need to do to make the SDA realise its potential for people experiencing severe mental illness and housing insecurity or homelessness? From what I understand on the housing provision side is that the SDA opportunities are largely taken up by large private developers. They have the capacity to take the risk to build without a guarantee of supply and knowing the person that they are building for.

91 Community housing, which is the NGO social housing provider, should have a big role in this space, but it does not. They are not large enough or wealthy enough to take on the risk of this type of development. Thought needs to be given to what structures can be put in place to support them being involved because they would be a more natural landlord than the private sector due to their focus on providing housing that is affordable for people on low incomes. The community housing model is especially effective for Disability Support Pension recipients because their income is higher and more stable than people receiving JobSeeker payments.

92 The other challenge that has not been realised is on the people side. Our perception is that only 25 per cent of those with NDIS packages with psychosocial disability have support coordination as part of that package. What that means is it is up to those with the disability to articulate the housing support that they need; they need to articulate a housing response that does not just mean a community residential unit. It is also up to the person with the disability to ask for the additional tenancy support they need – which first requires them to know that support is there. If they don't ask for it, they won't get it. In that context, the underutilisation of the SDA opportunity is perhaps not surprising.

93 As I understand it, nationally, there might be as few as 400 people with primary psychosocial disability in the NDIS who have SDA in their plan. I suspect there is also less market interest in the psychosocial disability side of things where there might be a perception that the tenants are more challenging. There might be some caution about that as well as the assumption that people are able to articulate the sort of housing that they want.

94 Ultimately, to get the package in that direction requires high quality support coordination and most people do not ask for that. It is not always the case that people with psychosocial disability will actually articulate their support coordination needs even if everyone else might think that they clearly would benefit from that.

95 In our sector, when we have been trying to get people into the NDIS, people have reported that supporting a client takes an excess of 25 hours to get them in. Our sector is funded to provide crisis response, and it turns away hundreds of people every day who want our assistance. We do not have the case management capability to do this work. Also, people experiencing transience can move around, which is a challenge to that coordination.

96 There are some plans within the NDIA of program development that could be helpful, such as: a new Community Connector Program targeting people who are homeless, improving the access process for people with psychosocial disability through a Commonwealth State working group on that and the introduction of a new support item called psychosocial recovery coach. However, these are all still assistance that people would need to be able to ask for, in order to receive it.

97 I understand that NDIA packages are running at an average of about 60,000 a year for psychosocial disabilities. They also have an underutilisation rate of 60 per cent in psychosocial disabilities because of the lack of decision support care coordination. In homelessness, we call it advocacy: supporting somebody to get what they understand they need, but also assisting them to articulate what might be available for them. That is what is missing.

DISCHARGES INTO HOMELESSNESS

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

98 Further to what I have said at paragraphs 67 to 74, one study shows[29] that 17.3 per cent of people who exit public specialist mental health services in Victoria use homelessness services within the same year. We have staff in Melbourne's public hospital psychiatric services estimating that more than one in four people exit into homelessness.

99 The population has grown and the number of psychiatric beds has not increased enough to deal with that growth. Inevitably and even before the population grew, there was pressure on psychiatric beds. As that population has grown, so has the price of housing, and so the affordability of housing for people on low incomes has diminished. It is a perfect storm of drivers for people vulnerable with severe mental illness, low income and psychosocial disabilities, to find themselves discharged into homelessness and re-entering prisons and health care units, rather than being supported at home through the ups and downs of life living with psychiatric disabilities. It is a false economy and it is poor care.

Key changes to reduce the rates of people being discharged from mental health services into homelessness

100 Everyone agrees that there should not be any discharges into homelessness and nobody wants that to occur. Most psychiatrists want to keep people in hospital as long as they need, but they also understand that you need a home to go to in order to sustain the good work done in hospital.

101 Unfortunately, while there is a policy expectation that that will not occur, it happens every day. Until we recognise that somebody has to take responsibility for the lack of supply of housing and a model where people need support help to get and retain housing, we are just going to be wasting money. We do need more acute psychiatric beds in Victoria, but

[29] State of Victoria, 2019, *Royal Commission into Victoria's Mental Health System; Interim report*, Parl Paper No. 87 (2018-19), p.369

we would need less if people had homes that they could stay in and be supported. Further, they would not be in such a terrible state of having to become homeless and spend time in prisons, gutters and emergency departments on their way to re-engage with mental health care.

COMMISSIONING

Commissioning approaches that encourage greater coordination between service providers to address the holistic needs of people e.g. people seeking support for mental health and housing

102 As Chair of Homelessness Australia, we have joined the Housing First Europe Homeless Hub. I have heard European, American, Canadian and English people talk about the challenges of dealing with these issues in their countries. One of the things that is internationally true is that when a country cannot provide housing that is needed, it turns its mind to service coordination. It is something that we can be busy doing while we don't actually tackle the problem. There is no doubt that you can improve the functioning of a service system with coordination to an extent, but it is around the margins. One of the things that very commonly happens with coordination is that government puts project coordination in for a while, then stops the funding, and so there is no structure or ongoing coordination. Coordination needs to be resourced and structured. That structure needs to be maintained and nurtured, but it is not the panacea that sometimes people would hope for and is a diversion from the main issues, particularly the lack of affordable housing, and service demand that is far greater than the system's capacity to respond.

103 We have to accept that at the moment, nobody is taking responsibility for there not being enough housing in our community in which people with severe mental illness can afford to live. Further, no one is taking responsibility for there not being enough support for people, so that even when we are able to provide them with housing that they can afford, there is not sufficient support to allow them keep their housing and maintain participation in their clinical mental health care.

104 We have to recognise that the opportunity is here for the Royal Commission to make sure that we do not continue to abrogate our responsibility as a community. That there is clear responsibility for delivering on supply of social housing that people with severe mental illness can afford, and for providing the support that they need to live well in that housing. This must be a priority for this Royal Commission.

sign here ►

print name Jenny Smith

date 15 June 2020

Royal Commission into Victoria's Mental Health System

ATTACHMENT JS-1

This is the attachment marked 'JS-1' referred to in the witness statement of Jenny Smith dated 15 June 2020

Jenny Smith *(MAICD, MPPM, MSW, BSW, BA)*

Curriculum Vitae 26 May 2020

Jenny's professional life has been dedicated to the public sector, across mental health, health and specialist homelessness services. This includes 29 years in leadership and management roles in policy, management, government, as well as earlier roles in training and service delivery.

Jenny began her career as a social worker and family therapist and her subsequent roles have included:

June 2011 to current	Chief Executive Officer, Council to Homeless Persons
October 2009 to June 2011	General Manager Medical Services, St Vincent's Hospital
November 2004 to October 2009	Manager, St Vincent's Mental Health
August 2000 to November 2004	Executive Officer, Manager Service Planning and Development, Mental Health Branch, DHS
August 1995 to August 2000	Area Manager, IW Area Mental Health Service, The RMH
October 1993 to August 1995	CEO, Community Health Services of Sunshine

In 2011, Jenny joined the Council to Homeless Persons (CHP), the peak body representing organisations and individuals in Victoria with a commitment to ending homelessness. CHP currently: seeks to influence government policy; provides the Homelessness Advocacy Service (HAS); leads consumer participation through the Peer Education and Support Program (PESP); produces the national homelessness publication Parity; and provides training and development to enhance industry capacity.

Jenny is passionate about applying her skills and experience to ending homelessness in Victoria and about working in partnership with: those who have experienced being without a home, the specialist homelessness sector; public sector providers; government and the philanthropic and corporate communities.

Across her career, Jenny has partnered with colleagues to author a number of papers published in refereed journals. These include: the Australian and New Zealand Journal of Family Therapy; Australian Social Work; and the British Journal of Psychiatry.

Jenny has been a clinical member of the Australian Association of Family Therapists since 1984; has received a lifetime achievement award from the Victorian Mental Health Social Workers sub group of the AASW; and currently Chairs RMIT's Social Work Industry Advisory Committee.

Jenny has also had experience in undertaking a number of mental health service reviews including leading a review of Forensic Community Mental Health (1998), and contributing to reviews of consumer participation in mental health (1999) and the Adult Acute Inpatient Services and State-wide and Specialist Services (2000).

Jenny has had considerable experience as a Board director of community sector agencies, and since 2016 has been the Chair of Homelessness Australia. Jenny also Chaired Victoria's Family Violence Housing Assistance Implementation Taskforce and is currently co-Chair of Victoria's Homelessness Advisory Committee.