PO Box 1183
Kensington VIC 3031

3rd July 2019

Ms Penny Armytage
Commissioner
Victorian Royal Commission into Mental Health

Dear Ms Armytage,

Please find attached a submission, on behalf of the Western Homelessness Network, into the Royal Commission into Victoria's Mental Health System. The Western Homelessness Network is a network of 18 community organisations managing approximately 80 homelessness programs across Melbourne's west.

We appreciate the significance of this opportunity for the deep structural reform and additional resources required to change the current and future opportunities of Victorians affected by mental health problems.

In our collective experience, the most vulnerable members of the Victorian community are those with mental illness who are also experiencing homelessness – whether living short or long term on the streets, in unsafe and insecure accommodation, or about to be discharged from a health or mental health facility into some form of homelessness.

We urge you to give special consideration to the estimated 4,500 Victorians with mental health issues turned away from homelessness services every year due to lack of capacity, as well as those that never make it to the door of a formal homelessness service.

As agencies supporting the most vulnerable members of the Victorian community in Melbourne's Western Metropolitan Region, we ask that you consider the specific cultural, social and economic factors impacting on those people we serve 365 days of every year. We believe that there are targeted and tailored initiatives that can help the young people, families and older people in our communities to both prevent future homelessness and remove them from the current cycle of homelessness and mental illness that thousands of them face.

This Royal Commission has the capacity to BREAK THE CYCLE of homelessness and mental health that has plagued our service system for decades, and we trust that your recommendations will address this problem for all Victorians, including those that we directly represent.

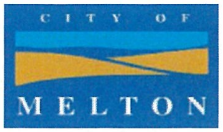
If you would like further information in support of this submission, please contact Sarah Langmore, Western Homelessness Networker at [redacted].

Yours sincerely,

Sarah Langmore
On behalf of the Western Homelessness Network


Caroline
Chisholm
Society


unison


CITY OF
MELTON


FLAT OUT


LATITUDE
directions for young people


mcm.
melbourne city mission
your future, your way


haag
HOUSING FOR THE AGED ACTION GROUP INC


THE SALVATION ARMY


HOPE
STREET


wombat
housing & support services


McAuley Community
Services for Women
A ministry of the Sisters of Mercy


Women's Housing Ltd.


Good Shepherd
Australia New Zealand


ELIZABETH
MORGAN HOUSE
ABORIGINAL
WOMEN'S
SERVICE INC


Uniting


North West
Regional Children's
Resource Program


Wintringham
SPECIALIST AGED CARE

Breaking the cycle of mental health and homelessness

Submission by the Western Homelessness Network to the
Royal Commission into Victoria's Mental Health System

July 2019

CONTENTS

NOTE: Quotes included throughout this report are from a 2018 survey of people approaching homelessness services in response to a question about the impact of homelessness on them – 43% of them identified as having some form of mental illness.

The Western Homelessness Network

A Network of 18 Specialist Homelessness and Family Violence Organisations, managing approximately 80 homelessness programs in Melbourne's West (see attached membership). These services meet every six weeks to improve responses to people who are homeless in the West through management of coordinated homelessness service system arrangements, consumer consultation, linkages with allied service sectors and shared professional development.

Introduction

The cost of responding adequately to the needs of Victoria's most vulnerable citizens – those experiencing mental illness and homelessness – is nowhere near as great as the individual and community-wide costs of failing to act.

This submission, prepared by the Western Homelessness Network (representing 18 specialist homelessness, family violence and allied services managing approximately 80 homelessness programs in the Western suburbs of Melbourne), addresses Question 2 of the formal submission process: *What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?*

The Network has focussed on this question specifically because, as a Sector, we know that homelessness causes mental ill health but that individuals are rarely able to address or stabilise mental health issues in the absence of secure, affordable housing. Addressing Victoria's housing crisis will reduce the numbers of people entering into homelessness and will enable women and children experiencing family violence to leave situations of violence early. This is, in turn, a preventative strategy, reducing the numbers of people experiencing mental ill health.

Mental ill health leads to poverty for so many people. Fluctuating health creates challenges for people who are trying to manage study and/or stable employment; reducing the earning capacity of many people experiencing mental health issues in the absence of family support. Poverty reduces the capacity of tenants to manage housing costs and so can lead to homelessness, which causes mental ill health.

Likewise, provision of affordable housing is central to stabilising mental health issues for those who are experiencing them. Practitioners from across the mental health and homelessness sectors have advised that it is extremely difficult for anyone to address mental ill health when there is no stability in their living arrangements and while a lack of housing continues to create stress and distress.

We present a number of recommendations, in addition to the key recommendation that the Government work with Federal and Local Governments to address Victoria's housing crisis, that we believe will increase our capacity to intervene earlier in responding to people experiencing mental ill health.

Homelessness has increased by 40% in Melbourne's west in the last five years, representing 23% of those experiencing homelessness in Victoria (to 5,712 people) and the number of people living in severely overcrowded situations has increased by 79%: nearly 3,000 people are living in housing that is four or more bedrooms short. (Census 2016). We know that these figures represent an undercount in the numbers of people experiencing homelessness in the West.

A recent survey of homelessness support workers in Melbourne's west identified that 74% of those people being supported by homelessness support workers are experiencing mental health issues. We know that these people are facing poverty, have frequently experienced trauma and that the complexity of the issues that they face are compounded by the impact of being without a safe and affordable home.

A survey of homelessness workers in 2015 showed that of the 597 people being supported by homelessness workers who participated in the snapshot, 74% identified or were assessed as experiencing mental health issues, but only 30% were in receipt of support through the mental health system.

Workers has reported that the mental health system is completely overstretched, that wait times for services are lengthy and that the system is confusing to navigate.

A 2018 survey of people experiencing homelessness highlighting the hugely detrimental impact that homelessness has on an individual's mental health. See Appendix B for quotes from these consumers about this impact (Northern and Western Homelessness Networks, 2018).

We therefore thank and commend the Andrews Government and the Royal Commission for making this commitment to improving the mental health system for Victorians.

Key recommendations

This submission calls on the Royal Commission into Victoria's Mental Health System to include in its recommendations:

1. **A monumental increase in affordable housing to enable the provision of secure and affordable housing as a central pillar in addressing mental health issues**. Victoria is experiencing a housing crisis, in both availability and affordability. Homelessness (and so mental ill health) will only be addressed through provision of affordable housing. Safe accommodation is critical for preventing mental ill health and for maintaining good mental health.

   Provision of a range of housing models is required to address the housing crisis that Victoria is facing:

   - There are currently 85,000 people on the Victorian Housing Register awaiting social housing, with very few housing allocations occurring.
   - 13,546 households experiencing or at risk of homelessness presented to Homelessness services in Melbourne's west for assistance in 2017/18. (In addition approximately 4,000 people a year are turned away from homelessness access points in Melbourne's west, without an appointment because of lack of capacity in the services.)
   - Only 2% of those people presenting to the homelessness service system will be able to access transitional housing; a model which provides the medium term housing stability with linked support, that is so critical for assisting people to address the complex range of issues that they are facing.
   - The two homelessness access points in Melbourne's west spent over $1M in 2017 paying for nights in private accommodation for people presenting to the homelessness system without housing. Almost all of this purchased accommodation in hotels and rooming houses was sub standard and inappropriate for vulnerable people (see "Crisis in Crisis": the appalling state of emergency accommodation in Melbourne's west: http://nwhn.net.au/admin/file/content2/c7/A%20crisis%20in%20crisis%20doc%20final%20040219_1550142202053.pdf

   Addressing Victoria's housing crisis will reduce the significant number of people who develop mental ill health as a result of homelessness and family violence, and therefore prevent additional burden on the mental health service system.

Further, provision of safe, affordable, appropriate housing provides individuals and families experiencing mental health issues with the necessary stability to address mental ill health.

A range of safe, affordable housing models, all with security of tenure, are required. This includes:

- provision of long term housing models for those people able to live independently (public housing provides the ideal security of tenure combined with flexibility for those who can live independently. For instance, the public housing model enables variable rental payments in response to fluctuations in mental health and employment participation);
- medium term congregate services (such as youth foyers, McAuley House for Women), transitional housing, Housing First models and supported transportable housing for people who require a period of time in more supported accommodation to stabilise their situation before they re-build a capacity to live independently (See Appendix C: Case studies 2 and 3 for the benefits of transitional housing with linked support); and
- permanent supported housing models with onsite support to assist people to manage their health, mental health and housing stability.

For some consumers, access to long-term, outreach-based support will also be required in addition to affordable housing to assist in maintaining their tenancy.

Only once an individual or family has been placed in stable and appropriate housing can they begin the process of stabilising their mental health, alongside other issues.

AHURI research published in 2016 identified that providing housing for people experiencing homelessness in Western Australia saved the health system $4,846 per person per year in the period 2009–12, mainly through people spending fewer days in hospitals and psychiatric care. Supported accommodation programs for people experiencing homelessness also led to an average of $2,397 (in 2011$) in reduced costs for the justice system (e.g. reduced prison time and engagement with police). (AHURI, 2018).

Evidence from both Australia and internationally shows that a Housing First model (providing sufficient affordable housing as a FIRST and unconditional response) is highly successful in assisting people with a complex range of needs, particularly those who have been sleeping rough, to stabilise their health, mental health and substance use issues.

> An AHURI report published in 2012 examined USA Housing First programs and found that they were successful in retaining accommodation for those people at risk of homelessness. A longitudinal study of 225 people in the USA compared the outcomes of those using traditional services and those using a Housing First program. The research found that 88 per cent of those in the Housing First program retained their housing for two years compared to 47 per cent in the other programs.
>
> Housing First programs can also be cost efficient for governments and the community. Data from one Housing First program in the UK found housing a homeless person cost £9,600 per person per year (excluding rent), which was around £1,000 per year less than placing the person in a shelter and nearly £8,000 less than placing them in a high-intensity support service (excluding rent) (AHURI, 2018).

What is the Housing First model and how does it work?

The Housing First model prescribes safe and permanent housing as the first priority for people experiencing homelessness. Once housing is secured, a multidisciplinary team of support workers can address complex needs through services like drug and alcohol counselling or mental health treatment. However, an individual's engagement with these support services is not required for them to maintain accommodation. Each individual is assisted in sustaining their housing as they work towards recovery and reintegration with the community at their own pace. Housing First is predominantly designed for helping those who are sleeping rough (i.e. those sleeping in improvised dwellings, tents, cars and parks).

While there is some variety in the way the model has been adopted by different countries, the guiding principle of Housing First is that safe and secure housing should be quickly provided prior to, and not conditional upon, addressing other health and well-being issues. In contrast, other models make housing provision conditional, such as by requiring individuals to abstain from alcohol or drug use or comply with mental health programs to qualify for housing. Such approaches can make it hard for those experiencing homelessness to become well enough to qualify for housing or make it difficult to maintain tenancy if they do get into housing. (AHURI, 2018)

The Western Homelessness Network argues that provision of housing first (whether through formal Housing First models or in terms of quick access to affordable housing with security of tenure), with linked support initially, is the most effective model for addressing homelessness and the range of complexities that it causes.

2. **Homelessness services adequately funded to enable provision of long term flexible support to consumers as they require it,** so that the consumer can receive support for as long as they need it and in an appropriate setting (i.e. at home, at a service, or elsewhere in the community). This support should be sufficiently flexible to respond to fluctuations in need over time. Effective provision of support is relationship based – a consumer recently identified that it took 15 contacts for him to trust his support worker sufficiently enough to begin to discuss his issues. Flexibility of funding would enable support workers to provide a range of supports as needed by consumers from early intervention to intensive responses to consumers experiencing a complex range of needs and to provide tailored responses to different cohorts.

   Homelessness support workers already use an effective strengths-based, outreach case management model. This model was replicated by the Department of Health and Human Services when responding to victims of the Victorian bushfires 10 years ago. This model was successful because it enabled holistic support in response to needs and goals, as identified by consumers. In that instance, the case management responses were extended up to three years in acknowledgement of the long-term impact of trauma. People experiencing homelessness and mental illness often have similarly severe histories of trauma, abuse and disconnection.

   The current homelessness support model is only impeded by the lack of flexibility in the targets, by the lack of resources and by a lack in security of funding. Services are currently funded to support consumers for an average of thirteen weeks and, at present, only 11% of those people presenting to the homelessness service system in Melbourne's west are able to access homelessness support.

Ideally Homelessness services would be sufficiently funded to move from a focus on crisis response to undertaking prevention and early intervention responses to reduce the numbers of people entering homelessness and/or experiencing family violence.

3. **Establishing 'anchor agencies' in Melbourne's West to lead localised service integration –** provide funding to existing case management services to enable them to 'lead' collaborative practices with mental health and other allied services. Sufficient funds would also be provided to local mental health and allied services to enable them to provide in-house as well as outreach-based support 'where the consumer is'.

   This integrated case management approach would be delivered through existing services that already have an established relationship with a consumer (such as homelessness services) and use a case management response to bring other relevant support services (such as legal, mental health and alcohol and other drug (AOD) services) into the case plan. Conversely homelessness services should also be funded sufficiently to outreach into mental health, AOD services or other first-point-of-contact services consumer present.

   The work already undertaken in the Melbourne's north and west since 2015 to bring the relevant service providers together - through the 'Making Links' project (see details in Appendix A of this report) – would make this region an appropriate place to immediately introduce and trial this new approach. Adequately funded evaluation throughout a trial of this approach would be critical to documenting outcomes and building an evidence base for possible rollout in other regions.

4. **Increasing capacity in the mental health system to provide greater accessibility for vulnerable consumers and a seamless response –** at a recent orientation to the AOD, mental health and homelessness systems in the Northern and Western Metropolitan Regions, it took four different people to describe the pathways through the mental health system. The system is fractured and completely overstretched. For those facing multiple other challenges, including family violence and homelessness, this makes the system even less accessible than for those with family and other personal supports. Consequently, consumers of homelessness services (and workers) have an extremely difficult time navigating the system to find the right service and then often cannot access the service required because a lack of capacity has led to development of rigid eligibility criteria.

   Current rigidity within the system means people often fall through the gaps between mental health services. For instance, workers referring young people to Headspace are frequently told that the young person's needs are too complex for Headspace. The support worker will then seek assistance through a clinical mental health service, such as CAMHS or Orygen – only to be told that the young person's needs are not complex enough. This leaves homelessness support workers supporting young people with serious mental health issues, unassisted by mental health professionals.

   Sufficient capacity is required in the mental health system to ensure that a service can 'hold' a client and respond to their mental health issues while they are seeking the appropriate service.

   Mental health services need sufficient funding and flexibility to enable outreach to consumers. Many people are so unwell that attending an unfamiliar service, at a designated time, is too challenging. Outreach based mental health support workers could visit consumers in locations in which they feel safe and secure or in conjunction with support workers with whom they already have a trusting relationship. (See Appendix C: Case Study 3 for an example of the benefits of outreach based mental health support.)

5. **Make co-design an intrinsic part of the policy and program design process, through a long term (5 year) commitment to consumer engagement activities** – consumers are best placed to identify the types of services that they would like to engage with, and the most effective means of engagement. Homelessness services in the West are well placed to facilitate an ongoing process of consumer engagement and consultation to ensure that consumers experiencing homelessness and mental ill health have their voices heard and respected. The Northern and Western Homelessness Networks have produced a guide to consumer participation and run an annual consumer survey to inform the development of the coordinated homelessness service system.
   (http://www.nwhn.net.au/admin/file/content2/c7/Client%20Participation%20Guide_1329808697989.pdf)

   A five-year consumer engagement process would allow sufficient time for a new culture of co-design to be developed and embedded into the service system, and evaluated for potential rollout in other regions. Co-design with consumers would involve the establishment of a consumer advisory group, surveys and focus groups with cohorts of consumers and consumer consultations on proposed approaches to key elements of reformed service system design.

6. **Allocating sufficient investment in data collection and research to explore tailored responses to a range of cohort groups – including those with high and complex needs such as moderate to severe mental illness –** in order to develop evidence-based interventions. Seminal research on pathways into homelessness (Johnson & Chamberlain 2015 and Johnson G, Gronda H and Coutts S, 2008) identifies differing pathways in to homelessness (mental health pathway, domestic violence pathway, housing crisis pathway, youth pathways (youth dissenters and youth escapers, substance use pathway) yet the current responses are not funded to operate differentiated or tailored responses according the pathway that a consumer has experienced.

   Only through adequately funded and long-term research and data collection will the service systems be in a position to design and deliver responses that are adequately tailored according to consumer need. This would include tailored responses for young people, women and children escaping family violence, Aboriginal and Torres Strait Islander people, and those from culturally and linguistically diverse backgrounds. The growing incidence of homelessness amongst older women is also a cohort that may require its own tailored response.

Homelessness makes me depressed and unable to function

The current situation

Decades of research have demonstrated strong correlation between mental illness and homelessness. However, the situation has significantly worsened in recent years, with overwhelming demand on both service systems feeding a vicious cycle of individual crisis and systemic failure.

The transition to psychosocial supports being provided under the National Disability Insurance Scheme (NDIS) adds another layer of complexity, and uncertainty, about how these service systems can respond.

Since 2012-13:

- the number of Victorians who have exited mental health facilities into homelessness has grown by **55 per cent** (Australian Institute of Health and Welfare, 2019, Specialist Homelessness Services Collection).
- the number of people accessing Victorian homelessness services who report having a mental health issue has increased by **84 per cent**. (AIHW 2019).

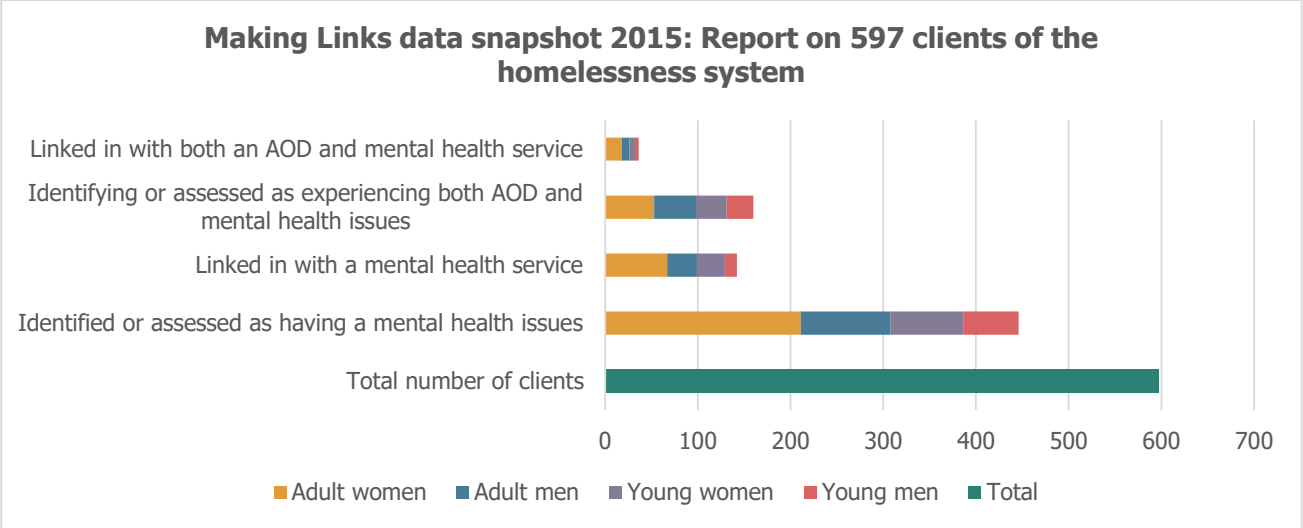
In 2015/16 3,157 people (19%) **presenting** to the homelessness service system in Melbourne's west reported that mental ill health was one of their primary reasons for seeking homelessness assistance (AIHW 2015/16). This demonstrates a significant under-reporting of the prevalence of mental illness amongst those experiencing homelessness through the formal data collection process – most likely related to the importance of building a relationship of trust between a client and a support worker before wanting to disclose something so commonly stigmatised and misunderstood.

In a 2019 survey of homelessness support workers within homelessness services in Melbourne's west practitioners identified that:

- **79 per cent of clients** were experiencing problematic mental health issues
- the experience of homelessness significantly impacted the mental health of around **74 per cent of clients** (WHN 2019)**.**

This is consistent with findings from a 2015 data snapshot undertaken in the Melbourne's north and west, which showed that 78 per cent of clients had an identified or were assessed by their support worker as experiencing problematic mental health issue (50 per cent of clients self-identified as such and workers identified a further 28 per cent as likely). Adult women were nearly three times as likely as any other group to identify a mental health issue (Making Links, 2015).

Of the 597 consumers identified through the snapshot, only 30% of those with an identified or assessed mental health issue were linked in with a mental health service. Over one third (160) of consumers were identified or assessed as experiencing substance use issues and mental health issues in addition to experiencing homelessness. Of these, only 30% were linked in with support through the AOD and mental health systems.



Homelessness made me suicidal, stressed, didn't want to contact with anyone. Felt extremely isolated. I felt so ashamed.

As acknowledged by the National Mental Health Commission, for people with lived experience of mental illness, finding and keeping their home is much harder than for the general population. For the most vulnerable and unwell, their life can become caught in ongoing cycles of homelessness, unstable housing and mental ill health (NMHC 2017:5).

Evidence from the discussion paper for the Productivity Commission's current review into the Australian mental health system shows that the impacts of mental illness and homelessness are very similar, including: unemployment, low income, low social capital, low social connectedness and social support, poor quality diet, limitations on physical functioning and physical diseases (Jorm 2018, p.1061).

Tragically, for these people both the mental health service system and the specialist homelessness service system in Victoria are stretched well beyond capacity and are unable to meet demand.

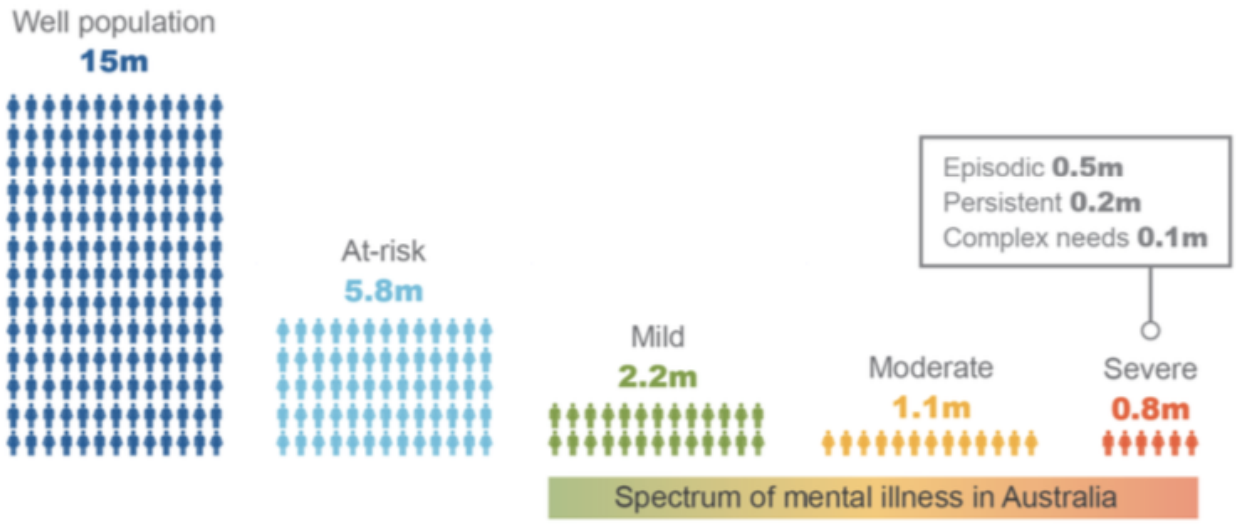
- Only about half of Victorians requiring mental health treatment receive it.
- Homelessness in Victoria has increased by 43% over the last decade and one in every six Victorians asking for assistance are turned away due to insufficient resources.
- **In the Western Metropolitan region, only 11% of those people seeking homelessness support will receive it**. (Western Homelessness Network data, 2019)
- According to the most recent Victorian Housing Register and Transfer list for social housing (March 2019) the Western Metropolitan Region has the greatest number of priority access applicants, with the Western Melbourne office, in particular, holding the greatest number of priority access applications (Victorian Housing Register, June 2019).

A major Victorian study from 2011 found that housing insecurity can both cause and prolong mental illness, with 15 per cent of people self-reporting mental health issues prior to becoming homelessness, and another 16 per cent developing mental illness only after their experience of homelessness (Johnson & Chamberlain 2011, *(1):*36).

> *Homelessness has impacted my mental and physical wellbeing and has made me resort to using drugs to cope with my situation.*

Of the nearly 25,000 Victorians currently experiencing some form of homelessness each night, only 29 per cent (7,250) are in supported accommodation services, with another 18 per cent (4,500) in rooming houses and 5 per cent (1,250) sleeping rough.

This breakdown of the homeless population has a similar profile to the breakdown of the national profile of people either experiencing or at risk of mental illness, with 8 per cent of those with mental illness in the most severe category (3 per cent with either persistent or complex needs), 11 per cent in the moderate category, and 22 per cent in the mild category (Productivity Commission, 2019:6).



[a] Estimated number of people (adults and children) in each group based on their mental health over the 12 months up to 31 March 2018. People were categorised as having a mental illness (mild, moderate or severe) if they had an episode of mental illness within the 12-month period. They were categorised as being at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children of parents with a mental illness.

Source: Productivity Commission estimates based on prevalence rates published in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) and NMHC (2014a); and population statistics published by the ABS (*Australian Demographic Statistics*, Cat. no. 3101.0).

Homelessness had mental impact as I was stressed and full of worry on not knowing where I will be at night as I was heavily pregnant.

What is working well

Local coordination of services in the Northern & Western Metropolitan regions

In 2015, homelessness, mental health and AOD services came together to start building partnerships and improving information sharing across these diverse systems for the benefit of their many mutual clients. The 'Making Links' project has resulted in much stronger working relationships and a number of joint initiatives, including a number of snapshot data collections, to build better understandings of how consumers and workers can navigate these often-complex systems.

A number of resources, including an orientation toolkit and data reports, have been produced and several forums run. This is an example of the type of proactive and locally based partnership that can happen across these service systems, and we believe the region is well positioned to help immediately establish the type of regional 'anchor agency' model described in our key recommendations.

For further details about the Making Links project, see Appendix A.

Housing first type approaches

As outlined in the recent AHURI research paper (Braekertz et al 2019:24-26), there are a number of small-scale integrated housing and mental health models, incorporating many of the elements of the Housing First approach, that are delivering positive results for consumers, as well as considerable cost savings to government. These include:

- **Journey to Social Inclusion (J2SI**) – J2SI is a Melbourne based program run by the Sacred Heart Mission in St Kilda, which aims to break the cycle of homelessness for people who have experienced chronic homelessness through the application of five key elements:
  - Assertive case management and service coordination
  - Housing access and sustaining tenancies
  - Trauma-informed practice
  - Building skills for inclusion
  - Fostering independence.

- **Housing and Accommodation Support Initiative (HASI)** - New South Wales – providing long term secure and affordable housing along with specialist mental health care clinical services and rehabilitation – which has also resulted in a number of tailored programs for Aboriginal consumers, boarding house residents, and people with severe and ongoing mental health issues.

- **Doorways Program** – Victoria – providing integrated housing and recovery support for people with persistent ill health and at risk of, or experiencing, homelessness. Involving hospitals, housing and mental health services, it is based on providing rent subsidies and additional supports for people in the private rental market.

- **Housing and Support Program (HASP)** - Queensland – savings of between $74,000 and $178,000 per consumer were achieved through supporting people who were homeless or in tenuous housing to connect with mental health services, disability support and community housing.

More recent evaluations of Housing First programs in Australia have shown that residents with psychosis, and people discharged from psychiatric hospitals, required fewer subsequent days each year in mental health units (Holmes et al 2017, Parsell et al 2016).

What's not working well

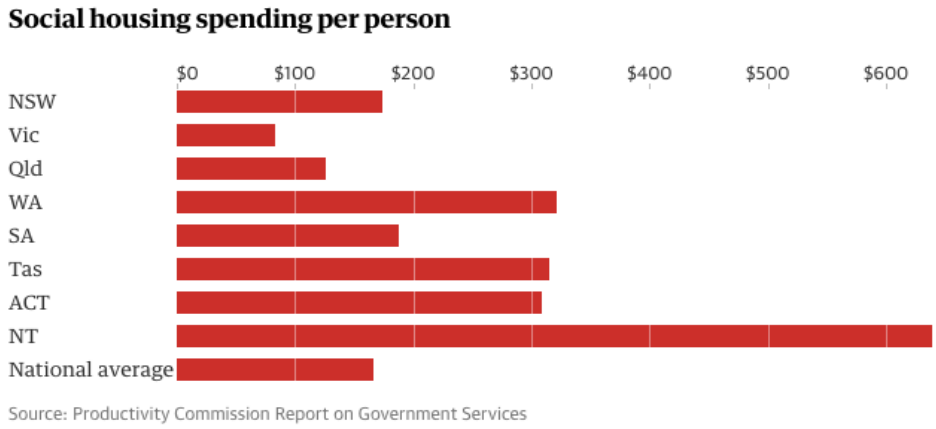
Constant worry, losing time chasing options, stress, sleeping problems, nightmares, financial stress, depression, panic attacks.

Lack of secure, affordable housing

The most fundamental problem facing people experiencing mental health issues and homelessness is a lack of secure, affordable housing. This is an issue across all parts of Victoria, but particularly in metropolitan areas.

The Government's own Rental Report for the March quarter 2019 showed that across all of metropolitan Melbourne there were just 35 rental properties affordable to a single person on Newstart, and only 148 across the whole of Victoria (DHHS 2019).

At the same time, around 85,000 Victorians are on the waiting list for social housing, with Victoria spending less per person on social housing than any other jurisdiction and almost half of the national average (Productivity Commission, 2018). This reflects the serious shortfall of affordable housing in Victoria compared to other jurisdictions, with long term social housing units representing only around 3.5% of total housing stock. This is clearly an inadequate response requiring immediate attention. Within Victoria's broader commitment to infrastructure, social housing must be treated as an investment in the long term infrastructure needs of the entire community.



Inadequate capacity in the mental health service system

As noted in the background section to the Terms of Reference for this Royal Commission, the mental health service system is under significant strain with only around half of those experiencing mental illness receiving treatment. The increased pressure on the service system over the past decade in particular has been described by many, including the Governor Linda Dessau, as being in crisis due to factors such as population growth, changing patterns of drug use and greater complexity of need. What is not mentioned is that the increasing housing stress facing vulnerable and low-income Victorians is also feeding the greater need for mental health support services.

The structural weaknesses of the mental health service system have been covered in detail by numerous reviews (Productivity Commission 2019:12) as well as the tangible and intangible costs this is having on individuals, families and communities (Productivity Commission 2019:8).

Clearly the overall mental health service system requires greater capacity and funding – but it is important that the needs of those with the most severe forms of mental illness, and with multiple and complex other needs, are adequately resourced.

Consumers have identified that homelessness causes a serious deterioration in their mental health. Practitioners in the homelessness and mental health systems have identified that it is not possible to assist someone to stablise their mental health issues while they are experiencing homelessness – that a stable home is required in order for people to address the range of complex issues that they may be facing.

Homelessness practitioners have also identified that many consumers find the mental health system difficult to navigate and rigid in its responses – generally requiring that consumers attend a mental health service at a specific time. Practitioners identify that many consumers would respond better to mental health support provided on an outreach basis – where they consumer is located or in conjunction with an existing support provider.

> *Homelessness caused mental health problems (anxiety from being uncertain) - never knowing when I am going to be kicked out of somewhere.*

Lack of service system integration

Multi-disciplinary support – or 'wrap around' services – are often needed for people with complex mental illnesses and experiencing homelessness. However, achieving this type of service provision has proved incredibly challenging for services that are funded under different service delivery contracts, with different reporting requirements and without the additional funding required to coordinate multi-disciplinary teams.

Practitioners from homelessness services need to work with clinical mental health services, mental health recovery teams, health treatment, disability support, primary health care, community legal services and addiction support to deliver a holistic response to someone with complex needs.

While there have been individual small-scale programs where this type of wrap around service has been trialled elsewhere (including the HASI in NSW and HASP in Qld), this has not resulted in scaled-up programs.

The use of a 'joint commissioning' model in the UK has been used to better integrate housing with a range of social services at the local level, including mental health, through government funding agreements (Braekertz et al, 2018:45). This is a model that could be considered in Victoria to address the current lack of system integration from a funding/contract perspective.

Note: Integration is considered a much better approach than formally linking or tying housing stock to specific mental health services – an example of this that hasn't worked in the past is the Transitional Housing/Mental Health Pathways Initiative.

> *Homelessness has meant constant worry, losing time chasing options, stress, sleeping problems, nightmares, financial stress, depression, panic attacks.*

Discharge from institutions

Discharge from mental health institutions and correctional facilities (including juvenile justice) into homelessness has been a problem for decades. The severe lack of affordable housing and increased demand on supported accommodation services over the past decade has only exacerbated this situation. While various inter-departmental initiatives have been tried, starting with the first Victorian Homelessness Strategy in 2000, the problem has not been addressed at a structural or practice level.

The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13 (AIHW 2019). Data provided to Corrections Victoria by transitional support service providers indicates that close to a half (44%) of female clients and a quarter (22%) of male clients became homeless when their funded program placement in the Intensive Transitional Support Program was completed (Willis 2018). (See Case Study 1, Appendix C.)

To reduce recidivism and relapse into mental illness, it makes social policy and economic sense to support people with severe mental health issues to transition out of psychiatric hospitals and prisons.

The cost of supporting someone:

- in an acute mental health bed is $917 per day (Productivity Commission, 2019: Chapter 13A.36)
- in prison is $324 per day (Productivity Commission, 2019: Chapter 8)
- in supported accommodation is just over $8 per day (SGS 2018:23) or $3000 per year.

Council to Homeless Persons research has found that the period of transition from a psychiatric hospital into the community is often marked by instability and stress. In particular, a lack of housing and poorly coordinated supports mean that many people exiting such facilities do not have their needs adequately met during this time, which gives them poor chances of remaining physically and mentally well.

On the other hand, mental health hospital dischargees who received transitional housing support required 22 fewer psychiatric in-patient bed days per participant – the related financial savings eclipsed the cost of providing this support. Consumers' living conditions also improved (Siskind et al 2014).

Developing severe anxiety because of the fear of the unknown.

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APPENDIX A

Making Links

A coordinated project between AOD, Homelessness, Mental Health Community Support Services and Family Violence Services in the North and West Metropolitan Regions.

Making Links has been a partnership between the AOD, Mental Health and Homelessness Sectors in Melbourne's north and west. The three Sectors established the Making Links project in 2015 in order to work together to improve our service systems for the benefit of shared clients.

Practitioners in each of the three Sectors identified that key to effective collaboration is access to more information about how to assist consumers/clients to navigate each of the three Sectors.

Making Links has developed an Orientation Kit, which can be accessed at:
http://nwhn.net.au/admin/file/content2/c7/A%20Guide%20to%20Making%20Links.pdf

The Orientation Kit provides information on eligibility, access, service pathways and service types for each Sector and included 'tips and tricks' for practitioners in assisting consumers to access each Sector.

In addition to developing the Kit the Making Links project has:

- Surveyed practitioners about their experiences of the three sectors and barriers to collaborative practice,
- Held two forums to explore the survey findings,
- Run three 'think tanks' to establish a collaborative response to frequent service users,
- Developed and trialled an approach to collaborative practice across Sectors, and
- Held two cross sector orientations.

More information about previous Making Links forums, data collections and practitioner surveys: can be found at: http://nwhn.net.au/Making-Links.aspx.

APPENDIX B

Consumer quotes on homelessness and mental health

43% of consumers who participated in the 2018 Northern and Western Homelessness Networks' Annual Consumer Survey identified as having mental health issues.

Q. What impact has homelessness had on your life?

Homelessness has impacted on many aspects of my life. Caused me a lot of stress and this affected my parenting. Homelessness caused many financial issues and worrying about if I can put a roof over my kid's heads.

Homelessness has caused loss of self-worth/value. Loss of social connection/integration. Negative/pessimistic mindset. Depression/anxiety.

Homelessness has caused my anxiety to intensify. Has made recovery from alcohol very difficult. Very embarrassed from family, causing isolation.

Homelessness means not feeling safe. Feeling very sad and have to take medication for depression. Hard to handle social situations. Don't know about future.

Homelessness affects my ability to trust people, my safety, my mental health - depression. Isolation. Stripped my confidence in life.

Homelessness makes me depressed and unable to function.

Homelessness made me suicidal, stressed, didn't want to contact with anyone. Felt extremely isolated. I felt so ashamed.

I've been homeless most of my life and it had a massive impact on my mental health, stability and a massive impact to me not be able to have my children and I am/was child ward of the state.

Homelessness has caused mental health issues and feeling rejected. I felt betrayed - like I was just existing, not living. It caused social isolation and schizo-depression.

Developing severe anxiety because of the fear of the unknown. My children seeing me struggle to leave the house and not understanding why. My children feeling scared and confused due to moving all the time.

Homelessness has been extremely stressful for the whole family particularly the children. It has impacted upon my mental health whereby I suffer with depression. Depression combined with a difficult breakup from my ex-partner, which involved domestic violence, has made life extremely difficult, very high stress levels.

Homelessness has caused mental health issues, physical issues, problems with trust, stealing food.

Homelessness has increased my stress, anxiety and depression. Nowhere to call home and feel comfortable. Changes in schools.

Homelessness means I had to live in a mouldy, crowded house. It affected my mental health extremely. I felt like I had no hope.

Homelessness caused psychological issues with mental health; financial; affected my daughter's education and learning due not having the stability; affected mine and my daughter's relationship and bond. I believe it has left a long-term impact on both of us emotionally; affected employment; self-confidence and self-esteem relationships with friends and family. Homelessness is hard to come back from mentally.

Homelessness had mental impact as I was stressed and full of worry on not knowing where I will be at night as I was heavily pregnant.

Homelessness caused mental health problems (anxiety from being uncertain) - never knowing when I am going to be kicked out of somewhere.

Homelessness has caused me to have depression and anxiety and I'm behind in my bills.

Homelessness has caused me stress and anxiety. I don't feel like I can start my life as I'm always moving.

Homelessness has meant constant worry, losing time chasing options, stress, sleeping problems, nightmares, financial stress, depression, panic attacks.

Homelessness brings a feeling of hopelessness and despair which led to depression in all of us – we felt that one of us would suicide if we were not reunited.

Anger/depressions/resentment. Constantly feeling unsettled. This has affected my ability to be in the present moment with my children. Feelings of worry and anxiety about where we will live. Feeling outside of the rest of the world who have secure housing. Not being able to give my children things because I can't afford to.

My mental health and wellbeing has been impacted a lot. I am unwell and feel disorganised, not confident and alone.

Homelessness has caused anxiety, depression, family breakdown, distress, unsure what will happen in future.

APPENDIX C

Case studies

Case study 1: Discharge into homelessness

A gentleman, who had been in a psych ward in the inner city, was released into homelessness, even though he had disclosed auditory hallucinations. Attended a homelessness access point service the next day. When in the waiting room he heard voices in his head about harming himself and others. He didn't alert staff but called his sister (who had an Intervention Order against him) who called an ambulance. The ambulance took him to same psych ward, which released him in to homelessness again that same day – still with hallucinations. He attended the homelessness access point again the next day. Reception staff were concerned that he appeared dazed and confused. He disclosed in interview that he was having thoughts of harming himself or others in waiting room. The staff called the CAT Team but could only leave message. They were concerned about this delays so called local psych ward, mentioning the consumer's name.

The psych ward staff called the police but didn't provide any information to the access point service. The Police undertook an intake over phone (10am). At 3.30pm the police rang to say they would not pick the man up. During the day the access point service checked in on him regularly and provided a room to himself when he needed it. By 3.30 the CAT team had not returned call. After the call with police, the access point staff called the local psych ward again. Staff there suggested calling an ambulance. While on the phone to the ambulance, the CAT team called. Ambulance service asked a mental health triage nurse to speak to the man and then said they weren't going to release an ambulance. The access point service had to find a taxi to take the man to local the local emergency department, which placed him in psych ward for 8 or 9 days, then released him back in to homelessness. By then his mental health had stabilised sufficiently for the access point service to undertake a full initial assessment and planning appointment.

The access point service couldn't find him any supported accommodation – (He is on the wait list for Flagstaff) but found him a place in a rooming house with no support. This is unlikely to stablise his mental health issues and, in all unlikelihood will exacerbate them.

Case study 2: The benefits of housing with linked support

J[redacted], a 19 year old single mother of a 6 month old, accessed transitional housing with a history of mental health issues. J[redacted] had been accessing mental health support through Headspace and later Orygen, but disconnected from this support when she became homeless. Upon stabilising in transitional housing, J[redacted]'s Homelessness Case Manager's attempts to re-engage J[redacted] with Orygen services failed as J[redacted] had received two years of prior support (meeting the maximum period of service with Orygen).

J[redacted]'s mental health deteriorated, child protection became involved and ultimately removed her child. J[redacted]'s mental health continued to deteriorate until she reached crisis point requiring police and CAT Team intervention.

Although the Homelessness Case Manager had attempted on numerous occasions to gain access to mental health support for J[redacted], it took a major crisis to receive a service. J[redacted] was hospitalised and placed on a treatment order. In the two months since the order has been in place J[redacted] has breached twice requiring hospitalisation.

The Homelessness Case Manager has been able to negotiate for an extension to the transitional housing tenure and can continue their support so that J[redacted] remains housed. It is unlikely this pattern of breaching order and hospitalisation will change in the short term, however in the long term the support and accommodation guarantee that J[redacted] has been able to access through the transitional housing program will assist J[redacted] to stabilise and to

manage her mental health, providing an opportunity for J[redacted] to sustain long term independent housing and reunification with her child.

Case study 3: The benefits of outreach based mental health support and cross sector collaborative practice

NB The details of this case study have been reduced down to the most pertinent aspects of the case managed support provided. Each outcome in this situation was the result of tenacious and complex support provision.

18 year old male from Rural Somalia. Sponsored by family on 112 (orphan) visa in 2016. Arrived in Australia with two other siblings. His relationship broke down with sponsor family after six months and was forced to leave and enter into homelessness.

He presented at an access point service and was referred to a homelessness support service for short term (as no case management support was available) support to look for share accommodation. A Somali interpreter was used at all appointments.

The homelessness support worker ascertained that the young man had:

- No English language skills.
- Current trauma from being excluded from family.
- No independent living skills.
- No understanding of basic welfare systems such as Centrelink.

The homelessness support worker advocated for homelessness case managed support and access to transitional housing. Eventually the young man was accommodated in a shared transitional housing property. The transitional housing broke down due to suspected mental health issues and incompatibility with the other tenant. The young man refused to engage with any other service.

The young man was transferred to a sole tenancy property. The Homelessness Case Manager worked on:

- Centrelink requirements and teaching how to report earnings and maintain payments.
- linked in with English education classes
- orientation to area and public transport
- intensive support for independent living skills. Cleaning, bed making, shopping, paying bills etc.

The Homelessness Case Manager suspected that the young man was experiencing mental health issues but was unable to get him to engage with mental health services. Numerous secondary consults with Orygen Youth health led to referral to the Refugee Access Program, which had an outreach capacity.

The Refugee access worker attended young man's property with the young man and his Homelessness Case Manager. The Refugee Access worker arranged for admission to inpatient unit and the Case Manager assisted with access to the young man.

Outcome

- Whilst in hospital the young man was diagnosed with schizophrenia and was placed on a Community Treatment Order.
- With the help of the Homelessness Case Manager, the young man was reconnected with family while hospitalised.
- At the young man's request the Homelessness Case Manager advocated for his sister to reside in transitional housing with him
- The young man was discharged back to transitional housing with his sister and received ongoing homelessness case management support.
- His Victorian Housing Register application for priority public housing was upgraded to an application for two bedrooms.
- He now resides in public housing with his sister and is linked in with Orygen Youth Health Intensive Support program.

2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Ms Sarah Langmore

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"Please see attached submission, which addresses this question."

What is already working well and what can be done better to prevent suicide?
N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"The most fundamental problem facing people experiencing mental health issues and homelessness is a lack of secure, affordable housing. This is an issue across all parts of Victoria, but particularly in metropolitan areas. Homelessness practitioners have identified that up to 70% of people experiencing homelessness, who they are supporting, are also experiencing mental health issues and that for 74% of these people, the experience of homelessness has significantly contributed to a decline in their mental health. Homelessness and mental health support workers have identified that it is nearly impossible for people to stabilise mental health issues in the absence of safe, stable, affordable housing with a security of tenure. See attached submission for a broader discussion of the impact of Victoria's housing crisis on the numbers of people experiencing mental health issues. "

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise

these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"See the attached submission for background to the following six key recommendations: 1.A monumental increase in affordable housing to enable the provision of secure and affordable housing as a central pillar in addressing mental health issues. Victoria is experiencing a housing crisis, in both availability and affordability. Homelessness (and so mental ill health) will only be addressed through provision of affordable housing. Safe accommodation is critical for preventing mental ill health and for maintaining good mental health. Provision of a range of housing models is required to address the housing crisis that Victoria is facing: There are currently 85,000 people on the Victorian Housing Register awaiting social housing, with very few housing allocations occurring. 13,546 households experiencing or at risk of homelessness presented to Homelessness services in Melbourne's west for assistance in 2017/18. (In addition approximately 4,000 people a year are turned away from homelessness access points in Melbourne's west, without an appointment because of lack of capacity in the services.) Only 2% of those people presenting to the homelessness service system will be able to access transitional housing; a model which provides the medium term housing stability with linked support, that is so critical for assisting people to address the complex range of issues that they are facing. The two homelessness access points in Melbourne's west spent over $1M in 2017 paying for nights in private accommodation for people presenting to the homelessness system without housing. Almost all of this purchased accommodation in hotels and rooming houses was sub standard and inappropriate for vulnerable people (see Crisis in Crisis: the appalling state of emergency accommodation in Melbourne's west: http://nwhn.net.au/admin/file/content2/c7/A%20crisis%20in%20crisis%20doc%20final%20040219_1550142202053.pdf Addressing Victoria's housing crisis will reduce the significant number of people who develop mental ill health as a result of homelessness and family violence, and therefore prevent additional burden on the mental health service system. Further, provision of safe, affordable, appropriate housing provides individuals and families experiencing mental health issues with the necessary stability to address mental ill health. A range of safe, affordable housing models, all with security of tenure, are required. This includes: provision of long term housing models for those people able to live independently (public housing provides the ideal security of tenure combined with flexibility for those who can live independently. For instance, the public housing model enables variable rental payments in response to fluctuations in mental health and employment participation); medium term congregate services (such as youth foyers, McAuley House for Women), transitional housing, Housing First models and supported transportable housing for people who require a period of time in more supported accommodation to stabilise their situation before they re-build a capacity to live independently (See Appendix C: Case studies 2 and 3 for the benefits of transitional housing with linked support); and permanent supported housing models with onsite support to assist people to manage their health, mental health and housing stability. For some consumers, access to long-term, outreach-based support will also be required in addition to affordable housing to assist in maintaining their tenancy. Only once an individual or family has been placed in stable and appropriate housing can they begin the process of stabilising their mental health, alongside other issues. AHURI research published in 2016 identified that providing housing for people experiencing homelessness in Western Australia saved the health system $4,846 per person per year in the period 200912, mainly through people spending fewer days in hospitals and psychiatric care. Supported accommodation programs for

people experiencing homelessness also led to an average of $2,397 (in 2011$) in reduced costs for the justice system (e.g. reduced prison time and engagement with police). (AHURI, 2018). Evidence from both Australia and internationally shows that a Housing First model (providing sufficient affordable housing as a FIRST and unconditional response) is highly successful in assisting people with a complex range of needs, particularly those who have been sleeping rough, to stabilise their health, mental health and substance use issues. An AHURI report published in 2012 examined USA Housing First programs and found that they were successful in retaining accommodation for those people at risk of homelessness. A longitudinal study of 225 people in the USA compared the outcomes of those using traditional services and those using a Housing First program. The research found that 88 per cent of those in the Housing First program retained their housing for two years compared to 47 per cent in the other programs. Housing First programs can also be cost efficient for governments and the community. Data from one Housing First program in the UK found housing a homeless person cost 9,600 per person per year (excluding rent), which was around 1,000 per year less than placing the person in a shelter and nearly 8,000 less than placing them in a high-intensity support service (excluding rent) (AHURI, 2018). The Western Homelessness Network argues that provision of housing first (whether through formal Housing First models or in terms of quick access to affordable housing with security of tenure), with linked support initially, is the most effective model for addressing homelessness and the range of complexities that it causes. 2.Homelessness services adequately funded to enable provision of long term flexible support to consumers as they require it, so that the consumer can receive support for as long as they need it and in an appropriate setting (i.e. at home, at a service, or elsewhere in the community). This support should be sufficiently flexible to respond to fluctuations in need over time. Effective provision of support is relationship based a consumer recently identified that it took 15 contacts for him to trust his support worker sufficiently enough to begin to discuss his issues. Flexibility of funding would enable support workers to provide a range of supports as needed by consumers from early intervention to intensive responses to consumers experiencing a complex range of needs and to provide tailored responses to different cohorts. Homelessness support workers already use an effective strengths-based, outreach case management model. This model was replicated by the Department of Health and Human Services when responding to victims of the Victorian bushfires 10 years ago. This model was successful because it enabled holistic support in response to needs and goals, as identified by consumers. In that instance, the case management responses were extended up to three years in acknowledgement of the long-term impact of trauma. People experiencing homelessness and mental illness often have similarly severe histories of trauma, abuse and disconnection. The current homelessness support model is only impeded by the lack of flexibility in the targets, by the lack of resources and by a lack in security of funding.Services are currently funded to support consumers for an average of thirteen weeks and, at present, only 11% of those people presenting to the homelessness service system in Melbourne's west are able to access homelessness support. Ideally Homelessness services would be sufficiently funded to move from a focus on crisis response to undertaking prevention and early intervention responses to reduce the numbers of people entering homelessness and/or experiencing family violence. 3.Establishing anchor agencies' in Melbourne's West to lead localised service integration provide funding to existing case management services to enable them to lead' collaborative practices with mental health and other allied services. Sufficient funds would also be provided to local mental health and allied services to enable them to provide in-house as well as outreach-based support where the consumer is'. This integrated case management approach would be delivered through existing services that already have an established relationship with a consumer (such as homelessness services) and use a case management response to bring other relevant support services (such as

legal, mental health and alcohol and other drug (AOD) services) into the case plan. Conversely homelessness services should also be funded sufficiently to outreach into mental health, AOD services or other first-point-of-contact services consumer present. The work already undertaken in the Melbourne's north and west since 2015 to bring the relevant service providers together - through the Making Links' project (see details in Appendix A of this report) would make this region an appropriate place to immediately introduce and trial this new approach. Adequately funded evaluation throughout a trial of this approach would be critical to documenting outcomes and building an evidence base for possible rollout in other regions. 4.Increasing capacity in the mental health system to provide greater accessibility for vulnerable consumers and a seamless response at a recent orientation to the AOD, mental health and homelessness systems in the Northern and Western Metropolitan Regions, it took four different people to describe the pathways through the mental health system. The system is fractured and completely overstretched. For those facing multiple other challenges, including family violence and homelessness, this makes the system even less accessible than for those with family and other personal supports. Consequently, consumers of homelessness services (and workers) have an extremely difficult time navigating the system to find the right service and then often cannot access the service required because a lack of capacity has led to development of rigid eligibility criteria. Current rigidity within the system means people often fall through the gaps between mental health services. For instance, workers referring young people to Headspace are frequently told that the young person's needs are too complex for Headspace. The support worker will then seek assistance through a clinical mental health service, such as CAMHS or Orygen only to be told that the young person's needs are not complex enough. This leaves homelessness support workers supporting young people with serious mental health issues, unassisted by mental health professionals. Sufficient capacity is required in the mental health system to ensure that a service can hold' a client and respond to their mental health issues while they are seeking the appropriate service. Mental health services need sufficient funding and flexibility to enable outreach to consumers. Many people are so unwell that attending an unfamiliar service, at a designated time, is too challenging. Outreach based mental health support workers could visit consumers in locations in which they feel safe and secure or in conjunction with support workers with whom they already have a trusting relationship. (See Appendix C: Case Study 3 for an example of the benefits of outreach based mental health support.) 5.Make co-design an intrinsic part of the policy and program design process, through a long term (5 year) commitment to consumer engagement activities consumers are best placed to identify the types of services that they would like to engage with, and the most effective means of engagement. Homelessness services in the West are well placed to facilitate an ongoing process of consumer engagement and consultation to ensure that consumers experiencing homelessness and mental ill health have their voices heard and respected. The Northern and Western Homelessness Networks have produced a guide to consumer participation and run an annual consumer survey to inform the development of the coordinated homelessness service system. (http://www.nwhn.net.au/admin/file/content2/c7/Client%20Participation%20Guide_1329808697989.pdf) A five-year consumer engagement process would allow sufficient time for a new culture of co-design to be developed and embedded into the service system, and evaluated for potential rollout in other regions. Co-design with consumers would involve the establishment of a consumer advisory group, surveys and focus groups with cohorts of consumers and consumer consultations on proposed approaches to key elements of reformed service system design. 6.Allocating sufficient investment in data collection and research to explore tailored responses to a range of cohort groups including those with high and complex needs such as moderate to severe mental illness in order to develop evidence-based interventions. Seminal research on pathways into homelessness (Johnson & Chamberlain 2015 and Johnson G, Gronda H and Coutts S, 2008)

identifies differing pathways in to homelessness (mental health pathway, domestic violence pathway, housing crisis pathway, youth pathways (youth dissenters and youth escapers, substance use pathway) yet the current responses are not funded to operate differentiated or tailored responses according the pathway that a consumer has experienced. Only through adequately funded and long-term research and data collection will the service systems be in a position to design and deliver responses that are adequately tailored according to consumer need. This would include tailored responses for young people, women and children escaping family violence, Aboriginal and Torres Strait Islander people, and those from culturally and linguistically diverse backgrounds. The growing incidence of homelessness amongst older women is also a cohort that may require its own tailored response. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A