T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Homelessness in Victoria

Melbourne—Wednesday, 12 August 2020

(via videoconference)

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WITNESSES

Dr Sarah Pollock, Executive Director of Research and Advocacy, Mind Australia; and

Dr Kerryn Rubin, Chair, Royal Australian and New Zealand College of Psychiatrists, Victorian Branch.

The CHAIR: Good morning, everyone. I declare open the Standing Committee on Legal and Social Issues public hearing for the Inquiry into Homelessness in Victoria. I am sure I do not need to say it to anyone here on the screen, but please ensure that your mobile phones have been switched to silent. May I first start these proceedings by respectfully acknowledging the Aboriginal peoples, the traditional custodians of the multitude of lands that we are gathered on today and pay my respects to their elders past, present and emerging. I very much want to welcome any elders or community members who are here today to impart information or are watching us through the World Wide Web. And I would like to extend that welcome to anyone who is watching us today. These are extraordinary times, but I think extraordinary times, as we know, sometimes result in some extraordinary changes, and homelessness is one that may benefit from these times. I think that is the great desire of this committee—to find some of those opportunities today. I would like to introduce our committee members. We have Kaushaliya Vaghela; our Deputy Chair, Tien Kieu; Tanya Maxwell; and Wendy Lovell. Today I am very delighted to be joined to assist us in our deliberations by Dr Sarah Pollock, the Executive Director of Research and Advocacy at Mind Australia, and Dr Kerryn Rubin, who is the Chair of the Royal Australian and New Zealand College of Psychiatrists in Victoria.

I just have some formal words to say to the witnesses before we get going. All evidence taken at this hearing is protected by parliamentary privilege, and that is provided under our *Constitution Act* but also under the provisions of the Legislative Council standing orders. Therefore any information you provide during the hearing is protected by law. However, any comment repeated outside this hearing may not have the same protection and any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament. As you can see, this is being recorded. You will be provided with a proof version of the transcript, and I would encourage you to have a look at that and make sure that we have not made any fundamental errors. Ultimately those transcripts will be posted on our website and will become part of the committee's final report. I welcome you to make some opening comments, and I think we might start with you, Dr Pollock, if you would like to make some opening remarks. And then we will go straight to you, Dr Rubin, before we then open it up for general discussion amongst the committee. Again, welcome and thank you.

Dr POLLOCK: Thank you, Chair, and thank you to the committee for the opportunity to present. Mind is one of Australia's leading community-managed mental health organisations, with services in Victoria, South Australia, Queensland and Western Australia, and last year we provided assistance to around 9700 people. We have particular expertise in subacute rehabilitation, all the way through to long-term support and housing solutions, particularly within the NDIS. We work largely with people who face complex challenges because of quite significant issues with their mental health.

In my opening remarks I am going to draw largely on a program of research that we have been conducting with AHURI, the Australian Housing and Urban Research Institute, over the last couple of years, which has really looked at the intersections between mental health and housing. The research is called Trajectories, so you will hear me refer to the Trajectories program, but I will also talk about the trajectories that we have developed based on the research findings. So in our submission to the committee we made reference to this research and we said that in the research we were able to construct really five trajectories. These are non-linear lived pathways that reflect people's experiences of their intersecting problems with their housing and with their mental health and their attempts to get assistance from the housing and homelessness systems and the mental health system. So of these five trajectories, three were negative and two were positive. I think one of the things that is very useful about the research is that we were able to identify the circuit-breakers that sit between the three negative and two positive trajectories, and these circuit-breakers are largely service system interventions that distinguish between these negative experiences and more positive experiences. These included access to secure, affordable and meaningful housing; support to maintain a tenancy; and connection to a trusted worker—it does not matter where the worker came from but it is someone who can help you when things start to go wrong, someone who can help you actually navigate the system and find the help you need.

To some extent that addresses what we found, which was quite poor service system literacy in the people we were talking to—help to manage mental health beyond the provision of medication and short-term or limited-term therapies and help to deal with trauma. I will say that again—help to deal with trauma. And for a third time—help to deal with trauma. I was staggered by the extent of trauma and the very limited opportunities that people had to really get decent trauma counselling—not just trauma-informed practice but actually assistance to resolve their trauma issues. And then there is early intervention when things go wrong. But the other thing, by looking at the two positive trajectories, we can also see the elements that need to be supported by policy to enable people to get well and to stay well. First and foremost: housing—people actually need secure, affordable and meaningful housing. Without housing, there is very, very little chance that people will actually be able to achieve and maintain wellbeing and go on to have a contributing and meaningful life. The other thing is that providing support to people who are not appropriately and securely housed—the support has limited efficacy, and I think that that then provides a diminishing return on the public investment in those supports. Equally, without support—so you house people but do not give them enough support—people cannot maintain their housing, so we go back to the same position.

One of the things we did with the research was we actually really tried to look at and think about: can we group or can we identify cohorts of people or cohorts of need? I think in our submission we made reference to four groupings of need. There are the people who actually are housed and appropriately housed, but they need extra help during periods when they are not very well or when they are very distressed or when things are not going well in their lives, and that applies to both people in social housing and private rental or home ownership. Without that support their situation will break down very quickly.

Then there is a group of people who actually need a medium-term, intensive housing-plus-support intervention. Often they are people who have been unwell or significantly unwell or unwell on and off for a long period of time, and the wheels have finally come off and they actually need quite a lot of intensive wraparound assistance to get the wheels back on and get back on track. And if that is provided, they actually then can go on to have a meaningful contribution in life. Medium term for us is between two and five years. If people still need assistance after five years, then they need long-term housing plus support and they are really the NDIS cohort.

The final group are the persistently homeless. I want to just talk a little bit about the persistently homeless group. In a way the persistently homeless group are people from the other three groups who have not had the support that they have needed when they have needed it or for long enough. In our view, on the basis of our research and also our system intelligence, people who are persistently homeless are homeless because our systems have failed them over and over and over again, often right back to when they were children. They are also homeless because there is not enough affordable housing. I think this is a result in Victoria of prolonged underinvestment in social housing. This is a cohort of people who need social housing. Private rental—not at first; maybe down the track, maybe in five years, maybe in 10 years, but at first private rental is not going to work for them. The Trajectories research indicated quite clearly that there are protective features of public housing and home ownership, which is not the home ownership group. This is a group that does need social housing, and our underinvestment has contributed to this persistently homeless problem.

I think when we look at the current Homeless to Home initiative that is underway in Victoria, there are some interesting things that come out of that. It says clearly that with the will and the investment, this is a cohort who can be housed, but they need substantial support once they are housed in order to remain on that positive trajectory to recovery and wellbeing. What we see is that if the supports are not sufficient enough or for a long enough duration, things go bad pretty quickly and their housing breaks down.

The agencies that we work with who are doing the assessments on the people who have been moved off the street into the hotels have said that people have very diverse needs, higher levels of need and more diverse or more complex than even they had realised. They often have terrible physical health, terrible dental health, significant issues with alcohol and other drugs, significant trauma that impacts on their ability to engage and relate to other people, social dislocation, histories of institutional engagement and limited capabilities. The kinds of capabilities that the rest of us develop for a contributing adult life, often that capability development has been interrupted by out-of-home care, by being kicked out of school, by being imprisoned, by being homeless et cetera, so they end up as adults with quite limited capabilities and damaged capacity to gain skills and really need a lot of support to do that.

Services often find it very difficult to engage with this group of people because of the massive amounts of trauma and because the people themselves have very low trust in institutions and service systems. This means it takes a really quite highly skilled workforce and a much longer time to do even the preservice, to just engage with them and build trusting relationships that then allow those people to come in to services and to start to receive assistance. It is a group that needs help with system navigation and care coordination. They cannot do that on their own.

What I would say in closing is our current service system configurations really struggle to provide the kind of integrated holistic and ongoing support that these people need, and one of the things that really concerns me is that we are moving into environments that are increasingly individualising funding. This reflects an individualised way of understanding deprivation—that somehow the problem rests in the individual rather than actually seeing it as at least in large part a function of social arrangements and policy arrangements that have failed these individuals and their families and their communities over and over again. That is all I would like to say at this point. Thank you.

The CHAIR: Thanks very much, and lots of questions will follow, I am sure, Sarah. Dr Rubin, if you would like to provide us with some opening remarks, that would be great.

Dr RUBIN: Thank you. I would like to start by also acknowledging the traditional owners of all the lands we are meeting on and from today and to pay my respects to their elders past and present. I am Dr Kerryn Rubin. I am Chair of the Victorian branch of the Royal Australian and New Zealand College of Psychiatrists. I am a consultant psychiatrist and I currently work in the public mental health system as head of adult psychiatry down on the peninsula.

Our college is a membership organisation that prepares and supports doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. As the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college, we have strong ties with other associations in the Asia-Pacific region. Currently we have over 1600 members, including more than 1200 qualified psychiatrists and 400 members training to be psychiatrists. I always need to start off explaining to people who we are.

I have to say, speaking after Dr Pollock, the messages are largely the same, because we are talking about the same group of people, the same problems. For the purposes of this inquiry I am going to focus our comments on the relationship between housing, homelessness and mental health, including how this intersects with the mental health system in Victoria, but I also want to touch on the intersection between this and our criminal justice system.

The relationship between housing, homelessness and mental health is a complex and multidirectional relationship. Poor mental health may lead to homelessness or insecure housing, but housing stress may be a trigger for poor mental health as well. Poor and deteriorating mental health has been shown to directly impact on housing stability. The *Trajectories* report that Dr Pollock was talking about indicated that people with a diagnosed mental health condition have a 39 per cent increased likelihood of experiencing a forced move within one year, with financial hardship in the past 12 to 24 months increasing the likelihood a person will experience deteriorating mental health. So it is this interrelated, complex situation.

What we find in the clinical systems is when people who have been unwell and in a mental health inpatient unit do not have a safe, secure and stable home to return to, there is little opportunity for personal recovery. They are very likely to be readmitted to mental health services or to face significant ongoing challenges to their recovery in the community. There is also a clearly established relationship between homelessness and relapse into substance use, which can further perpetuate poor mental health and poor engagement with treatment and can precipitate relapse or further deterioration.

Those of us working in the public mental health system are all too familiar with people being discharged from public mental health inpatient units into homelessness or inadequate or unstable housing. The decline in available and appropriate housing stock and services has a traumatising effect both on the consumers we see and on those who work in the system. When you have spent weeks working with someone and providing them with the treatment and care needed to support them in recovering from a severe episode of mental illness, it can be awful and sometimes quite soul destroying for them and for you to discharge them into homelessness,

knowing that this will start up a new cycle of problems for them—but the hospital bed is needed for someone else more unwell, often already waiting in the emergency department, and the cycle continues.

There is an intersection between the housing and mental health systems, with barriers to access contributing to negative outcomes for individuals, and the barriers exist across the systems. Often people enter the formal housing and mental health systems at a point when their need is greatest. People who have developed a severe and enduring mental illness with an associated deterioration in their daily living skills require really specific community-supported accommodation that meets their needs if they are to live and lead good-quality lives. Alongside the generally inadequate stock of social housing, there is a clearly quantifiable deficit in the availability of specific community-supported accommodations for people with severe and enduring mental illness that leads to unfair burdens on their families, their carers and them and an inappropriate use of acute psychiatric inpatient facilities.

We know that there are significant variations in service provision across Victoria both for mental health and housing, and there is high demand across both systems. Many individuals may face long waits to access the necessary mental health treatment they need and access to housing. The poor-functioning mental health system we currently have in Victoria has a negative flow-on effect to other services such as housing. People with no fixed address face barriers to accessing our mental health system. They are often shuttled between services with limited continuity of care and frequently fall between cracks or are lost to follow-up.

People who require inpatient admission face significant challenges post discharge where no housing is available. These challenges traverse all aspects of the biopsychosocial spectrum. The period following discharge is fraught with risk of suicide and relapse into harmful substance use, and this is significantly compounded by inadequate housing. It is essential people are discharged into an environment that is conducive to recovery. I know I keep saying this, but this means a safe, secure and stable home. I would reiterate the same message that Dr Pollock gave of trauma, trauma and trauma: traumatised people who do not have anywhere safe to go to are often retraumatised in the environments that they then go back into after hospital.

We need to thoroughly investigate the options and funding models for long-term and medium-term rehabilitation options for people with mental illness who require a supported living environment. Deinstitutionalisation was a much-needed social development, but we have failed those with enduring severe mental illness by not providing the long-term, stable and supported housing in the community that successful deinstitutionalisation required. We have also failed to provide adequate community mental health supports, and the royal commission into the mental health system is hopefully addressing that now.

I come back to the great need for long-term rehabilitation options for people with severe, enduring mental illness in order to enable them to live fulfilling lives in the community. For those who need help to live more independently, there are very limited options for long-term accommodation and fragmented supports currently available.

I want to touch particularly on the criminal justice system. Sadly we see growing numbers of people with severe mental illness landing in the prison system due to ineffective communication and coordination and a lack of appropriate housing and release. They are even more prone to falling through gaps that lead to ongoing homelessness, poor mental health, substance abuse and cycling in and out of contact with the criminal justice system. There is an abundance of evidence from overseas that has shown investment in housing and social support for this particular group of people addresses all of those issues and reduces further issues with offending. Benefits are society wide.

So I would like to come to my closing points. There is a need for a dedicated mental health, housing and homelessness strategy. The Victorian government currently has several strategies and policies relating to housing and homelessness as well as mental health, but we need improved policy integration between these areas. We need a system change that will have the potential to contribute to better housing and health outcomes for people who have experienced mental ill health.

The current COVID-19 pandemic has highlighted the stark realities of homelessness in Victoria and the great need for more affordable, appropriate and available housing. We welcome the Victorian government's actions in providing accommodation for those sleeping rough in the pandemic as well as the recently announced extension of this via the From Homelessness to a Home package. We hope that the proposed support packages,

including mental health, drug and alcohol, and family violence support will enable people to sustain a tenancy once they are able to move into long-term housing. But now more than ever it is essential for people to have a safe, secure and stable place to call home. This pandemic threatens not only our physical but our mental health, and we need to make sure that all Victorians have the support they need to maintain their wellbeing now and in the future, particularly our most vulnerable Victorians. We know that treatment for mental illness and substance abuse is far less likely to be successful if you do not have anywhere stable and safe to live. I do not see the complex intersection between poor mental health and homelessness as just a social issue or a health issue; rather, it is a fundamental challenge to us as a society. Who do we want to be? How do we want to support some of the most vulnerable and disadvantaged people in our society? Because personally I believe that right now we are all failing them. Thank you.

The CHAIR: Thank you both. That was, yes, a very good and strong call to action. We have got about half an hour for questions, so I will kick off. My first question is to you, Dr Rubin. Certainly it almost seems like the supported accommodation we are providing for people with mental health or acquired brain injuries is actually prisons. That seems to be where we are housing so many of our citizens who are experiencing mental health issues. But the discharge into homelessness—so the discharge from hospital into homelessness, and obviously we also see this discharge from prisons into homelessness—how does that happen? Are there no checks and balances that say you cannot actually discharge a person out of a hospital onto the street? Or should we actually make that a provision to make that not possible?

Dr RUBIN: It is one of the things I find hardest, and it is one of the things I sometimes do on a daily basis. The reality is if we were not discharging people who had nowhere to go, we would very quickly not have any movement through the mental health system. The issue is that, for a lot of people, after a week or two in hospital they do not require hospital anymore, and in that sense hospital in and of itself can become a place of incarceration—when you are being kept somewhere you do not need to be. The options are so limited.

On a personal level, much of the time it is about the time of day that we take somebody to SalvoCare and say, 'Look, we have no access to housing'. We have social work teams who have no access to housing. We do everything we can while people are in hospital to say, 'Look, where can you go so that you have got somewhere to go?'. People we are involved with long term, we try and put a lot of support into maintaining them in housing that they have got. But, quite frankly, we are maintaining people in housing much of the time that directly contributes to their poor mental health. We are talking about traumatised people who are in environments that are scary, where frequently they relapse into substance use because the person living next door is also the local dealer, who also has nowhere else to live if they are kicked out of there. So it is a complex issue, and fundamentally I would agree with Dr Pollock. There has been a vast underinvestment in having appropriate and safe housing which goes back to the late 80s, the early 90s, and has continued through. But with these broken-apart systems, from a hospital perspective the hospital would stop functioning within weeks if we did not discharge people when they were well enough to go.

The CHAIR: And we certainly heard that. We heard the cottage approach that St Vincent's has, which is a step down, but it is incredibly limited. Dr Pollock, it sounds like we are providing some of those wraparound services and some of those services to people right now because of COVID. So we have got people who have experienced homelessness who are being housed—maybe not finding a home but are being housed—and that has enabled us to provide some services to them. You mentioned the sort of long-term rehabilitation options and the need for them. What does that look like? Does that look like social housing but the individual has someone coming to see them all the time? Or does it mean more of a supported accommodation so there is, I guess, a kind of a central place where there are essential services and most of the people being accommodated there have got similar rehabilitation needs?

Dr POLLOCK: Or both, or a combination thereof. If I think about the models we have currently got, we have got in Victoria the PARCs, the prevention and recovery centres, that in the main provide step-up when people's mental health issues are escalating or step-down when they have been in hospital but they are not well enough to go home—they are not ill enough to stay in hospital but are not well enough to go home, so they step down into a PARC. The PARCs actually are a clinical function or a mental health conceptualisation, and they are really there to help people stabilise their mental health—so it is not really a housing and support solution. But obviously for somebody with precarious housing it prolongs, albeit by months, the period of time that they are in reasonable accommodation. We have also then got community care units of various forms, including a specific step-down from the Forensicare, the forensic facility—just down the road from me, actually—down in

Yarra Bend. Those last for up to two years. And again, the focus is on stabilising people's clinical mental health and assisting them build the skills that they will need once they go into more independent arrangements.

In Victoria too we have the EIPSR, the early intervention psychosocial recovery support—I cannot remember what it stands for. It is a community-based version of the same thing, so a packaging of clinical and psychosocial support around the person, where they live. I think the issue with those programs is, one, the question of duration. Some people do actually need that combination of intense housing-plus support for more than two years. The other is that with the current models when the period of time finishes—be it a month or six months, like in an extended PARC, or the two years in a CCU—we still hit the same problem that my colleague Dr Rubin has outlined, with: where do you go then?

So I think what we are lacking in Victoria is that medium-term solution that places people in social housing and then brings support to them in their social housing that can flex up and flex down as they need it and hopefully over a period of time actually diminish—but as their support needs diminish there is no pressure on them to then move house. Because often, if I think about the trajectory of interviews, people did really well for periods of time when they were in various forms of transitional housing with support or where they were in these mental health models that provide extended residential support, but things rapidly fall apart when the housing ends.

I think it is important to start thinking about models where the housing is consistent—the housing is secure, appropriate and meaningful. It has got to be housing that matters to the individual. It is not just dumping them, as Dr Rubin said, in the middle of some kind of terrible under-resourced public housing estate where many, many people have really significant problems but actually housing them and ensuring that that housing is ongoing—and then bringing the support into them. I think probably it is a relatively small minority that require residential plus support. I think if you have got really good support you can put people in social housing in the community and bring the supports to them.

The CHAIR: Just quickly, on that, I was actually talking to North Richmond health centre the other day, and they have been going into some of the hotels that are housing some of our homeless and providing particularly drug and alcohol services and some medical services. They were saying there was a really tremendous response to that. I understand that there has been some really dedicated mental health work being done as well during this time. I am wondering, Dr Rubin or Dr Pollock, if either of you have got any anecdotal or any information that you can tell us about what has been happening during this time when people have been housed in these hotels.

Dr POLLOCK: We understand that there is a mental health component to the homelessness to homes funding, but the details of that have not been released yet, so my guess is that the mental health work—other than clinical, which I will leave to Dr Rubin to address—that the psychosocial, social support, mental health work will be being undertaken by homelessness and housing agencies that feel that they have got those skills. So there is a specific component that has not come online yet.

The CHAIR: I am sorry, Doctor; my time has run out. I will move over to Deputy Chair Tien Kieu.

Dr KIEU: Thank you very much, Drs Pollock and Rubin, for being here today and also for presenting some very important issues around mental health, which is one of the main drivers of homelessness. We, the Victorian government, take it very seriously. We have the royal commission—as you know, it is ongoing—on mental health, and also recently there have been some announcements on mental health problems, particularly to deal with the present pandemic that is ongoing at the moment. Both of you mentioned that there may be more integration of policies and strategies, and that would be between the components of homelessness and mental health at the state level. I would like to find out and understand a little bit more about the NDIS and the state government. In your opinion, is there any coordination or is there any further coordination that should be in place, and how can we make that happen? Particularly with this as a very big problem, and it is ongoing and recurring, people have been homeless and it is not something easy to be resolved in such a short time, if at all. So what is your opinion about the system of NDIS and the state government? Do you see any further integration or any further input there that we need?

Dr RUBIN: I might go first if that is okay. I think the difficulty with particularly the population of Victorians I am talking about, some of the most unwell people with homelessness issues, is there are significant

trust issues due to trauma, due to mental illness, that Dr Pollock was talking about. And one of the huge difficulties we see with the NDIS is if people are not willing to engage with the NDIS, they are not able to access supports. And so in fact some of the most unwell, most vulnerable, most needy people will make it very clear that they want nothing to do with the NDIS, because they see it as another government agency that is going interfere in their lives.

It is very hard to help them, and sometimes this can mean it can take a year or two of working on this, helping them to see what the benefits for them will be, particularly because the NDIS asks them to identify that they have a disability. And for a lot of the people I see who do not agree that they have a disability, regardless of other people's perspectives, that is a deal-breaker. And so my concern is that we have seen more people fall through the cracks with the NDIS being the funding model for a lot of the supports this group of people would receive, even though I have also seen some people where the NDIS has completely changed their lives.

One of the difficulties for me—and this is not quite anecdotal, because this is supported by a survey we have done of our membership—is that in some ways the NDIS works better for people who are moderately unwell and can recognise that they are unwell and what supports they need. But for the people who are severely unwell, unless they have somebody they trust, who they give permission to work with the NDIS on their behalf, the capacity to access supports through the NDIS does not work well. There is a lack of coordination, often, of the supports. Even though the NDIS includes funding for a care coordinator and a support coordinator, it all depends on the level of experience and qualifications of that support coordinator.

And quite frankly some of the most complex people I think are too overwhelming and require some kind of higher level of support coordination. I think that point is where, from my perspective, state government, the local area mental health services or some of the larger organisations, like Mind, who do have an incredible depth of skill and capacity for managing complex situations in coordinated way, come in. One of the issues with the NDIS is that it can be far too piecemeal.

Dr KIEU: Thank you. You touched upon a very important thing there, which is about the recognition and also the admission of mental health. That is particularly a big issue in the general population as well as in communities like the Asian community where I come from. People do not want to admit that they have a problem with their mental health. It is something taboo that should be denied or should be ignored.

So how can we build the trust in order to deal with the trauma? That is a very important issue because if we do not have the trust from the people, they will not come in to the service for the support and they will not have their trauma relieved and be helped. So in terms of funding, in terms of policy, how can we do that? It seems to be a very big problem and needs to be dealt with somehow, so what is your opinion on that?

Dr POLLOCK: I might just answer quickly, because I want to just support everything that my colleague has said about the NDIS. I 100 per cent support what you are saying, and I think in talking to my colleagues in the homelessness agencies who are working in the Homeless to Home program, I actually asked my colleague at Launch Housing of the people that they are doing full assessments on what percentage he thought might be NDIS eligible. And he said probably between 15 and 20 per cent. Now, I think that that is very low. And I think that what that reflects—and this goes to your point, Dr Kieu—is the understanding of disability on the NDIA side. And I did the Aboriginal interviews in the Trajectories project, and the way that Aboriginal people speak about mental distress is not the same as how white people talk about it. In very crude terms, I think the NDIA understanding of disability is a very white understanding. If I think about this persistently homeless population, their functional impairment is really significant; and actually if you look at the Act, just on the basis of their functional impairment they should be in the NDIS. But because, I think, the scheme has this very narrow notion of what disability is, it fails to understand their debility. There are cohorts that experience significant debility, and I think that should be addressed by the NDIS because they have poor functional impairment. But unfortunately, because we have got this very limited notion of disability that actually rests in quite diagnostic framings, not in a functional framing, they do not get a look-in.

As to the question of engagement, especially with multicultural and multifaith communities, I think it is about working with those communities before you even try to work with people from those communities who might need extra assistance, and I just do not think we do that particularly well.

Dr KIEU: Thank you.

The CHAIR: Thank you. Tania Maxwell.

Ms MAXWELL: Thank you, Chair. Thank you, Dr Rubin and Dr Pollock, for your very informative and thorough coverage of the impacts of mental health and homelessness. I am wondering whether, Chair, it would be permissible for us to include the *Trajectories* report in our homelessness committee as a submission. I have been flicking through it while we have been talking, and it is certainly a very thorough and well researched report that I think would provide phenomenal information to go towards this.

We know that the complexities of homelessness and mental health are significant, and I am really interested to get some feedback. Whilst we have a cohort that we need to address and deal with now, I am extremely passionate about early intervention so that we are working with these families when children are at a very young age to address that trauma, put in preventative strategies, work from a collective impact approach so that we are modelling strength-based support—having that case manager working with that person and assisting them and being able to identify their needs long before they become homeless and having that person walk them through and support them until they are actually able to stand alone and do that themselves; and have someone, as you said, to support them once they are in a home. So, one, I am really interested to hear about your thoughts on early intervention but also to hear about your thoughts on: in a lot of rural areas, there is such an enormous—and I am talking years—waitlist, not only for people for housing but for people to receive mental health support. So I would love for you to cover those two areas.

Dr RUBIN: One of the tricky things about Zoom is knowing who goes first. I think, for me, this is a much broader question than just the relationship to homelessness, but as we are talking about, all of these things are interwoven. The whole concept of early intervention for me is a tricky one because we understand far better these days than we ever have before the relationship between traumas and the development of mental illness, poor mental health. In a sense, there is not a diagnosis you can pick that does not have a significant relationship to trauma because early adverse life experiences actually shape brain development. They change the way your brain functions and make you much more vulnerable to developing various conditions later in life. So, for me, early intervention actually starts before people are born. It is about recognising at-risk families and starting work with them early. We know that the same people who are in at-risk families are going to be at risk of homelessness. This is where I come back to agreeing completely with Dr Pollock. It is about providing these things in an integrated sense but also in a connected and ongoing sense, where they can step up and step down as needed in the home environment.

One way to argue it is if you were supporting somebody with mental illness who was living for a number of years in a house and the level of supports may have dropped, but they were then about to become a parent, you may look at some specific—there are some very good, evidence-based interventions. There are some wonderful programs. I always go blank in these settings, but I am happy to take this question on notice and provide you with some of the details that are being rolled out across Victoria right now which are effective. From my perspective that early intervention actually needs to start with parents before they are parents, because if we can avoid a lot of the early childhood trauma, we change people's trajectories.

This was demonstrated very effectively by John Bowlby, a famous English psychiatrist back in the Second World War, who looked at what happened with the children who were evacuated during the London blitz and how early traumatic experiences change the life trajectory so many years on. For some people, we can help, once that trauma is over, to correct their trajectories, but other people stay on a poor trajectory from that point onwards. So the more we can do in a broad, social, preventative sense is for me the true early intervention. If we start intervening with people once we already recognise that they are becoming unwell, it is probably—never too late but—far later than we should be intervening.

The CHAIR: Sarah, if you just wanted to comment very briefly, because we will need to move on.

Dr POLLOCK: The only comment I have got really is to agree with my colleague. I think we can probably provide some of the evidence of effective early interventions too. We did a lit review for the NDIA actually a number of years ago, and we will make sure that you have access to that too.

The CHAIR: Thank you. And also just going from Tania Maxwell's suggestion around the *Trajectories* report—if you could send that to us as well, we can treat it as a submission.

Dr POLLOCK: We certainly will. There is a final report that we are still in the process of preparing, which is on the Aboriginal Indigenous component, so we will make sure you get that when it is ready too.

The CHAIR: Very much appreciated. Thank you. Wendy Lovell.

Ms LOVELL: Thanks very much. We hear a lot about the problems and the problems and the problems, and we hear that all the time. What we are not hearing are the actual solutions. I am just wondering if you can tell us about some of the best models around the world that actually do provide a wraparound service with housing that has actually been proven to get results that we might be able to put forward as a suggestion to government from our committee.

Dr POLLOCK: I think in Melbourne, from a policy point of view, it is a Housing First model. Housing First is a model that provides people with secure, affordable, ongoing housing that they can stay in, and it is not conditional on anything like being clean from drug use or engagement in criminal justice. In other words, you keep the housing regardless of what is going on with you and your state of wellbeing and how you interact with people. In Melbourne we have Common Ground, which is a Housing First model. I believe—I am happy to check the detail and provide accurate detail on notice—that that is being scaled up now across five of the metro LGAs. That model has been rigorously evaluated. It started in New York. It has been evaluated in New York and Canada. And certainly for the people who are persistently homeless with mental health issues it works.

Ms LOVELL: Okay. So Common Ground is one. Are there any others? What do you think of the Haven model?

Dr POLLOCK: The Haven model that Mind runs? Yes, so the Haven model also works for people who need long-term housing plus support. And I think we can distinguish between the people for whom Common Ground and Haven—there are some differences in the cohort. Certainly the people in Haven have mental health issues, and because of the support they receive and actually the quality of housing they have 24/7 support. They are often people whose mental health will deteriorate very, very quickly, so I mean within a handful of hours they will go from being okay to actually needing to go to hospital. Having 24/7 support onsite in these units that people live in has actually been very successful in diverting the people away from ED and from acute care. We are in the process of evaluating the Haven model, and that evaluation is a four-year program of work that we are doing with La Trobe. We can certainly provide more detail about that, but yes, it also works.

Ms LOVELL: So I guess the next step is you go from something like Haven, where you have got 24/7 support, or Common Ground, where you have got 24/7 support. To get them into mainstream housing is the next step. I mean, public housing is a landlord; it is not a provider of services. And I think Dr Rubin said earlier, before, that one of the problems with the NDIS was the willingness of people to engage with services.

I have to say, Dr Pollock, that I was offended by your characterisation of public housing communities before as dreadful places to put people with mental health, because the vast majority of public housing residents are just good people who need some help, who are down on their luck and need assistance. As a former housing minister one of the real challenges that housing faces is people with mental health coming into communities who then go off their medication or refuse to engage with their service providers and then terrorise neighbourhoods. So there needs to be some wraparound services of them even when they are in community and public housing, but public housing is not the service provider.

So the answer to that is something that we also need to look at, and you are in those fields. I would be interested to know of models that you have seen around the world—not models that are working in Victoria but stuff that is working elsewhere, best practice that Victoria can look to.

Dr RUBIN: I might jump in here, and also I think maybe at least thinking about my comment about poor environments. I am not even particularly thinking about public housing, because actually for a lot of the people I see they have been sitting for six, eight, 10 years sometimes on priority lists. It is actually what is available for people before they even get into public housing, and there are some places where I sometimes go in the capacity of my work where I do not go without the police simply because they are deemed too unsafe to enter.

Ms LOVELL: So rooming houses and stuff, I agree with you, yes.

Dr RUBIN: Rooming houses, various other places like that. I take on board, certainly, I think some particular areas in public housing in Melbourne sometimes take on those characteristics. Other areas are quite different, but I think I would probably differentiate them. We are talking maybe about a difference between public housing as we have seen it and more social housing, more supportive communities for people that are both in the community but are safe and secure and where there is access to a graded level of services. So I am just putting in my vote of confidence and thanks to the Haven model. I have seen some incredibly dedicated people in that model look after people who but for living at Haven would probably be in hospital because of their levels of difficulty. And we certainly need more services for people with severe mental illness who really need that kind of 24-hour-a-day support.

Ms LOVELL: So therefore do you think we have actually deinstitutionalised too far?

Dr RUBIN: You see, I would differentiate that from an institution—where they are placed within the community, where people regularly come and go and access the community as opposed to being shut off from the community, but the home that they live in provides the necessary levels of support that they need. And when people move into public housing where they may be linked with a public mental health service who has the capacity to see them once a fortnight, that is not the support that a vast number of people who are unwell in our community need. So I think this is the difficulty. We need an integrated system that sees the housing difficulties and the mental health difficulties as the same problem. What you are highlighting is the difficulties with these split systems where we put somebody in a house without the right kind of support, or you give people support but they do not have housing. It does not work in either direction.

The CHAIR: I am really sorry, we are running close to the clock. I would just like to welcome Kaushaliya Vaghela for the final questions.

Ms VAGHELA: Thanks, Chair. Thanks, Dr Rubin, and thanks, Dr Pollock, for your presentation and also your submission. Because of the time constraint I will not ask long, multiple questions, I will just ask a short question: what should be the three strategic priorities of the government in addressing the homelessness issue?

Dr POLLOCK: I think the provision of more social housing has to be the number one priority. I think then ensuring that we have got these medium-term models that integrate housing and support would be the second. And now I will actually hand over to Dr Rubin while I think about the third.

Ms VAGHELA: All right. Okay.

Dr RUBIN: Look, Kaushaliya, I can talk specifically around mental health, and for me, particularly for this group of persons but actually for everyone in Victoria, I think what we need is proper integration between the mental health system, between the drug and alcohol support systems, between the housing systems. It is this piecemeal approach where, even if you are receiving all three services, they are not coordinated. They are not working together. There are a lot of people on individual levels who try and put together things for people, but I think we need to acknowledge that for people who have complex issues they need an integrated solution which addresses their housing, their substance use and their mental health needs, and it needs to be tiered depending on the level of dysfunction and disability.

Ms VAGHELA: I do not know if Dr Pollock has the third one, but I think we are running over time.

Dr POLLOCK: I think I would support Dr Rubin's suggestion of system integration, and what I would add to that is that in its implementation people need individual care coordination. We have got this two-level problem: we have got fragmented systems, and then we have got people who need to draw assistance from multiple systems who cannot do that without quite specific professional expertise that relies on quite considerable skill—not only knowledge of service systems but skills to engage with that individual and work with them to work out what is best for them.

The CHAIR: Thank you, Kaushaliya, and thank you, Dr Rubin and Dr Pollock. I think we could continue this conversation for quite some hours. You have really highlighted where some of those gaps are, but also some of the solutions in filling those gaps. You have helped us in that better understanding of that absolute intersection between mental health and homelessness and also the various needs of people at various times of their lives in, as you say quite poignantly, the trajectories that people are going through.

We will provide you with a transcript after this. Our Hansard team have been listening intently. You will be sent a copy of that. Please do have a look at it, and if we have made any misrepresentations we would look forward to your advice. Ultimately it will form part of our final report, as will the really wonderful conversation that we have had today. So thank you very much. We will just break for a couple of minutes while we bring in the next witness. Thanks, everyone.

Witnesses withdrew.