Royal Commission into Victoria's Mental Health System

Formal Submission – July 2019

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Sacred Heart Mission acknowledges the people of the Kulin Nations as the Traditional Owners of the land on which we operate. We commit to providing accessible and culturally appropriate services to Aboriginal and Torres Strait Islander people.

Contents

1. Executive Summary

Sacred Heart Mission (SHM) applauds the Victorian Government on the undertaking of the Royal Commission into Victoria's Mental Health System. We urge the Commission to prioritise holistic and trauma-informed care, and to improve access to the mental health system for people experiencing homelessness, mental illness, and chronic disadvantage.

At SHM, we see the impacts of trauma, homelessness, and mental illness every day. The relationship between trauma, homelessness and mental illness cannot be underestimated; but it is multifaceted and complex. Research has shown that traumatic events often occur as a precursor to becoming homeless – people leaving home to avoid ongoing trauma in the form of assault, child abuse and other forms of interpersonal violence' but it also drives trauma exposure – being homeless is a risk for experiencing further trauma. Trauma also drives social difficulties, impacting on an individual's sense of safety and connection with other people.

Importantly, exposure to traumatic events in both childhood and adulthood are associated with mental health problems. People with histories of trauma and mental illness are often at increased risk for losing housing or never gaining adequate stable housing.

It is therefore crucial prevent homelessness; or reduce its' length and severity to ensure individuals do not suffer repeated exposure to trauma due to homelessness. It is therefore essential that people with mental illness have access to safe, affordable, and accessible housing, including social housing and supportive housing.

Sacred Heart Mission is confident that the Royal Commission into Victoria's Mental Health System will be able to recommend changes to the system that are transformative and will make significant improvements to the current mental health system for future generations of Victorians.

However, the most transformative change to the mental health system will occur if the Royal Commission recommends an overhaul of the social housing system, rapid investment in housing and a state-wide Housing First approach. This will reduce the impact of mental illness on our society and enables people's recovery. It will keep people out of cycles of homelessness that exacerbates the pressure on acute mental health system, and leaves people vulnerable and unwell.

2. Recommendations

Recommendation 1: That a significant focus is placed on ensuring access to safe, affordable long-term housing, using the Housing First principles as this is essential to the delivery of an effective mental health response to the Victorian community.

Recommendation 2: That an investment is made into services that provide an individualised, intensive, trauma-informed response, in order to ensure that people with complex needs and chronic conditions have their needs met in the community rather than in clinical or emergency settings.

Recommendation 3: That specialist mental health roles be embedded within community organisations to ensure effective engagement of people experiencing social exclusion.

Recommendation 4: That the service navigators are embedded within the mental health system, to educate and work with clients to understand how they can better engage with systems that will support them into the future.

Recommendation 5: That Victoria re-invests in flexible support models that focus on social inclusion support for people with complex needs, outside of an individualised funding model like the National Disability Insurance Scheme (NDIS).

Recommendation 6: That evidence-based programs are expanded and scaled, such as our Journey to Social Inclusion (J2SI) that break the cycle of chronic homelessness and mental illness.

Recommendation 7: That further investment is made into the establishment of supported residential care facilities that provide care placements for people with complex mental illness, who require ongoing support.

Recommendation 8: That specialist mental health roles are embedded in aged care services both residential and community-based, who work with older people with mental health issues and histories of homelessness.

Recommendation 9: That Commonwealth Government is encouraged to increase the capacity of mainstream aged care services to support people with complex mental illness, to ensure older people have choice when it comes to deciding where they should live.

Recommendation 10: That changes to the mental health standards and further relevant legislation is made to ensure all mental health services have cultural safety embedded within their practices.

Recommendation 11: That an investigation into how the NDIS and Home Care Packages for aged people can be better coordinated to effectively support people with lifelong mental illness, while still operating in a recovery framework.

Recommendation 12: That a state-wide funding be allocated to enable people experiencing extreme disadvantage to participate in social inclusion activities for little or no cost.

Recommendation 13: That public awareness campaigns are funded to destigmatise mental illnesses, to prevent discrimination, to promote equitable access to stable housing and employment and improve social inclusion.

Recommendation 14: That trauma-informed care training, be mandatory for all organisations in Victoria that provide mental health services and support – for both client-facing and administrative staff.

Recommendation 15: That training in recognising the risks of suicide, and assertive intervention be mandatory for client-facing staff in organisations working within and interacting with the mental health system.

Recommendation 16: That investment is made into post-release support and planning and access to housing for people exiting prisons, to improve mental health and wellbeing, reduce recidivism and prevent homelessness for people exiting prisons.

Recommendation 17: That the requirements to be housed in order to access mental health and drug and alcohol services in Victoria, is removed from services access protocols.

Recommendation 18: That the requirement to be engaged in mental health or alcohol and other drug treatment services, in order to be eligible for some housing and/or supported crisis accommodation options, is removed from housing allocation protocols.

Recommendation 19: That Government investments in the development of mechanisms to share client information across a variety of service sectors, in order to provide effective, timely and holistic responses whilst maintaining privacy.

3. About Sacred Heart Mission

Sacred Heart Mission (SHM) has been delivering services and programs for people experiencing long-term disadvantage for over 35 years. SHM is committed to programs that build people's strengths, capabilities and confidence to participate in community life. This is strongly reflected in SHM's new service model which emphasises the development of innovative programs that facilitate social and economic participation so that individuals can develop independence and ultimately achieve their potential.

Every day about 400 people attend SHM's two engagement hubs and a significant majority of those people experience long-term homelessness and are living with acute mental health issues. As a result, SHM has developed a structured and effective assertive engagement approach to build relationships with people who are excluded from mainstream and specialist services and isolated from the broader community. A persistent, patient and proactive approach is the cornerstone of SHM's practice expertise. More recently, SHM further developed this approach to incorporate a therapeutic practice framework that focuses on acknowledging underlying trauma and an emphasis on building social connections away from the homeless subculture.

Today we are one of Victoria's leading agencies working with people who are experiencing deep, persistent disadvantage and social exclusion, particularly those who are long term homeless. SHM provides a broad range of services which fall into three main areas of service delivery:

Engagement Hubs include Sacred Heart Central and the Women's House which provide a safe space that is welcoming and supportive. The engagement hubs provide access to the necessities of life, health food, a shower, laundry facilities and medical assistance through our GP clinic. The hubs also facilitate access to our case management services and referral to specialist services.

Individualised Planned Support incorporates outcomes focused; time-limited service responses tailored to the individual. In many cases this will involve resolving a crisis situation, such as addressing immediate homelessness and improving safety and will being. Case Management services are provided at Sacred Heart Central, Women's House, Homefront and thorough the Wellbeing and Activities Program. Intensive Case Management is provided through the Women's House, GreenLight and the Journey to Social Inclusion (J2SI) program.

Ongoing Support provides specialist service responses for vulnerable members of the community, many of whom require a high level of support for an indefinite period. Our Sacred Heart Local provides support to older people and people with disabilities to live independently in the community. Our Rooming House Plus Program and Bethlehem Community are supported therapeutic residential services for people with complex needs including mental and physical health issues. Sacred Heart Community provides a home for life, in which older people can live in safety and rebuild social connections.

SHM delivers a series of programs that provide support to people experiencing homelessness, mental illness, and psychosocial disability:

- Journey to Social Inclusion (J2SI)
- GreenLight Supportive Housing Program (in partnership with VincentCare and the Salvation Army)
- Rooming House Plus Program (RHPP), in partnership with Community Housing Limited
- Early Intervention Psycho-Social Response (EIPSR), in partnership with Alfred Health
- Bethlehem Community
- Sacred Heart Local
- Sacred Heart Community
- Sacred Heart Central, and
- Our Women's Services.

For more details of these programs, please see our website – www.sacredheartmission.org.

3.1 Impact of trauma on mental health

At SHM, we work with people whose capacity to participate fully in community life is affected by trauma, deep, persistent disadvantage, and social exclusion. Trauma can be both a cause and consequence of homelessness. A study conducted by the Australian Centre for Posttraumatic Mental Health in 2012 highlighted that between 91% - 100% of people experiencing homelessness had experienced at least one major trauma in their lives; compared to 57% of the general population (O'Donnell, Varker & Phelps 2012). People experiencing homelessness also had higher rates of exposure to trauma in childhood, in comparison to the general population. For example, almost all evaluation participants in SHM's J2SI pilot program (87%) had experienced childhood trauma in one form or another, and the average age which they first experienced a traumatic event was just under 13 years of age (Johnson et. al 2011).

Trauma can have long-lasting effects on all aspects of someone's life, including how someone thinks, feels, and behaves. Trauma increases the chance of anxiety, depression, substance misuse, employment problems and suicide. The symptoms of trauma may include poor impulse control, anxiety, anger, depression, or substance use. A trauma survivor may need the ongoing support of mental health professionals and medication.

Trauma, homelessness. and mental illness are intrinsically linked - the majority of people who experience homelessness also experience at least one psychiatric disorder, and the prevalence of these disorders is much higher than in the broader community (O'Donnell, Varker & Phelps 2012). There is also evidence that some people become mentally ill as a result of experiencing chronic homelessness. Repeated exposure to trauma while homeless and its long-term impacts cannot be understated. Furthermore, people with histories of trauma and mental illness are often at increased risk for losing housing or never gaining adequate stable housing. This is the vicious cycle of trauma, homelessness, and mental illness that Sacred Heart Mission sees every day. The cycle can be broken with time, community and professional support, and stable housing.

At SHM, we support people to recover from trauma and support their recovery journey – no matter where they are in the process. SHM has a long history of supporting people with complex needs, including mental ill-health, mental illness, and psychosocial disability, as well as chronic homelessness and disadvantage.

4. Access to mental health services

SHM sees the impact of Victoria's complex and fragmented mental health system every day. We know that the demand for mental health services is continuing to increase, but under-resourcing of the system has meant that fewer Victorians are receiving appropriate mental health services.

There are several barriers for a person experiencing homelessness to access entry-level mental health support. The most common entry point is a general practitioner, who can recommend up to 10 subsidised counselling sessions via the Medicare Benefits Scheme.

Examples of these barriers include, but are not limited to:

- Suspicion of medical professionals, as a result of trauma
- Anxiety related to the requirement for a diagnosis of a mental health issue to refer an individual for counselling and the potential impact of the diagnosis on their lives (such as shame and stigma associated with specific conditions, such as schizophrenia)
- Not having a valid Medicare and/or health care card
- Being unable to access a bulk-billing GP service, as co-payments are likely to be too onerous
- Counselling sessions are subsidised; psychologist/psychiatrist services fully covered by Medicare are subject to long waiting lists
- GPs do not have enough knowledge of bulk-billing psychologist/psychiatrists to provide enough referral options that are appropriate for patients
- Group programs and therapies can be covered by Medicare, but are not widely recommended or taken up due to a lack of awareness of this option for patients
- Quantity of sessions subsidised are insufficient to support the individual's mental health.

As a result of these barriers, many individuals experience a progression and escalation of severity in their symptoms, until they present to emergency departments or in the justice system in crisis. The term 'the missing middle' has been used to describe young people with these characteristics (Orygen 2019). SHM has found that many of our clients can also be considered within this category. Many people experiencing homelessness are unable to access clinical services, such as the Homeless Outreach Psychiatric Services (HOPS), as they are not unwell enough; but they are too unwell to use or access a GP.

People experiencing homelessness are at extremely high risk of falling through the gaps. People we see at SHM languish within the mental health system until they are visually unwell, at serious risk of self-harm, or harm to others, before receiving help. From there, the road of recovery is often long, and complex given their exposure to trauma and experience of social exclusion. Victoria needs a more flexible and responsive mental health care system that can reach out more to people experiencing homelessness who are socially excluded, or the cycle of reliance on the crisis orientated system, of emergency hospital presentations and contact with the police and justice will continue.

SHM recently conducted an internal analysis of our client data across nine programs and found that on average 36% of clients who were accessing our services reported that they had a prior mental health diagnosis (SHM, 2019). What is particularly concerning, is that 49% of clients did not know if they had a prior mental health diagnosis. This indicates that

the mental health support provided by the primary care system is insufficient, unaffordable, or a combination of the two; and as a result, people do not receive support, or an accurate diagnosis prior to being in crisis. SHM found that many of our clients have received a series of misdiagnoses, which hampered their recovery.

SHM focuses on responding to clients' needs where they present to our services, primarily at our Engagement Hubs – Sacred Heart Central and Women's House. From our experience over many years with the HOPS program, we know that embedding specialist mental health roles within our services has a great impact for people experiencing, or at risk of homelessness. We have also developed mental health specific clinician and case management roles in specific programs, including EIPSR and GreenLight. The experience of these professionals is invaluable, and they provide effective and tailored supports to people experiencing complex mental illness and social isolation.

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Recommendation 3: That specialist mental health roles be embedded within community organisations to ensure effective engagement of people experiencing social isolation.

5. Navigation of mental health services

The Victorian mental health system is extremely complex and difficult to navigate. In part, this is because mental health treatment and support exists across the hospital system, community settings and the private system. Community mental health programs have historically been funded by both the State and the Commonwealth, and the interface between these is confusing and complex for people with mental illness and their families. People find themselves being referred between different organisations and programs that do not communicate with each other. In order to overcome this, SHM employs mental health clinicians and case managers within its' programs, to support clients to navigate the mental health system, and other systems they need to engage with. Many SHM clients have difficulty in navigating the services system, and do not understand how services operate and how to engage with them and are used to only receiving help when in crisis.

Many SHM clients do not regularly attend scheduled appointments and need support to understand how these systems operate. Our case managers identify areas where clients' navigation of the system is poor, and coach and support them to work within those systems and build their independence. An example of this are appointments, where workers manage the expectations of clients and by creating a precedent where they will not be prioritised over

others if they present to the service outside of their scheduled appointment time where one has been organised in advance. This supports clients to understand how appointment systems work, and therefore to navigate the broader services system.

The importance of informal supports (family, friends, and social support networks) for people experiencing mental health issues cannot be understated. Many people lack these support networks due to social isolation, and therefore rely on Sacred Heart Mission staff to provide social inclusion support. It is particularly challenging for organisations to effectively provide social inclusion supports in the context of the individualised funding models. With the mental health services system now operating within individualised funding models, such as the National Disability Insurance Scheme (NDIS), transitioning away from Commonwealth-funded programs such as Partners in Recovery (PIR) and Personal Helpers and Mentors Service (PHaMs), capacity for social inclusion support has been significantly reduced. These programs were extremely successful in building resilience, self-management and connection to community, and the loss of these is clearly felt by people with complex needs, including mental illness.

Recommendation 4: That the use of service navigators within the mental health service system are funded in order to educate and work with clients to understand how they can better engage with systems and supports.

Recommendation 5: That Victoria re-invests in flexible support models that focus on social inclusion support for people with complex needs, outside of an individualised funding model like the NDIS.

6. Best practice treatment and care models that are safe and person-centred

SHM prides itself on the use and development of evidence-based models of care across all its programs. In this section, three programs are discussed in detail.

6.1 The GreenLight Supportive Housing Program

GreenLight is a new $4.5 million supportive housing program, aimed at supporting people to access and sustain housing and keep out of the cycle of homelessness. SHM is working in partnership with VincentCare and the Salvation Army on this exciting program, funded through the Victorian State Government's 2018 Homelessness and Rough Sleeping Action Plan. Led by SHM, a multidisciplinary team of case managers, mental health clinicians and peer support settlement workers, will deliver tailored brief interventions, floating support, case management and service coordination services in 2019 and 2020, supporting people to establish a home and social connection.

A unique feature of GreenLight is the integration of the peer support model. The peer workforce is more established in the mental health and disability support sectors but is relatively new to the homelessness sector. SHM's experience with Peer Settlement Support

Workers within GreenLight will also contribute to the evaluation of the Peer Support Resettlement Program currently being undertaken by Council to Homeless Persons.

The Peer Settlement Support Workers provide supports to GreenLight clients who are socially isolated and help to bridge the power imbalance between staff and clients and upskill their colleagues in their understanding of trauma. These roles are also empowering for people who have experience as service users and may have experienced significant barriers into employment first-hand.

The Peer Settlement Support Workers have a lived experience of homelessness, and an awareness of the complexities of this experience, such as impact on mental and physical health and wellbeing, employment, and social participation. Julie*, a Peer Support Worker in the GreenLight shared her experience for this submission.

Julie, Peer Settlement Support Worker, GreenLight:

Julie's* homelessness started at a very young age. Her mother fled with her as small child to a women's refuge to escape violence perpetuated by her father. This was very distressing and scary time. In Julie's teenage years her mother lost her job and developed severe mental health issues which she managed by using alcohol and drugs. Julie's mother became unsafe to live with and meant she ended up becoming homeless.
Julie had many attempts at trying to access psychological services but often didn't fit the criteria, as she was either too complex or not complex enough. Julie found it very hard to be understood and was refused service or not referred on to appropriate services.
Eventually, after many attempts, Julie found some support through community mental health services and engaged in therapy. Julie worked very hard to improve her mental health which impacted on her everyday functioning and self-esteem. Julie lived in two different temporary housing settings while studying, and she found it very hard to find affordable and long-term accommodation and experienced a period of living in sublets.
Julie graduated with a degree in social work and is now a Peer Settlement Support Worker in the GreenLight program. She hopes to use her lived experience of homelessness and mental health to support client's settlement into long term housing.

The GreenLight team address the unique experience of homelessness and individual health and wellbeing factors that impact on people staying housed, including mental health issues. SHM is confident that the Peer Settlement Support Workers will be extremely successful in their roles and that this model can be applied to other housing and homelessness support programs into the future.

6.2 Journey to Social Inclusion (J2SI)

Journey to Social Inclusion (J2SI) program takes a relationship-based approach, provides long-term support, and works from the premise that if people can sustain their housing, this provides a solid foundation to improving other areas in people's lives. This includes improving mental health and wellbeing, resolving drug and alcohol issues, building skills, increasing connection with community, and contributing to society through economic and social inclusion activity.

There are five elements of the service model:

- Assertive case management and service coordination
- Housing access and sustaining tenancies
- Trauma-informed practice
- Building skills for inclusion
- Fostering independence

The J2SI program was piloted from 2009-2012 and supported 40 individuals from SHM in the local St Kilda area over a three-year period. The evaluation of the pilot found that 75% of participants were able to maintain stable housing for 4 years, including 12 months post-service delivery (Miscenko et al 2017). 80% of participants self-reported reduced health services utilisation (e.g., fewer emergency department or psychiatric unit admissions) (Johnson et al 2014). The case study of Donna*, a participant in the J2SI pilot, demonstrates how J2SI works intensively with the client over three years to support the person to break the cycle of homelessness and improve their mental health and wellbeing (Parkinson & Johnson 2014).

Client Case Study – Donna:

Donna* has a long history of homelessness and of involvement with the service system, since she was 13 and placed in foster care. Since then, she has been a client of a series of intensive support programs, and her finances are managed by state trustees. From 1991 – November 2009, Donna had 45 psychiatric admissions, and she has significant chronic health issues.

Donna is currently on a Community Treatment Order and is case managed by a psychiatric outreach team. She has undergone drug and alcohol treatment regimes in the past including residential withdrawal programs and individual counselling and has been on the methadone maintenance program for nine years. She continues to smoke cannabis daily, and occasionally uses amphetamines.

Donna engages in street-based sex work, and her identity is entwined in this, which makes it more difficult to stop engaging in sex work. She has very limited social networks and often describe herself as isolated and lonely. Donna's friendships are often intense and short lived, she then feels unsafe that these people know where she lives and fears that they will enter her house and contaminate her food. Despite the complexity of her needs, ongoing struggle to stay well and chaotic housing history in the past, Donna has sustained her Office of Housing property since April 2010, with the intensive support of the J2SI program. She has developed and maintains a garden and is caring for her pet cat.

Through the stability of the relationship with her support worker, Donna now has greater ability to identify patterns of behaviour and is willing to engage in dialogue about these patterns and the repercussions of her actions. There has been a marked decrease in "acting out behaviour" since commencing support, and Donna is working towards changing her behaviours. She has developed appropriate boundaries within the relationship. With intensive case management and skill building support from her case manager, Donna has gone onto complete a Certificate II level training whilst in the J2SI

program. She has also experienced a marked reduction in psychiatric hospital admissions since commencing the program.

J2SI Phase Two commenced in 2016 and is still underway. Features of the second iteration of the program included an expanded geographical catchment, expanded participant numbers (from 40 to 60 in each group) and partnerships with two other specialist homelessness services, VincentCare (Ozanam Community Care) and St Mary's House of Welcome.

As an indicative overview of the clients supported by J2SI (Phase Two), in the 2017-2018 financial year, internal data shows that:

- 60% presented with a housing crisis (i.e.: eviction), and 23% were residing in inadequate dwellings.
- 55% of participants presented to the program with mental health issues
- 58% of participants had a prior mental health diagnosis
- 16% of participants presented with problematic alcohol use
- 44% of participants presented with problematic substance use
- 8% of participants were Indigenous
- 16% had spent time in a psychiatric hospital or unit in the preceding 12 months
- 15% had spent time in a hospital in the preceding 12 months (excluding psychiatric)
- 10% had spent time in an adult correctional facility in the preceding 12 months.

In August 2018, we commenced delivery of J2SI Phase Three to 180 people (60 per year for three years) under the first Social Impact Investment (SII) with the Victorian Government.

The J2SI Social Impact Investment (SII) is an outcomes-based funding mechanism bringing together government, SHM, philanthropy and investors. It will demonstrate the efficacy of replicating J2SI on a larger scale (40 in original pilot to 180 participants in the SII) and pave the way for the replication of the model in other state and territories across Australia.

J2SI is primarily aimed at ending the cycle of chronic homelessness by taking a relationship-based, trauma-informed, and strengths-based approach in the context of long-term assertive case management. We also know that the program is successful supporting participants to address their mental health issues and reduce their involvement with crisis mental health services, as evidenced by a reduction in the use of psychiatric wards by 66% in the J2SI pilot (Parkinson & Johnson 2014).

Recommendation 6: That the investment is made into the expansion of evidenced based programs in Victoria like J2SI that break the cycle of chronic homelessness and mental illness.

6.3 Sacred Heart Community

Sacred Heart Mission operates Sacred Heart Community, a home for people with histories of homelessness and disadvantage who require 24-hour support care and support as they age. The program is funded as residential aged care, yet our resident profile is markedly different from that of other residential aged care facilities, in that:

- 95% of our residents have a history of homelessness
- We have 68% men in our community, almost the opposite to the general aged care population where women make up 70%
- Nearly 75% of our residents are under 72 years of age on admission
- 10% are over 80 years old (compared to 80% in the general aged care population)
- 25% are younger than 64 years old, in comparison to 1 in 25 aged under 65 in the general population
- Our residents' length of stay is 6.2 years, more than twice the average of general aged care (2.7 years).
- Our residents have almost twice the number of diagnosed mental health conditions per resident than the combined Victorian data (1.9 compared to 1 incident per resident)
- Significantly less occurrences of developing dementia (17% vs 51% in the Victorian data)
- 14 times the occurrence of psychoses (42% vs 3%), and
- 66 times the occurrence of other mental and behavioural presentations (66% vs 1%) (Trifiletti 2017).

In many cases, many years of rough sleeping and poor accommodation means that our clients are prematurely aged. Many also have increased health and medical needs, as a result of a lack of intervention or mismanagement over an extensive period (such as diabetes, heart problems, and liver disease caused by long-term alcohol misuse).

Sacred Heart Community is an extremely beneficial care setting for people with complex mental health conditions, where their illnesses are well managed with care and support tailored to meet their needs. This is a therapeutic community environment where older people with complex mental health needs can live a supported and fulfilling life.

At present, many residential aged care facilities do not accommodate people with complex mental illness, and many of our residents were refused care at other services due to their mental illness. One example is William*, a resident at Sacred Heart Community who had a series of inappropriate placements prior to moving to Sacred Heart Community, where their mental health needs were not being met (Trifiletti 2017).

Client Case Study - William:

William* is 60 years old and has been at Sacred Heart Community for nearly three years. He developed severe schizophrenia in his late teens, following his discovery of his mother, a Holocaust survivor, who had suicided at home. He turned to alcohol and drugs and was admitted to many hospital psychiatric units, including locked wards.

Before moving to Sacred Heart Community, William struggled to live independently: he couldn't manage his personal hygiene and his schizophrenia medication. He had lived in various supported accommodation facilities and was at grave risk of becoming homeless. He had become floridly schizophrenic and mainstream aged care could not meet his needs.

His sister, Grace*, a doctor and his sole carer for many years looked desperately for somewhere for him to live. As Grace observes: 'The problem with defining care as 'Aged Care' is that someone like William doesn't fit into existing categories or services, despite being at great risk of homelessness, and having a much shorter life expectancy due to his illness."

Though initially William did not want to be at SHM, he is now very happy here and feels that it is his home. Grace is confident that William will live at Sacred Heart Community for the remainder of his life.

She says: "Before coming here, William's life was completely unstable. Now, he has a clean room and clothes. He is safe, fed, his medication is administered to him and he doesn't go 'off the rails'. He's the most stable he's ever been. He's contented. He has meals in the common area and walks to the local shop. He is so different now. There is a contentment about him. He is not isolated. Now I know my brother is cared for."

Recommendation 7: Further investment is made into supported accommodation facilities that provide care placements for older people with complex mental illness, who require ongoing support.

Recommendation 8: That specialist mental health roles are embedded in aged care services both residential and community-based, who work with people with mental health issues and histories of homelessness.

Recommendation 9: That Commonwealth government is encouraged to improving the capacity of mainstream aged care services sector to support people with complex mental illness, to ensure consumers have choice when it comes to deciding where they should live.

7. Mental health and Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander people have experienced trauma as a result of colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. This trauma may unknowingly be passed from generation to generation.

Aboriginal and Torres Strait Islander clients are overrepresented within SHM services, 10% on average; in comparison to 0.4% - 0.8% of the population in the Local Government Areas which we primarily operate – City of Port Phillip, City of Darebin and City of Yarra. In

particular, we see the highest proportion of Aboriginal and Torres Strait Islander peoples in our case management programs at Sacred Heart Central and the St Kilda Intensive Outreach Team (SKIOT) programs (23%, 2017-2018 financial year). Proportions of Indigenous people were also significantly higher at the Central Engagement Hub (14%) and residents of Bethlehem Community (13%).

For Aboriginal and Torres Strait Islander people and people who maintain a spiritual association with land and place, the social and geographical displacement of homelessness may lead to even more mental health challenges. Cultural safety is crucial in mental health service delivery, to enhance individual and collective empowerment and provide more meaningful and effective pathways to Aboriginal self-determination (Dudgeon, Milroy & Walker 2014). In order to ensure cultural safety, people engaging with mental health services must have the opportunity to say whether they felt they were treated with respect and had their culture, values and preferences were considered, and they felt safe (Dudgeon, Milroy & Walker 2014).

Recommendation 10: That changes to the mental health standards and relevant legislation is undertaken to ensure all mental health services have cultural safety embedded within their practices.

8. Mental illness and other co-occurring illnesses and disabilities

Many of SHM's clients have co-occurring illnesses or disabilities, as well as mental illness. As their needs are highly complex, people often require a multi-disciplinary team approach to manage their care and supports. SHM clients have the added complexity of a history of chronic homelessness, disadvantage, and social isolation.

Sacred Heart Local our in-home support program for clients receiving a Home Care Package (HCP), supports via the Commonwealth Home Support Program (CHSP) or supports via the National Disability Insurance Scheme (NDIS), clients live in public housing, or rooming houses and require significant levels of support to manage their mental illnesses and disabilities.

The NDIS has been transformative within the human services sector, and the reforms have the potential to give people greater choice and control over their lives and supports they receive. However, for the full benefit of the NDIS to be realised, participants must be able to advocate for themselves, to receive appropriate supports, and have genuine understanding of what supports they need.

For SHM clients who have histories of complex trauma and homelessness, are socially isolated, have minimal financial resources, this is an unreasonable and complex task. For people with complex needs, particularly who have multiple disabilities and co-occurring illnesses, including mental illness, they are at serious risk of being left behind and stuck in the cycle of disadvantage by the system that was designed to improve their quality of life and wellbeing. Ultimately, the NDIS is not well-designed to support people with a psychosocial

disability, as it focuses on significant and lifelong disabilities, which is at odds with the recovery model for mental illness that has predominated the sector for many years. NDIS participants are obliged to consider their deficits when engaging in planning, and this is extremely disempowering and counterintuitive.

Recommendation 11: That an investigation into how the NDIS and Home Care Packages for aged people, can be better coordinated to effectively support people with lifelong mental illness, while still operating in a recovery framework.

9. Prevention of mental illness and suicide

It is estimated that 2.22 million adults, or 45% of Victoria's adult population will experience mental illness in their lifetime (Mental Health Victoria, 2018). For many members of the community, resilience and strong support networks means that periods of mental ill health and poor wellbeing can be managed, addressed and prevented from escalating. However, SHM clients experience extreme social exclusion and economic disadvantage, which places them at higher risk of developing a mental illness.

In order to address these issues for our clients, SHM delivers social inclusion activities funded through our fundraising revenue to complement existing formalised case management services and enhance outcomes for the individuals. These Health and Wellbeing programs provide activities that not only enhance physical participation, but also encourage independence and community connections. Activities such as a music group, yoga, tai chi, swimming, cricket, and football, provide opportunities for people to engage with others and improve their social interaction. People are supported to access other activities in the community, in line with their personal goals.

These activities recognise the importance of social connections and wellbeing, particularly for those experiencing extreme disadvantage. Staff members also try to support clients to attend wider community activities and build their independence. For example, a case manager might agree to meet them at a set time and location to attend a community activity, or at their house with the plan of catching public transport together, rather than providing them a lift. Though this approach requires a more intensive approach initially, it supports the client in the long term to build their social networks and resilience and equip them with the skills to prevent or reduce the severity of periods of mental ill-health.

In the 21st century, there is far greater knowledge and understanding of the importance of positive mental health and wellbeing than in previous decades. No doubt, this is in part due to the work of organisations such as BeyondBlue and Headspace, that work to destigmatise mental illness. However, significant stigma surrounding more complex mental illness is persistent, and particularly of disorders that present with symptoms of psychosis. Due to the ways in which these illnesses present, individuals who are unwell are also far less likely to be accepted for a rental property or employment opportunity. People with mental illness often find they are the 'last resort' for tenancies and jobs, meaning that their housing and employment (if they can work) is insecure. This can and does lead to homelessness and unemployment, and the cycle of social exclusion and economic disadvantage continues.

Recommendation 12: That investment is made into programs that enable participation in social inclusion activities for little or no cost.

Recommendation 13: That investment is made into public awareness campaigns to destigmatise illnesses, to prevent discrimination and promote equitable access to housing and employment and improve social inclusion.

The prevention of suicide is an extremely challenging area of mental health services and supports. Suicidal ideation and chronic self-harm are common conditions for people who have experienced complex trauma, and for people who have experienced homelessness (O'Donnell, Varker & Phelps 2012). All SHM staff engage in trauma-informed care training, which is essential to our practice. This is also important for staff who do not work with clients directly – as it builds an understanding of why we do what we do, and of cohesion across the Mission, so all staff are working towards the same goals and outcomes, even within different aspects of the organisation. Our experience tells us that complex trauma has long-lasting impacts on the lives of many Victorians experiencing mental health issues and believe all organisations responding to people with a mental illness should operate within this practice framework. It is also important that client-facing staff are trained in recognising the risks of suicide and have the ability and autonomy to engage in assertive intervention as early as possible when people are most at risk.

SHM has a history of successful program delivery that has long-lasting impacts on people with complex histories of homelessness, mental health issues and trauma. Unfortunately, despite our best efforts, we do know that suicide is a cause of death of some of our clients. We hope that one day, these deaths will be a relic of the past – but with rates of suicide increasing, Victoria has a long way to go in the prevention of suicide in the community.

Recommendation 14: That the trauma-informed care training, be mandatory for all organisations in Victoria that provide mental health services and support – for client-facing and administrative staff.

Recommendation 15: That training in recognising the risks of suicide, and assertive intervention be mandatory for client-facing staff in organisations working within and interacting with the mental health system.

10. Forensic mental health and the justice system

One of the most significant challenges of the prison system is managing community expectations of the purposes and goals of incarceration. Though one of the aims of the prison system is to rehabilitate offenders and prevent recidivism, the voting public struggles to understand these aims, and instead focuses on community safety and punishment of

offenders. This means then that public spending on mental health support for prisoners is not well received and provides a challenge for policy makers in communicating the benefits of these services in preventing further offending when an individual is released.

At SHM, internal data for the 2017/2018 financial year indicates that approximately 7% of our clients who are case managed via our Central Engagement Hub, and 10% of clients in the J2SI Phase Two program spent time in an adult correctional facility in the previous 12 months.

According Australian Institute of Health and Wellbeing (AIHW)'s recent study of the health of Australia's prisoners, more than half of prisoners expected to be homeless on release (AIHW 2019). It is vital that people exiting prison can access stable accommodation to support their rehabilitation after their release.

For many people exiting prison, education and support are required to navigate the system and maintain regular appointments, as well as secure tenancies. It is our view this support should be provided as part of exit panning prior to release. Without this support, including mental health support, many will simply reoffend or become entrenched in homelessness.

Recommendation 16: That investment is made into pre-and post-release support and planning, including access to housing for people exiting prisons, to improve mental health and wellbeing, reduce recidivism and prevent homelessness.

11. Mental illness and problematic alcohol and substance use

There are other additional layers to accessing mental health services for people, who misuse alcohol and other drugs. Problematic alcohol and drug use can be both a cause and a consequence of mental illness, and is frequently linked to trauma, as these substances can be used as an unhealthy outlet to manage the impact of trauma. It also leads to people being denied access to mental health services or a mental health assessment, being told they need to be clean and sober to access support.

it is unrealistic to expect people who have experienced homelessness and trauma to be able to cease problematic substance use independently in order to receive mental health services. In addition, individuals may be excluded from accessing drug and alcohol and/or mental health services until they are housed. Given the current waitlist for social housing in Victoria, many people 'bounce' between various types of homelessness – rough sleeping, couch surfing, transitional housing and crisis accommodation and do not receive support for their complex needs, increasing their vulnerability and their mental health and substance use issues are not addressed.

Embedded in SHM's models of service delivery are the Housing First principles; a recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing. It is accompanied by the provision of tailored and individualised supports. For people experiencing homelessness, mental illness and problematic drug and alcohol use, Housing First is particularly vital and

people should not be obligated to engage in treatment or support in order to be eligible for housing.

Similarly, harm minimisation is important to consider when supporting people who misuse substances; it is more effective to support people to reduce or minimise use, and regain control, rather than expecting they will be able to abstain completely. In cases of dual diagnosis of mental illness and alcohol and drug issues, these need to be tackled in tandem, the evidence base we have gathered through the J2SI program, tell us that wrap around support that is consistent and long term gives people the best chance at recovery.

Recommendation 17: That the removal of requirements to be housed in order to access mental health and drug and alcohol services in Victoria, be removed.

Recommendation 18: That people do not need to engage in mental health or alcohol and other drug treatment in order to access community or social housing

12. Pathways and interfaces between Victoria's mental health services and other services

Many of SHM's clients access a variety of services across the social services system – primary care, clinical mental health, housing and homelessness, family violence, the NDIS, justice, income support and so on. The way these systems intersect with each other is extremely complex, and pathways to accessing these services are extremely challenging for many of our community. Each time a person accesses one of these services, they find they need to repeat their stories in order to prove eligibility and gain access to these services. This can be extremely re-traumatising for client, who have already overcome significant barriers to engage with one part of the system. Repeating their stories over and over is disempowering and can very easily turn someone away from the system altogether, leaving them without viable options to getting help when they need it. Many clients bounce around different services, due to the complexity of their needs.

SHM is a trauma-informed organisation, which means that all aspects of service delivery are organised around the recognition and acknowledgement of trauma and its prevalence. At a minimum, trauma-informed care services aim to provide an increased sense of safety and strive to avoid any re-traumatisation of their service users. We do this by building strong relationships with our clients, as well as establishing boundaries and role expectations.

At SHM, we have a Client Management System that creates a single client file for use across all our programs, it enables staff to provide holistic care for clients and prevents any duplication or loss of client data. Such a system would be beneficial across the community services sector. If organisations had greater capacity to share data for clients who are accessing a variety of services, it would improve outcomes for clients, and reduce the burden on clients to retell their stories, risking re-traumatisation. It is very important that clients' privacy is respected and maintained, in line with legislation and privacy standards.

However, at present, it is difficult for service providers to interact with each other and provide the best care and pathways for clients due to restrictions placed on them by privacy legislation and the complexities of the services system.

Recommendation 19: That investment is made in ways to share client information across a variety of services, that balances effective and holistic service delivery with maintaining clients' privacy.

12. References

Australian Institute of Health and Welfare (2019). *The health of Australia's prisoners 2018*. Cat. no. PHE 246. AIHW, Canberra.

Dudgeon, P. Milroy, H and Walker, R (eds.) (2014). *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, ACT.

Johnson, G, Kuehnle, D, Parkinson, S, Sesa, S & Tseng, Y (2014). *Sustaining exits from long-term homelessness: A randomised controlled trial examining the 48-month social outcomes from the Journey to Social Inclusion pilot program*. Sacred Heart Mission, St Kilda.

Johnson, G, Parkinson, S, Tseng, Y & Kuehnle, D (2011). Long-term homelessness: Understanding the challenge - 12 months outcomes from the Journey to Social Inclusion pilot program. Sacred Heart Mission, St Kilda.

Mental Health Victoria (2018), Saving Lives, Saving Money: The case for better investment in Victorian mental health. Elsternwick, Victoria.

Miscenko, D, Vallesi, S, Wood, L, Thielking, M, Taylor, K, Mackelprang, J & Flatau, P (2017). Chronic homelessness in Melbourne: The experiences of Journey to Social Inclusion Mark II study participants. Sacred Heart Mission, St Kilda.

O'Donnell, M, Varker, T, & Phelps, A (2012). Literature Review: The Nature of the Relationship between Traumatic Events in People's Lives and Homelessness. Australian Centre for Posttraumatic Mental Health, University of Melbourne.

O'Donnell, M, Varker, T, Cash, R, Armstrong, R, Di Censo, L, Zanatta, P, Murnane, A, Brophy, L & Phelps, A (2014). The Trauma and Homelessness Initiative. Report prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria, Melbourne.

Parkinson, S & Johnson, G (2014). Integrated intensive case management in practice: Final process evaluation of the Journey to Social Inclusion program. Sacred Heart Mission, St Kilda.

Trifiletti, G (2017). My Community My Way (internal document), Sacred Heart Mission, St Kilda.

Sacred Heart Mission (2019). Reaching the Right People Report 2018 (internal document). Sacred Heart Mission, St Kilda.

*Note: All names have been changed.