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# Southern Homelessness Services Network (SHSN) Submission to the Royal Commission into Victoria's Mental Health System

This submission provides background on the Southern Homelessness Services Network (Section 1); an analysis of the key action areas for the Royal Commission focussing on mental health and homelessness (Section 2); and SHSN's responses to the Commission's questions based on a survey of our member agencies (Section 3).

## 1. About the Southern Homelessness Services Network

The **Vision** of the Southern Homelessness Services Network (SHSN) is an end to homelessness in Southern Region of Melbourne (covering the local government areas of Bayside, Cardinia, Casey, Frankston, Glen Eira, Greater Dandenong, Kingston, Mornington Peninsula, Port Phillip and Stonnington).

The **Mission** of the "Victorian Homelessness Networks is to facilitate, inform and support regional homelessness services and stakeholders to work together to co-ordinate services to people who are experiencing or who are at risk of homelessness."

The SHSN comprises all funded Specialist Homelessness Services in the Southern Region including services providing crisis, transitional, long term, family violence and youth support and accommodation. Our members include Launch Housing, the Salvation Army, WAYSS and Sacred Heart Mission. The SHSN also supports allied service sectors working in homelessness. The SHSN is a resource for the homelessness sector in the South.

The key strategic SHSN objectives are:

1. To promote and support innovation, knowledge sharing and expertise in the best interests of consumers
2. To foster relationships and collaboration between service providers to ensure timely, coordinated and effective responses
3. To act as a conduit between the Department of Health and Human Services and the regional service sector homelessness related data, issues and trends to inform policy
4. Working together to end homelessness

# 2. Key Action Areas – Mental Health and Homelessness

The collective knowledge and experience of the SHSN members show that homelessness and mental health require as much funding and attention as family violence so the Government is commended for this Royal Commission into Mental Health and we anticipate that these issues will be addressed as a matter of urgency.

This section of the SHSN submission focusses on homelessness and mental health and the intersection of these complex service systems. This section highlights the key action areas for the Royal Commission to address in its investigations. This is supported by further discussion of the issues in section 3 responding to the Royal Commission questions.

Before exploring the key actions areas, it is important to set the context with the current definitions and categories of homelessness used in Australia. The widely accepted Australian Bureau of Statistics (ABS) definition of homelessness in Australia is:

> *When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement is in a dwelling that is*
>
> - *inadequate;*
> - *has no tenure, or if their initial tenure is short and not extendable; or*
> - *does not allow them to have control of, and access to, space for social relations (AS 2016).*

The ABS measures homelessness by different groups which include:

- people who are rough sleeping
- people in supported accommodation for the homeless
- people staying temporarily with other households
- people living in boarding houses (referred to as rooming houses in Victoria)
- people living in severely crowded dwellings (requiring 4 or more extra bedrooms for all household occupants) (ABS, 2016).

All of the people in these categories are counted as homeless by the ABS.

## 2.1 Homelessness and mental health service systems

Recent AHURI research into mental health and homelessness systems (Brackertz, N. et al, 2018:1) found that:

- *there is a lack of affordable, safe and appropriate housing for people with lived experience of mental ill health*
- *secure tenure allows people to focus on mental health treatment and rehabilitation*
- *integrated programs addressing housing and mental health are effective but do not meet demand for these services*
- *discharge from institutions poses significant risks for homelessness and mental health*
- *housing, homelessness and mental health are interrelated*
- *the National Disability Insurance Scheme (NDIS) is reshaping the mental health system*
- *there is a mental health service provision gap under the NDIS*
- *housing, homelessness and mental health are separate policy systems with little integration, which contributes to poor housing and health outcomes for people with lived experience of mental ill health.*

Lack of housing and experiencing homelessness exacerbates stress and other mental illness triggers. Homelessness can mean exposure to violence and further trauma particularly when sharing (unsupported) accommodation with people who are mentally unwell such as in rooming house accommodation. Without appropriate, safe, affordable housing as an exit from psychiatric care, people become caught in a cycle of homelessness and emergency admissions which is costly to the Government funding these services and damaging to individuals caught in this cycle. There should be a stated Victorian Government policy of no discharge from any psychiatric/mental health facility into any category of homelessness.

In turn, the failure to properly respond to homelessness (by providing affordable, safe, long term appropriate housing) is exacerbating the demand pressures faced by Australia's mental health system, leading to worse outcomes for consumers. This decreases the efficiency and effectiveness of the resources used for mental health and homelessness making it difficult to achieve meaningful lasting outcomes for clients of both systems.

Many people experiencing mental ill health have a range of multiple and complex needs requiring a flexible multidisciplinary approach which can be accessed as needed rather than time-based services. A greater focus is required on integrated multidisciplinary services that include professionals from a range of disciplines as part of a service delivery team. For those with higher levels of support needs, wrap-around support teams may include practitioners supporting mental health recovery, including peer support, clinical mental health and health treatment and disability support, primary care, housing, community legal services, and addiction support.

Joined up mental health and homelessness responses are also required for people with "lower level" mental illnesses such as anxiety and depression who are often missed by a mental health service system focussing on the most acute needs. Other groups requiring tailored approaches are people in prison or with experience of incarceration and Indigenous Victorians who are over-represented in use of homelessness services. In addition, women and children escaping family violence are a large cohort of homelessness service users who may require specialist mental health responses.

Providing timely mental health treatment and support and safe affordable secure housing for disadvantaged people should be seen as both mental illness prevention and treatment.

## 2.2 Mental health, poverty and homelessness

Poverty, homelessness and mental illness intersect. The lack of sufficient income makes is difficult for people to find adequate accommodation, look after their mental and physical health and to engage in social and economic participation. Mental illness is a direct cause of poverty for many people and poverty can contribute to stress and poor mental health. Poor mental health is also strongly associated with reduced employment increasing risk of living in poverty (Frijters, P., et al, 2014:1058-1071).

The Productivity Commission found that 34 per cent of those receiving the Disability Support Pension are doing so due to mental illness (Productivity Commission, 2019:19). Some Centrelink recipients (on Newstart and Youth Allowance) lack sufficient income to exist, never mind thrive and be well (mentally or physically). People on these allowances are trapped in poverty, contributing to the ever-widening increases in inequality in Victoria.

The SHSN client group are excluded from the private rental market due to high rental costs, lack of rental histories and discrimination. An increasing market in private rooming houses has arisen to fill this space. Rooming houses in Melbourne commonly cost $200-$240 per week taking up the majority of a Newstart allowance, leaving little money for food, transport, clothing and other essentials.

The situation with private rooming houses is becoming so dire with some exploitative managers taking advantage of people in a myriad of ways. Rooming houses residents overwhelmingly report rooming houses to be dangerous and violent, dirty, and harmful to their mental health (Goodman R, et al 2013). Rooming houses are common accommodation for people with psychiatric illnesses who cannot access other housing options (Goodman R, et al 2013). It is not uncommon for residents go to rooming houses straight from mental health facilities.

Our member agencies have few other options for emergency accommodation and often place clients in these rooming houses, as well as low amenity motels and hotels. These issues are also raised in the *Crisis in Crisis Accommodation* paper by the Northern and Western Homelessness Networks both in relation to rooming houses and hotels/motels that are used for crisis accommodation by our member agencies in the homelessness sector (2019). The paper draws on an extensive survey of consumers of homelessness services which also found that 80 per cent of the respondents identified as having a mental health issue, The paper includes quotes from clients about their experiences in these forms of emergency accommodation including –

> *I get sent to this "boarding house" which is full of bedbugs a mattress covered in black mould a window that doesn't lock and I'm supposed to pay 280 dollars a fortnight for the privilege ... oh and the boarding house comes with crack heads too. I haven't bothered going back to "housing" (Northern and Western Homelessness Networks, 2019:6).*

The paper includes the case study of Judy who said

> *There were times when it was not safe to leave the room for hours - even just to go to the toilet because it was so unsafe. I also felt scared to leave the room unoccupied as things had been stolen from the house… I had never been in this position before in my life. You have to be in this (the crisis housing and homelessness system) to fully understand what it is like. I could never understand how bad it was until it was in it (Northern and Western Homelessness Networks, 2019:9).*

The SHSN held a Summit on private rooming houses in April 2019 bringing together over 100 participants to discuss the different factors/aspects of private rooming houses resulting in ideas/commitment for joint work moving forward to improve the safety and appropriateness of rooming house options for vulnerable people in the Southern Region. Please refer to the SHSN Rooming House Summit Outcomes Report for recommendations on this issue specifically (SHSN, 2019).

## 2.3 What works?

The SHSN recommends that the Royal Commission investigate local, national and international models of care and support for people experiencing homelessness and poor mental health to assess what works. AHURI found that there are a range of evidence based responses to meeting the different needs of different groups of people experiencing homelessness and poor mental health. These models need to be scaled up to meet the demand for such services (Brackertz, N. et al, 2018). This research provides a comprehensive national review of the issues relating to mental health, housing and homelessness and has many useful recommendations for consideration by the Royal Commission.

The SHSN recommends the following models, as a starting point, for addressing the nexus between homelessness and poor mental health:

- investigate "Housing First" models as an effective response to poor mental health and homelessness
- provide housing with support – eg Common Ground models for chronic homelessness and mental illness and scatter site/integrated models for other cohorts (see Parsell, C. et al 2014:25) for models of supportive housing as part of a mental health intervention)
- step down facilities from mental health facilities where people can be accommodated in a safe, secure and affordable environment to stabilise their mental health
- mental health outreach workers out-posted to homelessness services to provide support as people enter the homelessness service system
- sustain tenancies and support people at risk of homelessness to stay housed and stay healthy
- address poverty and inequality by advocating for the Commonwealth Government to raise Centrelink payments as a starting point
- provide sufficient public housing and mental health services to meet demand

# 3. Response to the Royal Commission Questions

***1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?***

There is much stigma and discrimination around mental illness and there is much stigma and discrimination around homelessness. There is a commonly held misconception that people become homeless because they have a mental illness. Whilst in some circumstances, mental illness is a contributing factor to becoming homeless, it is more likely to be a symptom of homelessness. Research shows that the stress of experiencing homelessness negatively affects people's mental health with homelessness more likely to trigger poor mental (and physical health) than causing homelessness (Chamberlain C. et al, 2007). This research found that 30 per cent of the study cohort had mental health issues and just over half had developed mental health problems after becoming homeless (Chamberlain C. et al, 2007:29).

Our sector's work in breaking stereotypes and increasing understanding and empathy is primarily through listening to and sharing the stories of people's lived experience of homelessness (and mental illness). Everyone's story is different. Explaining myths and misconceptions about mental illness and homelessness is critical to reducing the stigma and discrimination. Through meeting and talking to people with lived experience, the community can relate to their stories and experiences and increase their understanding instead of making assumptions and passing judgement. It is hard for people to experience good mental health when there is stigma and insufficient understanding and empathy in the community.

Improving community understanding can be done in a number of ways:

- in the media – through media campaigns and through education the media around homelessness and mental illness. Useful examples are the Council to Homeless Persons are running the inaugural Victorian Homelessness Media Awards and have developed a media guide on homelessness reporting (https://chp.org.au/media/)
- in schools – early intervention and prevention of homelessness by providing students with information about homelessness, mental health and how to access help for themselves or their friends should they need to
- public awareness education campaigns around mental health can also address homelessness stigma
- people with lived experience of recovery from mental ill health and homelessness can be ambassadors to reduce stigma and discrimination and to advocate for government to provide timely treatment and safe affordable housing for disadvantaged people as mental illness prevention and treatment
- increase understanding of the different categories of homelessness to break down stereotypes – including people staying with family and friends, severe overcrowding, rooming houses, rough sleeping. All of these categories have associated stress and potential trauma that can trigger or exacerbate poor mental health

Education around mental health needs to encourage parity in understanding (and resourcing) between physical and mental illness. While there is an awareness of depression and anxiety and to a growing extent suicide, there are still a lot of misinformation and fear around psychosis, bipolar disorder and the impact of trauma.

Reducing stigma and discrimination should focus on the very disadvantaged and vulnerable groups who experience compounded disadvantage (poor mental and physical health, trauma, violence, chronic homelessness, incarceration, etc) rather than be targeted at the "middle class" experience of mental illness. This group is often seen as "choosing" to be homeless rather than their homelessness being understood as a result of having no choices due to their compounded disadvantage.

***2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?***

There are supportive services for people experiencing homelessness and people experiencing poor mental health but very few services offer what is most needed - long term, affordable, appropriate and safe housing in the community of choice with mental health supports as needed.

Specialist Homelessness Services staff have good insight into mental health problems of people who are experiencing housing instability and homelessness. Our staff are generally trained in mental health first aid and suicide prevention and regularly work with people experiencing poor mental health and psychiatric disability. Despite this, specialist homelessness services staff are generally not trained mental health workers and there is a gap in supporting people experiencing mental illness and homelessness.

There are some programs within community mental health sector that are funded (or were funded) to provide flexible and responsive support to people within a stepped model of care. Responsive services that provide the right treatment at the right time are what is required for our target group. Effective programs have a longer funding cycle which leads to an experienced, skilled and stable workforce who are knowledgeable about linkages in their community. They are not pilot programs. Preventing mental illness becoming more serious could involve people being able to receive the right care at the entry point into homelessness services. This could be achieved through out-posted mental health workers in homelessness entry points/agencies.

There are a range of mental health services that work well for people who are homeless but as the AHURI research shows, these models need to be scaled up to meet the high level of demand. Some of these include:

- Elizabeth Street Common Ground and Doorway – and other supported housing models
- Homeless Outreach Psychiatric Services - HOPS teams (though from anecdotal reporting HOPS would benefit from more holistic approach rather than the clinical/medical model)
- 24-hour phone services
- step down facilities from acute in patient care (eg PARC) to help people without accommodation or support at home to stabilise before leaving care entirely
- dual diagnosis services as some people are excluded from mental health services if they using substances and some are excluded from drug and alcohol services if they have a mental illness
- multidisciplinary outreach teams including mental health expertise – for example some of the new Victorian Government funded rough sleeping outreach and supportive housing teams

Some service responses can exacerbate poor mental and physical health and risk of homelessness and or mental illness recurring. For example, highly distressed people present at hospital emergency departments and are turned away because they do not meet the criteria for a psychiatric admission and having been provided with no information about non clinical support. Hospitals discharge directly to our member services when our staff have few viable accommodation options to offer. Often our staff can only accommodate people leaving hospital in short term motel accommodation or rooming houses which are often dangerous and stressful living arrangements as there are very limited accommodation options for people who are homeless, including those with poor mental health.

Shorter wait times/priority for mental health support for clients experiencing or at risk of homelessness may help our clients access the mental health support they need. More

resources need to be in place for people to access a range of treatment options including counselling, psychology, psychiatry, support groups and outreach support. The current number of funded sessions under current GP mental health plan is simply insufficient. In addition, training and education for GPs around mental health and homelessness is required.

The most effective service responses for people experiencing chronic homelessness and mental illness have both accommodation and support. These should include more crisis and long term supported accommodation options for all cohorts, and more public and social housing to provide dignity and stability for people who are at risk of homelessness. The impact of this will prevent further deterioration in mental health, and allow more intensive and timely access to/engagement with mental health services.

Psychiatric hospitals and facilities should keep people in hospital until they are well enough to be discharged. The Victorian Government needs to mandate that patients should not be discharged from any form of psychiatric/mental health facility into any category of homelessness including rooming house accommodation.

***3. What is already working well and what can be done better to prevent suicide?***

Specialist Homelessness Services staff are well trained in recognising and asking the correct questions of a person contemplating suicide and conducting risk assessments. We need to continue to build on this knowledge and educate all support services profit and not-for-profit who assist with homelessness eg crisis accommodation, community support centres etc, about suicide prevention. All front-line workers and supervisors should undertake accredited ASIST training. Better crisis and long-term accommodation options for all cohorts would also help reduce suicidal ideation, attempts and completions (see response to question 2). Funding has been provided to connect services together and protocols are being developed in order to provide a supportive response to affected communities/families and thus reducing traumatic impact and preventing copycat behaviour.

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

Lack of safe, affordable, appropriate housing exacerbates stress and other mental illness triggers. Homelessness can mean exposure to violence and further trauma particularly when sharing (unsupported) accommodation with people who are mentally unwell such as in rooming house accommodation. Without appropriate, safe, affordable housing as an exit from psychiatric care, patients/clients become caught in a cycle of homelessness and emergency admissions which is costly to the Government funding these services and damaging to individuals caught in this cycle.

Our members stated

> *Lack of safe, affordable and appropriate housing makes it difficult. People cannot be expected to experience good mental health if they are living from hand-to-mouth, stressed about where they will be living and security of tenure, or residing in unsafe rooming houses without the space for personal choice and social interactions. It's also really difficult to maintain engagement with social and psychological support if you have no fixed address or are having to prioritise basic needs such as shelter, food and warmth.*
>
> *Homelessness services are swamped with people who report that mental health issues are contributing to their homelessness, or putting them at risk of homelessness.*

Anxiety and depression are common amongst people experiencing homelessness. The lack of stability, high stress of day to day uncertainty and exposure to or threat of violence increase the levels of anxiety and depression for people at risk of or experiencing homelessness. Experience of homelessness may cause post-traumatic stress disorder for some people. These

mental health concerns need to be addressed as well as the more acute/serious illnesses such as schizophrenia. Anxiety and depression can make it difficult for people to engage in with services and engage in social and economic participation.

Long waiting times to receive diagnosis, access care and lack of long term supports make it hard for our client group to experience good mental health. Lack of integration between homelessness and mental health services is also an issue. Creating friendlier and less clinical space for those accessing mental health treatments for both first time and long-time service users would help our client group feel more comfortable accessing mental health services. We would recommend co-designing service spaces with mental health consumers.

Poverty and the lack of sufficient income for people on Youth Allowance and Newstart makes it difficult for people to experience good mental health. The Commonwealth Government has made it increasingly difficult for people to access the Disability Support Pension which is substantially higher than Youth Allowance and Newstart. It is particularly hard for disadvantaged people on low incomes or receiving lower end Centrelink payments as they lack sufficient income to exist, never mind thrive and be well. Rooming houses commonly cost $200-$240 per week taking up the majority of a Newstart allowance, leaving little money for food, transport, clothing and other essentials. How are people on these low payments supposed to have good mental health?

Fragmented services make it difficult for people to access the services they need and to stay engaged for the time required to become well. Services have been further fragmented by the NDIS business/service model. Removing community mental health services has further disengaged and excluded our client group from accessing mental health services.

Improvements could be made to ensure there is appropriate timely support for people when they at the mild end of the spectrum to prevent mental health worsening. Improve service navigation by ensuring there are straightforward gateways into mental health treatment and homelessness e support eg at emergency departments, with Police, GPs etc.

***5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?***

People experiencing homelessness are one of the “communities” experiencing poorer mental health that the Royal Commission should focus on. This includes all categories of homelessness and all type of poor mental health. One of the key contributing factors to homelessness is poverty. Poverty also makes it more difficult to prioritise health and mental health due to the costs of accessing services, other barriers such as stigma re poverty and homelessness and people having priorities other than health such as affording food, rent, keeping custody of children, etc,.

Poor mental health outcomes are part of the compounded disadvantage experienced by people who are homeless which may include trauma (including intergenerational), violence, poor physical health, barriers to accessing a range of mainstream services, poverty, lack of social connection and isolation, unemployment, incarceration, etc.

Groups who are higher risk of both mental ill health and homelessness include Indigenous Australians and people who have been incarcerated (and especially those people that fall into both categories). These groups need specialist mental health responses to address their specific needs including experience of racism and stigma (of incarceration). Refugees and asylum seekers experiencing homelessness are another “community” with higher risks which are exacerbated by Federal Government policies cutting income support payments and making it difficult to access required services. Women and children escaping family violence who experience homelessness may also require a specialist mental health response.

People with multiple and complex needs are often excluded from a range of service systems. We hear about people who are too unwell for homelessness services but not unwell enough to access mental health services demonstrating a serious gap in available services.

Once people are housed, services need to be available to help them settle and stabilise, particularly after mental illness and/or long periods of homelessness. Often support cease once people experiencing homelessness access housing, contributing to the cycle of homelessness and the costs to the individual and society.

***6. What are the needs of family members and carers and what can be done better to support them?***

People experiencing homelessness, especially chronic homelessness, often lack the support of family members. There may be shame and stigma within the family about homelessness, poverty and lack of ability to support oneself and/or family. Experience of family violence (a common contributor to women's and children's homelessness) can lead to accommodation in a different part of Melbourne away from family and supports. People who are estranged from their families should not be forced to work with them if they do not wish to, particularly in the case of family violence. Families may be burnt out after trying to help family members who are spiralling downwards in their mental health.

A range of services already exist to support family members, friends, and carers of people with a mental illness. These can provide practical, financial, and emotional support through services such as respite care, training, and peer support. Perhaps a specialised service for families of people experiencing homelessness and mental illness may be required to address these specific needs.

***7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?***

Higher wages, improved conditions, including safety and support for staff and being valued by the community would assist the mental health workforce. Access to clinical supervision and security of tenure, and ongoing up-to-date professional development in line with best practice principles would also assist. Addressing issues of burnout and staff stress are also required to keep people in the sector. s

The NDIS has seen a diminishing of experienced and qualified staff due to lower pay points and fragmented employment conditions. Increase funding length for programs as staff are unwilling to risk leaving their current job for a year contract and risk a program not being refunded. This does not provide job security and stability. Adequate resourcing for sufficient staff to do the required work will also help reduce burnout.

Any organisation employing peer workers must have very robust mechanisms in place for supporting this workforce. Working with clients can be triggering so requires good and regular supervision and reflective practice. Peer workers must receive payment for their work. Peer workers should be more widely employed, with training and recruitment pathways developed to encourage people with lived experience to work in the sector.

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

As discussed above, the compounded disadvantage experienced by people experiencing homelessness and mental illness makes it difficult for them to participate in social and economic activity due to lack of skills, motivation, opportunity, connection, support and due to discrimination. Social and economic participation and meaningful activity are critical for stabilising mental health and to finding sustainable pathways out of homelessness. Stable and secure housing provides a base for social and economic participation. Engaging in social and

economic participation is difficult without a stable affordable safe home. It can be difficult for people to sustain their engagement if their housing is at risk.

Addressing poverty and ensuring Centrelink payments are sufficient to meet the needs of people with mental illness will enable increased social and economic participation. The current payment levels further entrench social and economic exclusion

Changes to individualised rather than group mental health support models have also lead to further exclusion of people with experience of chronic homelessness from services. Supported group models, particularly drop in models, provided a safe, inclusive space for our client group who are often socially isolated and may not have space for meeting friends in their accommodation. Removal of funding for drop in models means that these people are more likely to congregate on the street as they have no safe space to gather. This has led to increased community safety problems and fear from the community as well as increased vulnerability of people experiencing homelessness gathering in the public places. This has become an issue for local government who manage local community spaces.

Social enterprises employing and skilling people with mental health issues and who have experienced homelessness have worked well in some places, provided sufficient support is in available for participants. These programs provide a step up to employment and often are linked to education and training so participants received qualifications as well as work experience. These models can be further explored and scaled up to meet the demand.

***9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?***

Housing and housing with support for those who need it should be a priority of the Royal Commission in addressing the mental health of Victorians. Safe, secure, appropriate and affordable housing provides the basis and stability to address other issues such as mental illness. All other mental health interventions are likely to fail if people do not have a safe, affordable and stable home. Issues to be explored regarding housing include:

- how to increase housing supply to meet the demand for people with a mental illness
- how to provide more housing choice in location of choice with high amenity including access to services, public transport, etc
- how to provide more diverse housing stock that meets the variety of needs – eg singles, larger families, single parents

Ensuring a timely response to housing and mental health support for all Victorians when needed should be a priority for the Royal Commission. The system should make it easier to return to access mental health care at different levels from acute through to recovery. Recovery is not linear and providing support when needed along the way can prevent recidivism of mental illness and. There are a range of mental health conditions that can directly impact on people maintaining their housing including hoarding.

Governments should use a long-term cost benefit analysis approach to drive investment into more public housing, considering public housing as social infrastructure supporting a range of outcomes including mental health outcomes. Preventing homelessness and mental health is cost effective in the longer term for society, the economy and for the individuals involved.

***10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?***

See response to previous questions.

***11. Is there anything else you would like to share with the Royal Commission?***

No further comments

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