



Mental Health and Homelessness: Bringing Together Clinical and Community Services

Michelle Francis, Julie Hartley, Barbara Wyatt

Presentation Overview

- Overview of the catchment
- Overview of the Mental health and Homelessness Program(MHHP)
- Partnership overview
- Case study
- Future direction of the program



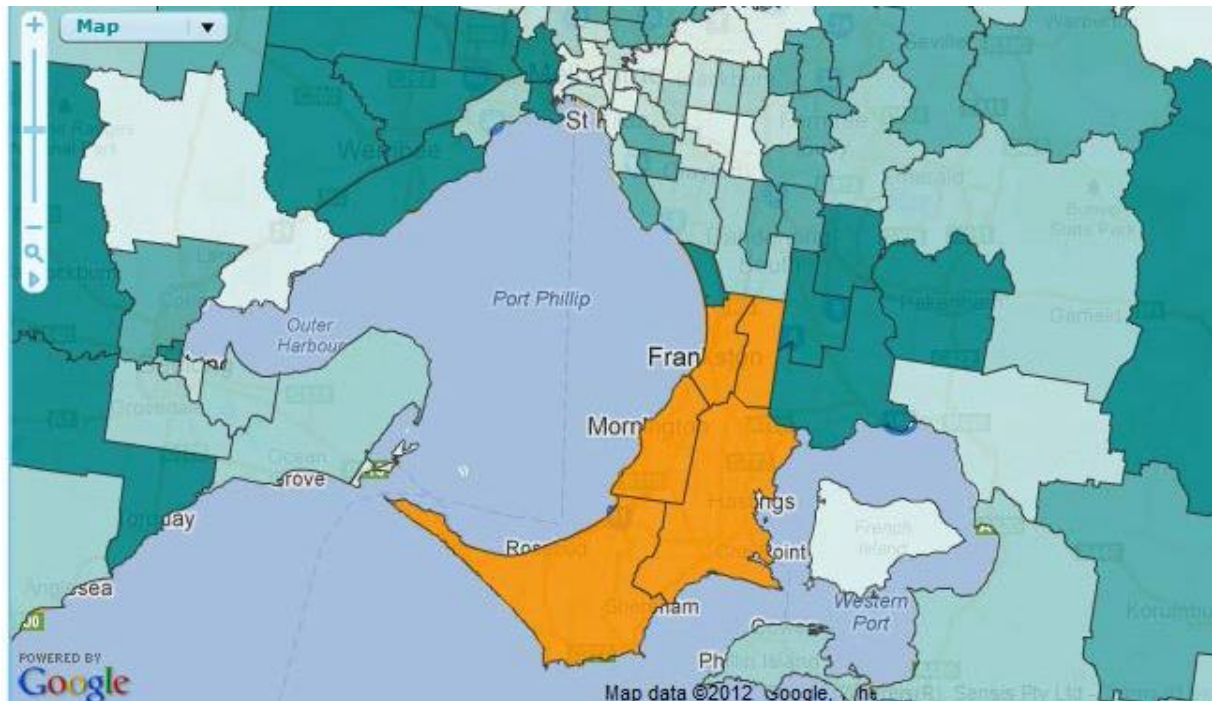
The Mental Health and Homelessness Program

Breaking the Cycle: *reducing homelessness initiative*

Victorian Government initiative allocated \$37.34 million over 5 years to under the NPA Supporting National Mental Health Reform



Frankston- Mornington Peninsula catchment



Catchment Demographics

- Frankston Dandenong corridor estimate of homelessness (40 people per 10, 000)
 - Inner City estimate (38 per 10, 000)
 - Outer city estimate (28 per 10, 000)(Frankston/Mornington, primary care partnership, Population health atlas, 2012)
- About 20% of all ED presentations are by people experiencing homelessness
- Centrelink: one of the top 6 areas for homelessness nationally(Medicare local, population health fact sheet, homelessness housing and health,2013)



Public Housing

- 48% of priority housing applicants within the Southern Metropolitan region are from the Frankston-Dandenong Corridor (June- September 2012) (DHS, Public Housing and Transfer Waiting List 2012).

(Medicare local, population health fact sheet, homelessness housing and health,2013)



The Mental Health and Homelessness Program

- **Primary homelessness** is experienced by people without conventional accommodation (e.g. sleeping rough or in improvised dwellings);
- **Secondary homelessness** is experienced by people who frequently move from one temporary shelter to another (e.g. emergency accommodation, youth refuges, "couch surfing");
- **Tertiary homelessness** is experienced by people staying in accommodation that falls below minimum community standards (e.g. boarding houses and caravan parks).

Ref: (Medicare local, population health fact sheet, homelessness housing and health,2013)



What we do?

The Mental health and Homelessness Program aims to break the cycle of long term homelessness for people experiencing severe and enduring mental illness, significant co morbidities and high and complex support needs. The program supports up to 25 individuals aged sixteen years and older at any one time. It is a partnership between the lead agency Mentis Assist (community mental health), Peninsula Health (clinical mental health) and the Salvation Army (housing service). The Program is delivered by a multi-agency, multi-disciplinary team and is unique in its setting within a clinical mental health service.



Partnership

The client group faces different barriers for each service:

- Lack of follow up in the community
 - Lack of support to access housing
 - Lack of treatment for health and mental health
 - Lack of liaison and co ordination across services due to limited resources
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- Clear admission criteria
 - Shared understanding and responsibility for assessing the criteria



Multi Agency Working

- Operational leader (program manager)
- Shared sense of team identity whilst all staff retain links with their organisation
- Shared work space (mental health clinic- Peninsula Health)
- Regular steering group meetings and contact



Benefits of multi agency working

Benefits:

- Information sharing across agencies
- Learning and development opportunities
- Less “falling through the gaps”
- Improved engagement with services
- Improved access to services
- Improved understanding of services and roles



Benefits of co location

- Onsite access to:
 - Financial counselling
 - Peer workers
 - Groups (i.e. community, hearing voices, CBT etc)
 - Psychiatrist
 - Acute(CATT)
 - Medical doctors
 - Neuropsychology
 - Doorways
 - Ephams
 - Adult and aged psychiatry teams



Access to clinical Services

- Embedded within the clinical and community service system
- Direct access to:
 - Clinical mental health support(youth, adult, inpatient, community, aged, PARC, SECU, CCU, MHHARP)
 - Physical rehabilitation
 - Acute(CATT)
 - Neuropsychology
 - Psychiatrists
 - Dental
 - Doctors
 - Maternal health
 - Allied health



Who are we?



Mentis Assist

1.0EFT Program Manager
3.6 EFT Case Managers
0.4 EFT Administration Assistant



Peninsula health

1.0EFT Senior Clinician RPN 4



Salvocare Eastern

0.4 EFT Housing Worker



What we do?



Lead Agency

- Case management
- Program Management
- Transitional housing



What we do?

Clinical Governance and support



Access to:

- Psychiatry
- Consultation
- Inpatient and community
- Acute



What we do?



SALVOCARE
EASTERN

- Initial housing assessment
- Housing applications
- Access to material aid
- Access to crisis housing
- Facilitation of long term housing options
- Capacity building
- Relationships with housing providers



Peninsula
Health



Program Criteria

Criteria:

- Age 16 +
- Long term homelessness: having slept rough continuously for 12 months or more; or having experienced episodic homelessness for at least three years
- Have a severe and enduring mental illness
- Complex and high support needs
- Experienced difficulty in engaging or maintaining engagement with services
- Be linked to the Frankston and Mornington Peninsula catchment



Referral Process

- Via Mentis Assist intake
- Via any staff member in the program



Referral Pathways

Referrals come from a range of Services and people:

- Assertive Outreach
- Direct from treatment providers
- Police
- Shire Rangers
- Mental health and Community services
- Drop in Centres
- GP's
- Psychologists
- Previous and Current Clients
- Court liaison



Typical Client demographics

- Severe and persistent mental illness
- Long term homelessness
- Personality disorders
- Substance use disorders
- Unmet physical health needs
- Disconnection from community and support
- History of trauma
- Coexisting disability such as ABI, intellectual, physical
- Experiences of entrenched poverty and social exclusion(employment, education, community, family)
- Frequent contact with police and correctional services
- High users of emergency and psychiatric services



Underlying Principles

- The needs of this client group are not well met by mainstream services. People experiencing severe and enduring mental illness, long term homelessness, personality disorders and severe psycho social impairment require a long term, individualized, holistic and community based approach.



MHHP Model

- Assertive Engagement
- Service provided in the community
- Long term
- Focussed on therapeutic alliance
- Recovery focussed
- Trauma informed
- Equal focus on health, mental health, psycho social and spiritual needs
- Partnerships with specialist services
- Care coordination and advocacy



MHHP Model

- Team based approach
- Stepped care
- Each client knows at least two members of the team well
- Low case loads!



Supported by

- Police
- Shire rangers
- Legal service
- Local real estate agents and housing providers
- Reputable rooming house proprietors
- Local drops in and meals services
- Drug treatment (NSP, clinical liaison, direct treatment)
- Material aid providers
- Community info and support
- Centrelink
- Council



Case study

- Breaking down barriers between services
- Involvement in clinical decision making/treatment
- Advocacy
- True collaboration
- Working with family
- Community linkages
- “going the extra mile”
- Genuine belief in the individual



Future Directions

- Funded until June 2017
- AOD clinician to be embedded within team
- Evaluation of AOD input to program



Thank you

Our partners, services and individuals that have supported and continue to support the program.



Contact



ph 03 5970 5000

fax 03 5970 5055

email info@mentisassist.org.au

web www.mentisassist.org.au

For better mental health

