

Improving linkages between mental health and welfare services to better care for homeless people with a mental illness

Evaluation of the Integrated Homeless Mental Health Initiative

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Definition of Homelessness

- A homeless person is without a conventional home and lacks most of the economical and social supports that home normally affords. She/he is often cut off from the support of relatives and friends, she/he has few independent resources and often has no immediate means of support and in some cases, little future prospect of self support.

Definition of Homelessness

- **Absolute homeless (primary homeless):** People without conventional accommodation (living on the streets, in deserted buildings, improvised dwellings, in parks, etc.).
- **Relative homeless (secondary and tertiary homeless):** People staying in boarding houses, people using emergency accommodation services, or people with no secure accommodation staying temporarily with friends or relatives in private dwellings.

Homelessness

- In Australia:
 - 2006 census - 106,000 living homeless
- In Melbourne:
 - About 20,000 people
 - Shrinking affordable housing increases pressure for people at risk of homelessness
 - Limited funding for support agencies so difficulty preventing people becoming/remaining homeless

Mental Illness Causes Homelessness

- 30% of the homeless in Melbourne experience a mental illness, more if substance use is included
- Paranoia/delusions can result in fear about existing housing or conflict with neighbours
- Poor personal or housing hygiene can result in evictions
- Depression, disorganization and cognitive impairment prevent sustained work

Homelessness Causes Mental illness

- In homeless mentally ill, 50% develop mental illness only after becoming homeless
- Mental illness triggered or exacerbated by:
 - Constant social and practical instability
 - High risk of victimisation or assault
 - Increased physical health problems
 - Increased substance misuse

Factors Complicating Mental Health Treatment

- Chronic and severe mental illness
- Poor insight
- Multiple psychiatric or other health problems
- Substance misuse
- Reluctance to engage in health care
- Transience

Integrated Mental Health Initiative in Melbourne's Inner South

- Moving from an assertive outreach model to an integrated model
- Place clinical staff within non-clinical agencies full time

Assertive Outreach Model

- Recognition of the importance of addressing needs as perceived by the person
- Clinicians go to locations frequented by homeless (soup kitchens, crisis accommodation)
- Provision of adequate time to build relationships based on trust
- Assertive outreach with flexible hours
- Appropriate responses to unpredictable fluctuations in needs and capacities
- Cross service coordination and linkages
- Housing stability as key goal

Problems with Assertive Outreach Model

- Separation of mental health and other services
- Workers focus on different issues
- Different approaches to problems based on health or welfare model of care
- “Barrier” issues e.g. sharing information, case planning

Alfred HOPS

- Multidisciplinary case management
- Small caseloads
- Offer brief intervention and ongoing case coordination
- 8 hr /day
5 day/week



Hanover Southbank

- 46 bed emergency accommodation for singles and some couples
- All residents allocated a housing worker
- AOD and a range of health and wellness support

Sacred Heart Mission (3 sites)

- Drop-in meal and resource centre for 300-400 people/day
- Women's crisis accommodation
- Women's House (WH) - drop in resource centre for women



Initiative Aims

- Improved identification and engagement with consumers
- Holistic intervention to improve overall quality of life
- Early intervention to prevent crisis presentations
- Relationship building to improve engagement
- Improved housing stability
- Improved staff capacity

Focus on Education of Welfare Agency Staff

- Formal sessions
 - Mental state assessment
 - Medication adverse effects
 - Personality disorder
 - Behavioural management
- Informal education through:
 - Observation of modelling in shared consumer assessments and interventions
 - “Corridor consultations”

Demographics of referrals to HOPS

- Approx 200 referrals annually from community agencies to HOPS
- Average age mid-30s
- 6% arrival from interstate in the past 2 months
- 20% Currently case managed area mental health service
- 25% Admitted to any Victorian Psychiatry inpatient unit in past 12 months
- 30% Presented to the Emergency Department in past 12 months
- 55% Currently identified alcohol and substance misuse

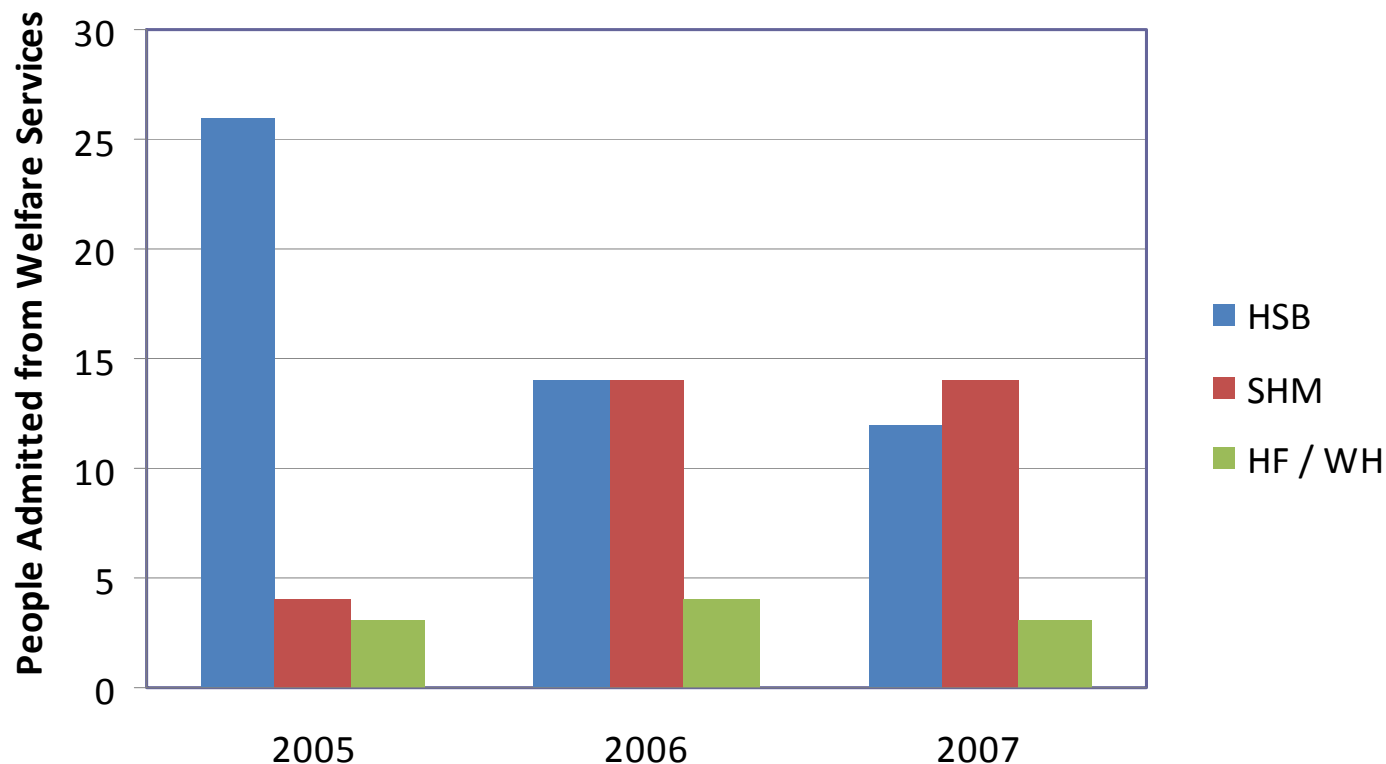
Reasons for referral

- 45% Psychotic symptoms
- 30% Depression and self harm
- 10% Aggression
- 10 % Medication issues
- 15% General assessment

Outcome of Referral and Initial Assessment

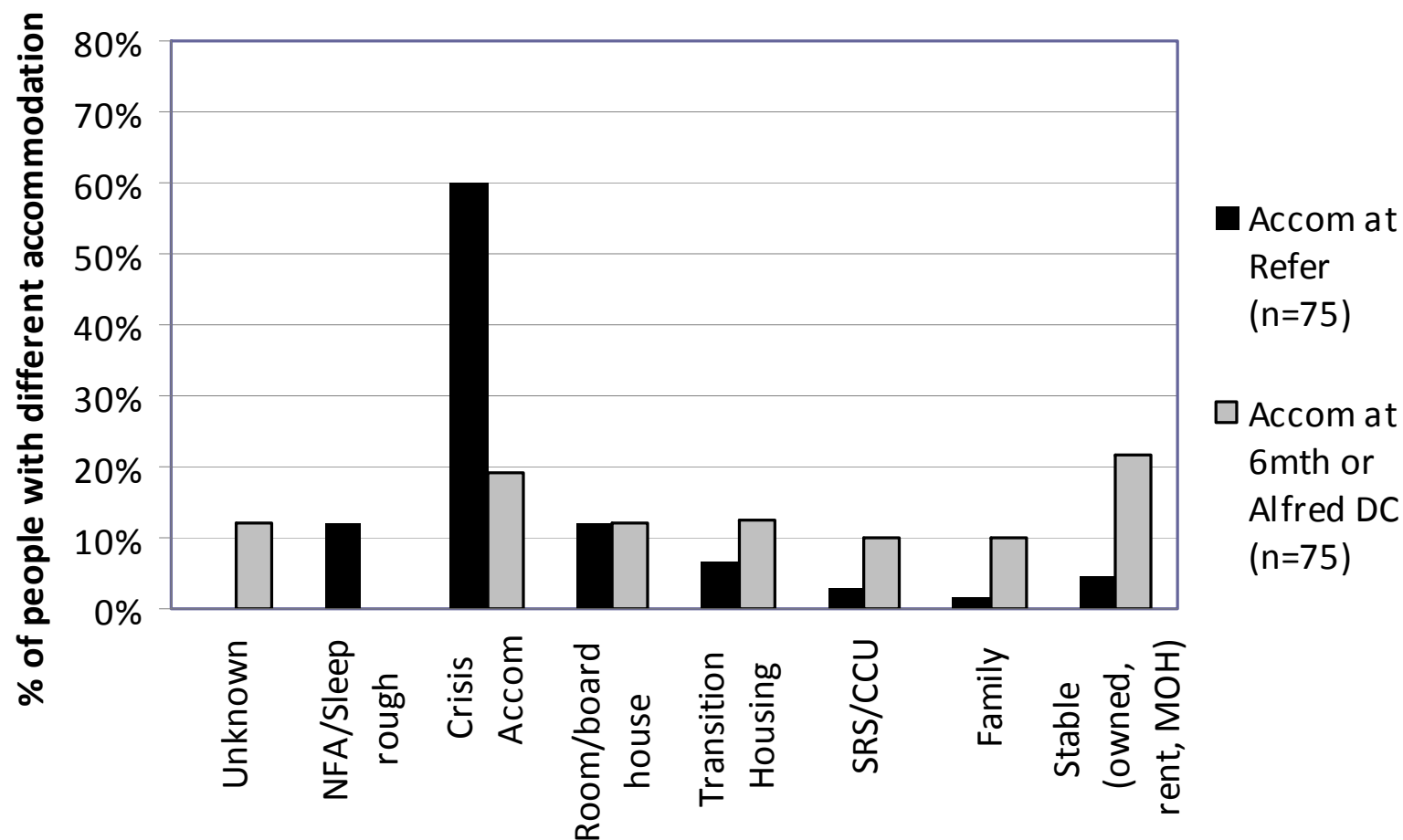
- 45% Secondary consultation only
- 10% Refuse assessment
- 15% Assessed and referred to other agency
- 30% engaged into psychiatric treatment (inpatient or community)
 - 53.4% up to 1 month
 - 33.9% 1-12 months
 - 12.7% case management for over 12 months

Inpatient Psychiatry Admission



Sig. differences in frequency of admission across the services pre and post initiative, $\chi^2(4, n = 94) = 12.53, p = .01$

Accommodation at Referral and six months in those clients case managed for at least one month



Consumer Feedback

Benefits	Challenges
<ul style="list-style-type: none"> • Practical and mental health help given that developed trust (e.g., housing, children, work) • Helped link into other health or support agencies (e.g., dentist, alcohol and other drug) • Consumers could see the same person over a long period, even coming from other regions to continue with one worker • Staff were understanding of people and their priorities • Staff were available, happy, efficient and respectful 	<ul style="list-style-type: none"> • MH staff have limited time and people must still rely on the Crisis service after hours • Increased resourcing is needed to allow staff more time to socialise • Specific services for teenagers and much older people limited

Staff Feedback



Benefits	Challenges
<ul style="list-style-type: none">• Improved identification and engagement with people with a Mental Illness• Decreased critical incidents and need for hospitalization• Improved MH responsiveness• Improved interagency communication (“know person on the other end of the phone”)• Improved staff capacity• Improved continuity of care• Improved consumer experience of mental health care	<ul style="list-style-type: none">• Staff turnover disrupts relationships between agencies and with consumers• Different protocols for sharing information can lead to a lack of clear communication at times• At times lack of understanding of skills & limits of staff from partner services• Mental Health Services governed by geographical boundaries• Difficult to resource multiple sites

Summary

- Small injection of funding assisted culture change between partner Mental Health & welfare agencies
- Service Integration with co-location resulted in:
 - Improved identification, engagement and crisis prevention for people suffering homelessness and mental illness
 - Improved housing stability for people able to be sustained in case management
 - Consumers given greater choice over how to access and engage in Mental Health care and supported to identify and achieve personal goals
 - Staff & Consumers positive about impact for them

Conclusion

- Any attempt to address the needs of homeless people with mental illness needs to shift from a "health" model of care to an integrated recovery model that addresses the broad range of social problems alongside the health problems.
- Targeted mental health services to homeless people must be integrated with housing services, but also need to be linked with primary care, physical health services, rehabilitation services, employment services, financial support services, substance abuse services and the justice system.

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