MENTAL HEALTH HOMELESS PATHWAYS

SECOND EVALUATION SNAPSHOT | APRIL 2021

WHAT IS MENTAL HEALTH HOMELESS PATHWAYS (MHHP)?

Since early 2019, the MHHP program has been operating across the Royal Perth Bentley Group (RPBG) to improve service delivery to mental health (MH) patients experiencing homelessness. The MHHP is active in identifying patients who are homeless and their support needs, providing discharge planning advice, and connecting people to housing and community support. Community follow up and supporting people to get housed are key features of the program, as once people are stably housed, other health and psychosocial issues can start to be addressed. Currently the MHHP is staffed by only one senior social worker who works across RPBG services including: Bentley Health Service (BHS), Royal Perth Hospital (RPH) mental health wards and community outpatient settings.

The MHHP recently won a 2020 EMHS Excellence award, was a finalist in the WA Mental Health Awards 2020 Innovation for Change and highly commended in the national Australian Council of Healthcare Standards Awards for Non-Clinical Service Delivery 2020.

CORE ELEMENTS OF MHHP

INTEGRATED, MULTIDISCIPLINARY HEALTH CARE AND OUTREACH

- Holistic approach
- Assertive Outreach
- Empathetic Staff
- Multidisciplinary Approach
- Case Management and Coordination of Services
- Continuity – Through Care Model
- Range of Health Care Services

HOUSING FIRST AND HOUSING FOCUSED SUPPORT

- Immediate access to Housing with no housing ready conditions
- Consumer choice and self-determination
- Recovery Orientation
- Individualised and person driven support
- Social and community integration

WHAT SUPPORTED HAS MHHP PROVIDED?

Between May 2019 and March 2021:

1,217 PEOPLE IDENTIFIED AS HOMELESS OVER RPBG WITH MH HISTORIES (including 417 BHS and RPH MH wards, 186 community outpatients over EMHS and 614 RPH admissions)

112 SUPPORTED INTO HOUSING AND ACCOMMODATION

40 DIRECTLY HOUSED VIA MHHP IN FOREVER HOME (including private rentals, supported MH facilities, reuniting with family and into public housing)

16 PEOPLE CASE MANAGED

138 CLINICIANS TRAINED IN HOUSING FIRST, VI-SPDAT AND BY NAME LIST

18 HOMELESS PATHWAYS CHAMPIONS TRAINED

MENTAL HEALTH INPATIENT USAGE IN THE TWO YEARS PRIOR TO MHHP SUPPORT

For the 417 patients identified as homeless within BHS and RPH MH wards they accumulated the following mental health hospital admissions in the two years prior:

23,647
DAYS ADMITTED AS MENTAL HEALTH PATIENT

$35.8MIL
BED DAY COSTS*

$86K
AVERAGE COST* PER PERSON
(over two years)

Overall, 44 people had admissions over 100 days, including one individual who was admitted for 753 days.

"Having a home means safety and security. I have a base. I can make it mine; this is something I have never had before. It feels amazing – I can even get a kitten now!" – **MHHP Patient**

Snapshot developed by Home2Health Team at the School of Population and Global Health, The University of Western Australia

* Data only includes the cost of psychiatric inpatient admissions and associated hospital use during admission (i.e. excludes ED presentations and non-psychiatric inpatient admissions). Average inpatient admission based on $1,514 per day as per AIHW (2021) Mental Health Services in Australia Report for the 2018-19 period in WA (table EXP.7).

THE UNIVERSITY OF WESTERN AUSTRALIA
HOME 2 HEALTH School of Population & Global Health The University of Western Australia
Royal Perth Bentley Group

KEY ELEMENTS OF SUPPORT AND ENGAGEMENT ACTIVITIES

ACCURATELY IDENTIFYING HOMELESS PATIENTS

Improving identification of patients experiencing homelessness across RPH Bentley Group, including:

- daily identification of NFA patients admitted
- recording homelessness status where it has not been previously identified
- daily updating of health databases with NFA status
- adding people to the By Name List and doing VI-SPDATs

ADDRESSING INDIVIDUAL NEEDS

- Identifying housing, psychosocial, and other needs and advocating on patient behalf to access support
- Connecting people to services that can assist with housing, legal, financial, social support, NDIS
- Providing practical assistance to facilitate access to support (e.g. completion of NDIS applications, housing priority listing support letters and applications, paperwork for ID, connecting with Centrelink, referral to community support services)

FACILITATING SAFE DISCHARGE PLANNING

- Connecting people to GPs and community health services
- Working alongside hospital multidisciplinary teams to advocate for safe/ appropriate discharge
- Community follow up of patients post-discharge in the community (e.g. home visits, assertive street outreach, linking in with community supports and capacity building)

CONNECTING PEOPLE TO HOUSING/ ACCOMMODATION

- Streamlining referral pathways with accommodation providers
- Facilitating access to short-term accommodation options to avert discharge into the streets
- Working with welfare officer (Bentley) to get patients onto priority public housing waitlist
- Provide practical move-in assistance (e.g. brokerage for furniture)
- Linking in with other wrap-around support services once housed (e.g. After Hours Support Service)

CAPACITY BUILDING AND UPSKILLING OF STAFF AROUND HOMELESSNESS

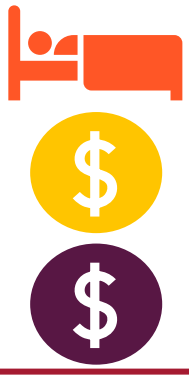
- Training clinical staff and social workers in RPH-Bentley group to identify and document homelessness
- Recruiting and training of 'homeless pathways' champions
- Building strong connections with hospital staff in different areas (e.g. social work, Aboriginal Liaison Officers, mental health clinicians) to facilitate pathways of care
- Development of homelessness resources and shared with Clinician's via Intranet Hub Page

HEALTH OUTCOMES - REDUCING MENTAL HEALTH HOSPITAL USE

OF THE

23

PEOPLE NOW HOUSED FOR AT LEAST ONE YEAR



	ONE YEAR PRE-HOUSING		ONE YEAR POST-HOUSING
MH INPATIENT DAYS	**3,167**	→	**68**
	$4.8MIL	→	$103K
in costs* (year pre) / (year post)			
per person (year pre) / (year post)	$208K	→	$4.5K

CASE STUDY

Background: Lincoln is an Aboriginal male in his late thirties who was diagnosed with treatment-resistant schizophrenia a decade ago. He experiences extremely violent auditory and visual hallucinations (exacerbated by ongoing polysubstance use), which have led to suicidal ideation and 49 days spent admitted at Bentley Mental Health in the year before he was housed. Lincoln has a history of aggression towards staff, smashing neighbours' windows and other aggravated behaviours when unwell. Lincoln also suffers from Diabetes, has a complex trauma history, a chronic history of street homelessness and fractured family relationships.

Support Provided: The MHHP social worker supported Lincoln into short-term accommodation post discharge, before he was housed in late-2020 in his forever home. He now receives After Hour's Support which consists of psychosocial support and diabetes management via Homeless Healthcare and has been supported to get an NDIS package to provide core and capacity building support. Lincoln continues to engage with the MHHP social worker and is compliant with his Depot; since getting regular medication, Lincoln has become very calm and cooperative and now wants to engage more with the community.

Current Situation: Through his NDIS package, Lincoln has recently engaged with a NDIS provider that can support him with his goals which include social opportunities, connecting to culture, literacy classes, building independence and volunteering opportunities. He also recently got his licence back and is saving up for a car so that he can visit his family in the country. Lincoln has had only 1 admission post-housing and was only there for 4 days due to having a home to go back to. He states that *"having this home keeps me happy, keeps me safe, keeps me well and now family are proud of me".*