Making Links Project:
Phase One Report

A coordinated project between AOD, Homelessness, and Mental Health Community Support Services

Northern and Western Metropolitan Melbourne
January 2016
# Table of Contents

1. **Introduction**
   
   a. Background p. 3
   b. Project Aim p. 4
   c. Project Objectives p. 4
   d. Key contacts p. 4

2. **Data snapshot**
   
   a. Graph 1: Percentage of people with a comorbid issue p. 6
   b. Worker survey p. 8
   c. Graph 2: Summary of qualitative staff responses p. 10

3. **Forum Report**
   
   a. Proposed priorities p. 14

4. **Statement of Intent**

5. **Next steps: Phase Two**

**Appendices**

- Appendix 1: Perceptions of each Sector – sourced from the Staff Survey
- Appendix 2: Summary of the Ideas brainstorm: Strengthening Our Service Response for Shared Clients
- Appendix 3: Summary of the AOD Sector
- Appendix 4: Summary of the Mental Health Sector
- Appendix 5: Summary of the Homelessness Sector
- Appendix 6: Summary of the Northern Family Violence Service System
- Appendix 7: Responding to family violence in the West
- Appendix 8: Case study
Introduction

During 2015 the Northern and Western Alcohol and Other Drugs (AOD) and Mental Health Catchment Based Planners and Homelessness Networkers established a joint project to progress the shared priorities of improving coordination and linkages across the three sectors in Melbourne’s north and west. We acknowledge the participation of the Department of Health and Human Services in the forum.

The consultation phase of the project commenced with three components:

- **A one day data collection snapshot** completed by workers in the three sectors: this was to get a picture of clients that might access services in our three sectors on any one day.
- **A survey of workers** in the three sectors: to start to quantify workers’ views on the strengths and opportunities for improving the integration between sectors.
- **A cross sector Making Links Forum**, held on 3 December 2015: bringing the sectors together to create a shared understanding of how clients are accessing services; how each service system operates; and, to provide an opportunity to explore how to improve service coordination.

This report provides an overview of this phase of the project.

Background

The 2014 re-commissioning of the AOD and Mental Health Community Support Services (MHCSS) sectors brought with it the introduction of sector-specific catchment based planning and the creation of the area planner roles, which are charged with progressing coordinated sector priorities. This sector planning is mirrored in the Homelessness sector, which has been operating as a coordinated service system, with a shared strategic plan, for the past six years.

The establishment of the Making Links Project provides the opportunity for greater cross sector collaboration, which is a priority area identified in all three sectors:

- The MHCSS /Alcohol and Other Drugs Regional Stakeholder Forum highlighted the importance of inter and intra-network coordination. With wide-ranging input, this forum’s prioritisation process emphasised the need to establish and rebuild relationships, information sharing and integration with other services, including with each other and homelessness services.
- It was also recognised that the re-commissioning of the MHCSS and AOD services has created significant change, service disorientation and disruption in service provision and quality client
responses. This has been reported universally, with feedback received from clients as well as from those working in clinical and managerial capacities.

- Improved coordination with the AOD and Mental Health sectors was identified by the Northern and Western Homelessness Networks and the Northern Integrated Family Violence Services Partnership as a key strategic priority for 2015.

**Project Aim**

**Phase One**

To improve coordination and linkages across the AOD, Homelessness, Mental Health and Family Violence sectors for the benefit of shared clients.

**Phase Two**

To broaden the achievement of this aim across other sectors, such as the Family Violence, Primary Health and Justice Sectors.

**Project Objectives**

Based on extensive consultation, the Making Links project was brought together with the following key objectives:

- Create a shared understanding of who our shared clients are and how they are accessing services
- Provide an orientation to each other’s service system
- Create an opportunity for collaborative problem solving in response to client and systems issues
- Enable cross-sector networking
- Provide an opportunity to explore how to improve service coordination for shared clients, and
- Better understand the potential further change to each other’s sectors, in particular concerning:
  - The recent release of the Aspex review of the MHCSS and Drug Treatment Services
  - The forthcoming NDIS, and
  - Anticipated changes in the Housing & Homelessness sector.

**Key contacts**

The Making Links project has been convened by:

- Grant Liptrot, Catchment Based Planning Manager, Cohealth: 9411 4345 or grant.liptrot@cohealth.org.au
- Sarah Langmore, Western Homelessness Networker: 0407 832 169 or sarah@wombat.org.au
• Meredith Gorman, Northern Homelessness Networker: 0424 112 445 or Meredith.gorman@launchhousing.org.au

• Louise Richardson, AOD Health Service Planner, Uniting Care ReGen and Odyssey House Victoria, Ph: 9420 7616 or LRichardson@odyssey.org.au.

Thanks also to the Northern Integrated Family Violence Committee for their presentation at the Forum. They will be represented in Phase Two of the project by:

• Sarah Johnson, Northern Regional Integration Coordinator, Northern Integrated Family Violence Services, Ph: 9484 1666 or sarahj@whin.org.au.
Data Snapshot

In preparation for the Making Links forum, staff members across the three sectors were asked to report on people they were currently working with (either in their case load, or in the case of intake workers, all the people they assisted on one day). In total 235 workers completed the data snapshot, 39 from the AOD sector, 66 workers from the homelessness sector and 140 from MHCSS. On the single day across the three sectors, data was collected on 2,275 clients.

With regard to the cohort they were currently working with on that day, case workers or clinicians in each of the three sectors were asked to identify:

- How many clients reported need in one or both of the other sectors
- How many additional clients they assessed as having needs to be met by the other sectors
- How many clients were receiving a service from one or both of the other sectors
- How many would benefit from receiving such a service from one or both of the other sectors.

From this data we were able to begin to quantify the crossover between our three service sectors and a strong shared need across the three sectors emerged.

Graph 1: Percentage of people with a comorbid issue

One quarter of all clients presented with needs across all sectors. Of the people with at least one identified need, 57% was identified by the client and 32% by the worker. The survey data distinguished between male and
female and by age. In terms of raw data, approximately twice as many people over 25 presented with multiple needs compared to those under 25. It is likely that this can at least partly be explained by the relative number of people accessing the sectors.

A fairly even split between male and female clients was identified with some minor variation. This trend for gender was generally consistent across all items. In relation to people with at least one identified need 52% were female and 48% were male. This contrasted with workers identifying the need when the client hadn’t: 46% female and 54% male. A similar trend was evident for people with multiple needs, males and females equally self-identified; however, workers identified males with multiple needs at a higher rate, 56% to 44% for females.

The table below captures some other key findings.

<table>
<thead>
<tr>
<th>Finding</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>57% of people who identified as homeless and currently receiving service within the AOD or mental health sector are linked to homelessness services</td>
<td></td>
</tr>
<tr>
<td>89% of those people who identified as homeless who are not currently linked to homelessness services would benefit from a service</td>
<td></td>
</tr>
<tr>
<td>40% of people with identified mental health issues and currently serviced within another sector are linked with a mental health service</td>
<td></td>
</tr>
<tr>
<td>23% of people with AOD issues and currently serviced within another sector are linked with an AOD service</td>
<td></td>
</tr>
<tr>
<td>Only 30% of people with needs across the three sectors are linked across all three sectors</td>
<td></td>
</tr>
<tr>
<td>Of those with needs across all three sectors but not currently linked, respondents’ report 48% of those clients would benefit from engagement with the three sectors</td>
<td></td>
</tr>
</tbody>
</table>

It may be possible to draw some inferences from this data, in particular, workers identify homelessness as an issue requiring intervention and support at higher rates than the other two sectors. Workers may be providing support beyond their specialist field reflecting a broader human service response, when possible. The higher reports of comorbidity reported for people over 25, notwithstanding the potential concerns outlined earlier, may reflect more entrenched complexity in this cohort and the need for a broader approach.

**Limitations**

A note of caution is warranted when interpreting this information. Due to the recent reforms in the AOD and MHCSS sectors in particular, data available to the project was limited. Our services are delivered in an environment of ongoing change, and it was felt that there was benefit in proceeding on best available
data instead of waiting for access to ‘perfect data’. The data here is limited to what was reported by workers who participated in the snapshot, and is not drawn from a review of client data. It only addresses the homelessness, AOD and MHCSS sectors, so does not cover all human service needs. A more detailed analysis of the data is available in the attachments.

Future iterations of this project will look to include a review of client data from our respective databases, survey questions may seek academic review for validity and the project will explore opportunities to include data from other sectors.

**Worker Survey**

In addition to the data snapshot, a worker survey was developed to draw out the perceptions of staff members working in the system. In total, 151 workers completed the survey across the three sectors. In terms of experience in their sector, 30% of respondents have been working for less than 2 years, 26% for between 2 and 5 years and 44% for more than 5 years.

More than half of the staff members from the AOD sector report making referrals to the other sectors (67% of respondents have made referrals to homelessness services and 55% to mental health). This contrasts with the other two sectors, both below 40%. Across all three sectors, approximately 44% of survey respondents had made a referral; a total of 329 referrals were reported. Clients already linked to services or clients not having a need were the two primary reasons reported for not making referrals.

A series of statements were put to respondents to build an understanding of workers perception about how easy or challenging it is to work in partnership with the other two sectors. Their collated responses are tabled below and summarised in Graph 2 (p.9).

In relation to working with the AOD sector, as reported by homelessness and mental health workers:

**Table 1 Working with the AOD sector**

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Partially Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found the referral process into AOD services straight forward</td>
<td>28%</td>
<td>44%</td>
<td>28%</td>
</tr>
<tr>
<td>My clients found the referral process straight forward</td>
<td>12%</td>
<td>39%</td>
<td>49%</td>
</tr>
<tr>
<td>I was able to share information about my client (with consent)</td>
<td>62%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>Ability to work in an integrated way with AOD services to meet client need</td>
<td>26%</td>
<td>47%</td>
<td>27%</td>
</tr>
</tbody>
</table>
In relation to working with the homelessness sector, as reported by AOD and mental health workers:

**Table 2 Working with the Homelessness sector**

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Partially Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found the referral process straight forward</td>
<td>37%</td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>My clients found the referral process straight forward</td>
<td>24%</td>
<td>48%</td>
<td>28%</td>
</tr>
<tr>
<td>I was able to share information about my client (with consent)</td>
<td>67%</td>
<td>30%</td>
<td>3%</td>
</tr>
<tr>
<td>Ability to work in an integrated way with homelessness services to meet client need</td>
<td>30%</td>
<td>48%</td>
<td>22%</td>
</tr>
</tbody>
</table>

In relation to working with the mental health sector, as reported by AOD and homelessness workers

**Table 3 Working with the Mental Health sector**

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Partially Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found the referral process straight forward</td>
<td>26%</td>
<td>59%</td>
<td>15%</td>
</tr>
<tr>
<td>My clients found the referral process straight forward</td>
<td>22%</td>
<td>51%</td>
<td>27%</td>
</tr>
<tr>
<td>I was able to share information about my client (with consent)</td>
<td>29%</td>
<td>29%</td>
<td>42%</td>
</tr>
<tr>
<td>Ability to work in an integrated way with AOD services to meet client need</td>
<td>32%</td>
<td>43%</td>
<td>25%</td>
</tr>
</tbody>
</table>

A note of caution with the reported findings, many respondents left items blank in the survey, so percentages were calculated against those completing the item.
Graph 2: Summary of qualitative staff survey responses

- I found the referral process in to AOD services straight forward
- I found the referral process in to Homelessness services straight forward
- I found the referral process in to Mental Health services straight forward
- My clients found the referral process in to AOD services straight forward
- My clients found the referral process in to Homelessness services straight forward
- My clients found the referral process in to Mental Health services straight forward
- I was able to share information about my clients (with consent) with AOD services
- I was able to share information about my clients (with consent) with Homelessness services
- I was able to share information about my clients (with consent) with Mental Health services
- Ability to work in an integrated way with AOD services to meet client need
- Ability to work in an integrated way with Homelessness services to meet client need
- Ability to work in an integrated way with Mental Health services to meet client need
Respondents were asked to provide a narrative about their perceptions working with the other two sectors. This narrative text has been collated and key themes extracted. A summary of the themes is available as an attachment (Appendix 1).

Some of the key findings include:

- Comments on the intake or entry points into the service systems: Respondents were divided on the effectiveness of a centralised (mental health and AOD) vs. a dispersed access point intake system. Generally respondents favoured single entry points however many were concerned about the length of the intake assessment process and the length of waiting for a service.

- Staff members were viewed in a positive light between sectors: Respondents felt workers in other sectors were professional and committed to good practice.

- Suggestions for system improvements fit mainly into system, process or practice based issues, and were explored further at the Making Links forum. Specific themes emerged around:
  - Better communication and collaboration
  - Regular opportunities for networking, orientation and knowledge sharing
  - Mechanisms for better understanding of each other’s practice and approach to client work.
Forum Report

The purpose of the Making Links Forum was to bring the three sectors together to create a shared understanding of how clients are accessing services; how each service system operates; and to provide an opportunity to explore how service coordination can be improved.

The Forum was facilitated by Kris Honey of KNH Consulting and attended by 110 representatives of the AOD, Mental Health, Integrated Family Violence, Primary Health and Homelessness Sectors and from the Victorian Department of Health and Human Services.

This was an action-based forum. The aim was to draw on the expertise of the participating Sectors to develop practical steps to address issues raised through our data collection with the specific objective of improving responses to shared clients.

The Forum commenced with a presentation from representatives of each Sector on the services provided by the sector and the respective client service pathways. The Northern Integrated Family Violence Services also provided information on the Integrated Family Violence System. This was followed by a presentation on the data from the one day data snapshot and the key findings from the worker survey responses. As previously discussed, the data has highlighted a sizeable number of people who are currently experiencing issues that intersect across all the participating Sectors.

Launch Housing then presented a case study (Appendix 6), telling the story of a woman who has had contact with the AOD, Mental Health, Family Violence and Homelessness Sectors over a period of about 25 years. For five to six of these years, Susan was living in her car. The case study provided a sobering reminder of the extent of difficulties and complexity of issues being faced by the significant number of people who are experiencing substance use, mental health issues and who are homeless.

In small groups participants then brainstormed possible actions to strengthen service responses for shared clients prompted by the following themes that had emerged from the worker survey:

- Systems responses/improvements
- Worker knowledge/practice improvements – working better with people with AOD/Mental health/housing issues – core competencies
- Working together to address demand – diversion, brief intervention
- Opportunities to work together with shared clients- coordination
- Shared approaches to shared clients – collaboration [Frequent service users]

A summary of the outcomes of this brainstorming exercise is provided in Appendix 2.
The groups were then asked to identify up to three of their ideas, develop these further and present them to the whole group. After all the ideas had been presented, each person was asked to vote on the top three actions they most supported. They could allocate five ‘points’ to their first choice, three points to their second choice and one point to their third. The following section on Proposed Priorities lists those ideas presented in the order of the votes they attracted (see pages 13 – 15).

At the end of the Forum a number of participants expressed their interest in being part of a working group to take the outcomes from the session forward. This group met for the first time on 11 December 2015 and has formed itself as a Steering Group to progress the key priorities identified at the Forum.
Strengthening Our Service Response for Shared Clients – Proposed Priorities

Introductory comments

In a brief discussion on the proposed priorities comment was made on:

- **The importance of asking clients what they thought**: Their views should be sought about what they think will make a difference before the priorities are determined. A number of agencies have consumer consultation structures and mechanisms that can be better utilised.

- **The importance of taking account of the existing service infrastructure**: There are specific services, for instance, that have a focus on clients with complex needs such as MACNI, Services Connect and PIR [although PIR is not available in Wyndham and Hobson’s Bay]. It is important to consider what is currently in existence before creating new service responses.

There needs to be some further thinking on the proposed priorities, as some may seem to duplicate or to outline an approach that contradicts the other. For example, in order to strengthen coordination of services to shared clients: the first priority – “Mc Hub” (Interim Title) - suggests physical co-location while other ideas look to systems and processes changes; the second most popular action proposes targeting a group of shared clients and developing a specific response to that cohort. There is merit in developing multi-pronged approaches to addressing client need in a coordinated way, and we must remember that what might work for one group of clients may not work for another.

In considering what actions to pursue, the group suggested focusing on ‘quick wins’ in helping to facilitate buy-in and to build on the momentum of the Forum. Other - equally important - actions will take time to plan and implement, there is support for ongoing cross sector engagement to develop these.

The task for the working group was to review the proposed priorities and to develop a plan of action. The group met on December 11 to commence this process.

Proposed Priorities

Each table at the Forum was asked to propose up to three priorities from their brainstorm list. These were then presented to the room and each person had an opportunity to vote on their top three. The proposed priorities are ordered according to how many votes they attracted.

1. **McHub [102 votes]**
   - A desk space, hosting rostered practitioners from complementary services on a regular rotation. The benefits are knowledge sharing; individual clients get a wrap-around service in a timely manner; and client centred approach. So time saving, dollar saving, and efficient.
   
   - Co-location with a service response that has the following characteristics:
     - Shared planning tool that meets all clients cross sector needs
     - External key worker – PIR; HOMHS
     - Central assessment point with highly skilled and highly trainers assessors with the allocation of a key worker
     - Cross sector trauma informed practice.

2. **Shared Responses [92 votes]**
   - Develop a common frequent service user (FSU) register
• Create area based panels to develop plans for FSUs. They would meet quarterly to triage, share information and direct action
• Target top 100 shared clients intensively [like Taskforce 1000]
• Members of the panels would have the authority, scope and resources to dedicate
• The intent is to reduce demand; address chronic needs group; and, make way for more early intervention and prevention work.

3. Shared Practice Model [71 votes]
• Develop common ground amongst the three sectors
  o Shared language
  o Holistic approach [person centred]
  o Practice guidelines
• Relationship building within catchments [networks]
• Shared responsibilities
  o defining roles
  o care planning – case conference
• Shared training to support consistency [better understanding] and best practice

4. Collaborative intake assessment and service delivery [55 votes]
• ‘One stop shop’ approach
• Apply principles of care coordination including clinical case meetings
• Improve resources, skill development and knowledge
• Have centralised intake across AOD, community mental health and housing and homelessness support services. In coming together they would reduce duplications of information so the client doesn’t have to tell their story numerous times. [note: as long as there is client consent]

5. Communication/Information Sharing – Practical things we could do now [47 votes]
• Feedback post referral - regular updates and shared plan
• Need to identify who takes the lead in case coordination
• The first step would be to share plan

6. Reciprocal rotations for staff into other service sectors [46 votes]
• Would be a six month rotation
• Would require some resourcing. Previous DHS had provided some support.
• Particularly relevant for those working in the intake/access part of the service response

7. Brief interventions while people are on waiting lists [46 votes]
• Ensure support for all clients on waiting lists – regular contact and online waiting module that provides self-management strategies and centralised data base which captures all the services [where they are and what they offer].

8. Clients requiring multiple supports [29 votes]
• Co-case coordination, including client, meetings to enable cross sector planning
• ‘Common’ tool development and framework to capture meeting information and planning
• One plan with clarity regarding roles and responsibilities
• Consent regarding information is covered
• Record of meeting
• Identifies the key worker to organise/facilitate meeting and take record of meetings and distributes

9. **Opportunities for workers to gain understanding of different service sectors [29 votes]**
   • Forums for workers
   • Orientation agreements
   • Secondary consultations
   • Shadowing opportunities
   • Co-location
   • Attending clinical reviews

10. **Shared Consent [ROI] for information Sharing Across Service Sectors [29 votes]**

11. **Positive approach by workers [8 votes]**
   • Improve worker approach to referring clients to intake services. Look at language being positive; frame of reference positive and helpful; positive motivational; and inspiring others.

12. **Centralised Triage [0 votes]**
   • Activate referral for sector specific comprehensive assessments along the model of 000 for fire, ambulance and police
   • Use the learning from Services Connect and provide a centralised case allocation function [e.g. Child First] for complex clients and provide regular/scheduled orientation for new workers in each sector
   • As a step out or extension to centralised triage secure flexi-funding to allow for one worker doing active case coordination [distinct form case management] and funding for client to be able to access different services.

13. **Shared/contemporary services information directory [0 votes]**
   • Defining boundaries/catchments
   • Providing information on waiting lists – how to enrol/register and current wait times.
Statement of Intent

The cross sector Making Links Steering Group has produced the following ‘Statement of Intent’ identifying each Sector’s commitment to progressing the cross sector priorities identified at the Making Links Forum. The Statement of Intent will be circulated to each Sector for comment and sign off in February 2016.

Making Links

A coordinated project between AOD, Homelessness and Mental Health Community Support Services in the North and West Metropolitan Regions.

Statement of Intent

The signatories to this Statement of Intent endorse the work of the Making Links Project to improve coordination and linkages across the AOD, Homelessness and Mental Health services for the benefit of shared clients.

Each Sector is represented on the Project Cross Sector Steering Group. Membership of the Steering Group is open to other sectors identified as assisting shared clients.

Each of the Sectors involved in progressing this work acknowledges that this cross sector work, whilst drawing on the specialist fields of expertise of each of the individual Sectors, will focus on agreed collective needs and the shared priorities of improving coordination and linkages across Sectors.

The signatories support the progress of the shared priorities for 2016 identified at the Making Links Forum (and fine-tuned by the Cross Sector Steering Group) through four time limited working groups:

- **Orientation Working Group** - to develop opportunities for sharing training, orientation and information across the three Sectors.

- **Frequent Service User Working Group** - to consider mechanisms to improve our work with shared clients who have complex needs.

- **Practice Working Group** – to work on case coordination, incorporating shared tools ie assessment, referral, case review.

- **McHub Working Group (working title)** – to progress the “McHub” proposal tabled at the Forum with a focus on exploring ease of access for clients, ease of access to information for workers, and reducing the complexity of intake and assessment processes.
The four Working Groups, plus the Steering Group meetings, will initially be resourced by the Homelessness Network Coordinators and the AoD and Mental Health Community Support Services Catchment Planners in the North and West Metropolitan Regions. A Terms of Reference including timeframes and venues will be developed by each Working Group in the initial stages of each group's formation. The Networkers and Catchment Planners will convene and resource the groups with the role of chair shared amongst all working group participants. The aim is for the working groups to become self-sufficient overtime and able to drive processes on their own.

The working groups will report regularly to the Cross Sector Steering Group. Participants in the Steering and Working Groups will commit to keeping their Sector informed of the progress of this work.

The Steering Group will report regularly to the governance groups of each of the participating Sectors (i.e. Homelessness Local Area Service Network). Any project proposals for practice and system developments will be directed to these governance groups for sign off.

**Next steps: Phase Two**

The cross sector Steering Group that was formed after the Making Links Forum will establish Working Groups that will progress the project throughout 2016:

- **Orientation Working Group** – to develop opportunities for sharing training, orientation and information across the three Sectors.

- **Frequent Service User Working Group** – to consider mechanisms to improve our work with shared clients who have complex needs. One proposal to be explored is the establishment of catchment based panels across our Sectors working together on shared support for clients experiencing complex issues.

- **Practice Working Group** – to work on case coordination, incorporating shared tools like assessment, referral, case review. This Working Group will work on improving case coordination, case planning, feedback following case planning, improving understanding of respective roles, using an agreed case review process as an opportunity to understand each other’s sectors better, incorporating management of confidentiality, who takes the lead in case coordination, allocation of responsibilities, the extent to which client does or doesn’t participate, identification of program gaps through practical case review process.
• “McHub” Working Group – to progress the “McHub proposal” tabled at the Forum with a focus on exploring ease of access for clients, ease of access to information for workers, and reducing the complexity of intake and assessment processes.

Invitations to join the Working Groups have been sent to all those who participated in the Forum and more broadly, to the AOD, Mental Health Community Support Services, Integrated Family Violence and Homelessness sectors.
Appendices
# Appendix 1: Perceptions and Comments on the AOD Sector

<table>
<thead>
<tr>
<th>Systems Responses</th>
<th>Process Responses</th>
<th>Practice Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake/Referral</strong></td>
<td><strong>Process Responses</strong></td>
<td><strong>Practice Issues</strong></td>
</tr>
<tr>
<td>Long waiting periods for service</td>
<td>Fragmented and complicated process</td>
<td>Professional and Collaborative Response</td>
</tr>
<tr>
<td>System is overwhelming</td>
<td>Difficult to navigate</td>
<td>Difficult for clients with dual diagnoses to navigate the system</td>
</tr>
<tr>
<td>Barriers in place to limit working together</td>
<td>More information needed about the AOD referral process.</td>
<td></td>
</tr>
<tr>
<td>Intake requires too much information</td>
<td>Phone intake is too long</td>
<td></td>
</tr>
<tr>
<td>Inadequate capacity for prevention/early intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What is working well</strong></td>
<td><strong>Accessibility of central intake number</strong></td>
<td><strong>Quick response</strong></td>
</tr>
<tr>
<td>Integration with other services</td>
<td>Easy to locate intake details</td>
<td>Consistent response</td>
</tr>
<tr>
<td>Simple, straightforward process. Clients have fed back that they find the process easy to manage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Areas requiring improvement</strong></td>
<td><strong>Easier intake process for people with multiple needs</strong></td>
<td><strong>Limited feedback following referral</strong></td>
</tr>
<tr>
<td>Too strict service criteria</td>
<td></td>
<td><strong>Inadequate numbers of dual diagnosis staff</strong></td>
</tr>
<tr>
<td>Lack of service options, linked across sectors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long waiting periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficultly in navigating the system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Suggestions for improvements</strong></td>
<td><strong>Greater flexibility in intake</strong></td>
<td><strong>Focus on collaboration</strong></td>
</tr>
<tr>
<td>Drop in options for clients with multiple needs</td>
<td>Map intake and referral pathways</td>
<td>Time to communicate and work together</td>
</tr>
<tr>
<td>More capacity detox/rehab</td>
<td>Simplify assessment</td>
<td>Opportunities for joint training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review joint clients together</td>
</tr>
</tbody>
</table>
## Perceptions and Comments on the Homelessness Sector

<table>
<thead>
<tr>
<th>Systems Responses</th>
<th>Process Responses</th>
<th>Practice Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake/Referral</strong></td>
<td>Crisis Driven</td>
<td>No appointments/long wait</td>
</tr>
<tr>
<td></td>
<td>Lack of housing</td>
<td>Straight forward</td>
</tr>
<tr>
<td><strong>What is working well</strong></td>
<td>Centralised access points</td>
<td>Straight forward intake/referral</td>
</tr>
<tr>
<td></td>
<td>Less rigid criteria</td>
<td>Information cards are useful</td>
</tr>
<tr>
<td></td>
<td>Range of options</td>
<td>Solution focussed</td>
</tr>
<tr>
<td><strong>Areas requiring improvement</strong></td>
<td>Lots of services to navigate</td>
<td>Referral pathways unclear</td>
</tr>
<tr>
<td></td>
<td>Lack of information for those outside system</td>
<td>Better linkages with intake services</td>
</tr>
<tr>
<td></td>
<td>Housing Stock</td>
<td></td>
</tr>
<tr>
<td><strong>Suggestions for improvements</strong></td>
<td>Establish communication channels</td>
<td>Information on system/service navigation</td>
</tr>
<tr>
<td></td>
<td>Available service publication</td>
<td>Services to complete Assessment information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More direct referrals</td>
</tr>
<tr>
<td>Intake/ Referral</td>
<td>Systems Responses</td>
<td>Process Responses</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
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<tr>
<td></td>
<td>Long wait times</td>
<td>Phone assessment is difficult for some</td>
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<tr>
<td></td>
<td>Catchment locations confusing</td>
<td>Process is difficult to understand</td>
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<tr>
<td></td>
<td>Need clarity about role of Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone assessment is difficult for some</td>
</tr>
<tr>
<td>What is working well</td>
<td>Comprehensive needs assessment</td>
<td>Updates on needs register/vacancy</td>
</tr>
<tr>
<td></td>
<td>Flexible service</td>
<td>Anyone can refer</td>
</tr>
<tr>
<td></td>
<td>Centralised Intake</td>
<td></td>
</tr>
<tr>
<td>Areas requiring improvement</td>
<td>One state wide number</td>
<td>Streamlined and shorter referral process</td>
</tr>
<tr>
<td></td>
<td>Service mapping publication</td>
<td>Focus on those with complex needs</td>
</tr>
<tr>
<td></td>
<td>Better links with clinical services</td>
<td></td>
</tr>
<tr>
<td>Suggestions for improvements</td>
<td>Coordination across sectors</td>
<td>Greater flexibility in use of service tools</td>
</tr>
<tr>
<td></td>
<td>Address waitlist</td>
<td>Coordination across sectors</td>
</tr>
<tr>
<td></td>
<td>More workers</td>
<td>Workshop – cross sector referral pathways</td>
</tr>
<tr>
<td></td>
<td>Increase range of services</td>
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</tbody>
</table>
Appendix 2: Strengthening Our Service Response for Shared Clients – Ideas Brainstorm

Note: Each group’s response is in the one cell within each table. Not all groups provided ideas across all of the themes. The ordering of the groups’ responses within each theme is random. The order in which the responses to the themes occur is based on the number of groups who provided responses to each theme.

It is interesting to note the level of interest in shared approaches to shared clients; stronger collaboration in relation to shared clients; and opportunities to strengthen worker knowledge and development. Some of the same ideas reoccur across these theme areas.

a) Shared approaches to shared clients – collaboration (frequent service users)

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<tr>
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<tbody>
<tr>
<td>● Collaboration in relation to developing cross-sectional relationships through professional development and secondary consultation</td>
<td>● Share data across all sectors – authorised environment</td>
<td>● Better shared data portal/information sharing/interconnected client management systems</td>
<td>● Partners in Recovery</td>
<td></td>
</tr>
<tr>
<td>● Recognising that there needs to be a change in culture. Be more prepared to share resources, knowledge and experience across all sectors</td>
<td>● Ground level collaboration and higher level collaboration</td>
<td>● Where we can share our high priority clients</td>
<td>● Flexibility</td>
<td></td>
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<tr>
<td></td>
<td>● “Collective Impact”</td>
<td>● Learn from where similar programs have been rolled out in other sectors</td>
<td>● “Whatever it takes” attitudes</td>
<td></td>
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<td></td>
<td>● Service Coordination Care Plans by one case manager</td>
<td>● Flag raised between services</td>
<td>● Shared framework to identify FSU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case conferencing</td>
<td></td>
<td>● What is an FSU?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consistency of approach</td>
<td></td>
<td>● All services can access this information</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>● Dual diagnosis sector – colocation</td>
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<td></td>
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<td></td>
<td>● “Multiple eligibility”</td>
<td></td>
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<td>● Multidisciplinary teams</td>
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<td></td>
<td>● Feedback post referral</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Intake – invite other support services to intake with new clients</td>
<td></td>
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<tr>
<td>● AOD and MHCSS – collaborating complex needs, short-term AOD interventions, plus long-term MHCSS</td>
<td>● Taskforce 1000 type responses</td>
<td>● Development of shared care plans – with work towards client ownership/management</td>
<td>● Case conferences</td>
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<tr>
<td></td>
<td>• Quarterly area based panels</td>
<td>● Reducing the possessiveness of “our” documentation</td>
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<tr>
<td></td>
<td>• Across all sectors, members have the authority to dedicate actual resources and time</td>
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<td></td>
<td>• Top 100 shared clients</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td>• Shared case plans – utilising PIR</td>
<td>• Case conferences</td>
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<td></td>
<td>• Co-location of services</td>
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</tbody>
</table>
### b) Worker knowledge/practice improvements – working better with people with AOD/mental health/housing issues – core competencies

<table>
<thead>
<tr>
<th>Training across all three</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focused on all three</td>
</tr>
<tr>
<td>• Complexity - Practice improvement to support consistency and best practice approach to be the same across all sectors based on understanding (deep) of all three sectors</td>
</tr>
<tr>
<td>• Develop shared understanding across all three sectors and relationship building within catchment. Shared responsibility. This is a good starting point</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language/frame of mind/message clinicians give to clients/negative thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Using intake number as general information, not purely for referral/assessments</td>
</tr>
<tr>
<td>• Central database [pooling all services together]</td>
</tr>
<tr>
<td>• Feedback passed back to workers and other services involved</td>
</tr>
<tr>
<td>• System improvement – intake systems for AOD, MH and H – communicating and integrate screening</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared orientation sessions for clients with complex needs – regular/scheduled. Different sectors describe their services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Encourage each sector to perform the initial screen for other sectors as part of the referral process [e.g. MIND does the AOD initial screen when referring clients to AOD]</td>
</tr>
<tr>
<td>• Combine all centralised intake into one (initial task to ask the client what service they want) and then utilise the sector tool or develop an appropriate cross-sector tool</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Secondment/transferring between sectors in intake and assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clear ‘appeals process’ to</td>
</tr>
<tr>
<td>• Intake and assessment (i.e. eligibility)</td>
</tr>
<tr>
<td>• Allocated number of sessions</td>
</tr>
<tr>
<td>• Planners to explore data from access points in regards to those who don’t continue to referred service where do they go? What is the number that declined at multiple points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Understanding the best options or lack of options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care coordination, intake/assessment, referrals, terminology – all mean something different depending on where you’re working</td>
</tr>
<tr>
<td>• Networking opportunities</td>
</tr>
<tr>
<td>• Understanding eligibilities</td>
</tr>
<tr>
<td>• Opportunity to debunk myths</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How can we easily access information services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• By workers</td>
</tr>
<tr>
<td>• By clients</td>
</tr>
<tr>
<td>• For different services – AOD, MH, H</td>
</tr>
<tr>
<td>• Regional perspectives</td>
</tr>
<tr>
<td>• Whole of sector [i.e. across regions]</td>
</tr>
<tr>
<td>• Shared orientation [AOD, MH, H] for each sectors new workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities for workers to gain understanding of service systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Forums</td>
</tr>
<tr>
<td>• Orientation to services</td>
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<td>• Secondary consultation</td>
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<td>• Shadow opportunities</td>
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<td>• Reciprocal rotations in each sector</td>
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<th>Cross sector service placements and visits</th>
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<tbody>
<tr>
<td>• Lead agency provides ‘hub’ desks for visiting agencies/workers</td>
</tr>
<tr>
<td>• Can see clients</td>
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<tr>
<td>• Research/evidence</td>
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<tr>
<th>Trauma informed practice across all sectors</th>
</tr>
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<tbody>
<tr>
<td>• Training and sharing knowledge about this complex client group</td>
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</thead>
<tbody>
<tr>
<td>• Training and sharing knowledge about this complex client group</td>
</tr>
</tbody>
</table>
### c) Opportunities to work together with shared clients – coordination

<table>
<thead>
<tr>
<th>Opportunity/Challenge</th>
<th>Co-location/shared use of facilities</th>
<th>Cross-sector training</th>
<th>Services Connect?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared orientation sessions for clients with complex needs – regular/scheduled. Different sectors describe their services</td>
<td>E.g. what happens with Salvos and Vincent Care</td>
<td>Spend time with each other</td>
<td>Make use of cross sector experience/secondary consults to become normal approach</td>
</tr>
<tr>
<td>Encourage each sector to perform the initial screen for other sectors as part of the referral process [e.g. MIND does the AOD initial screen when referring clients to AOD]</td>
<td>Builds relationships with other sectors</td>
<td>Regular training session – skill share opportunities</td>
<td>Willingness to share – change to culture of protecting domain</td>
</tr>
<tr>
<td>Combine all centralised intake into one (initial task to ask the client what service they want) and then utilise the sector tool or develop an appropriate cross-sector tool</td>
<td></td>
<td>Access to each other’s publications – subscribe to each other’s news</td>
<td>Bring all sectors together</td>
</tr>
<tr>
<td>PIR/care coordinator role in each catchment</td>
<td>Share assessments – one template</td>
<td>Promote and utilise existing coordination initiatives – for example Services Connect, PIR, MACNI</td>
<td>AOD and mental health service providers located at housing services</td>
</tr>
<tr>
<td></td>
<td>Skill development, service knowledge</td>
<td></td>
<td>Services Connect type model</td>
</tr>
<tr>
<td></td>
<td>Intake important</td>
<td></td>
<td>Colocation</td>
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<td></td>
<td>Gap in services depending on region</td>
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</table>

### d) System responses/improvements

<table>
<thead>
<tr>
<th>Improvement/Requirement</th>
<th>Providing service sector bulletins/updates to other sectors which are targeted at/tailored to workers in other sectors</th>
<th>Willingness to pick up clients who might be more appropriate for your service [rather than extending because already receiving a different service]</th>
<th>Acknowledge other comorbidities – i.e. chronic pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Catchment based planners – developing/issuing sector updates to other sectors</td>
<td>Family service specific responses – funded for that purpose</td>
<td>One consent form</td>
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<td>One assessment tool</td>
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<td></td>
<td>Shared consent with prompts for including all services</td>
<td>Online publication/guide to each other’s sectors</td>
<td>Develop a tool that can be accessed by all stakeholders that enables up to date information about the “service system” in its entirety</td>
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<td></td>
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<td></td>
<td>One central intake that covers all human services – state based</td>
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</tbody>
</table>

### e) Working together to address demand – diversion, brief intervention

<table>
<thead>
<tr>
<th>Initiative/Approach</th>
<th>True sharing/integration of workspaces [beyond simple colocation]</th>
<th>Understanding/knowledge of the pressures of each sector</th>
<th>Interim response like IR2 in the homelessness service system to provide short term case management</th>
</tr>
</thead>
</table>

### f) Other – skill development/resilience building for clients

<table>
<thead>
<tr>
<th>Program/Approach</th>
<th>Utopia</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>A program that focuses on skill development and resilience building for clients</td>
</tr>
<tr>
<td></td>
<td>Addressing some of the actual causes of our clients’ issues</td>
</tr>
<tr>
<td></td>
<td>Each of our sectors clients share many of the same determinants</td>
</tr>
</tbody>
</table>
Appendices 3 – 7: One page summaries of each of the Sectors

Appendix 3 - AOD Sector

Appendix 4 - Homelessness Sector

Appendix 5 - MHCSS Sector

Appendix 6 - Family Violence in the North

Appendix 7 – Responding to family violence in the West
The N&W Metro AOD service includes the following partner organisations. Your treatment could be provided by any one of these agencies.

NORTH & WEST METRO
ALCOHOL & OTHER DRUGS SERVICE

We acknowledge the traditional custodians of Australia and we welcome all Aboriginal and Torres Strait Islander people to our service.

Front Cover: Artwork inspired by Chris Thorne. There are five pillars that are upheld by the residents and staff at Odyssey House Victoria. This artwork represents counting these pillars on one hand. They are Respect, Concern, Honesty, Trust and Love.
North & West Metro Alcohol & Other Drugs (AOD) Service

Odyssey House Victoria and UnitingCare ReGen are working in partnership with a range of community local health and welfare organisations to deliver treatment services across North and West metropolitan Melbourne.

Each Victorian area has its own telephone number. The number for the north and west metropolitan region is 1800 700 514 (freecall).

Further information regarding treatment services in other areas can be found by contacting 24hr DirectLine on 1800 888 236.

What to expect from our services

- Call 1800 700 514 (freecall)
  - We will ask you the right questions to see if our services are right for you.

- We can organise a personal assessment or if not, we will help connect you with other services

- Assessment*
  - The assessment* will help us to plan your treatment options

- Treatment and Support
  - Together we will work toward your recovery goals
  - Your family can be involved if you wish

* Clients aged 16-20 can choose to be seen by either a youth or an adult service
  - With your consent we will share your information with those involved in your care
  - Your information will be kept on one electronic shared record

Eligibility

Our Intake staff will help identify your individual needs and which services will provide the most suitable support.

Other Services

Odyssey House Victoria and UnitingCare ReGen provide a range of other services to support individuals and families affected by AOD use. These services include:

- Youth counselling
- Residential withdrawal
- Residential rehabilitation

Alcohol & Other Drug (AOD) Treatment Services

- Intake and Assessment – a centralised service to coordinate people’s needs and entry into treatment services
- Counselling – including a range of individual services and group programs
- Non-Residential Withdrawal – supporting people to undertake withdrawal at home or as an outpatient
- Care & Recovery Co-ordination – a broad support service for people with more complex needs
- Referral – access to a range of other AOD and community support services
Homelessness Services in North and West

Initial Assessment and Planning Services — provide an initial assessment, risk assessment, prioritisation for and access to homelessness resources and short term planning. Limited funds are available for emergency accommodation, private rental and housing establishment.

Interim response 2: Short term targeted assistance to individual/households who have are awaiting housing and/or homeless support, aimed at diverting households from the homelessness system or reducing escalation of their crisis.

Crisis supported accommodation: Congregate supported accommodation i.e Youth Refuges, Family Violence Refuges and supported accommodation for single men, single women or families. The average stay is 6 weeks.

Transitional support: outreach based case managed support to assist people to access stable housing and address any issues that have contributed to homelessness. The average length of support is three months.

Transitional housing: short term, stand alone accommodation, with support. Managed according to the Residential Tenancies Act. The average tenancy is 20 weeks.

Access to the homelessness service system

- **Call 1800 825 955**
  - State-wide 24 hour number
  - diverted to the nearest access point during the day
  - Free call from landlines
  - Those calling on mobiles need to ask for a call back
  - Answered by St Kilda Crisis Services overnight

- **Present to a Homelessness Access Point Service**:
  - **VincentCare Northern Community Hub** in Moreland/Hume; 175 Glenroy Road, Glenroy; Ph: 9304 0100
  - **Haven Home Safe** in Whittlesea, Banyule, Darebin and Nillumbik; 52-56 Mary Street, Preston; Ph: 9479 0700
  - **Launch Housing** in Yarra and the CBD; 68a Oxford Street, Collingwood; Ph: 9417 2500
  - **Yarra Community Housing** in City of Melbourne, Moonee Valley, Hobson’s Bay, Maribyrnong and Wyndham; 112 Victoria Street, Seddon; or Ph: 9689 2777
  - **Salvation Army Social Housing Services (SASHS)** Western in Brimbank and Melton; 6/147 Harvester Road, Sunshine, Ph: 9312 5424
  - **Frontyard Melbourne Youth Support Service** 19 King Street, Melbourne; Ph: 9614 3688
Homelessness services in Melbourne’s north and west

Call 1800 825 955 Freecall from landlines

If you are
- 16 or over
- Homeless or at risk of homelessness
- Looking for support and housing

Present to a homelessness access point

Initial Assessment & Planning
- Housing, support & risk assessment
- Prioritised for resources
- Short term planning, including possible access to brokerage

Housing Establishment Fund

Private Rental Brokerage Housing

Interim Response

Diversion from homelessness

Prioritisation for homelessness support and accommodation Referral

Crisis Supported Accommodation

Transitional Support

Transitional Housing

Long term housing
Mental Health Community Support Service

Service Types under MHCSS

Individualised Client Support Packages

- **Recovery Oriented support**: Focus on the needs of the person with activity individually determined.
- **Strengths based**: We use the skills and other qualities of the person to focus the work.
- **Outreach**: Most work takes place in the person’s home or other setting as appropriate
- **Group supports**: People can engage in group activities
- **Advocacy, support and service navigation**: This includes carers and the broader community

Residential Rehabilitation

- **Longer term**: 12-24 months of live-in shared accommodation
- **Adult or youth based**

Who are MHCSS clients?

- People aged 16-64 years
- People living with Psychosocial disability (also referred to as Psychiatric Disability)- A functional impairment stemming from mental illness
- The greater the impairment, the higher priority for service
- Linked to NDIS transition:
  - Impairments that are likely to be permanent
  - Impairments that result in substantially reduced psychosocial functioning

Access is through centralised Intake

Inner North Catchment    NEAMI  1300 379 462
North West Catchment    NEAMI  1300 379 462
South West Catchment    NEAMI  1300 379 462
North Catchment        EACH    1300 785 358

Service Demand

Varies by catchment, number of people currently on needs register

Inner North  106 people
North       201 people
North West  25 people
South West  31 people
MHCSS: how the service works

Any Referral Source welcome with consent.
Neami: 1300 379 462
EACH: 1300 785 358

Initial phone screen (less than 10 minutes)

Facilitated MH Referral (ie PHAMS, PIR)
Not Appropriate/Ineligible for MHCSS

CRISIS/CLINICAL REFERRAL

Residential Rehab Referred to Bed Based Selection Panel*

Individual Client Support Packages (ICSP) NEEDS REGISTER (Active Wait List management)

Referred to ICSP MHCSS “Comprehensive Assessment” when a vacancy arises

Mental Health Community Support Services (MHCSS) Intake Flowchart (Neami National)
Integrated family violence service system: Melbourne’s northern region

Northern Integrated Family Violence Services (NIFVS) is the partnership that leads the integration of family violence and related services in Melbourne’s northern metropolitan region. We support women and children who have experienced family violence as well as men who use family violence.

Family violence is a pattern of coercive control that one person exercises over another in order to dominate and get his way. It is behaviour that physically harms, arouses fear, prevents a person from doing what she wants, or compels her to behave in ways she does not freely choose.

For more information, including intake pathways and a service directory, visit: nifvs.org.au
**Entry points**

Women, children and men may enter the service system at a number of different points:

- **Police and justice**
  - Police attending a family violence incident may issue a Safety Notice and will send an ‘L17’ referral to Berry Street (for women), the Men’s Active Referral Service (for men) and Child Protection (where children are present)
  - A woman might apply for a Family Violence Intervention Order at a Magistrate’s Court or through the police

- **Specialist family violence services**
  - A woman might refer herself and any children, or be actively referred by a service, into a specialist family violence service
  - A man might call the Men’s Referral Service or be mandated to attend a Men’s Behaviour Change program through a court

- **‘Mainstream’ services**
  - A woman might disclose having experienced family violence to a mainstream (non specialist family violence) service
  - A man might disclose having perpetrated family violence to a mainstream (non specialist family violence) service
  - A child might disclose they have experienced family violence to a school or health service

For full intake pathways for women, children and men, visit: nifvs.org.au/about/the-northern-region/intake-pathways

**Services available**

Women, children and men may access a number of different services, including:

- **Women’s family violence services**
  - **Intake and case management**: Berry Street Northern Family and Domestic Violence Service
  - **Refuge and case management**: Crossroads Family Violence Service and Georgina Martina Inc.
  - **Statewide**: Safe Steps Family Violence Response Centre, Elizabeth Morgan House Aboriginal Women’s Service and InTouch Multicultural Centre Against Family Violence
  - **Counselling and group work**: provided through the NIFVS Counselling and Support Alliance

- **Children’s family violence services**
  - **Case management**: Bright Futures Children’s Specialist Support Service
  - **Counselling and group work**: provided through Bright Futures and the NIFVS Counselling and Support Alliance membership including Berry Street and Anglicare

- **Men’s Behaviour Change services**
  - **Intake**: Men’s Active Referral Service
  - **MBC providers**: Kildonan UnitingCare, Sunbury Community Health Service, Plenty Valley Community Health Service

Contact family violence services on the numbers, below:

**Safe Steps Family Violence Response Centre (24 hours)** 1800 015 188

**Berry Street Northern Family & Domestic Violence Service (M-F 9am-5pm)** 9450 4700

**Men’s Referral Service (M-F 9am-9pm)** 1800 065 973
Making Links Forum - Case Study - Susan

Client characteristics

Susan is a woman in her early 40’s experiencing homelessness. On referral to the HISP program she was living between her car and her elderly father’s Office of Housing property in the outer northern area of Melbourne.

Susan’s mother, who has an intellectual disability, moved into a nursing home approximately 10 years ago. Her relationship with her father is extremely problematic. Ongoing family violence is a key feature of their relationship.

She does not have any ongoing relationships with any other family members. Susan is extremely socially isolated.

Susan has been on the Disability Support Pension since 1998.

Susan has a range of chronic health & mental health issues.

Why did the client access the program?

On referral, Susan was sleeping in her car. She had been doing this off and on for five to six years. Ongoing issues of family violence were reported between Susan and her father. As her mental health deteriorated these episodes increased in both severity and frequency. In September 2013, the violence escalated and Susan ended up in a woman’s refuge.

In the late 1990’s, Susan had visited a GP seeking treatment for severe back pain as a result of injuries she sustained in a car accident. The GP prescribed high levels of drugs of dependency, namely morphine, without seeking specialist advice. This resulted in Susan’s morphine addiction. Subsequently, this GP was disciplined by the medical board for negligence and poor practice.

Susan was also engaged with a psychiatrist for OCD, depression, anxiety and occasional panic attacks. She has been diagnosed with post-traumatic stress disorder from a serious sexual assault. Susan has experienced ongoing emotional loss and grief on a number of levels for most of her life.

At the point of referral to HISP, Susan’s relationship with both her current GP and psychiatrist was not always positive or constructive.

She has a formal diagnosis of:

- Borderline Personality Disorder
- Major Depressive episodes
- Obsessive Compulsive disorder
- Morphine addiction
- Post-Traumatic Stress disorder
- Chronic pain disorder

In late October 2013, Haven Home Safe (HHS) made a referral on Susan’s behalf to the HomeGround Intensive Support Program (HISP) at HomeGround. Susan had presented at HHS seeking housing options.
HISP is funded by the Department of Health. It takes its referrals primarily from the Prioritisation Lists at two NE Metro Homelessness Access Points - HomeGround (Collingwood) and Haven Home Safe (Preston) as well as a number of local ACCOs. The program’s catchment areas are the CBD, Yarra, Darebin, Banuyle and Whittlesea. Its target group are those:

- Of Aboriginal and Torres Strait Islander background, in particular those who identify as being part of the Stolen Generation.
- With high levels of assessed vulnerability, particularly chronic homelessness.
- With a mental health illness who are also experiencing homelessness and are not currently or effectively linked with clinical or community mental health support

Susan meets the last two of the prioritisation criteria.

**Access to the program?**

On October 2013, Susan was referred to HISP from HHS Homelessness entry point.

HHS stated that they had been unable to get the local area mental health clinical service to see her, and the northern non clinical services stated they could no longer work with her due to her BPD related behaviour. She had exhausted Housing Establishment Funds (HEF) and the local family violence women’s service refused to have her at their refuge due her behavioural issues and her drug dependency.

Shortly after receiving the referral, a HISP case manager met with Susan to discuss her support needs. Susan agreed to receive support from the HISP team.

**What support was provided?**

**Housing:** Susan was placed on the prioritisation list (PL) at HomeGround and HHS for a one bedroom transitional housing property. At the time there were over 1000 households on both lists waiting for a transitional housing (TH) property. One bedroom stock numbers are also low in the region so HISP knew that there would be a lengthy wait. In the interim a range of short term crisis options were arranged, driven in part by several instances of family violence. In December 2013, both Susan and her father obtained Apprehended Violence orders against each other.

HISP made a number of referrals to FV refuges but these referrals were rejected due to refuge’s concerns over Susan’s medication regime. They stated that because she was prescribed take-home morphine that this could put other residents at risk.

After a series of crisis accommodation stays, Susan was housed in a community housing unit in Fitzroy. HISP made referrals to the local council meal services, a local Personal Helpers And Mentoring (PHAMS) program and local GP.

Within four months of the tenancy, Susan moved out of unit into an informal private rental opportunity with an owner. HISP were not in agreement with this choice but Susan felt it was a good idea. This accommodation lasted less than a week after the private owner called the police to have her removed from the premises.

Susan was then HEF’d to a hotel for a week and then offered a transitional property in Fitzroy managed by HomeGround Services.

She had been on the PL lists for more than 6 months by this stage.

An application was submitted to Office of Housing (OoH) - Homelessness with Support Category under the Housing First eligibility criteria.
Susan was at the TH property for just over 17 months before being made an OoH offer. She has been at her new property for two months.

**Medication:** At the time of referral, Susan was prescribed a script for a bottle of liquid morphine, every six days, from her GP. There was limited and not always effective oversight of this arrangement by the GP, a pain specialist and addictive medicine expert. She was also prescribed varies drugs from the benzodiazepine family.

**Mental Health:** In relation to her Obsessive Compulsive Disorder, Susan wears gloves outside of the house and wears outdoor clothing over indoor clothing to avoid contamination and has ritualistic superstitious thoughts associated with money and their numbering. All of these behaviours make an ordinary task, which may take 20 minutes for someone without OCD, take a few hours for Susan to complete. Her depression and anxiety is severe and affects all aspects of daily living. Her sleep pattern is extremely disordered.

**Case Management Support:** HISP’s work with Susan is intensive in nature. Direct support (face to face) is up to 6 – 8 hours per week with additional 3 – 4 hours non direct support time spent on referrals, case coordination and admin related to the care plan.

Referrals, linkages and tasks include;

- Referrals to several new GPs to manage her morphine and other health needs (Susan was discharged by a number due to her complex behaviour)
- Assessment by a AOD service (partially successful)
- Assessment by Clinical Mental Health Services (unsuccessful)
- Referral to MHCSS service (unsuccessful)
- Referral for dental and optical services
- Referral to St Vincent’s pain specialist
- Links to all of the charity and meal services in local area
- Referral to a service that provides friendship
- Cat’s health check and grooming by veterinary hospital
- Applying to various charities for financial assistance
- Weekly transport to GP and pharmacist to pick up morphine and other medications

**Case Coordination:** HISP arranged a number of case conferences throughout the support period. These were only partially successful. It was difficult to engage clinical MH services in the process and HISP perceived a reluctance to get involved from their end at times.

Her MH issues were at times downplayed and her behavioural issues over emphasised. There was a sense that MH felt that they had tried to engage before and because it wasn’t successful in the past that further attempts were not considered feasible.

**Brokerage:** HISP has spent a substantial proportion of brokerage on Susan, up to $3000. This included funds for crisis accommodation, white goods, furniture, veterinary bills and groceries.

**Support/Behaviour Management Plan:** HISP has developed a Housing and Support contract that is implemented on a month by month basis outlining roles and responsibilities, expected behaviours, consequences, goals and timelines.

This plan has been implemented due to some of the more complex and challenging behaviours that included attempts to split staff, excessive multiple texts, voicemail and phone calls, blame shifting to staff for her situation and threats of suicide.
OUTCOMES:

HISP will be working with Susan for at least the next 2 years, there is much still to be done but so far, the following outcomes have been achieved;

1. Housing and homelessness:
Susan has been accommodated in hotels when in crisis. HISP referred her to a long term community housing provider in Fitzroy and she accepted a property in the inner north area. This tenancy lasted approximately four months; she voluntarily left to pursue a private rental arrangement that lasted less than a week. She was accommodated in emergency accommodation and housed in a transitional property managed by HomeGround in May 2014. An application for Office of Housing was submitted.

Susan moved into her permanent OoH property in October 2015.

Since being referred to HISP there were eight to ten different accommodation stays from October 2013 – October 2015.

2. Health and wellbeing
Susan has a co-morbidity of mental disorders and problematic substance use. HISP has been working intensively with Susan in an attempt to find the appropriate supports and give Susan the opportunity to improved health and wellbeing outcomes for her.

Susan smokes up to a packet of cigarettes a day and has a poor diet that consists of up to three coffees a day with eight shots per coffee, cans of soft drink and energy drinks. Her physical appearance is very frail and she has badly stained teeth. HISP has linked her with a dental service and regularly accompanies her to visits with the local GP.

Her substance use of morphine and other benzodiazepine for her pain has declined slowly, she is now on a planned reduction scheme. This will be a very slow process. She continues to use high quantities of several prescribed drugs. However, since linking her with the current GP, there has been a marked decline in doctor shopping.

The outcome of the referral to the Drug and Alcohol service was that they offered secondary support the GP in reducing her current dosage.

The referral for a non-urgent assessment to the clinical mental health service was repeatedly rejected. HISP continues to advocate for Susan to receive clinical MH services and has requested a further assessment based on other reports from her previous psychiatrist. Susan is being reassessed by the service currently.

3. Extra support services
Susan has been referred to many services in the local area ranging from the local charity services that offer weekly grocery hampers, benevolent services that offer daily meals and other options to access food vouchers and so on.

A referral has been made to the local council for meals on wheels and assistance with cleaning. Susan was referred to a local agency for day programs and community access services; however she has not taken these up due to her poor health.

4. Crisis and acute service use patterns
Susan has accessed crisis assistance for hotel accommodation at times when she has left permanent housing options.

She has not accessed the hospitals and when staff has recommended she go to hospital emergency service because of her complaints of crippling back pain, she refuses.
Susan does have a history of doctor shopping for multiple benzodiazepine type drugs to control her pain. HISP is currently trying to get an updated assessment with a pain clinic and are working on having extensive AOD treatment plan implemented.

**Reflections:**

Susan’s situation is very complex. It has been difficult to get AOD, MHCSS or Clinical MH services involved. These difficulties have been exacerbated in part by the recent reforms to both sectors.

As is often the case, clients with a dual diagnosis like Susan can be difficult to refer as there can be significant resistance from both AOD & MH services to provide support. This has been very challenging for both Susan and the team supporting her.

Better understandings and collaboration between sectors are really essential for better support and outcomes; we need to find ways to work together more effectively, especially with very complex clients like Susan.