Mansfield Vulnerable People Project 2016

The stakeholders acknowledge the generous support of the Mansfield Primary Care Partnership in enabling this project to be undertaken.

Final Report

Development of a model of care to improve health and social outcomes for people at risk of or currently experiencing homelessness in the Mansfield Community

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Introduction

Volunteers have been identified as an integral part of the Mansfield Community.

Key volunteer organisations in Mansfield identified a service gap for those at risk of or experiencing homelessness in the community (the target group). The current service delivery environment is considered fragmented and uncoordinated in its response to the health and social needs of the target group.

Stakeholders believe improved access to health and social support services for the target group will help to break the cycle of crisis this group often experience. This would result in improved community connection, improved resilience, a reduction in stigma attached to public housing and improved community attitude toward recipients.

This project has been undertaken to provide volunteers in the Mansfield Community with a Model of Care (MoC) to support homeless people or those at risk of experiencing homelessness to improve their health and social outcomes.

Whilst those at risk of or currently experiencing homelessness will have immediate needs, the MoC prioritises these first and foremost but also sets the client on a path to identify and address underlying causes that are contributing to their immediate situation.

Goals, objective and outcome of the project

Goal

To improve health and social outcomes for those at risk of or experiencing homelessness in the community.

Project Objectives

1. Provide a report on the existing service system for a person at risk of or experiencing homelessness in the community.
2. Provide a review of any existing relevant service models for people at risk of or experiencing homelessness in the community
3. Develop an integrated sustainable model of care across agencies for people at risk of or experiencing homelessness in the community

Outcome

An evidence based, integrated and sustainable model of care tailored to the local service system and community environment.

Homelessness in Australia

Every night around 100,000 people are homeless.

Not all of these people are sleeping rough in public places. Many are living in temporary or makeshift accommodation, with family or friends, in specialist homelessness services or in substandard boarding houses.

The most widely accepted definition of homelessness in Australia describes three kinds of homelessness:

- Primary homelessness, such as sleeping rough or living in an improvised dwelling
- Secondary homelessness including staying with friends or relatives and with no other usual address, and people staying in specialist homelessness services
- Tertiary homelessness including people living in boarding houses or caravan parks with no secure lease and no private facilities, both short and long-term.

Homelessness does not simply mean that people are without shelter. A stable home provides safety and security as well as connections to friends, family and a community. Homelessness makes it very difficult to hold down a job or lead a healthy and stable life. [i]

Factors influencing the risk of becoming homeless

Homelessness can affect anyone. People who are homeless come from all age groups, and include women and men and people from all cultural backgrounds.

Contributing to the risk of homelessness is a chronic shortage of affordable housing supply that is estimated to be over 500,000 rental dwellings for those on the lowest household incomes. Disadvantaged Australians on very low incomes, who rely on income support, are at constant risk of homelessness as they struggle to find affordable housing. They do not have financial resources to withstand unexpected or irregular expenses (such as unforeseen health costs, accidents, utility increases and any increases in rental charges). Schemes to support low income households, such as the Commonwealth Rent Assistance (CRA), have failed to maintain parity with rental increases and costs.[ii]

There are many factors at both a structural and individual level that can lead to homelessness. The factors that may increase a person's risk of becoming or remaining homeless can include:

Structural factors:

- Poverty
- Unemployment
- Lack of affordable housing

Personal circumstances:

- Discrimination
- Poor physical or mental health
- Intellectual disability
- Drug and alcohol abuse
- Gambling
- Family and relationship breakdown
- Domestic violence
- Physical and sexual abuse

Housing and health

Poor health can contribute to being homeless, and being homeless can lead to poor health. Limited access to health care can make it worse. That's why the health of homeless people in Australia is worse than that of the general population.

Homelessness removes stability and connection in people's lives. People who move away from their home and local community often leave behind important supportive relationships and networks. This makes it harder to participate in employment, maintain children's education and retain contact with family and friends.

In addition to higher rates of mental illness, people who are homeless experience poor dental health, eye problems, podiatry issues, infectious diseases, sexually transmitted disease, pneumonia, lack of preventive and routine health care and inappropriate use of medication.

Children are particularly vulnerable to the traumatic effects of homelessness. It disrupts schooling and other important opportunities to build resilience that come, for example, from participation in sporting and cultural activities. Poor education is a risk factor in future episodes of homelessness. Children who have been homeless are more likely to experience emotional and behavioural problems such as distress, depression, anger and aggression.

Homelessness often takes the form of living for long periods in marginal accommodation, rather than a single period of sleeping rough or staying in a specialist homelessness service. People may move home several times before they get long-term, stable housing. For children this may mean several new schools at a time when their education is already disrupted.

Homelessness can become part of a cycle of intergenerational disadvantage, in which younger generations in some families miss out on the opportunity to participate in the economy and the community. In some communities across Australia, families and individuals are caught in a cycle of low school attainment, high unemployment, poor health, high imprisonment rates and child abuse.

- *Housing and health are clustered.* People in precarious housing have, on average, worse health than people who were not precariously housed. This relationship existed regardless of income, employment, education, occupation and other demographic factors.
- *The poorer people's housing, the poorer their mental health*. The more elements of precarious housing people experienced simultaneously, the more likely they were to experience poor mental health.
- The relationship between health and precarious housing is graded. *As health (mental or physical) worsens, the likelihood of living in*

precarious housing increases.

- *Poor health can lead to precarious housing*. Those with the worst mental or physical health were the most likely to be in precarious housing. People with the worst mental health were the most likely to be in unaffordable housing, the most likely to live in poor-quality dwellings, and the most likely to have experienced a forced move. Those with the worst physical health were the most likely to live in poor condition dwellings and the most likely to experience overcrowding.[iii]

Environmental scan

A comprehensive environmental scan of the Mansfield service system was conducted as part of the project to inform the development of the MoC.

A range of sources were used to compile the scan including the Human Services Directory, local data bases provided by key contacts, and steering committee members and direct contact with a number of agencies across the catchment.

The criteria used to inform the scan included; accessibility (location the service was delivered and in what capacity), cost and eligibility. Identified organisations/ agencies were then stratified against the health and social outcomes specified in the MoC.

More than100 services were identified as part of the scan.

These were then collated according to the response levels identified in the support pathway for ease of use for the volunteers. A more detailed list has also been captured but is not applicable to the model of care at the response level 1 or 2 (see Figure 1).

The scan led to a number of 'gateway' agencies being identified with well-established approaches to homelessness, family violence, sexual assault, mental health – psychosocial, and drug & alcohol service sectors

A full copy of the environmental scan has been provided as part of the project.

Phase 1 Development of the Model:

Figure 1: Support Pathway Framework

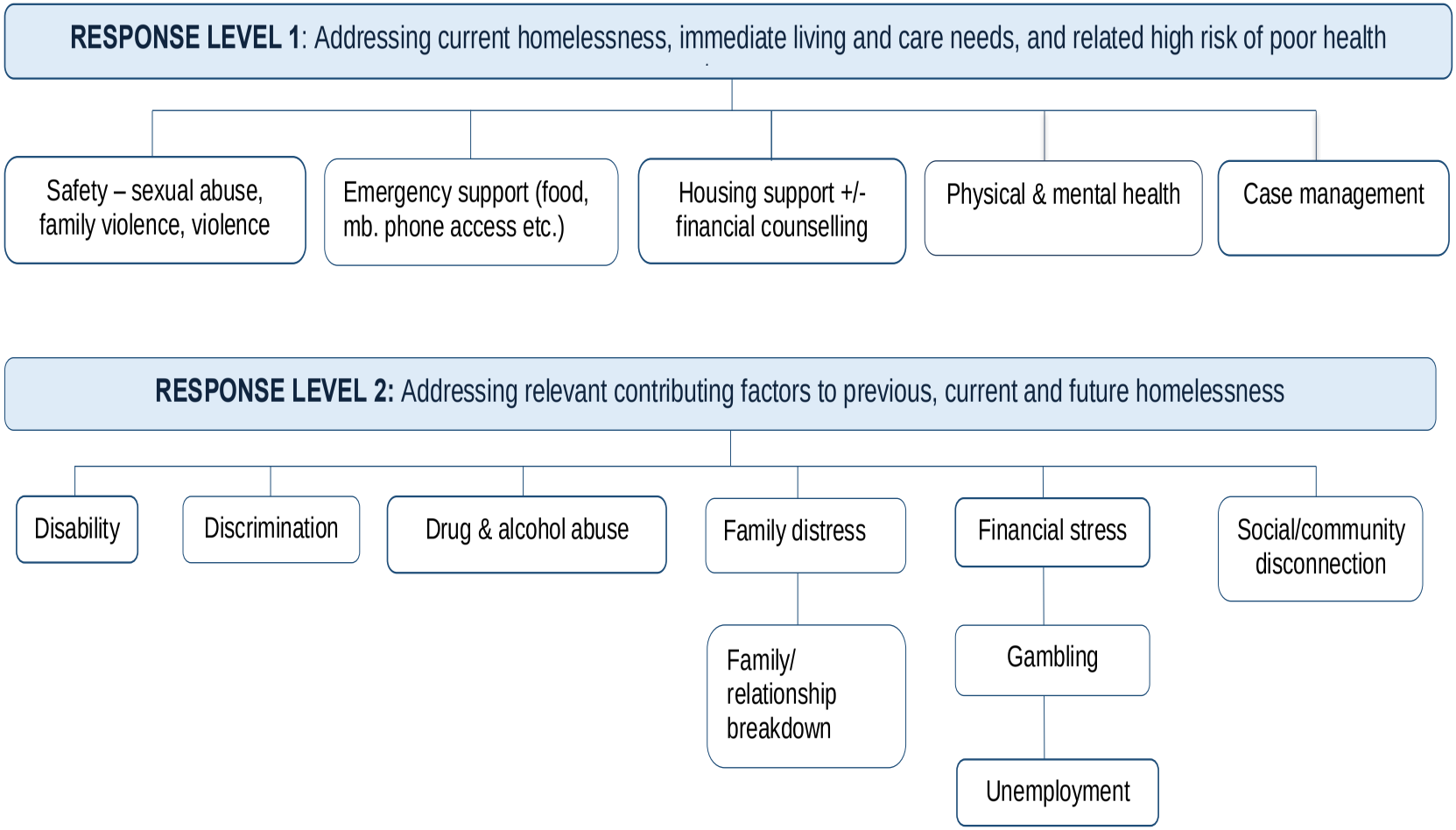
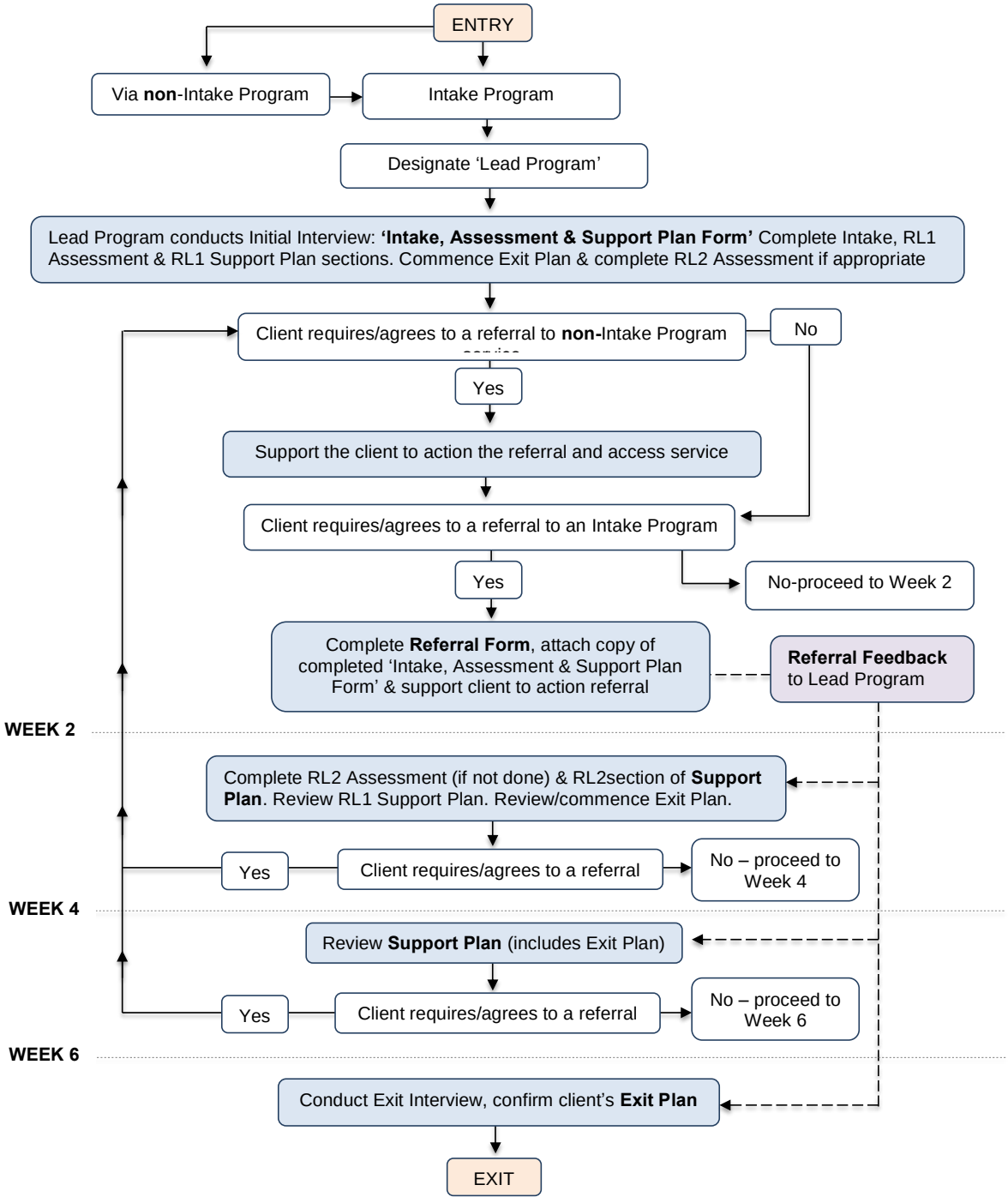

RESPONSE LEVEL 1: Addressing current homelessness, immediate living and care needs, and related high risk of poor health
Safety – sexual abuse, family violence, violence
Emergency support (food, mb. phone access etc.)
Housing support +/- financial counselling
Physical & mental health
Case management
RESPONSE LEVEL 2: Addressing relevant contributing factors to previous, current and future homelessness
Disability
Discrimination
Drug & alcohol abuse
Family distress
Family/ relationship breakdown
Financial stress
Gambling
Unemployment
Social/community disconnection

Figure 2: Model of Care Flow Chart



A full copy and details of the Model of Care has been provided as part of the project.

Overarching principles for the model of care

The MoC is built on the following principles for success identified in the evidence summary:

1. Building rapport and a relationship between the client and the volunteer/worker
2. Collaboration and coordination across the service system
3. Holistic view of health, the social and ecological model
4. Strengths based, client centred and self-determined
5. Participation and inclusion
6. Individually responsive and flexible
7. Capacity building
8. Sustainable

Overview of model of care

The MoC is designed to support people accessing the Mansfield & District Welfare Group, Mansfield Shire Council Financial Counselling and St Vincent de Paul Mansfield Conference (including the Hames House program) who are currently experiencing homelessness or are at high risk of homelessness. The aim of the MoC is to facilitate timely, appropriate access to support services to address the participant's immediate needs and prevent future or ongoing homelessness and improve health outcomes.

Health literacy (individual and environment) is critical to the success of this program. Individual health literacy includes the motivation to participate in health, and competency in accessing and navigating the health service system. A health literacy environment includes policies, processes and relationships that exist within the health system that make it easier (or more difficult) for consumers to navigate services. It includes the communication processes and relationships that exist between consumers and healthcare providers, for example, the use of shared decision-making processes and checking that information has been understood.

Features of the model

Early intervention – the model provides an assessment and referral pathway process that facilitates timely referrals supporting the client's capacity to prevent further crisis cycles whilst addressing immediate needs

Holistic– the model addresses the broader social and health determinants impacting on the client, and looks to address a combination of these rather than one determinant in isolation

Highly contextualised to Mansfield – the model has been informed and created by local providers working on a local coordinated response to homelessness or high risk of homelessness

Capacity building – the model and approach provides scope of practice as a volunteer resource whilst building the capacity of the clients

Transferable and sustainable – the model is built around the existing service system and can be implemented at any level within it

Client centred and facilitates ownership & accountability from the client - promotes a strengths based approach, with the client at the centre of identifying their own key issues and actively planning support pathways.

Builds health literacy - from both the client and service provider perspective through service system navigation support

A gateway resource – complements the 'Open Door' approach to regional homelessness service coordination and provides an initial referral into the appropriate support pathway

Best practice service coordination - aligns with best practice service coordination principles

Phase 2: Pilot Implementation

A pilot implementation phase is recommended for a six-month period to identify structural and implementation issues and review the MoC based on practical application to a range of clients in the Mansfield community. This length of time will allow for a number of clients to move through the pathway and for the collection of evaluation data.

An evaluation mechanism needs to be established. This should allow for the collection of key data relating to client experience and outcomes and the identification of issues relating to the MoC and associated forms.

A case evaluation form is suggested that sits within each client file and is completed across the course of the client contact. This would detail key information regarding the outcomes of the client's movement through the pathway, the client's willingness to participate and the client experience through the pathway.

In addition to this, a journal or template for reflective notes could be provided to each of the volunteers implementing the model of care. These notes would detail the observed ease of use, efficiency and flow of the MoC from the volunteer's perspective. This could also detail any observed issues of use (these issues may be structural issues relating to the MoC forms and flow), or implementation issues (relating to outcomes of using the model of care) that could be tabled by the Steering Group. The Steering Group then have the task to problem solve and identify ways to mitigate the issues.

A communication strategy will be essential to the communication of the MoC and the engagement of key gateway agencies.

Recommendations

The MoC should be piloted as directed in *Phase 2: Implementation* to identify and then alleviate structural and implementation issues and refine the Model based on practical application. In addition to this there are a number of other recommendations to support the implementation of the Model of Care and its effectiveness.

Recommendation 1: Develop a communication strategy for the Model of Care

Communication will be central to the implementation of the MoC. A strategy would help to support a coordinated approach to communicating the model, the intake forms and referral pathways to agencies involved in the sector.

Recommendation 2: Championing the Model of Care

The steering group need to continue to meet and refine the MoC throughout Phase 2. This will support problem solving and continuous improvements to the MoC and associated tools. The steering group have a key role to promote the MoC and implement the communication strategy as the voice of the MoC and lead its application across the Mansfield community.

Recommendation 3: Inter-agency agreements

Built into the communication strategy, inter-agency agreements need to be established that detail expectations and minimum requirements between agencies in relation to the referral, follow up and case management of clients. These will clarify agency expectations and be an important mechanism to protect professional relationships between agencies.

Recommendation 4: Expanding the model of care

At the conclusion of the six month pilot period the steering group will review the intake agencies and consider engaging other potential intake agencies across the community that may have contact with homeless people or those at risk of homelessness.

Recommendation 5: Advocacy to break the cycle

The information garnered through this project and the implementation of the MoC provides the Mansfield community and the steering group with a platform for advocacy on a range of levels. This advocacy is likely to be more successful if it is approached as a collective rather than as individual agencies. Advocacy may take the form of local activity, e.g. work with the local GP clinics to negotiate bulk billing for all homeless people or advocacy at a State or National level on broader political issues affecting homelessness e.g. housing reforms, mental health reform or increases in funding for the homelessness sector. This could be done via a range of mechanisms including position statements, policy statements, support for other organisations and active campaigning.

Recommendation 6: Support, invest and recognise the vital role of the volunteers

Support and build the capacity of the volunteers implementing the MoC to understand the relationship between health and homelessness and the

trajectories that often lead to homelessness. Support the volunteers with appropriate training in understanding health within the social model of health and the myriad of factors contributing to homelessness.

[i] The Road Home, *A National Approach to Reducing Homelessness*, White Paper Homelessness Taskforce, Department of Families, Housing, Community Services and Indigenous Affairs 2008, http://www.aihw.gov.au/homelessness-white-paper-road-home-national-approach-reducing/

[ii] The Salvation Army (2016), Policy Statement 2016-2017, p. 18-19 accessed via www.salvationarmy.org.au / salvos.org.au

[iii] Mallett, S, Bentley, R, Baker, E, Mason, K, Keys, D, Kolar, V & Krnjacki, L (2011). *Precarious housing and health inequalities: what are the links? Summary report*. Hanover Welfare Services, University of Melbourne, University of Adelaide, Melbourne Citymission, Australia.