Making Links

Frequent Service User Project

Think Tank 2: Expert Show and Tell Notes

Introductions and welcome

Louise Richardson, AoD Health Services Planner, Odyssey and ReGen, acknowledged the traditional custodians of the land on which we are meeting and welcomed everyone to this second of three 'think tanks' for the Making Links Frequent Service User project. Louise reflected that in Think Tank 1: A Shared Understanding, we explored definition of frequent service users (and what this means across sectors), international research in to definition and intervention and then, with the Privacy Commission, explored managing privacy implications whilst sharing information across sectors.

In this Think Tank we will hear from participants in a number of existing providers across sectors involved in projects that we think we can draw learnings from to inform our project. We will end today with a discussion of all our learnings to date.

In Think Tank 3 will we use all our learnings to develop our cross sector project.

Louise noted that the family violence sector has been one of the four sectors involved in the Making Links project. The Family Violence sector has determined that the workload and extent of change resulting from implementation of the Royal Commission in to Family Violence recommendations. Even though we don't have family violence sector as an active participant, it is important that we retain a family violence and client safety lens on the development of our project.

Recap of Think Tank 1

The group discussed the three key messages that participants had taken from Think Tank 1:

Mandate:
We felt the question of whether or not the group wants to go ahead is yes. The group appears to have a shared understanding and combined view about what we want to achieve.

There are a lot of existing programs – may be we need to focus on linking up what we do. This group has a lot of evidence about what works and it is primarily housing first.

Who is the target group:
The target group has multiple vulnerabilities and let's not forget the group that are outside this.

Response:

- How does substance use fit within the framework. People have complex issues and current substance use issues can add to the capacity of consumers to attend appointments/engage with the service syste. How does this fit within the service design?
- Where can we make the most impact?
- Collective impact as a pathway forward.

Information sharing:

- Data
- Perception is not always real in terms of barriers to information sharing. Data sharing seems possible.

The target group

The group reflected on where we got to in Think Tank 1 in our think about the target group for this initiative.

Include people who are in housing but whose housing are at risk.

The target group has such high levels of multiple vulnerabilities.

The descriptions capture the possible target group but we need to decide where to start.

For some reason people in this target group are not getting the response that they need from multiple service systems.

The key feature is that the system is struggling to provide a response.

The extent of impact on the service system is a key feature.

Multiple instances of service system failure and service system impact are the two key features.

Of the Launch Housing top 25 most frequent service users 100% of the women have mental health and substance use issues; 92% of the men have mental health issues and 75% have substance use issues. 70% of the women

Homelessness is a key issue. Do our target group need to be frequent service users of all systems. It is likely that they will all be experiencing all three issues but may not be frequent services users of all three systems. Given the complexity of issues, they will either be homeless or at risk of homelessness or have a history of homelessness.

There was some appetite in Think Tank 1 to start with the Launch Housing list of the list of the top 200 most frequent services users by assisting those who have AoD and mental health issues from this list.

In Think Tank 1 there was a discussion about having identified our target group, we wanted to discuss where the best point of intervention with this group is. Do we intervene at the point of high frequency or do we identify their characteristics to assist us to identify people at risk of becoming frequent service users to assist us to respond earlier.

There are people on the streets who clearly have complex issues and high levels of vulnerability but are not presenting to any of our service systems. Do we focus on people who are engaged with one of our systems or are we assertively seeking those who are not presenting to our service system. How do we create a response that can be available to people when they feel ready.

Are there people who would be interested in engaging with our systems if the systems operated differently?

DHHS Multiple and Complex Needs Initiative (MACNI)

Sarah Acreman

Multiple and Complex Needs Initiative Coordinator; Western Melbourne and Brimbank Melton Areas

See attached powerpoint. Sarah was unable to attend so the group discussed the powerpoint and the MACNI application form.

MACNI was designed following research about 100 individuals. Only one organisation present has successfully referred someone to MACNI – the bar is now very high.

One of the key issues is what MACNI can offer over and above current responses. The budget is very limited. Often those people who are assisted through MACNI bring with them very high cost and high risk to community. Generally there is criminal justice involvement.

Learnings from MACNI:

- Having a coordinator to bring the responsive sectors together is very useful.
- MACNI has funds available which enable a targeted service response.
- MACNI is working to engender systemic change.
- Critical MACNI success factors are independent authorisation and sophisticated service coordination.
- Collaboration and shared risk are critical.
- Interdisciplinary collaboration requires the shared development of goals, outcomes, new responses.

Discussion:

- The Care and Recovery Coordination project has highlighted that sometimes when a coordinating agency is available, other providers step away.
- Coordination has to be identified as a 'buy in' not 'walk away' model.
- Independent authorisation is a critical factor. Coordination programs such as Partners in Recovery exist but do not have any authorisation – participation by other programs is voluntary.
- Sometimes individual programs will meet a client's immediate needs and then 'closes' but many programs do not have capacity for follow up and sustained engagement so people 'bounce back'.
- Real engagement with these individuals can take a year – few systems have capacity for extended periods of engagement and support.
- With these individuals there is probably no finish point for engagement. How do our systems provide the duration of support that is needed?
- Some mechanism is required to enable the shared development of goals, outcomes, new responses.
- What will the development of safety hubs through the Royal Commission and the NDIS mean for this initiative.
- PIR are likely to become coordinators of support through NDIS. This system is likely to be able to provide a lifetime of support to individuals if needed.
- How many of the top 100 frequent service users are NDIS eligible. Most have mental health issues but the program will need to show that the issues are enduring. Launch Housing will assist the consumers to 'jump through the hoops' for NDIS assistance.
- Should this project think about the intersection with NDIS. NDIS is likely to become one part of the response but not the answer.
- Can this project be considering which NDIS stakeholders are best placed to provide a response to these consumers? How do we intersect with NDIS providers? Should services within this project consider becoming NDIS providers or partner with services that are NDIS providers.

Taskforce 1000

Anne Horsley

Taskforce 1000 Coordinator,
West Division

See attached powerpoint.

Introduction to Taskforce 1000
Anne identified that there are two Taskforce 1000 in each Division. Taskforce 1000 commenced in 2014 in response to the over representation of children in out of home care.

The project identified Aboriginal children in care at the time the project commenced (about 1,000 children), worked to improve their situations and to identify and respond to systemic issues impacting those children.

Process
The project began with information gathering: community consultations, file audits, consultations with young Aboriginal people in care.

18 Area panels were held bringing together senior DHHS staff, community providers, police, education, Aboriginal Community Controlled Organisations. Each child's situation was presented and panel members responded.

Child Protection workers took away a plan to respond to the issues identified at the panels.

Each Area developed an action plan in response to the themes that developed.

Findings/themes
One finding was that a three generation genogram had not been completed with most of the young people in care so the understanding of their connection to the Aboriginal community was often inadequate.

Four driving factors were identified: homelessness, mental health, AoD and family violence. 90% of Aboriginal children in care had witnessed/impacted by family violence in their homes. 90% of mothers were documented as having a mental health issue. A high proportion of fathers had been incarcerated.

Lack of cultural connectedness was a significant issue.

The numbers of children entering care will only be improved if the driving factors are addressed.

Seven main arms to the Western Area response:

- Quality kinship and carer support
- Early intervention
- Optimal education, health and wellbeing
- Strengthing the role of ACCOs
- Enhanced case planning
- Improve integration and accessibility of the service system
- Cultural connectedness.

Key learnings of Taskforce 1000:

- Scrutiny and authorisation at the highest levels. The role of the independent commissioner has been critical to the project. The Government committed to a statewide Taskforce 1000 Steering Group with high level representation. Each Area has presented action plans to this Steering Group – outcomes are monitored by the Steering Group. The Steering Group is supported by an Aboriginal Children's Forum (led by the ACCO in the area) and Area Working Groups.
- The process of Taskforce 1000 has made connections stronger between stakeholders – ACCOs, education services, child protection, Department of Justice, Youth Justice. In some case Protocols did exist between providers but had lapsed.
- One outcome was the establishment of an 'entry in to care' panel to monitor, evaluate and inform entry in to care for all Aboriginal and Torres Strait Islander children and young people and to ensure that all alternative options have been fully considered. The Panels have not been formally evaluated yet.

- Information sharing is a key issue – how can the formal service system talk with ACCOs. There is work underway to address this.
- Authority to make decisions.
- Data has been made available to the Sector that hadn't been routinely shared previously.
- The use of tools has enhanced practice.
- Partnership work is improving, even across States, as a result of project.
- The tone of the Panels was very respectful – of consumers and of other panel members. Panel members came together with a shared sense of dismay about failures of the service system on individuals. Panel members have focussed on working together respectfully.
- There has been no backlash in terms of confidentiality. The Commissioner had access to de-identified information but panel members didn't – although panel members often recognised participants.

Homeless Outreach Mental Health and Housing Service (HOMHS)

Chris Platt and Dean Alexander

Program Manager, HOMHS and Senior Manager Community Mental Health Residential Services

See attached powerpoint

Overview of HOMHS

HOMHS is located in the CBD and covers the Cities of Melbourne and Moonee Valley. The role of HOMHS is to provide a pathway out of homelessness for adults (16-65) who have long term or repeated homelessness and a severe and enduring mental illness (that will require ongoing management). HOMHS focuses on providing a coordinated approach to improve outcomes, reduce crisis, provide an appropriate gendered response to women.

HOMHS is a partnership between cohealth, Inner West Mental Health Service, Launch Housing and McAuley Community Services for Women, employing 10 practitioners from a variety of disciplines. The service is co-located with a variety of other homelessness and health focussed agencies.

The program provides: assessment, recovery support (Collaborative Recovery Model), team support, assertive outreach, secondary consultation, key worker in a team context. The service prioritises women. HOMHS is a long term program, based on consumer need.

The benefits for consumers include faster, more integrated service responses. Support provision is intensive. Consumers interact with fewer workers who are participating in more coordinated decision making. The service can continue to support people who are transient. Case workers can draw on the knowledge and resources of each of the partner agencies, which reduces duplication of effort.

Challenges: Reporting requirements are time consuming (covering different systems), differing agency policies and expectations must be managed, providing out of area assistance.

Staff/client ratio are about 1:7 or 8

Learnings:

- Operating as a team enables staff development, collaboration, mutual respect
- Co-location is beneficial
- Easier access to stable housing is a critical component – only 1 of their 27 consumers has returned to homelessness
- Complementary healthcare models are necessary to meeting the diversity of consumer need. Emergency department and prison presentations have been reduced by 57%.
- HOMHS is an effective housing first model.

Discussion:

If someone is stably housed out of area, the service stays involved for about six to eight weeks and involves an handover to another agency.

Most consumers are already known to clinical mental health services.

When the service has capacity, the consultant will consider referrals to the project. Over the past three months, approximately six new consumers came in to the service. Referrals are direct to the service. Typically referrals come from John Cade at Royal Melbourne Hospital.

Launch Housing Frequent Service User Project

George Hatvani & Noach Kronich Service Development Manager - Research, Service Development & Advocacy and Project Officer, Launch Housing

See attached powerpoint

Overview of the project
George provided an overview of the Launch Housing Philanthropic Project, which provides a response to the top 25 most frequent service users at Launch Housing. The project was provided with funding for a coordinator and some brokerage.

Having identified the top 25 most frequent service users through a data project, Launch had to find the individuals and engage with them in order to find out whether they wish to participate in the project.

Launch Housing is working through case summaries of the top 100 most frequent service users. These case studies highlight the numbers of workers from the service system who have had contact with these people.

Intended outcome: Stable long term housing and links to prevent future homelessness.
Social impact: Lower impact on crisis services and emergency services, greater use of preventative primary and secondary health services, greater social participation and inclusion, increase life expectancy.

Demographics
Of the top 25, the women are younger on average than the men; the average length of homelessness amongst women is 8 years. Nearly all the women had children but have lost access to them. (See powerpoint and notes from Think Tank 1 for the demographics of the 25 most frequent service users.)

The work to date:
All consumers who have been asked whether or not they would like to participate in the project have said yes. The coordinator is providing primary support to 3 people; co-case management with 8 people, is monitoring 11 people and has been unable to contact 3 people.

The project does not have automatic access to housing so the consumers being assisted are still experiencing multiple housing moves. The coordinator often doesn't know where consumers are. Some consumers have moved in and out of stable housing options. How can we ensure that stable housing can be held during periods of absence? The project assists consumers to fund alternate accommodation options whilst the consumer funds ongoing transitional or rooming house accommodation (that they are moving in and out of).

In some instances contact is almost daily to assist a consumer to manage their housing option.

How does support differ from other programs?

- Continued engagement – no eligibility/exclusion criteria
- Housing first – includes moving away from any notion of 'housing readiness'
- Launch Housing has responsibility for finding housing options.
- Engagement is the responsibility of the service, not the client – be ready when the client is ready
- Each consumer is different – there are no unifying characteristics.

Learnings

- The importance of an internal authorising environment
- Engagement, rapport then provision of service
- We have to find ways to 'stick' with consumers throughout periods with loss of contact.
- Issues of trust are central – it is very difficult to establish trust in a time limited project.
- Trauma informed responses are necessary – an understanding of the impact of trauma on an individual's behaviour
- The work is slow and outcomes feel temporary and precarious
- Case coordination is hard – the worker is isolated
- Should the service have entered in to a 12 month project without being able to offer long term assistance

Discussion
How do we support this client group who all experience poverty?

Staying engaged with people who may not always be able/choosing to be engaged is complex.

Services are often not available at the point someone is in crisis i.e lack of after hours options – the system is not stable.

Workshop: "From learnings to design"

DHHS is moving increasingly towards panel models bringing providers together but we also need the resources on the group. Project coordinators spend much time trying to find resources to coordinate. What function do ***panels*** serve? Buy in from amongst those present; expertise; improved coordination of practice; multi-disciplinary assessment creating a single narrative; creates an authorising environment; assists to highlight systemic issues; shared problem solving.

Service Connect targets were skewed to 'easy' consumers. The benefit for consumers was in having one worker who assisted them to navigate the service system.

Are we increasingly moving towards multi-disciplinary teams?

Complex for workers to undertake direct service response and coordination work at the same time.

One solution is to focus on how we can improve access and reduce barriers within our own services. How can we adapt our own approaches in order to assist us to engage better?

How can we draw on ***individual's natural supports,*** community connection or help them to build community connection or recognise community connection.

People, resources on the ground

- Multi-disciplinary
- Team
- Key worker/Coordination

Brokerage: The Doorway Housing First model took mental health funding and allocated it to private rental subsidies. We need to be creative in working across funding streams. The program uses a creative combination of funding to enable people to access private rental. Eventually the tenant takes over the cost of the private rental. The project targets people engaged in clinical mental health services.

An authorising environment is key.

Effective evaluation with consideration of long term benefits/outcomes and economic/social benefits. Mindful establishment of evaluation from the outset of a project.

Collaboration/case coordination is key – coordination can even help us to find people

Housing first.

Structures that drive accountability – having a piece of work driven by data, program logic, monitoring framework, agreement of outcomes, outcomes measures. Collective impact encourages shared stories, shared data, shared definition of aims and outcomes, agreed outcomes, measures of outcomes.

Opportunities to improve practice and to improve systems – commitment to shared learning and development. Organisations can blame the individual.

Information sharing need not be a big issue.

There has been a funds investment in all the projects highlighted.

Each project was developed on the basis of evidence.

Each project had an authorising environment – on the other hand, projects sometimes fall over because there is a shift in the authorising environment (i.e government changes). We haven't formally obtained CEO buy in at this point.

Funding: Could we argue for social impact bonds/social investor? Could organisations that would other wise be experiencing costs from supporting these consumers in the long term contribute funds for the project?

Flexibility – being able to adjust approaches, identification of outcomes.

Assertive outreach – principle of support as long as the person needs it and capacity to assertively find and engage with consumers.

In changing the response to these individuals, we are potentially taking them out of their comfort zone.

The issues of trust and attachment is enormous for many of these individuals. We are potentially offering an attachment but need to be able to offer ongoing connection (to counter an experience of trauma). Most of of our system is based on short term responses. We need to help establish ***connection to a team,*** rather than reliance on a single worker. We need to build from rapport with an individual to connection with a team – to build trust in a team. The team then needs to communicate highly effectively. Some services use informal settings such as BBQs to introduce team members.

How do we establish a team response across disparate services?

Team/collaborative work is less isolating for workers – sharing responsibility creates a more supportive work environment.

What is the role of broader programs such as ***recreation programs***? Community development work? Art programs? Funding cuts have led to a reduction in these programs – they assisted to create community connection.

How will this group fit in with NDIS? A) Is there an opportunity for people to access responses/resources that they don't currently have access to. B) Could we be providing a range of responses to these consumers so that consumers can then identify through NDIS that this is the type of response that they want? We are in the early days of establishment with NDIS but we do need to consider the intersection with NDIS. Whatever we develop could be put in to the NDIS marketplace.

Design thoughts:

- A virtual, inter-disciplinary team able to undertake shared visits
- Regular team/project meetings
- Develop a trauma informed, housing first model
- Senior practitioners for frequent service users in each of the systems – forming a coordinated shared care team
- Partnership with a real estate agent as a social investor
- Mercy Health has funding coming for complex care workers that could potentially be allocated to this consumer group if we can use the evidence
- Politically – hit services where it hurts – ie where consumers are costing the system ie emergency department presentation
- Service systems to examine their practice to improve access – develop agency improvement plans in response to these consumers.

Actions:

- ***Participants come to Think Tank 3 with some 'pitches'***
- ***The group needs to give consideration to what can be achieved here? How do we sell this in the different sectors?***
- ***George to circulate or present on collective impact approaches.***

Next steps: Think Tank 3

The aim of the next Think Tank is to design a cross sector response to those who we identify as being in our target group. (6 October, 10 am – 2.30pm, Hume Global Learning Centre