Mobile Community Outreach Team (MCOT)
Mental Health & Homelessness

Mission Australia’s Michael Project (2007-2010)

• 70% of all clients of the service indicated they had been diagnosed with a mental health disorder by a health practitioner, with the following major disorders:
  
  33% with mood disorders, 35% anxiety disorders, 17% psychotic disorders.

  20% of clients screened had post-traumatic stress disorder (compared with 1% of the adult male population).

• 50% indicated substance use disorders / dependence.
MCOT - what it is

- Small team staff (2 nurses and .5 consultant psychiatrist)
- All referrals are from AOT and HSW staff
- Provides specialist mental health assessment and commence treatment
- Screens and refers for general health and drug & alcohol problems
- Provide consultation, advise and support to AOT’s, HSW’s
MCOT model (direct interventions)

The model incorporates:

- Use of engagement, motivational interviewing and other theories.
- Assertive outreach
- Early intervention
- Specialist assessment
- Dual diagnosis principles (i.e., working together with BOTH mental health and drug and alcohol presentations)
- Shared care (care-coordination)
- Time limited shared care/treatment
- Transition
CLIENT (MCOT engagement pathway)

On the street

Crisis and Transitional Accommodation

Assertive Outreach Team

Housing Support Worker

Consent to participate - yes

Contact made by:
- Word of mouth
- Accom/Housing Provider
- ED's

Mental Health Concerns Identified

MCOT REFERAL
Case I.D
Casual Contact Yes
Engagement with client MH Activation Treatment

MCOT MH Transition Process
MCOT linkages with Mainstream Mental Health
- MHERL/CERTS
- Clinics
- Inpatient/Outpatient
- Community MH, D&A
- General Health
- Forensics

MCOT Mental Health Consultation Advice and Advocacy
- Assist in linkages with community Mental health
- MH consultation
- Advice to assist in establishing NPA (notification for housing)
MCOT Treatment and Care Coordination of Rough Sleepers

Engagement and Assessment
(over a period of 1 to + sessions)

Treatment

Mental Health
- Mental health
- AOD
- Physical health

Mental Health Transition Process
- MHERL/CERTS
- Community Mental Health Clinics
- AOD Services
- Inpatient/Outpatient
- General Health
- Forensics

Case Planning
(Shared Support Plan)
- Case Conference of
AOT + MCOT + HSW + Client
Completed
CASE STUDY 1 - THE HOMELESS REFUGEE
THE HOMELESS REFUGEE

• Mr. SK.
• Late 30s. Kurd. Spoke several languages.
• In Australia 4 years
• Homeless 4 months, rough sleeping
• Previously in a Hostel and prior to that state housing.
• Prior psychiatric contact. Thought to have PTSD
THE HOMELESS REFUGEE

- Presents via NGO
- Several interviews done with interpreters present and on phone.
- Presented as disheveled
- Volatile and easily irritated
- Switched language used frequently.
- Unable to articulate what he wanted.
THE HOMELESS REFUGEE

- Where to from here?

- Matters develop........
THE HOMELESS REFUGEE

- Hospitalised.
- Treated Under MHA
- Diagnosis was of a schizophrenic illness
- Role of MCOT in hospitalisation
- HSW in accommodation.
- Transfer to local area mental health service
THE HOMELESS REFUGEE

KEY MESSAGES

• Keep an open mind clinically. Do not foreclose on diagnosis.
• Diagnosis leads to correct treatment.
• Language /communication problems.
• Vital role of NGO in housing him successfully.
The Outcome:
CASE STUDY 2: THE MOTHER & DAUGHTER
MOTHER AND DAUGHTER

- The L family
- Mother in 50’s, daughter in 30’s.
- Had home, part owners.
- Mother known to have bipolar disorder.
- Daughter no formal diagnosis but intellect limited and history of aggressive behaviours.
- Evicted from the home after it was condemned.
MOTHER AND DAUGHTER

- Ended up in a park with a menagerie......
- On the move ....
- Several contacts made but events took over..
- The taxi ride story
- Assistance from local council with animals
- Overnight hospitalisation
- Sent to NGO on discharge!
- Currently in temporary accommodation
MOTHER AND DAUGHTER

Any ideas??
MOTHER AND DAUGHTER

KEY ISSUES

• Problem long in making. Multiple agencies involved.

• “Elderly squalor “ syndrome is multifactorial and difficult to intervene with.

• The pair come together complicated matters.

• Inter Agency Communication and planning rather that one agency being solely responsible
Current situation - Captain Stirling Hotel
CASE STUDY 3 - JOHN
JOHN

- John is a man in his 50’s.
- Well known to MHS with a schizophrenic illness and alcohol abuse and dependence
- Was living behind a drop in center for some years.
- Occasionally had hospitalisation for “social reasons”
- Poor physical health. Incontinent of faeces
JOHN

- Engaged with MCOT..
- Hospitalised
- Referred to Hostel... not a successful placement...
- Why not?
JOHN

- Expectations altered.
- Agreed to a different hostel
- Then under a Public trust and Guardianship order.
- New placement seems successful
- Still drinks, close to his suburb and its social connections, eats well, physically much better. GP involved at Hostel.
KEY ISSUES

- Lessons for MH services.
- Correct use of State Guardianship System vital
- Quality of Life and Dignity.
The Outcome:
MENTAL HEALTH ON THE STREETS

KEY MESSAGES

1. Mental health is complex.
2. Homelessness is complex.
3. There is a need for specialist mental health homelessness services.
4. Homeless people with mental illness are one of the most vulnerable groups in society.
5. Effective service delivery can only occur in partnership.
6. There is a need for a range of options for accommodation.