



Catherine House Inc.

Integrated Services provide Pathways out of Homelessness for Women with Co-morbidity issues

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SIU Drug and Alcohol/Mental Health / Housing Integration Project

Project aim: demonstrate best practice in the integration of mental health, drug and alcohol, and housing services with a view to reduce recurrent homelessness, by developing:

- 1: Integrated case management service responses for homeless women presenting with mental health and drug and alcohol problems (using a holistic case management approach).
- 2: Close collaborative partnerships with key mental health, housing and drug and alcohol agencies (using an integrated service delivery model).



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Partnership with Catherine House

- **S I U goal: Reduce recurrent homelessness**
- **Site: Catherine House Emergency and Transitional programs**
- **Length: 18 + Months**
- **How: Twofold Integrative Model**
 - Internally: within Catherine House: holistic clinical support to 50 women including 13 Indigenous women
 - Externally: Establish collaborative Practice with relevant agencies through developing memorandum of understanding.



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Why a Demonstration project ?

- **Develop/ test interventions for a particular client group.**
- **Construct a detailed profile of clients group.**
- **Systematic, continuous process incorporating and analysing feedback from intervention in order to refine models.**
- **Evaluation focused.**
- **Scope to generalise or replicate.**
- **Different from Pilot trials more concerned with logistic of rolling out a new service model.**
- **Focus on context resources and practical issues.**



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Client Profile 1

Mental Health

- Prevalence: Up to 50% of psychosis illness, 95% suffered from either depression and or anxiety disorders (inc 20% PTSD, CSA) 12% BPD and at least 12% reported self harm.

Drug and alcohol

- Over 80% Polydrug users; swapped medication and substances according to perceived needs and availability. Drug most used was speed (50%) followed by cannabis, alcohol and opiates (not heroin) all around 30% and last heroin (below 10%) and methadone (8%).

Health:

- 50 to 60% cases of severe chronic/ acute often untreated conditions (cancer, heart disease, diabetes, asthma etc); around 35% BA Injuries.

Recurring Homelessness

- Most clients had more than one episode of homelessness before presenting to CH. For the few who didn't, early and effective engagement was crucial to prevent future homelessness.



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Client Profile 2

Illegal activities:

- Around 30% of women who are homeless and present at Catherine House reported to engage or have engaged in criminal activities. Most do not disclose this information.

Chronic pain issues:

- Many women have ongoing untreated and or undiagnosed chronic pain issues and ensuing medication/ drug use issues.

Racial background.

- On average 20% of clients were Indigenous
- A least 10% of clients came from a middle East middle eastern background
- 35% of project participants were from non English speaking backgrounds.

Income:

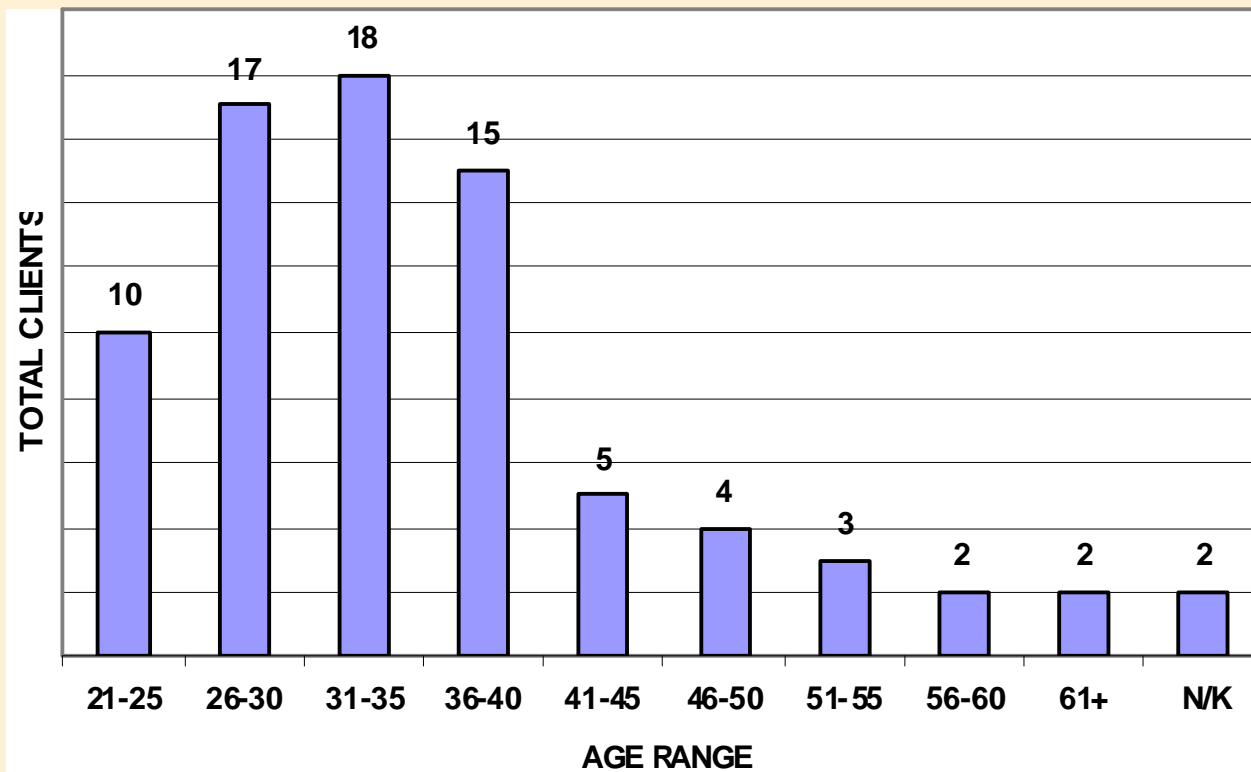
- The majority of women presenting to Catherine House are unemployed and receive Centerlink payments, at least 50% are on DSP.



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Client's age

(Early phase of the project only)





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Evidenced Based Best Practice Project Principles

- **NIDA**
- **MH guiding Principles**
- **MH Recovery Model**
- **Community Continuous Care Model**
- **Co morbidity and homelessness**
- **Motivational / Strength based**
- **Engagement Principles in working with D&A users**
- **RP, HM, Stages of Change, crucial for co morbidity.**



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Why did it work?: Environment

- 1. Residential site.**
- 2. Safer environment from usual Homelessness, Drug and Alcohol, and Relationship issues.**
- 3. Assertive engagement and case management and willingness to manage complex needs.**
- 4. Support/ need responses were timely/ immediate.**
- 5. Services were culturally sensitive/ easily accessible inc LT accommodation options.**
- 6. Access to educational/recreational activities.**



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Why did it work?: Hope

1. Co morbidity assessment + holistic integrated case management coordinated by 1 worker.
2. Co morbidity issues were addressed early.
3. Clients were part of all decision making regarding co morbidity issues.
4. Clients felt that their issues were addressed /felt supported to try new things.
5. Clients felt empowered/ had a range of options.
6. Alternative options were found when needed.



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Why did it work?: Integration

- Positive and pro active collaboration
- Common aim: reduce homelessness, reduce co morbidity as a barrier to housing/ life.
- Establish clarity of responsibility
- Housing first: access to a range of accommodation suited to individual needs
- Celebrating success!



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What was demonstrated?

- Engagement and relationship are keystones of success. Skilled workers are needed.
- Long-standing cycles of homelessness can be broken.
- Assertive, active processes get results.
- The model can be effective for Aboriginal women.
- Capacity to address systemic barriers was low.
- Relapse is likely and should be anticipated.
- Site and attitude are crucial.



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Conclusion

**Integrated Services provide
Pathways out of Homelessness
for Women with Co-morbidity
issues.**



Recommendations:

- **Integrative Model of Care across the Homeless sector.**
- **Co morbidity services across Human Services Sector.**
- **Mental Health treatments in function of impairment.**
- **Assertive outreach availability.**
- **Closer collaboration amongst agencies.**
- **More flexible drug & alcohol services**
 - eg: women' only detox, and outpatient detox.
- **Range of housing options**
 - **Fast tracking to H SA**
 - **Women only boarding H**
 - **DAMP and Wet accommodation.**
 - **Affordable SRF**
- **GP/Psychiatrists to bulk bill**



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Thank you for your interest
and attendance today!

Special Thanks to :

SIU

DASSA

Project Steering Committee Members

Every Catherine House staff member

DFC policy & research Unit

SANDAS