City East Community Mental Health Service
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Thank you for the opportunity to provide information for the inquiry into these areas of homelessness.

As you may be aware the Mobile Clinical Outreach Team (MCOT) is a clinical service based at the City East Community Mental Health Service as part of East Metropolitan Health Service. MCOT comprises of:
0.4 FTE Consultant psychiatrist
0.4 FTE Administration
2.0 Clinical Nurse Specialist
1.0 Senior Social Worker
MCOT is currently funded federally through the Mental Health Commission, in response to the 2008 Council of Australian Government's establishment of a National Partnership Agreement on Homelessness, to support several Non-Government Organisations (NGOs) working through the Street to Home (STH) initiative.
MCOT's initial role was to provide the clinical support to this program as well as upskill the NGOs through education, support and development.
Through this ongoing support MCOT has developed significant relationships with the homeless sector and attends Collective Homelessness Action Meetings and Combined Street to Home Meetings. MCOT also attends Tom Fisher House twice a week and meets with other assertive outreach workers in the streets, such as Tranby, Cyrenian, Homeless Health Care (HHC), Passages, Uniting WA, Ruah St Patricks, St Barts among others. MCOT continues to frequently visit these services and provide face to face as well as over the phone referrals and enquiries to support these services. MCOT historically has a high percentage of indigenous clients & has developed working relationships with Aboriginal officers from many NGO's as well as good working relations with workers at Wungen Kartup (Aboriginal Psychiatric Services).
As part of our assertive outreach role, MCOT is often called by STH services to assess street present clients who are presenting with possible mental health problems. The police and rangers, as well as members of the public, call us for assistance. Presentations are often aggravated by concurrent drug and alcohol abuse. We assist by providing thorough mental health assessments and advise and develop a viable plan for this person, bearing in mind least restrictive practice. Often this assessment leads to hospitalisation. When the decision to hospitalise is made, MCOT as a team is required to liaise with Police, ambulance, hospital, fulfill all mental health legal requirements in relation to the Mental Health Act and provide detailed documentation for handover to the hospital. The process of admitting an individual under the Mental Health Act can take several days by the time other agencies involved are available. Coordinating this often requires over 30 phone calls to organise this, ties up a staff member usually for 6 hours plus of the shift with paperwork included if all goes well.
MCOT has amply fulfilled its original role. It is often, through necessity, that we provide a bridge between clinical services for people who are homeless and who are hiding in the shadows of homelessness. These people often have a severe and persistent mental illness and are certain to fall through the gaps of mainstream services including STH if they are not assertively assisted by MCOT.
Many chronic homeless people suffering a mental illness do not fit the model of S2H, Advance to Zero (A2Z) and mainstream mental health services (MHS). They require a service tailored to their CURRENT needs. This is due to the very nature of major mental illness, whereby these clients

actively avoid services, including assertive outreach services. Many have fallen through the cracks of traditional discharge and prison release and are lost to follow-up. This is compounded by clinical mainstream services who are unable to provide ongoing clinical care to people without a 'viable residential address'. To support a person to retain their accommodation MCOT has had to Coordinate Care with 13 agencies for one client in the past. This included police public trust, 2 drug & alcohol agencies, 2 general hospitals, 3 NGO's and counselling services. As well as non-official supports like family, local shops etc. This is a very labour-intensive skill base that requires education of the people around to overcome prejudices & support people who are having difficulties managing their own emotional reactions to the challenging behaviours of the client.

MCOT see those who have left their wife and four children with a psychotic depression, those released from prison or those who are too disorganised to link with mainstream clinical services due to their schizophrenia and acquired brain injury. We also see people who are discharged into homelessness from hospitals and mental health units requiring clinical follow-up. Mainstream services usually require a residential address to provide a service. This week we had an email (a not uncommon occurrence) asking how to refer to MCOT as a client was moving to the city & the local ATT could not accept this referral as the patient was homeless. We also see those who's paranoia and psychotic symptoms, do not allow outreach workers to engage effectively with them. Psychotic people by nature do not trust for reasons known only to themselves. This will often lead them into the shadows of homelessness where they can stay invisible! Sometimes these individuals are also battling addictions. It is these people MCOT is providing an ongoing service too, and once the patient is 'stabilised', we are often unable to discharge and refer onto mainstream services due to the need for assertive follow-up, secondary to the complexity of their needs.

Most current MCOT clients have a significant history of eviction leading to 'chronic' or 'entrenched' homelessness. It is these clients who suffer a mental health disorder, as well as a comorbid disability that require assertive case management. These clients need differing low threshold accommodation options and a quick turnaround support provision. NDIS takes several months to access and build a team around a client with complex needs. MCOT has witnessed many evictions occurring not as a fault of the clients, but the fault of landlords and providers who are not flexible enough to maintain housing and supports for people with complex needs. It is often the first option sought that a person is made homeless rather than work through difficulties in tenancy and provision of services. It needs to be understood that for someone who has such complex needs, they are reliant on others to provide for their needs. This can lead to "blacklisting" and the person is unable to return to this accommodation or other accommodations managed by that provider. With only a few large providers in the Perth area this significantly reduces the housing options for that person in the future. Step down or step-up clinical services are required for this group. Many of the MCOT clients fit into this category.

MCOT often works with very unwell people that remain sleeping rough and do not require hospitalisation due to having no alternative 'clinically supportive' service to recover within. It could be compared to a Hospital in the Home option, without the home.

There is also a need for homeless services to be able to respond to the homeless youth that is younger than 18-year-old. We are often seeing adolescent youth with complex needs that are also homeless. We need to respond to this group as early as possible to avoid entrenched homelessness to develop.

In response to the following areas, MCOT would like to offer some suggestions for consideration.

1. the current funding and delivery of services
2. 'All Paths Lead to a Home', Western Australia's 10-Year Strategy on Homelessness 2020-2030
3. existing data systems and how data informs service delivery
4. any other related matter,

MCOT would like to offer the following for consideration.

Current funding for MH support services is significantly lacking, or so inflexible that they limit the people they can service. Clinical services such as MCOT need expansion. This is evidenced in other states where each local area has their own' homelessness team' within their Continuing Care Teams.

Basing clinical workers with NGO's part time is a viable consideration to break down the siloing of knowledge and resources.

'Super clinics' or cohabitation of services and resources could be considered. In effect the development of a multi-disciplinary, multi service and provision team. This could include clinical, primary health, Drug & alcohol as well as NGO's.
Data and information systems that are accessible to multi organisations is required to limit expenditure and provide greater information sharing.
Having short term accommodation funding available for services for clients in crisis situations and getting the homeless person off the street allowing for transitioning them into longer term accommodation as they settle. This would need to be very physically flexible housing to allow for the client's needs at the time. This allows for the ongoing assistance to be provided to complex clients and to alleviate some of the problem saturation issues to be worked through.
Mental ill health, AOD issues, along with homelessness are chronic relapse conditions. This can lead to clients' entering the forensic services. MCOT have seen the need for services to take this into account more readily to prevent clients falling into homelessness again by raising the threshold for eviction.

Management of longitudinal relapse and crisis requires responsiveness as well as a spirit of generosity. Case management meetings are very underutilised where teams and organisations are bought together to resolve support issues for clients. 3.1 of All Paths Lead to a Home, Priority highlights the need for a tailored response for vulnerable cohorts. This requires coordination as well as resources.

Improvement in the video conferencing equipment and utilisation of the same would increase the utilisation of this technology available and provide far better client outcomes.

Pre-release time and resources are necessary to optimise outcomes for the vulnerable. Too often does MCOT engage with clients recently released from prison & inpatient services who have no services in place and have already significantly declined in function. So much so that the homeless person is already requiring hospitalisation. With improved planning, coordination and referral, we would see a significant reduction in hospitalisation, homelessness as well as reoffending and problematic behaviour in the streets.

Currently the Prison in Reach Transition Team (PITT) are providing a brilliant service but this is hampered by a lack of planning and warning on release date and are often left scrambling to find accommodation and services for someone with only days before release.

Recent experience with services such as the bail support service are highly influential in assisting people who have court proceedings and charges. They have provisions for a telephone, food parcels as well as putting people up in a hotel for a period. This allows services to engage with them because then the person can be contacted reliably. Resources are often a necessity for homeless people.

Start Court also provide an outstanding service to those with a mental illness and homelessness who are facing the legal system. Start Court are made up of a team of mental health clinicians and allied health working alongside the judicial system in an allocated court room specific to mental health needs. Clients are supported through the sentencing process with outreach support and attempts to link them with available services.

Ultimately there is a need for more staff in MCOT and assertive outreach clinical services. Our current resources allocation only allows MCOT to work with 30 clients, however we are running at 50% over capacity nearly all the time, trying to reduce the number of people in the community who are not serviced. We currently have a psychiatrist 2 days of the week. The shortfall on the other three days significantly hampers the provision of service to active as well as referred & acute clients. We are having to decline referrals due to acuity and chronicity as we have so many chronic people that have been lost to mainstream services.

Again, thankyou for the opportunity to provide input into this enquiry and if you consider MCOT could offer clarification on any of the information and opinions we have offered we would be happy to meet with you to discuss our views.

Yours Sincerely
Cliff Holmes.
Acting Team Leader MCOT.