



Mental Health Shared Care: Sharing a recovery-based approach to case management for clients in Yarra

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St Vincent's

*Continuing the Mission of
the Sisters of Charity*

St. Vincent's Mental Health



- **Area mental health service**
- **Inner city catchment
Pop. 220k.**
- **Adults 16 – 65**
- **Multi-disciplinary
clinical staff – 250**
- **750 ongoing
consumers**
- **Comprehensive
programs**
 - **Continuing care**
 - **Mobile Support and
Treatment**
 - **Crisis Assessment
and Treatment**
 - **Homeless Outreach**
 - **Acute Inpatient
Service**
 - **Community Care
Residential
Rehabilitation**

Clarendon Clinic



- **Community Mental Health Service for the City of Yarra**
- **52 Albert St, East Melbourne, 3002**



Continuing Care Team (CCT)

- 15 case managers
- Caseloads of ~25
- multidisciplinary



Mobile Support Team (MST)

- 7 case managers
- Caseloads of ~10
- Multidisciplinary
- Assertive outreach in community



Crisis Assessment & Treatment Team (CATS)



- **25 clinicians**
- **24/7 service**
- **Multidisciplinary**
- **Triage**
- **Acute assessment**
- **Early Discharge Management**



Clarendon Homeless Outreach Psychiatric Service (CHOPS)



- 5 case managers
- Caseloads of ~8
- Multidisciplinary
- Assertive outreach in community
- Homeless or at-risk



- **Alliance Partnerships between clinical mental health & Psychiatric Disability Rehabilitation and Support Service Sectors**
 - **MOU signed in November 2006**
 - **Inclusive of Alcohol & Drug services**
- **For a cohesive recovery & rehabilitation service system**
- **Alliance meetings monthly**
 - **Agenda: Pathways for shared consumers**
 - **Shared recovery & rehab plans**
 - **Cohesive service delivery**

Shared model of care



- **The Strengths Model: Case Management with People with Psychiatric Disabilities (1998 – First edition, developed by Charles Rapp, US)**
 - Focus on strengths not deficits
 - The person is in charge
 - Community as oasis of resources
 - People continue to learn, grow & change
 - Case manager- client relationship is primary
 - Primary setting is the community

Shared Care: Homeless service



- Working partnerships between CHOPS and various service providers to meet the needs of homeless clients in Yarra
- Portfolios held by individual CHOPS clinicians
- Homeground
- Connexions
- St Mary's House of Welcome
- Turning Point
- GPs
- Housing (Anchorage, Flagstaff, Yarra Housing, etc)

Shared Care: Homeless service



HOMEGROUND

- Weekly Team Meeting at Homeground
- Secondary & Tertiary consultation
- Orientation to mental health service for new staff – providing a mental health framework
- Continuum of Care for clients

Shared Care: Homeless service



CONNEXIONS

- Referrals for mental health assessment
- Secondary consultation
- Continuum of Care for clients – access
- Connection to Primary Health Care providers

Shared Care: Homeless service



ST MARY'S HOUSE OF WELCOME

- Twice weekly scheduled liaison visits
- Referrals for mental health assessment
- Secondary consultation
- Continuum of Care for clients – access

Keys to successful shared care

- Cross sector collaboration.
- Client consent.
- Shared model of care - client-centred, goal-directed model – “Strengths”.
- Model integrated with all aspects of the Service – strategic plan, quality plan, training plan, policies and procedures
- Ongoing visible support and endorsement by the Managers of the services through the Alliance Meeting
- Significant service investment – including financial