

# Housing First Partners Conference – April 2018

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# **Housing First, Healthcare Too:**

**Driving Coordinated Entry through Your Local Mental Health Provider**



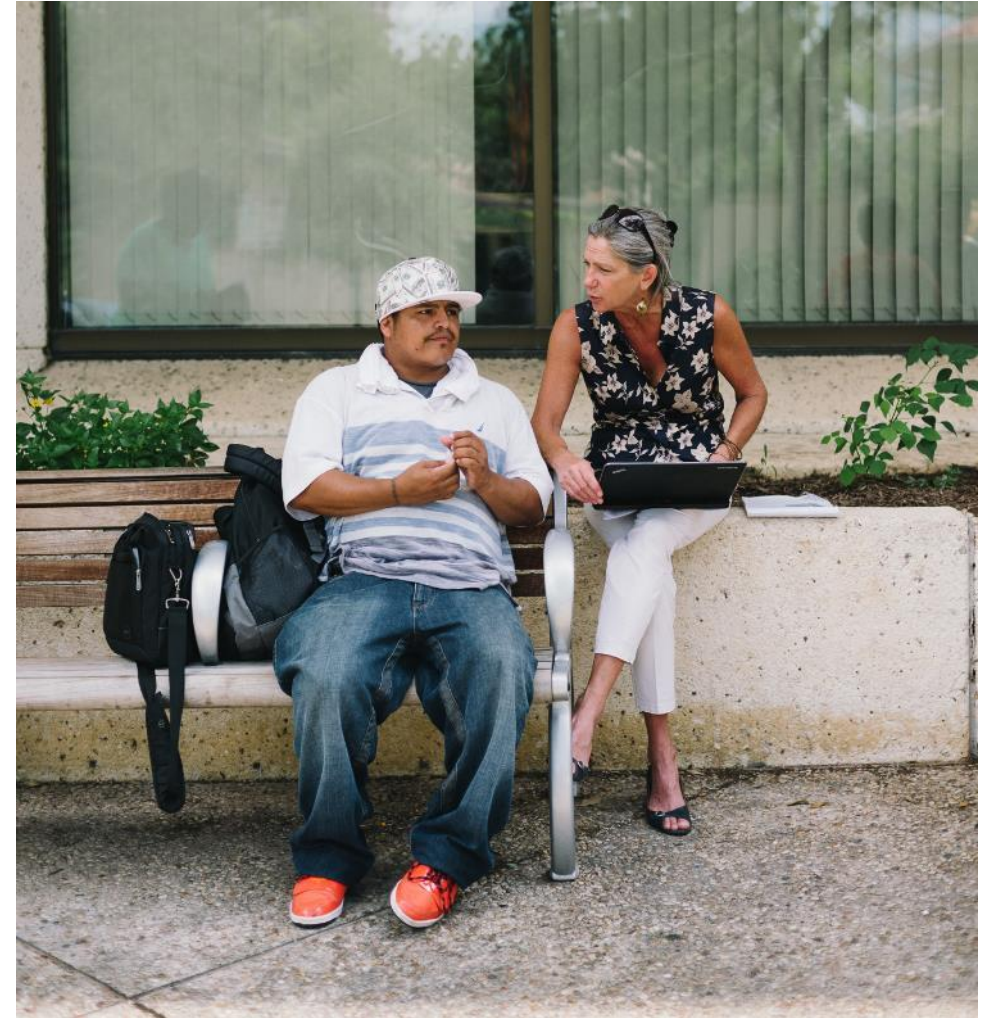
# Learning Objectives

- Recognize the need for a mental health provider at the table when designing your homeless services system
- Identify the benefits of having a mental health partner in system transformation
- Discuss advantages and challenges of providing both housing and case management by the same team



## Audience Question:

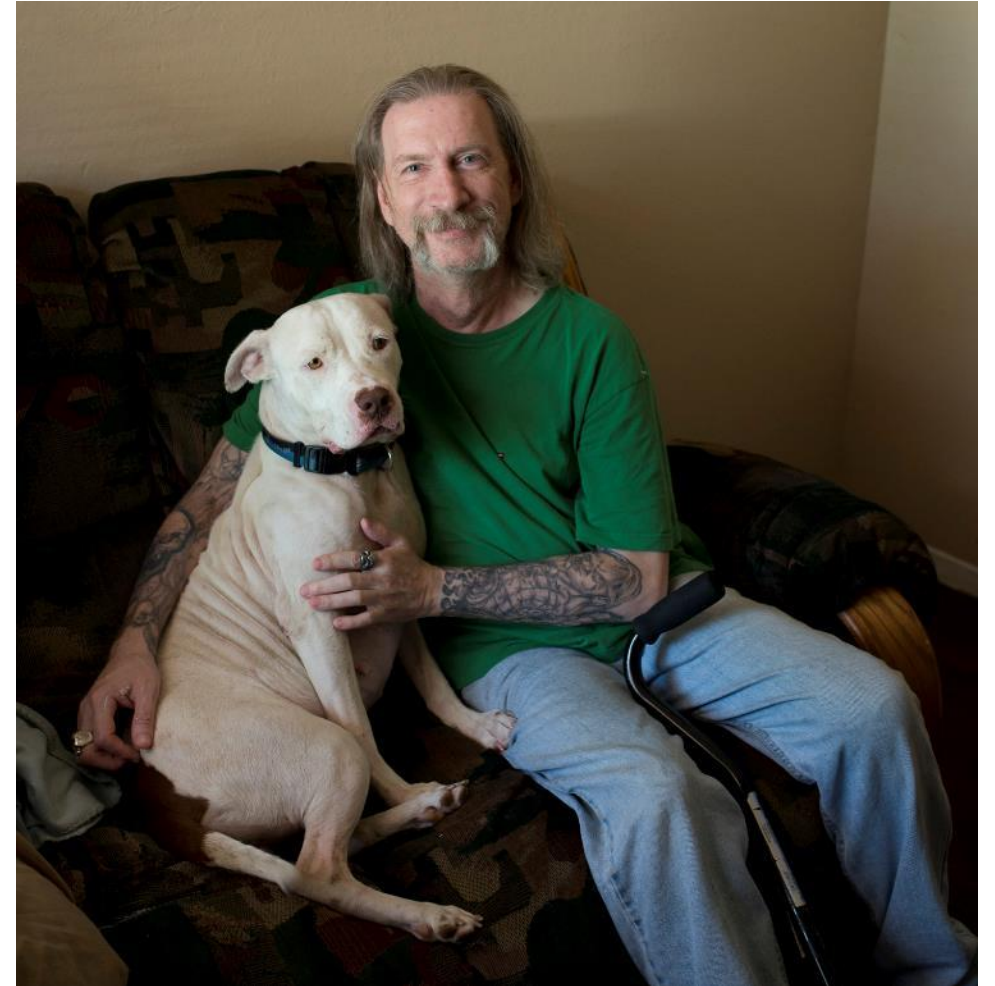
What have your experiences been like in working with mental health providers?



# Overview

Integral Care helps people build health and well-being so everyone has the foundation to reach their full potential.

We support adults and children living with **mental illness, substance use disorder** and **intellectual and developmental disabilities** in Travis County.



# About Integral Care

Integral Care provides community-based mental health, substance use disorder and developmental disabilities services in Travis County.

**25,000**

Travis County  
residents served  
each year

**\$109M**

Annual Budget

**40+**

Locations with  
direct services and  
mobile teams

**50yrs**

Of proud  
service across  
Travis County



# Our Homeless & Housing Services



# Our Impact

## Our Impact

**20+**

Years Serving  
Homeless  
Community

**21**

Housing &  
Homeless  
Programs

**103**

Housing  
Staff

**\$28.3 M**

Housing &  
Homeless  
Services Budget

**462**

Permanent  
Supported  
Housing Units

**3000**

Homeless  
Individuals  
in Services

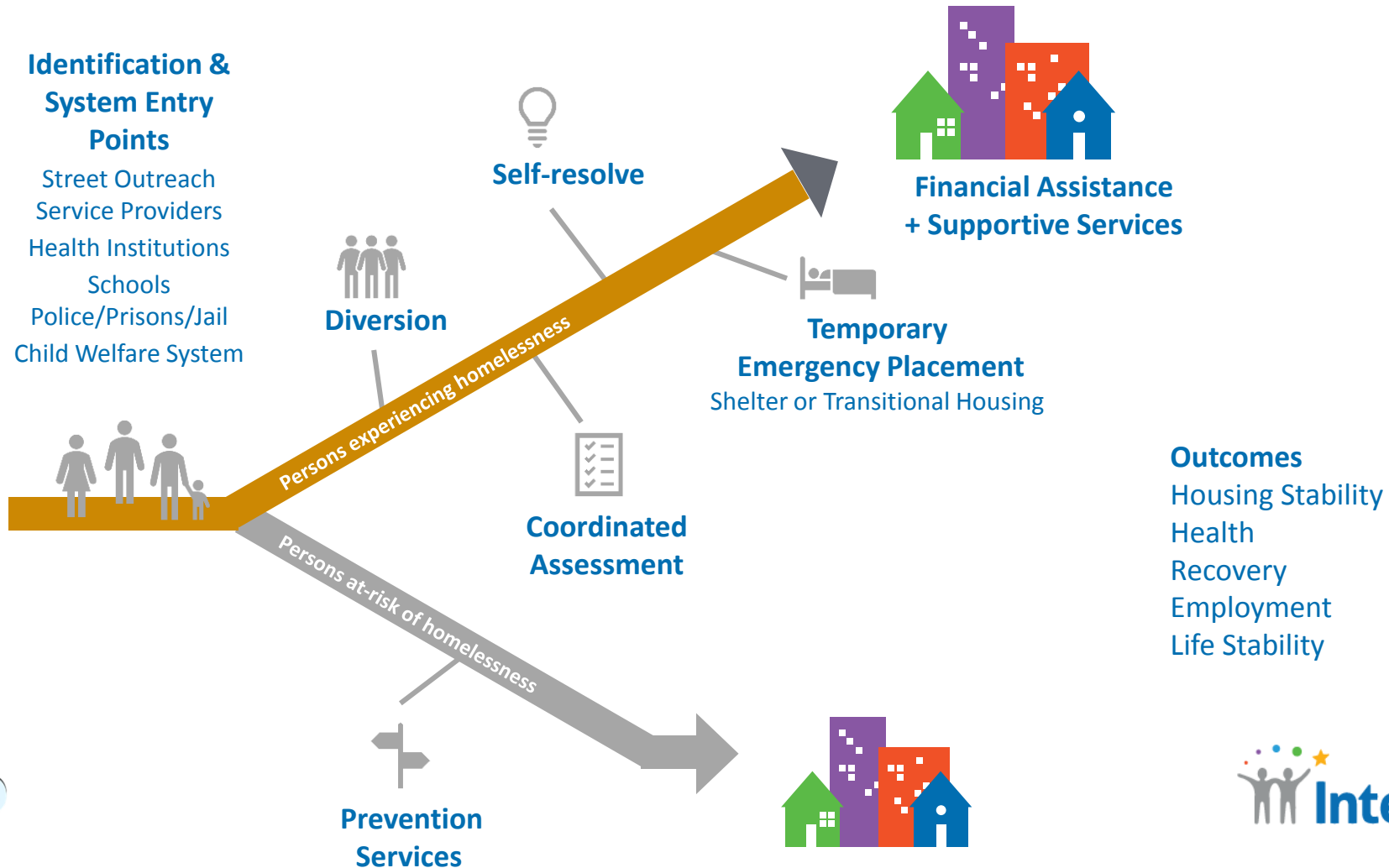




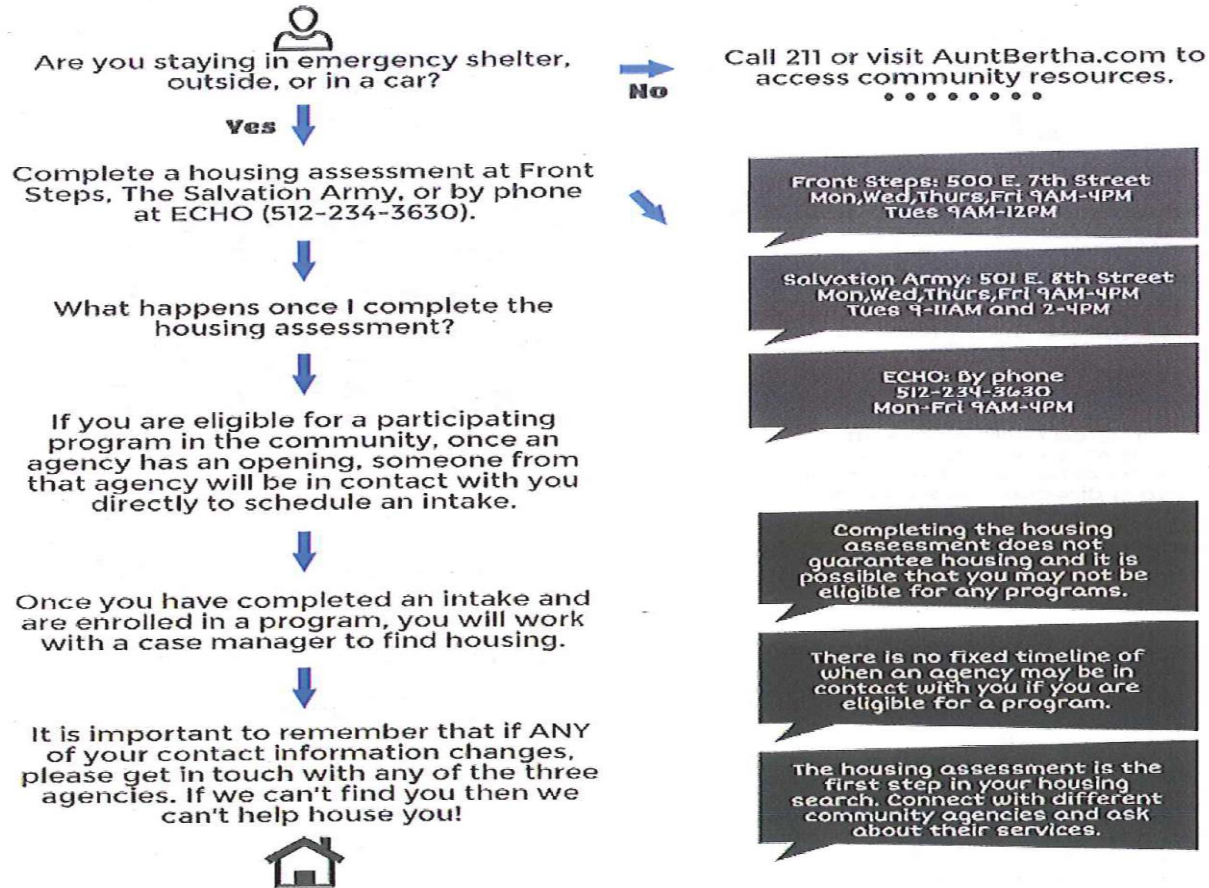
# About ECHO

- The Ending Community Homelessness Coalition (ECHO) is a non-profit that plans, develops, and implements community-wide strategies to end homelessness in Austin/Travis County, Texas.
- It is the lead agency for the Austin/Travis County:
  - HUD Continuum of Care (CoC)
  - Homeless Management Information System (HMIS) Database
  - Coordinated Entry System

# Our System to Prevent and End Homelessness



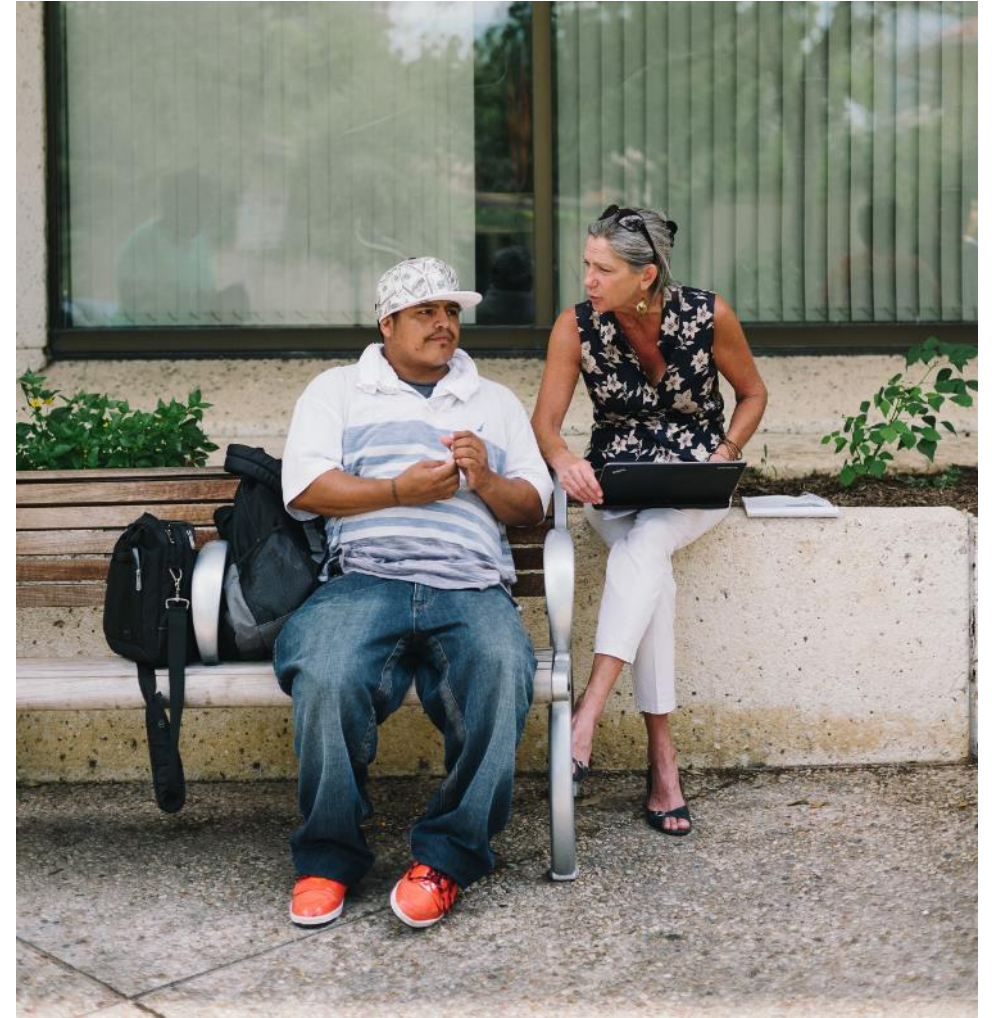
# Coordinated Assessment



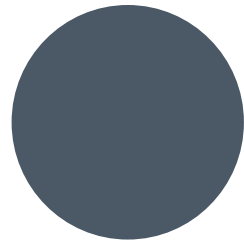
# The Truth.....

Homeless people are a population known to be highly vulnerable to trauma, a result of the triggering events to becoming homeless and the considerable social isolation, discrimination, and adversity suffered when homeless.

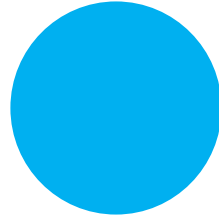
(Archard & Murphy, 2015)



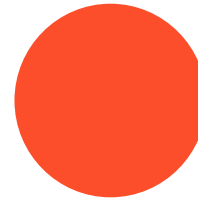
# Individuals experiencing homelessness in Travis County



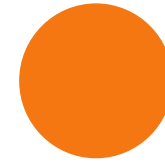
**67%**  
Can't access  
employment/  
do not have any  
earned income



**61%**  
Access healthcare  
through an  
emergency room  
or do not access  
any healthcare



**56%**  
Have experienced  
trauma or abuse  
in their life



**44%**  
Currently  
experience  
mental health  
issues



# What does partnership look like in practice?

- Mutual System Access – Multiple, intentional opportunities for clients to co-enroll or “cross over” between systems
- Services Provision and Design – Service standards and workflows are designed from the start with dual service needs in mind
- Expertise and Specialization – Reliable service partnerships mean that respective experts can sharpen skills and be brought in where needed most, rather than everyone trying to become a jack-of-all-trades
- Regular communication – Real-time feedback and communication at multiple organizational levels, to catch gaps and opportunities in real-time

# Where did we start?

Identified need for  
coordination and  
communication

Legal  
considerations/data  
entry systems

Specific MH  
referrals

Necessary?  
Redundant?

What does the  
system need to look  
like to serve ALL?

Building from  
scratch together





# System Design Considerations

Ensuring  
privacy/confidentiality  
of MH/SA information

Building questions  
about MH into  
Coordinated  
Assessment

Easy identification of  
individuals on  
prioritization list as  
having MH needs

Physical proximity of  
CA specialists and MH  
staff

Availability of mobile  
CA and MH intake



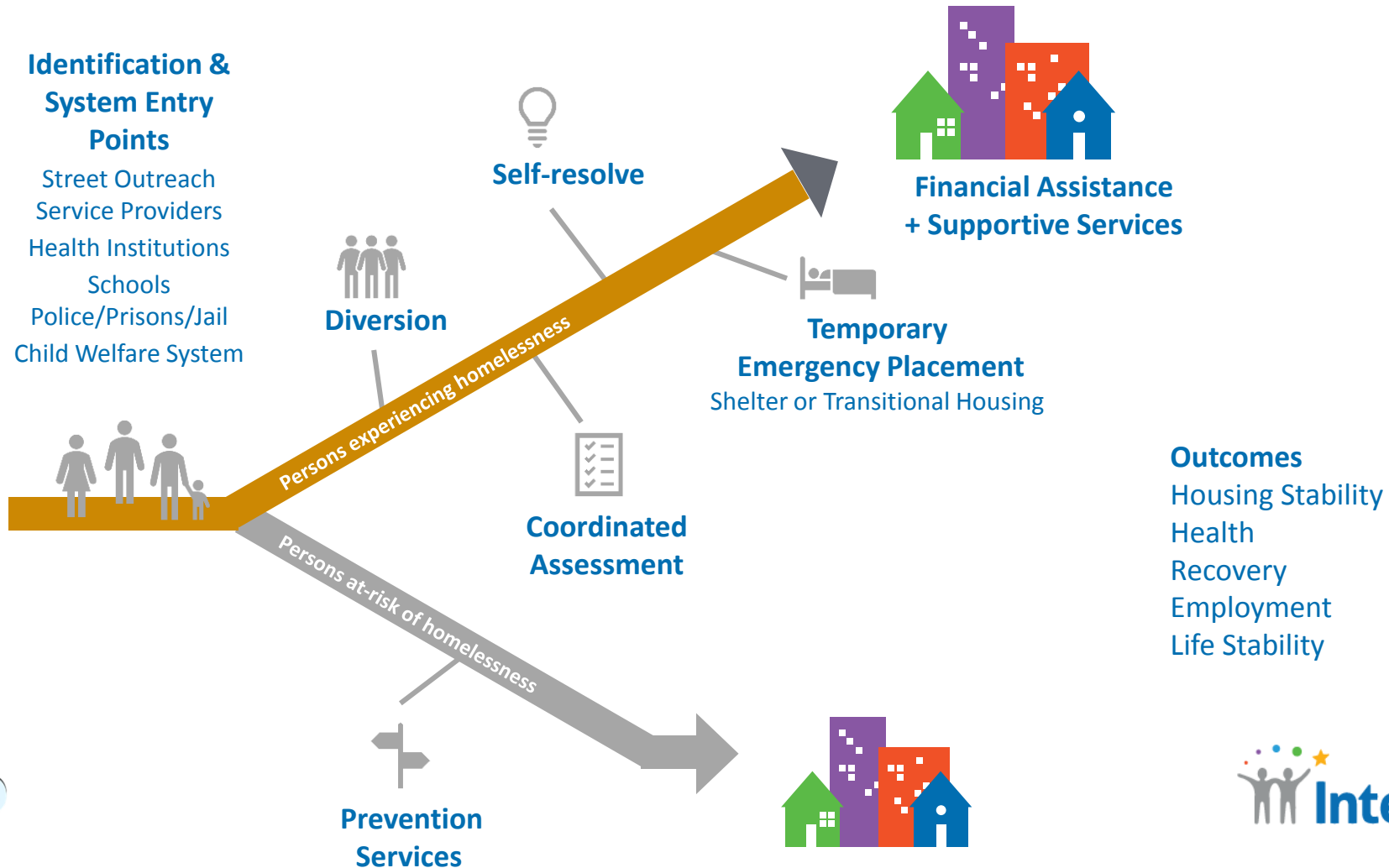


# How is the LMHA involved?

- Outreach teams
- Mobile intake for entry into services
- Dedicated Landlord Outreach support
- Housing Case Management (RRH and PSH)
- Counseling
- Peer Support
- Supported Employment Specialists
- SOAR Specialists
- Staff embedded in criminal justice system



# Our System to Prevent and End Homelessness



# Housing AND Mental Health Case Management



- Case management and supports for housing stability and for mental health provided by same individual
- Reflects reciprocal impact one has on the other – can focus more on one or the other depending upon need
- No issues with communication across providers
- May be difficult for same staff to give attention to housing issues if mental health crises arise

# Housing OR Mental Health Case Management

- Highlights need for clear communication – between staff as well as with the individuals being served
- What info is okay to freely share?
- Need to know who is doing what to avoid duplication or confusion
- Housing supports may end, MH supports can continue indefinitely
- Necessary recognition that one affects the other



# ECHO's role in collaboration

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Weekly meetings with  
housing providers, including  
Integral Care

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Maintenance of prioritization  
lists and referrals

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Creation of BOLO and  
Outreach lists



# What can happen if we do not partner?

Providers work isolated from each other

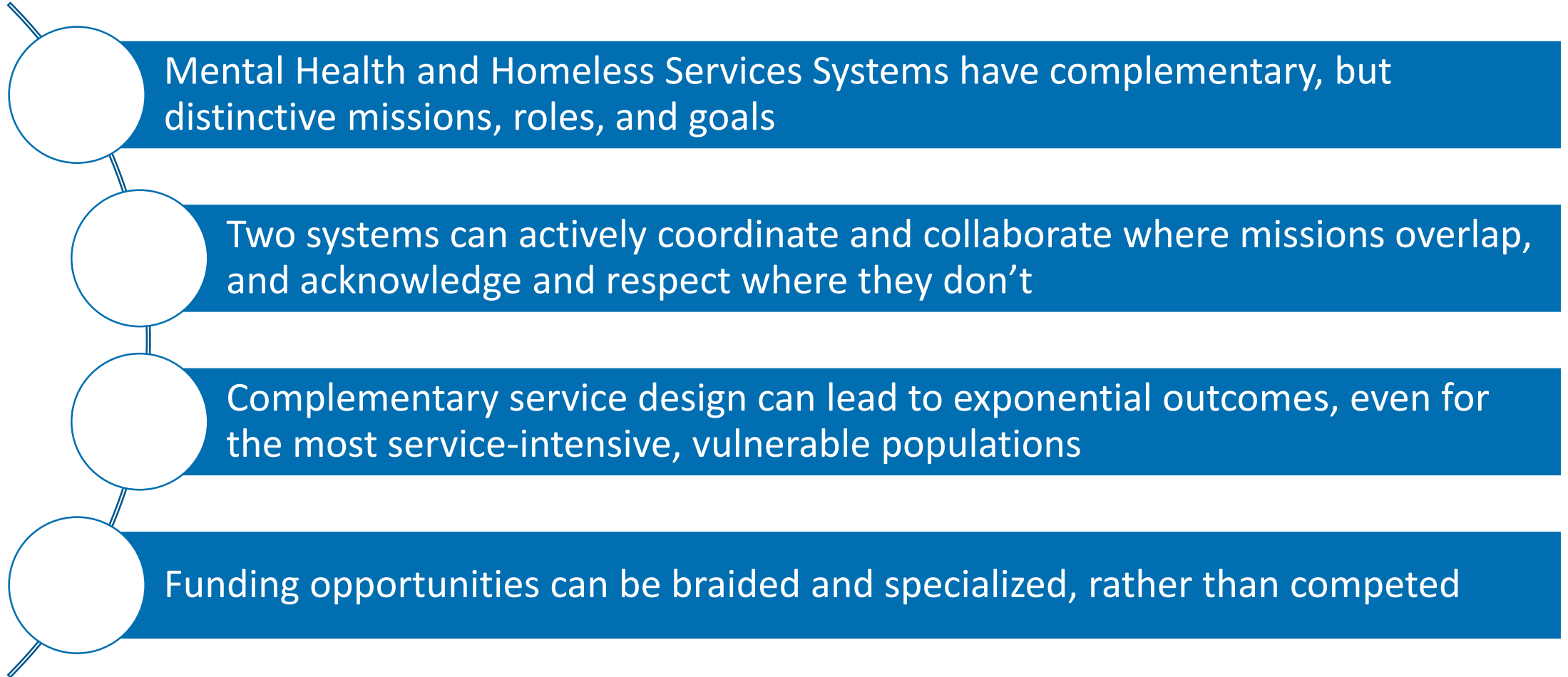
- Can duplicate services OR not provide necessary critical services

Individuals seeking services experience frustration and unnecessary barriers

- Important information is not shared across providers



# How do things tie back to larger systems?



# What is next?

Additional areas/resources to build into the system

- Employment, benefits, peers?



More partners to provide services

- Mobile VI-SPDATs



Expanding capacity for all areas

- Navigation AND services







# Questions????

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