VacSeen Mental Health Project (Big Bird) Outcomes Report

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Introduction to the Program

In Australia, approximately 20 per cent of people over the age of 16 experience a mental health disorder in any given year; however, this figure jumps to 54 per cent among people who have or are currently experiencing homelessness (Australian Institute of Health and Welfare, 2022).

People experiencing homelessness are faced with numerous barriers when accessing mental health support – individual, structural, and institutional. In early 2023, talks began to implement a pilot program at one of the local homeless shelters in Brisbane, Big Bird, to provide on-site mental health support to residents and reduce barriers to access. The pilot program began on 28/03/2023, running for two hours weekly on Tuesdays. This project was implemented in collaboration with VacSeen, Beddown, Big Bird, and North Brisbane Psychologists.

Big Bird can be classified as short-term supportive housing – providing subsidised accommodation with onsite supportive services such as a medical doctor, drug rehabilitation services, housing and employment support, and mental health support. However, many residents had been living at the shelter for two or more years at the time of implementation of the mental health pilot program. Access to the shelter is not predicated on participation in mandatory treatment or sobriety goals established by service providers – taking a housing first as opposed to a treatment first approach.

The onsite mental health program was delivered by a social worker, alongside a counselling placement student and two volunteers from the University of Queensland's Bachelor of Psychology program. The original goal of the pilot program was to provide onsite assessment and brief interventions while facilitating access to longer-term bulk-billed psychological care.

This report provides an overview of the preliminary outcomes and learnings from the pilot program for the support period 28 March 2023 to 6 June 2023.

Types of Presentations

Big Bird has the capacity to house approximately 70 residents on a given night. Demographically, residents at Big Bird are mostly male between the ages of 20 and 60, with approximately 2/3 having histories of substance use disorders (SUDs), violence, and/or criminal records. All residents are adults over the age of 18. Some of the residents are long-term, having been residing at Big Bird for several years. Others are more transient and may only use the accommodation short-term or on an ad-hoc basis.

Table 1 highlights the most common presentations of the residents of Big Bird when engaging with onsite mental health supports.

Table 1. Types of Mental Health Presentations Experienced by Residents at Big Bird	
Homelessness	Anxiety
Substance use and abuse	Depression
Family conflict	Sex worker safety
Grief and loss	Personality disorders
Adverse childhood experiences (ACEs)	Aggression/anger management
Trauma (PTSD and cPTSD)	Chronic illness
Peer conflict	

Consistent with Onapa's et al. (2021: 449) finding that, in Australia, substance use disorders amongst homeless populations are more than three times higher than the general population, a large portion of the residents who engaged with the mental health worker experienced a substance use disorder (SUD). Most of these residents presented in the pre-contemplation or contemplation stages of change readiness.

Amongst the female residents at Big Bird, many engaged in sex work as their primary source of income. Most of these residents were in the pre-contemplation and contemplation stages of change readiness, and expressed frustration over limited options and resources to earn income through alternative means as well as limited resources to promote safety while engaging in sex work. All of the women who identified as sex workers experienced an SUD co-morbidity.

Intergenerational trauma was a common presentation, impacting nearly all of the residents of Big Bird who engaged with the mental health worker. This included sub-presentations such as family conflict and family estrangement, grief and loss, adverse childhood experiences and early trauma, and involvement with child protection and criminal justice systems.

Anxiety and/or depression were present and persistent for most of the residents at Big Bird. This is consistent with research by The Homeless Hub (2021), who posit that housing and food insecurity create and exacerbate mental illness – most commonly anxiety and depression.

Many residents presented with chronic mental health presentations such as personality disorders (i.e., schizophrenia, borderline personality disorder, adjustment disorder); the symptoms exacerbated by their co-occurring experience of housing insecurity. A few residents presented with chronic health conditions such as diabetes, cancer, HIV/AIDS, and Hepatitis B & C.

Aggression and anger – that is, long-term mal-adaptive patterns of directing personal distress at others or avoiding/withdrawing contact from others in a violent or aggressive manner – was a common presentation requiring intervention at Big Bird. This may be seen as a survival strategy employed by people experiencing homelessness to keep them safe on the streets. Echoing research by Rueve & Welton (2008), whose findings show that rates of violent and aggressive behaviours are significantly higher amongst those from lower socio-economic social locations, in populations with reduced social stability and in populations with high rates of unemployment. Given that the residents were informed of their eviction from the shelter during the course of the pilot program, it makes sense that an increase in aggressive behaviour was noted as residents felt increasingly uncertain and anxious about their futures.

The increase in anxiety, depression, and aggression resulting from the news of their unanticipated and imminent eviction from Big Bird shelter had the added consequence of increasing peer conflict onsite. Much of the mental health work that occurred during the pilot program focused on reducing harm and creating opportunities for pro-social engagement and expression.

Many of the residents experienced co-morbidities, creating compounding vulnerabilities.

The unanticipated eviction that occurred only a few weeks into the implementation of the onsite mental health clinic meant that mental health support re-focused to provide the necessary emergency response interventions. According to Christensen (2023), it in only after social factors, such as access to housing and food, are stabilised that people experiencing homelessness are able to engage productively with mental health services to generate meaningful change.

Key Activities of the Program

Housing, combined with support services to help homeless people remain housed, has been identified as a prerequisite for meeting the needs of homeless people with mental health concerns (Tsemberis, 2011). The pilot program to deliver supportive mental health services on location to people experiencing homelessness was designed to help meet the psycho-social needs of people residing at the shelter. This is consistent with best practice literature, which demonstrates that service agencies at which homeless individuals can access immediate services such as material supports, physical and mental health care and case management seem to be viewed more favourably and used at higher rates in this population compared to other means (Hopkins & Narasimhan, 2022: 3; Winiarski et al., 2020: 110). Originally, the intention of the pilot program was to create pathways to long-term mental health interventions in the community; however, this goal was amended following the announcement of the imminent eviction of the residents of Big Bird a few weeks into implementation to reduce harm and increase access to alternative accommodation.

Table 2 highlights the primary interventions delivered throughout the preliminary reporting period of the pilot project.

Table 2. Mental Health Interventions Delivered at Big Bird	
Motivational interviewing Supportive counselling Harm reduction De-escalation and crisis management Nutrition and Mental Health Group Creative Expression – Breaking the Stigma Group Referrals to external supports Cognitive behavioural therapy - DBT	Case conferencing and Assertive Community Treatment (ACT) Empowerment and advocacy Anger management (individual and group) Psychoeducation Solution-focused brief therapy Community liaising Emergency supplies community donation drive

Table 3 shows how these interventions were administered based on the level of contact/engagement clients had with the onsite mental health worker.

Table 3. Types of Activities based on Level of Engagement		
Fully Engaged Residents	**Partially Engaged Residents**	**Non-Engaged Residents**
• Cognitive-Behavioural Therapy Interventions • Behavioural Therapy Interventions • Interpersonal Therapy • Assertiveness Training • Regulation and Relaxation Interventions • Referrals to external service providers	• Motivational Interviewing • Solution-Focused Brief Therapy Interventions • Informal conversation and rapport building • Psychoeducation • Referrals to external service providers	• Informal conversation and rapport building • Psychoeducation/Skill-Building • Safety Planning • Crisis Interventions • Observation and Feedback

Interventions administered throughout the pilot program can be divided into three categories – individual interventions, group interventions, and community interventions.

Individual Interventions

The mental health worker was available onsite weekly to provide mental health support to residents through one-on-one therapeutic interventions as needed. Given that this population primarily sits within the pre-contemplation and contemplation stages of change, motivational interviewing was the primary therapeutic intervention – an approach focused on increasing a person's motivation to make positive change in their lives. Another common intervention applied was dialectical behavioural therapy. Specifically, the mental health worker engaged people to strengthen their distress tolerance skills through the advancement of pro-social coping, regulation and co-regulation techniques, and positive and creative expression.

The transient nature of the population receiving support meant that often, the mental health worker engaged several of the clients for one session only. Solution-focused brief therapy was used with more transient clients to assist with goal setting, planning and accessing resources in the community. This intervention included delivering psychoeducation, including education on navigating the relevant social, financial and community support systems.

Harm reduction was a key focus on individual interventions. Substance use disorders were the most common presentation co-occurring with homelessness for the residents at Big Bird. Several of the women disclosed engaging in sex work to finance their substance use/abuse. Harm reduction work included psychoeducation, building awareness of harm reduction resources in the community (e.g., needle exchange programs, RESPECT, anonymous STI testing clinics) and referrals to the onsite GP. Harm reduction and psychoeducation resulted in residents feeling empowered to take action to improve their circumstances.

In addition to providing on-site crisis and counselling services, the social worker also served as a liaison to broader community supportive services by providing referrals to outside providers. This included advocating on behalf of residents to improve access. External referrals and community advocacy was primarily focused on access to housing assessments and alternative emergency or long-term social housing. Safe and affordable housing is a mental health issue; and supporting homeless individuals to access appropriate housing is a mental health intervention. According to Onapa et al. (2021: 448), housing is a primary determinant of both physical and mental health, and access to housing is widely accepted as a key intervention to address some of the mental health disparities that exist among the homeless. The mental health worker provided referrals, engaged in case conferencing with external service providers and, in some cases, accompanied residents to services such as CentreLink to support residents accessing financial support and emergency payments; and to HART4000, Micah Projects, and Brisbane Youth Service to support access to housing.

Following the announcement of the imminent eviction of the residents at Big Bird, the focus of intervention was amended to provide crisis management support through de-escalation and anger management activities with residents. Individual interventions in the category included distress tolerance skill building (dialectical behavioural therapy); regulation and co-regulation techniques; cognitive behavioural interventions to manage anxiety; and provision of opportunities for healthy and pro-social feelings expression.

Group Interventions

Group interventions were used to aid in building rapport between the mental health worker team (i.e., social worker, student, and volunteers) and the residents at Big Bird. Group interventions for

mental wellness also served the function of providing pro-social activities on-site for the residents to engage in; and opportunities for peer-to-peer relationship development, support and learning.

Group activities were delivered in an open-group format, so all residents interested in participating were able to join in. Groups were designed to cover a variety of topics and to provide entertaining and enjoyable activities that promoted both social bonding and individual mental wellness.

Table 4 shows the types of mental health groups delivered onsite with a brief description of each.

Table 4. Group Activities Supporting Mental Wellness for Residents at Big Bird	
Group Type/Activity	**Description**
Nutrition and Mental Health	- Guided residents through meal preparation of a low-cost, high-nutrition, no-refrigeration required meal preparation. - Discussion on links between adequate nutrition and mental health. - Handout provided to residents who did not participate in the group. - Opportunity for prosocial engagement with other residents and support staff.
Creative Expression – Breaking the Stigma	- Guided residents through a creative activity (DIY badges and t-shirts), using messages that highlight the systemic nature of the housing crisis. - Discussion about the systemic (as opposed to individual) factors that result in homelessness. - Psychoeducation about system navigation and self-advocacy. - Opportunity for prosocial engagement with other residents and support staff.
Moving Together through Anxiety	- Exercise to teach residents to resist the urge to pull away from others and/or become reactive when experiencing anxiety. - Psychoeducation about the psychical, psychological and social impacts of anxiety. - Developed needs-based communication skills. - Opportunity for prosocial engagement with other residents and staff.
Boxing Circuit – Anger Management	- Provide healthy way to release stuck emotions and outlet for expression of anxiety/frustration/anger. - Provide opportunity for psychical activity to boost endorphins and feel-good hormones. - Provide alternative to physical violence directed at other residents. - Opportunity for prosocial engagement with other residents and staff.

Therapeutic group activities provided residents with opportunities to increase their comfort and level of trust with the mental health team, increasing their engagement and participation in individual therapeutic activities also. Groups also provided opportunities for residents to get to know one another better and strengthen peer relationships.

Community Interventions

According to Hwang & Burns (2014: 25), it is important for mental health workers to work not only with individuals and groups to deliver mental health support, but it is also critical to address social policies and structural factors that result in homelessness.

The unanticipated news of the eviction of Big Bird opened up the opportunity for the mental health team to engage the broader community. The team implemented a community organising strategy to support the residents at Big Bird facing eviction, many of whom with nowhere to go but the streets. Specifically, the team organised a community donation drive to ensure that, in the event of a worst-case scenario, residents would have tents and supplies to keep them warm through the winter months. Additionally, the counselling placement student spearheaded a media campaign to put pressure on government and community organisations to provide housing.

Luckily, the emergency tents and winter supplies were not needed as most residents secured alternative housing. These items were delivered by volunteers to others in the community already sleeping rough.

The media campaign had the impact of pressuring government to take over the lease of the facility, granting Big Bird residents a three-month extension to secure alternative accommodation and preventing the 70+ active residents at the time the eviction was announced from being forced onto the streets.

Outcomes

According to self-reports from the residents at Big Bird, benefits of having a mental health worker onsite include: an increase in general wellbeing – specifically, less time feeling depressed; greater sense of certainty; increased ability to regulate difficult emotions; and more social cohesion amongst the residents. Staff-reported benefits of the pilot program include: observation that residents are more likely to be on good behaviour on days mental health workers scheduled at the shelter (i.e., decrease in substance use; improvement in general mood); increase in pro-social activities onsite that residents can engage in; improvements in social relationships between residents; and an increase in number of residents moved into more permanent housing accommodations.

Table 5 highlights some of the specific outcomes achieved under the mental health pilot program at Big Bird.

Table 5. Preliminary Outcomes of the Pilot Mental Health Program and Big Bird	
- Supported 70+ residents to obtain housing (referral support, case management support, advocacy). - Supported five+ residents access benefits through Centrelink (crisis payment, job seeker, DSP advance). - 15+ residents completed nutrition and mental health group. - One resident admitted to medical respite (hospital care). - Completed 25+ moving plans with residents.	- Referrals and support to two residents to access in-patient substance use rehabilitation. - Set up boxing circuit onsite to promote healthy expression of anger - nine people participated in group, used ongoing. - Delivered emergency winter supplies to 70+ residents (blankets, warm clothes, sleeping mats, household items for those who secured alternative accommodation)

The positive outcomes achieved under the mental health pilot program at Big Bird, despite the unanticipated changes to the original goals with the announcement of the shelter closure, demonstrate the incredible value of bringing services directly to the people who need them. The informal time spent with residents (e.g., joining them in common areas for meals) was crucial in laying the foundation for the crisis response surrounding surprise eviction, helping to reduce barriers to engagement associated with institutional trauma.

The following section of this report outlines key reflections and learning following the initial implementation of the mental health pilot program at Big Bird.

Reflections and Learnings

There were many reflections and learnings resulting from the pilot implementation of the onsite mental health worker at Big Bird. Learning centred around four key areas - environment/intervention setting, relationship-building and therapeutic consideration, client engagement and retention, and measuring outcomes.

Environment/Intervention Setting

The site was set up with an office for the mental health worker to use when engaging residents. This only occurred for the initial two weeks of the pilot program as it quickly became evident that residents were not comfortable using the office space provided. The residents preferred to engage the mental health worker in more informal locations such as going to the park, sitting on the steps across the street from the shelter, or finding a quiet corner of the common area.

Relationship-Building and Therapeutic Considerations

Residents found a more informal rapport-building approach much more comfortable. Winiarkski et al. (2020:110) suggest that, while the homeless population present with myriad mental health and social needs, they are consistently less likely to seek out professional support due to low perceptions of trustworthiness of service providers, a fear of judgment from service professionals, and historical experiences of institutional trauma. This is a critical consideration for mental health service providers working with people experiencing homelessness. Many of the homeless people at the shelter shared stories about their frustrations and perception of injustice when navigating social and mental health supports in the past. An informal approach that provides adequate time for rapport and relationship building to deliver services onsite is more likely to encourage treatment initiation, engagement, and retention.

Person-centred, preventative, and trauma-informed models of therapeutic intervention are essential when working with people experiencing homelessness and help prioritize and address the complex issues faced by this population. Flexibility, adaptability and responsiveness by the mental health worker are critical skills required to meet the needs and uphold rights of this population. The uncertainty faced by people experiencing homeless in most areas of their lives means that session plans and more structured approaches are nearly impossible to follow. Re-assessing needs and responding to residents ‘where-they-are-at’ was crucial when interacting with clients and their rapidly changing circumstances.

Client Engagement and Retention

Client retention and continuity of care are significant challenges when providing mental health support to people experiencing homelessness. Whether recently or chronically homeless, the task of addressing myriad needs of this demographic – physical and mental health, financial stress,

involvement with the criminal justice system, and housing and food insecurity – can be daunting for both mental health practitioners and those receiving services. Client retention first requires relationship-building to facilitate the establishment of short-term, realistic treatment and prevention goals. Goals should be set by the clients themselves with clearly defined mechanisms for achieving and monitoring progress to increase retention.

During the pilot mental health project at Big Bird, the mental health worker noted significant barriers to client readiness to engage in consistent, long-term therapeutic interventions. Specifically, the transient nature of the population and the unanticipated eviction of the residents created barriers to client readiness to engage in long-term therapeutic interventions through referrals to North Brisbane Psychologists, which was one of the intended outcomes at the outset of this project.

The uncertainty and precarity of the housing situation for the residents at Big Bird facing eviction on the streets was prohibitive in achieving this goal. According to Onapa (2021:451), "as housing status improves, access to care and maintaining participation in treatment also improves." As such, supporting the residents to access secure housing – whether temporary emergency accommodation or long-term social housing – became a critical activity to support the mental health of residents.

Additional barrier to participation in long-term therapeutic interventions included: not having access to a phone; lack of transportation; financial constraints; unfamiliarity navigating social support systems (system illiteracy); and prioritising pressing concerns such as searching for employment or housing, food and clothing, or getting out of/healing from dangerous or violent relationships.

Measuring Outcomes

Ongoing monitoring and measuring of outcomes are difficult when working with people experiencing homelessness. The transient nature of the population means there is little opportunity for follow-up with people who have engaged with onsite mental health supports.

As discussed previously in this report, homeless people are likely to had negative experiences with the service sector, creating a sense of distrust. Given this dynamic, those residents who engaged with onsite mental health support were reluctant to complete standard tracking tools (e.g., DASS21) in order to get an accurate baseline and track progress.

Given the high rates of co-morbidities in addition to their experience of homelessness, many of the residents at the shelter were observed to have significant fluctuations in functioning and capacities day-to-day. The mental health worker has not been able to spend sufficient time with residents to adequately assess whether improvements/regressions experienced by residents are part of their typical fluctuation patterns or actual changes in the residents' baseline presentations.

The outcomes presented in this report are based on direct observation, resident self-evaluation, and evaluations from Big Bird staff.

Concluding Remarks

Mental health care is crucially needed amongst the homeless population. The mental health pilot project at Big Bird demonstrated the value of bringing support directly to the people who need it.

While the goals of the project were amended to accommodate for the implementation of a crisis response strategy following the announcement of the eviction, there is clear evidence to support the continuation of such a program at a similar location to facilitate ongoing care and support for people experiencing homelessness in the community.

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