Te Ope Whakaora

Supportive Accommodation Services

" I just want somewhere to call home..."

Homelessness

Homelessness is defined as a living situation where people with no other options to acquire safe and secure housing are: without shelter, in temporary accommodation, sharing accommodation with a household, or living in uninhabitable housing.

Temporary accommodation

Living situations are considered 'temporary accommodation' when they provide shelter overnight, or when 24-hour accommodation is provided in a non-private dwelling that is not intended to be lived in long-term. This includes hostels for the homeless, transitional supported accommodation for the homeless, and women's refuges. Also included are people staying long-term in motor camps and boarding houses, as these are not intended for long-term accommodation.

3 Services

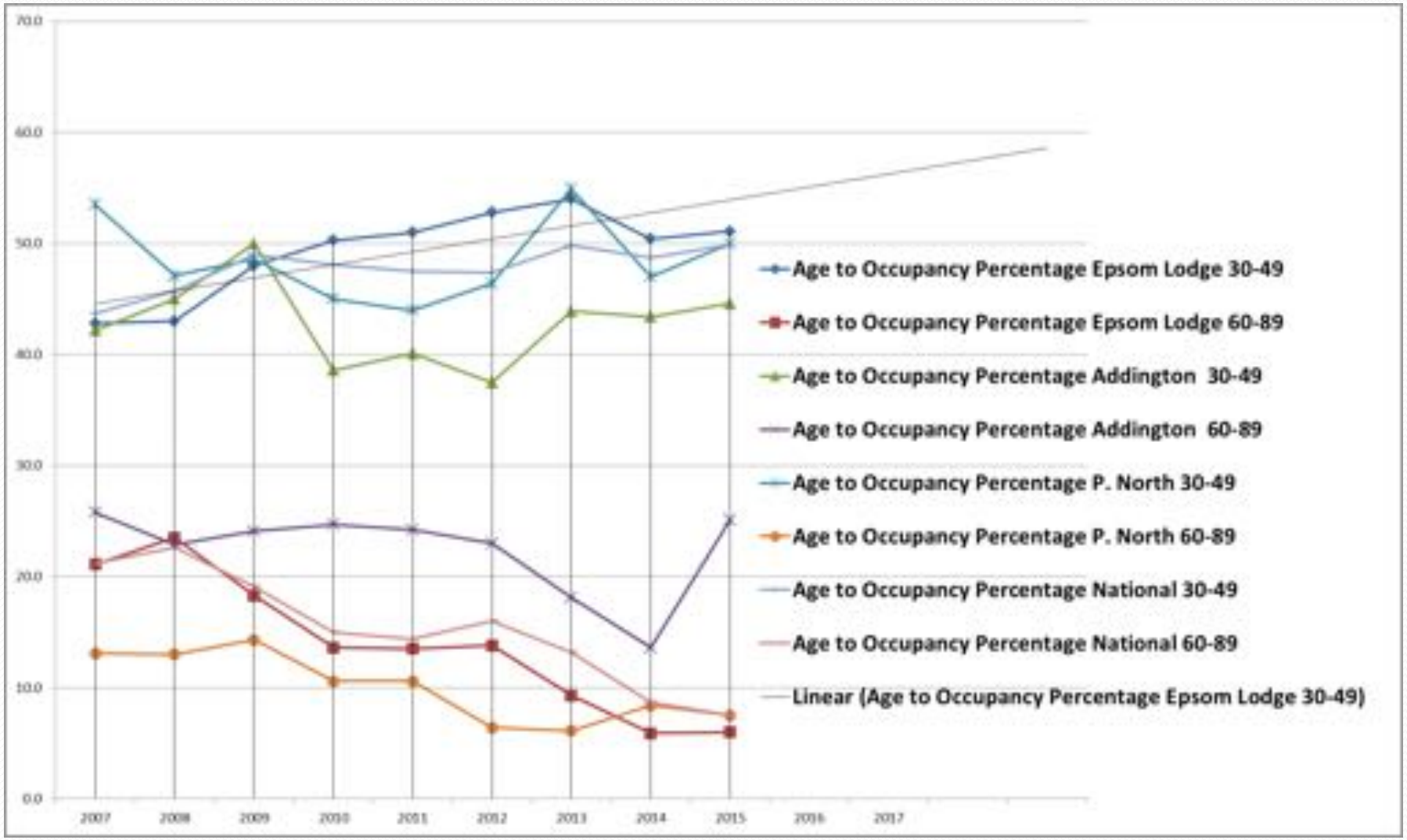
3 City's

199 Beds per night

43,078 beds per year

Challenges:

- Public Expectations
- Government Social Policy
  - Increasing client complexity
- Government Contracting Requirements
  - Funding competition
  - Outcomes verses Impact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Age to Occupancy Percentage Epsom Lodge 30-49
Age to Occupancy Percentage Epsom Lodge 60-89
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Age to Occupancy Percentage Addington 60-89
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Age to Occupancy Percentage National 60-89
Linear (Age to Occupancy Percentage Epsom Lodge 30-49)

Client A - 26 year old Maori male

Clinical diagnosis: Nil known

Referred from: City Mission - Homeless

Presenting issues: Living in Park - No information available re past/medical/mental Health/Social issues etc

Care/Service engagement: After admission and in completing social/medical plan, discover significant behaviour issues, incontinence, un-medicated epilepsy, memory issues (Possible head trauma as has been observed banging his head against pole in public). He manipulates staff and other residents to to gain advantages, makes up appointments and has made Police Complaints against other residents which have been proven to be false. Ideations of grandeur relating to cultural standing, publically chanting Te Reo disturbing others, no ID or Bank Acct.

Ongoing extensive work to establish medical history and MH/ID Assessment and plan for future health treatment. Working with service partner who is threatening to disengage due to client non-engagement.

Excluded from DHB services as issues at this stage deemed by medical authorities as behavioural or GP manageable.

Client B - 41 year old Maori/Cook Island female

Clinical diagnosis: Low Intellect+ behavioural

Referred from: Sister via Citizen's advise Bureau

Presenting issues: Health, Obesity, Diabetes, Huge Debt, Illiterate, Relationship issues, Son in CYFS care, Unable to live independently.

Care/Service engagement: Subsided stay because of debt; Requires advocate & support in all appt's. Unable to use public transport due to intellect/behaviour. No ID except a community card and no Bank Acct. Government services will not consider her for subsidised/supported care. She has behaviour levels of a dysfunctional 12 year old. She throws tantrums when upset and damages property. Yell's, cries, slam's doors, plays music loudly, tells made up stories on others. When she doesn't get the attention she desires will state "you don't care nobody cares about me I'm going to kill myself." Has tried to get out of moving vehicles when she doesn't get what she wants. There has been MH engagement but not currently as most of her issues are behavioural. She has a trespass order on her and can not go back to family since she made a false report to CYFS on her sister causing her sister's child to be taken into care.

Client C – 17 year old European male

Clinical diagnosis: ADHD and Autism

Referred from: Youth Line/CAMHS

Presenting issues: Family breakdown, Youth Justice matters, Homelessness

Care/Service engagement: Poor personal health care/ADL's. Fabrication of past events and personal involvement in activities which are then acted out in a way that validates his ideations. Very susceptible to being influenced/manipulated by others. Uses illicit drugs for self medication.

As a result of family breakdown, he became disengaged with MH services and staff find him un-motivated and resistant to appropriate referrals and service input.

Staff having to meet daily and invest significant time to manage ADL's and social interactions at all levels. Resistant to any medical management of his condition which makes EL engagement difficult and problematic.

Working with DHB to source long term supported accommodation, (7 Months) but without EL service it is believed he would have fallen through cracks and we believe that there is no other healthy options available to him.

Client D - 33 year old NZ European female

Clinical diagnosis: Addictions; Borderline Personality Disorder

Referred from: Mental Health West

Presenting issues: Social refugee because of family abuse, awaiting admission into residential addiction services.

Care/Service engagement: Child of Incestuous family. Physical/emotional/sexual abuse from young age. Came mentally unwell. Found on admission to be 'cutter' severe eating disorder, drug abuser/ poor social skills and self awareness. Staff required to closely monitor eating/behaviour/interaction with others. Staff required to accompany to A&E to deal with cutting and with threats of suicide – 5 x suicidal ideation in last 4 months. Under ACC for sensitive claim but unable to get self to counselling. MHS unwilling/reluctant to engage due to her lack of engagement with them. No concept of healthy relationships – constant support around advances by men. Refused AOD Residential treatment due to MH and Behavioural issues.

Resident for 6 months and finally have transitioned her to MHS Supported Accommodation after basically threatening to discharge to A&E