



# **Mental Health Association of Central Australia**

## **Service Report**

**January to June  
2005**

# CONTENTS

<b>1. Administration Report</b>	<b>3</b>
<b>2. Pathways Rehabilitation Program</b>	<b>8</b>
<b>3. Life Promotion Program Report</b>	<b>20</b>
<b>4. Prevention &amp; Recovery Program Report</b>	<b>26</b>
<b>5. Outreach Program Report</b>	<b>29</b>

# Administration/Management

Claudia Manu-Preston: Manager

The Mental Health Association of Central Australia (MHACA) community has been working towards building on past achievements and continuing to provide recovery based, community services. To follow is a summary of the activities that MHACA Administration has achieved in the Management and Coordination of MHACA Services objectives.

***This report should be read together with Annual Report 2004 – 2005.***

## 1. Governance

The Committee is the governing body of the Mental Health Association. The mentoring support for the consumer representative positions has contributed to supporting consumer input at the highest level of decision making for the organization. Please refer page 6-7 of the Annual Report.

The MHACA Committee and staff (at time of writing this report) are as follows:

Chairperson:	Steve Fisher
Deputy Chairperson:	Vacant
Secretary:	Jill Deer
Treasurer:	Mark Keyworth
Public Officer:	Maya Cifali
Organisational Rep:	NTARAFMI (waiting for staff replacement)
Organisational Rep:	Salvation Army, Helen Steer
Consumer Rep:	Leo Welin
Consumer Rep:	Leonie Wehr

Committee meetings are held monthly and are regularly attended by most members. The following figures indicate the percentage of meetings attended as a trend, with the average attendance rate being 71%.

7 July 2004:	4 out of 10	= 40%
17 August 2004:	8 out of 10	= 80%
13 September 2004:	7 out of 10	= 70%
8 November 2004:	9 out of 9	= 100%
6 December 2004:	6 out of 9	= 66%
3 February 2005:	6 out of 9	= 66%
7 March 2005:	7 out of 9	= 78%
11 April 2005:	6 out of 8	= 75%
9 May 2005:	4 out of 8	= 50%
6 June 2005:	8 out of 9	= 89%

## Analysis Report

Activities undertaken through

<b>January</b>	<b>Action</b>
Extra supports over New year requested	2-week Calendar of events organised for Christmas-New Year period  Outreach Program commences at MHACA
<b>February</b>	<b>Action</b>
New programs Sub-Acute and Outreach acquired	Extension and update of the MOU between CAMHS and MHACA developed
Financial reports information not showing year-to-date figures.	Update financial management policy
Priorities of promotion and consolidating programs within MHACA structure	Promotional plan developed
Lack of office accommodation issues	Letters sent and received from National Trust declining temporary extension. Purchased new 1 bedroom flat
<b>March</b>	<b>Action</b>
Lack of office accommodation issues	Letter sent to Penny Fielding and all local real estates.
Administration fee issues	Update of Administration fee policy
Recruitment for new programs	Job descriptions/adv./orientation of staff
Tenancy Issues	Additional landlord support required
Feedback sought re: NT Consumer Satisfaction	Consultation workshop discussed
<b>April</b>	<b>Action</b>
Senate Inquiry input sought	Held Cent. Australian consultation wkshop
Extra consumer committee position support	Committee reps mentoring support in place
Lack of transport for Outreach	Outreach vehicle purchased

Association act changes	Public Officer to undertake with recommendations for the full committee.
Payment of medication policy at CAMHS	Requested medication policy for clarification- organised forum to provide information about criteria for payment of medication and definition of hardship.
Disability Support Pension concerns	Meeting held with Centrelink staff to discuss possible changes
<b>May</b>	<b>Action</b>
Lack of transport	Purchase of a vehicle for Sub-Acute program
Issues around independent consumer/carer input	CACAG –Central Australian Consumer/ Carer Advisory Group developed  Schizophrenia week promotions
Orientation of new staff members	Service development workshop developed and undertaken
SANE Media feedback on how people with a mental illness are portrayed on television	Workshop developed and undertaken.
Membership fees reviewed and raised	To be considered with Constitution amendments
Lack of information regarding events and outings	Monthly calendar of events developed
<b>June</b>	<b>Action</b>
Stress management for staff	Staff support system developed to include debriefing and massage
Substance Abuse issues for young people	Organized a community information evening on the marijuana and mental illness.
Lack of interagency mental health networking in Central Australia	Update of organization chart  Developed together with the Division of Primary Health Care and MHACA managers Mental Health Reference Group for Central Australia that meets quarterly

## 2. Quality Improvement Activities

MHACA has approached quality improvement activities using a systems-based approach. For the previous period the quality improvement activities include:

- 2 Staff Planning days held on service development (information, planning and promotion)
- 1 Budgeting workshop
- Performance management system reviewed
- Financial Management Policy updated
- Administration Fee policy updated

Please refer Annual Report pages 4-5, 8-9.

## 3. Partnership and Advocacy

Partnership activities are undertaken within each program area. The following activities have been undertaken by management - please also refer to Annual Report pages 4-5 and 8-9:

Organisation/Dept	Activity
CAMHS:	Mental Health Awareness Training workshops, and Accreditation
Alice ARAFMI:	Relapse Prevention and Anti Discrimination /Mental Health Council forum presentations by Consumer and Carers
<i>Mental Health Week:</i> Anzac Hill High School - Charles Darwin University - Running and Walking Club -	Mental Health Week Forum Mental Health Week Youth Forum Fun Run/Walk
Division of Primary Health Care:	Interagency Mental Health Group

MHACA provides advocacy at the broader systems level. MHACA has been focused on advocating for better access to services and extending the therapeutic options for consumers. MHACA supports and refers people with personal complaints to the Disability Advocacy Service or the Community Visitor Program.

The advocacy forums MHACA participated in include:

- CAMHS Senior staff Meetings
- NT Mental Health Coalition
- Northern Territory Community Advisory Group
- Ausienet Consumer/Carer committee
- Mental Health Council of Central Australia

Structures such as our monthly Consumer Business Lunch have provided direct information from MHACA's client base as a basis of information for advocacy work.

The working agreement between MHACA and CAMHS constitutes the way in which ongoing consumer participation operates. (Refer the revised MOU)

**During the reporting period the MHACA was represented on the following boards and committees:**

- NT Council of Social Services (NTCOSS)
- NT Primary Mental Health Intersectoral Reference Group
- NT ACROD

**During the year the MHACA was a member of the following organisations:**

- Northern Territory Community Advisory Group
- NT Mental Health Coalition
- NT Health Consumers Voice
- NT Chamber of Commerce
- NT ACROD
- NT Council of Social Services
- NT ARAFMI

## **4. Mental Health Promotion**

Raising mental health awareness is an important part of MHACA's role because the level of mental health awareness within a community underpins the community's ability to promote mental health, prevent mental ill health and recognize and respond to mental health

### ***inBalance***

A major promotional strategy has been the quarterly MHACA newsletter, *inBalance*. In the past 6 months MHACA has produced 2 editions (refer reference documents). This resource is used to promote mental health literacy and reduce the stigma of mental illness. The regular features include committee and staff updates, other service provider news, consumer and carer stories, self-help information, resources available and news of conferences and workshops. The newsletter continues to grow in content and quality and MHACA has continued to receive positive feedback about this resource.

MHACA Mental health promotion is embedded in the everyday interactions between clients and staff, and the collaborative work with other service providers. For more information on MHACA's targeted promotional activities please refer to the Annual Report page 20-21.

## **5. Financial Accountability**

Please refer to the Treasurer's and Auditor's report on page 22–28 of the Annual Report for financial accounts and the financial analysis.

# Pathways Rehabilitation Program

Megan Rackley: Coordinator

*Sixteen of the programs active clients currently have employment. Eight have positions in open paid employment, four are in sheltered employment and four people are working as paid mental health advocates/consultants for community agencies.*

## 1. Provision of a recovery-focused rehabilitation program

The service provides recovery focused rehabilitation programs to individuals with a mental health issue. The program is based upon the principals outlined in Annexure A. The service has an established data collection and reporting process. We are currently reviewing our consumer input mechanisms, with the aim of increasing the consumer input into the program.

Individuals are assisted to develop individualised recovery programs utilising the existing community resource base to effect community reintegration. An integral component is networking with mainstream services and providing support to ensure a positive experience for the consumer and agency. The program increases the consumer's capacity to reintegrate into the community through employment and educational opportunities.

The program works collaboratively with Central Australian Community Mental Health Services with over 90% of clients being co-casemanaged. The referral process outlined in our joint protocol is utilised and a close working relationship has been established. The program also works closely and collaboratively with other community agencies to ensure a range of services and opportunities are accessed (see table 3).

The program has an excellent working relationship with the local educational and employment agencies. One individual has completed two years of nursing while four are approaching two years in their positions at Coles Supermarket. All of these individuals experience major mental illness. Sixteen individuals have vocational positions or placements in either voluntary, paid sheltered or paid open employment (see table 4).

Recreational and social activities are provided individually on a limited basis, and in conjunction with Outreach in the form of monthly social outings. Peer support has continued as a daily program. The premises are open daily from 8.30am to 12.30pm for consumers to utilise while the weekly Women's Group has continued. This group has received positive feedback from those who attend and also from referring Community agencies. A Walking Group has been offered three days per week and a monthly Calendar of Activities is produced to inform consumers and community agencies of coming events.

Consumers and some agencies have identified the need for an accessible and ongoing daily program of recreational and social activities. This is being provided partially through the Outreach Program but could be potentially expanded into a week of day program activities should funding become available. However it should be noted again, that integrated educational and employment opportunities are more likely to produce an improvement in quality of life and an increase in social networks outside of the mental health system (Curtis,2001).

This last six months has seen rehabilitation take on a community training role, with the intention of destigmatising mental illness thus improving service availability and accessibility for our consumers. One of our rehabilitation officers has trained as a Mental Health First Aid Trainer. Training has been delivered to Lifeline, Red shield Hostel and the Salvation Army, with DASA and St Johns planned for September.

Due to the difficulty experienced in obtaining completed evaluation forms feedback is now mainly received via the consumer forums and informally from other agencies and caregivers. The consumer forums are a joint activity with the association's advocacy and promotion branch. The last 12 months has seen the further development and establishment of paid consumer advocates/consultants with 5 consumers paid as consultants over the past 6 months.

- 1.1 The Pathways Program provides a service for 25 people (table 1). Twenty-one of these are active and four are inactive. There are 9 women and 16 men, 7 identify as Indigenous people while 3 are from a non-English speaking background. There were five new referrals with 3 self referred and 2 from CAMHS (see table 2).
- 1.2 Data shows a decrease in individual contact hours per time available over the first six months and then a substantial increase in time over the second six months (table 1). This was due to both the number of consumers established in their programs and not requiring as high a level of support and demands on rehab staff time by other program areas. From February to June additional staff were employed allowing further intensive work to occur. The Outreach Support and Subacute projects were allocated a considerable amount of hours by the Program Coordinator which resulted in fewer client hours in the first six months. These 12 months saw a focus on employment as many of the programs clients have progressed through educational placements into an employment focus. The data reflects the programs shift to a vocational focus. The women's program and peer support also receives a high level of input with the majority of clients participating. These provide valuable peer support which literature indicates is important in the recovery process (Deegan, 1988). They also focus on social skills training and build prevocational skills.
- 1.3 The majority of consumers have engaged in mainstream services as part of their goals (see table 3). The person's individual goals dictate which services are appropriate. Some individuals begin with attending the women's or men's program before progressing to other activities and this is reflected in the data.
- 1.4 Of particular interest is the continued improvement demonstrated by many of the programs initial clients with many now receiving minimal input (see table 6). Many of these individuals are previous clients of the Clubhouse and long-term specialist service users. It is also observed that while relapses may occur the recovery time is discernibly quicker and individuals report feeling more in control. The high score obtained by some of the services newer clients reflects their circumstances-high functioning individuals not able/ready for the workforce but seeking to extend their social network.

## **2. Provision of individual support plans**

- 2.1 The majority of consumers attending the program participate in the development of an individual plan. The only exception to this is those individuals who attend the men's or women's groups only, and those who are not yet ready for the formal process. The plan is strengths oriented and goal focused. It encourages people to think about both short term and long term goals. As part of the individual support plan clients are encouraged to complete a wellness plan. The wellness plan looks at ways the client can address stress and identify triggers. It also incorporates a crisis plan.
- 2.2 The plans are reviewed at least every three months, and this is documented in the individual files though often more frequently, clients are encouraged to review goals at each meeting and are given the opportunity to add further goals. The process is one of ongoing evaluation and review.

## **3. Programs accessible and appropriate to different individuals from the population**

- 3.1 The service has actively sought equal gender representation. Brochures have been placed at Women's Information Centre and a Women's Group established. At 30 June the service provided programs for 9 women and 16 men. The increase in numbers of men in the program, is due to an increase in access from the Red Shield Men's Hostel. It provides peer support and social skill training through a wide range of activities, some with the Outreach program.
- 3.2 Brochures have been placed with indigenous organisations in town, as well with Multicultural Community Services. A representative from MCS sits on the MHACA committee. The service is able to access an interpreting service. The service employs staff from a range of cultural backgrounds, which facilitates accessibility. At 30 June the service provided programs for seven indigenous people and three from a non-English speaking background.
- 3.3 The program has a formal protocol with CAAODS outlining the referral process between the two agencies. Brochures have been placed with CAAODS. Clients are informed of the availability of home visits, and psychologist clinics. The program assists clients to access these services.

## **References**

Curtis L, *Personal Communication*, march 2001

Deegan, P (1988. "Recovery: The Lived Experience of Rehabilitation." *Psychosocial Rehabilitation Journal*, Vol 11 (4), pp. 11-19.

**Annexure A:**

The newly developed Rehabilitation Program needs to incorporate the following principles of mental health recovery into service development:

1	Use individualized approaches to rehabilitation that are recovery focused, timely and culturally effective.
2	Approaches used must assist consumers to lead independent and integrated lives in the local community.
3	Approaches much include coordination of the range of services required/necessary to meet the individual rehabilitation needs of each consumer.
4	Evidence-based best practice approaches must form the basis of all service delivery.
5	Rehabilitation approaches must implement partnership activities and use collaborative planning to facilitate individuals becoming connected with the broad range of mainstream services and lifestyle opportunities and supports that are available in the community.
6	Consumers and carers must have a key role in planning and evaluating the service and must be able to influence the way in which their service needs are met.
7	Consumers must be actively involved in the development and review of individual recovery plans.
8	The rehabilitation service must be integrated into the community, linked through collaborative relationships, shared interest and common goals.

**Table 1: Client Contact**

	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	TOTAL
<b>CLIENTS</b>													
NO:IN REHAB PROGRAM	31	27	27	27	24	23	22	24	24	24	24	25	
NO: MALE	17	13	13	13	12	12	12	15	15	15	15	16	
NO: FEMALE	14	14	14	14	12	11	10	9	9	9	9	9	
NO: NESB	6	5	5	4	4	3	3	3	3	3	3	3	
NO: ATSI	8	7	7	7	7	7	7	7	7	7	7	7	
NO: ON WAITING LIST													
NO: NEW CLIENTS		1						3				1	
EXITS	5				3	1	1	1					
<b>INDIVIDUAL CONTACT HOURS</b>													
PROGRAM PLANNING/REVIEW	20.5	11.25	13.75	12.5	11.25	5.5	4	29.5	31.5	27	18	36	220.8
COUNSELING	1	6.5	3.5	6	4.5	3	4.5	23	20.5	22.5	18.5	30.5	144
SOCIAL SKILL DEVELOPMENT	4.5	3	6	3.5	3	5.5	6	14.5	14	11.5	14.5	14.5	100.5
EDUCATION	1.5	0.5						3.5	4	3.5	1	6	20
EMPLOYMENT	6.25	6.75	2.25	4.5	3.25	0.75		4	4.5	0.5		3.5	36.25
MENS/WOMENS GROUP	13.3	10.75	13.5	8.25	4.5	10.5		11	6.5	15	10.5	10.5	114.3
RECREATION	3.8	6	5.75	3			3	5.5	9.5	7.5	7.5	11	62.5
OTHER	3	4		1.5		1		4	9	4	7.75	8	42
<b>TOTAL CONTACT HOURS</b>	<b>53.25</b>	<b>48.75</b>	<b>44.75</b>	<b>39.25</b>	<b>26.5</b>	<b>26.25</b>	<b>17.5</b>	<b>95</b>	<b>99.5</b>	<b>91.5</b>	<b>77.75</b>	<b>120</b>	<b>740</b>
<b>DOCUMENTATION (HOURS)</b>	<b>25</b>	<b>20</b>	<b>15</b>	<b>14</b>	<b>12</b>	<b>11</b>	<b>3</b>	<b>30</b>	<b>35</b>	<b>32</b>	<b>30</b>	<b>48</b>	<b>275</b>
<b>NO: INDIVIDUAL PLANS IN USE</b>													
DAYS WORKED IN MONTH	10	18	16.5	15	18	8	1	16	18	11	15	15	161.5
WORKER 2	9.5	12	11	9	8	9	17	40	41	26	31	30	243.5
HOURS WORKED IN MONTH	68	117	107.3	97.5	117	52	6.5	104	117	71.5	97.5	97.5	1053
WORKER 2	72.8	76.8	72.8	57.6	46.4	57.6	125	233	234	178	208	205	1567
AVAILABLE CONTACT HOURS	77.68	104.6	97.33	83.31	86.34	60.56	88.8	183.9	187.2	138.9	165.1	163	1437
% CONTACT /HOURS AVAILABLE	50.3												

**Table 2 : Referrals**

	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
<b>NO: OF REFERRALS TO:</b>													
CMHT						1							1
ANGLICARE									1			1	2
EMPLOYMENT ACCESS	1							2	1	1	1		6
CDU/TAFE/LEARNING CENTRE												2	2
BINDI									1				1
CRS	1				1	2			1				5
CENTRELINK													
BATCHELOR													
TERRITORY HOUSING/HOUSING	1	1	1	1				1					5
RED CROSS						1							1
SALVATION ARMY	1	1	1	3	1	1							8
RSPCA		1											1
GREENING AUSTRALIA													
YMCA									1			1	2
ST VINCENT DE PAUL													
GENERAL HEALTH													
CHILDCARE AGENCIES													
OTHER									2				2
TOTAL REFERRALS													36
<b>NO: OF REFERRALS FROM:</b>													
CMHT		1										1	2
AOS													
MHU													
SELF								3					3
<b>OUTCOMES OF REFERRALS</b>													
NO: REFERRALS ACCEPTED		1						3				1	5
NO: REFERRALS NOT/ACCEPT													
NO: REFFERRALS WITH DRAWN													
NO: PUT ON WAITING LIST													

**Table 3 : Interagency Co-Case-management**

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
<b>NUMBER OF MEETINGS RE INDIVIDUAL CONSUMER PROGRAMS / ISSUES</b>													
CMHT	17	19	7	9	9	4		13	10	7	17	13	<b>125</b>
AOS	1												<b>1</b>
EMPLOYMENT ACCESS	9	1	7	3	4	2		7	4	6	5	3	<b>51</b>
COMM/ REHAB SERVICE	4	5		1					1			1	<b>12</b>
BINDI		4		4	1			4	7	4	4	2	<b>30</b>
CENTRELINK								1					<b>1</b>
TAFE,CDU,LEARNING CENTRE	6	2						1		2	2	2	<b>15</b>
DISABILITY SERVICES	2								1			1	<b>4</b>
CONGRESS													
RED CROSS				1									<b>1</b>
CENTACARE												6	<b>6</b>
SALVATION ARMY			1	3	1			2	14	7	5	1	<b>34</b>
MHU			1			6							<b>7</b>
HOUSING								2	1				<b>3</b>
YMCA									1				<b>1</b>
N.T.CARERS													
GREENING AUSTRALIA		5	1	3	1								<b>10</b>
I.A.D.													
GENERAL HEALTH		1						5	2		2	2	<b>12</b>
APS		1											<b>1</b>
RELATIONSHIPS AUSTRALIA		1	1										<b>2</b>
FACS								1	1		3	1	<b>6</b>
ANGLICARE/LODGE								1	2	1	4	1	<b>9</b>
CAAODS													
ALUKKURA													
OTHER			4		3			2				3	<b>12</b>
<b>TOTAL</b>													<b>343</b>

**Table 3 : Interagency Co-Case-management (cont)**

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
<b>NUMBER OF MEETINGS</b>													
CMHT	1	4	2			1		4	1	1	2	1	8
HOUSING								1					
MHU													
ALICE OUTCOMES													
EMPLOYMENT ACCESS			1					2					1
CRS												1	
DS													
TERRITORY HEALTH SERVICES				2	1	1						1	4
WOMENS INFORMATION CENTRE													
ARAFMI													
BINDI				1									1
TAFE													
LIFELINE													
RED CROSS													
MULTICULTURAL COMM. SERV.													
FAM.VIOLENCE NETWORK													
RELATIONS.AUSTRALIA													
CADPHC													
APS/CPS	1	1											2
OTHER	2	2	4	3		3			1		1		16
<b>TOTAL</b>													<b>32</b>

**Table 4 : Consumer Satisfaction**

	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
<b>CONSUMER SATISFACTION SURVEY</b>													
NO: SURVEYS DISTRIBUTED													
NO: SURVEYS RETURNED													
PERCENTAGE SATISFIED CLIENTS													
<b>FORUM NO: OF</b>													
CONSUMER	1	1	1	1	1	1	1	1	1	1	1	1	12
<b>MH PROMOTION</b>													
NO: OF AGENCIES BROCHURE DISTRIBUTED													
COMMUNITY MARKET STALL				1							1		
<b>COMMUNITY SUPPORT</b>													
NO: CARER/FAMILY SUPPORT	4	1	4	1		1		12	10	3	3	1	40
COMMUNITY AGENCY SUPPORT	1	1	1	3	3	1			1	2	6	4	23

**Table 5 : Consumer Outcomes**

<b>NO. OF CONSUMERS ATTENDING</b>	<b>JULY</b>	<b>AUG</b>	<b>SEPT</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APRIL</b>	<b>MAY</b>	<b>JUNE</b>
<b>EDUCATION</b>												
CDU/TAFE	2	1	1	1	1	1		1	1	1		
BACHELOR/IAD												
OTHER												
<b>EMPLOYMENT</b>												
VOLUNTEER EMPLOYMENT			1									
PAID EMPLOYMENT (SHELTERED)	4	4	4	4	4	4	4	5	5	5	5	5
PAID EMPLOYMENT (OPEN)	9	9	8	8	8	8	8	8	8	8	8	8
WORK TRIAL (OPEN)	1	1										
ADVOCACY/CONSULTANCY WORK	1	2	3	3	3	2	2	3	2	1		
<b>SOCIAL SKILLS</b>												
NO. ATTENDING GROUPS OR SOCIAL ACTIVITIES	8	6	8	6	2	6		9	14	9	7	10
<b>WORK/EDUCATION</b>												
NUMBER ASSISTED IN OBTAINING MOBILITY ALLOWANCE, TAXI VOUCHERS TRANSPORT ASSISTANCE	16	8	15	9	2	9		20	35	19	7	9
OTHER												
<b>TOTAL</b>	<b>41</b>	<b>31</b>	<b>40</b>	<b>31</b>	<b>20</b>	<b>30</b>	<b>14</b>	<b>46</b>	<b>65</b>	<b>43</b>	<b>27</b>	<b>32</b>

**Table 6: Role Functioning Scale – Outcome Measurement**

CLIENT	RFS	DATE	RFS	DATE	RFS	DATE	RFS	DATE	RFS	DATE
1	2.5	18/07/2001	4	12/31/01	4	30/06/2002	4.1	31/12/2002	4	30/06/2003
2	1.75	18/07/2001	4	31/12/2001	4.5	30/06/2002	4.75	31/12/2002	5	30/06/2003
3	3.13	18/07/2001	4.25	31/12/2001	4.25	30/06/2002	4.87	31/12/2002	6.37	30/06/2003
4	1.57	18/07/2001	3.63	31/12/2001	2.75	30/06/2002	inactive		D/C,1/03	
5	3.75	18/07/2001	DC		4	30/06/2002	6	31/12/2002	6	30/06/2003
6	1.33	18/07/2001	3.37	31/12/2001	3.25	30/06/2002	3.5	31/12/2002	3.87	30/06/2003
7	3.12	18/07/2001	5.25	31/12/2001	5.5	30/06/2002	5.62	31/12/2002	D/C,1/03	
8	4.13	18/07/2001	6	31/12/2001	6.25	30/06/2002	6.25	31/12/2002	6.12	30/06/2003
9	2.63	18/07/2001	DC		3	30/06/2002	5.25	31/12/2002	4.75	30/06/2003
10	3.63	18/07/2001	5.25	31/12/2001	5.5	30/06/2002	5.75	31/12/2002	5.12	30/06/2003
11	3.5	30/07/2001	4.5	31/12/2001	3.75	30/06/2002	4	31/12/2002	D/C,6/03	
12					5.75	10/05/2002	5.9	31/12/2002	5.75	30/06/2003
13					4.25	17/04/2002	inactive		D/C,1/03	
14					1.8	8/04/2002	2	31/12/2002	D/C,6/03	
15					6.25	10/05/2002	D/C,12/02			
16			5	17/02/2002	6	24/06/2002	D/C,12/02			
17					5.75	24/06/2002	5.75	31/12/2002	5.75	30/06/2003
18					4.5	24/06/2002	5.75	31/12/2002	5.5	30/06/2003
19							3.5	3/12/2002	D/C,2/03	
20					3.75	12/11/2002	4.5	31/12/2002	3.75	30/06/2003
21					4.5	24/10/2002	5.4	31/12/2002	6.75	D/C,6/03
22					5.5	15/08/2002	5.75	31/12/2002	6	D/C,6/03
23							2.5	20/01/2003	3.87	30/06/2003
24					5.25	27/08/2002	5.75	31/12/2002	5.5	30/06/2003
25					5.5	5/11/2002	D/C,12/02			
26					6	30/08/2002	inactive		D/C,6/03	
27					3.37	20/08/2002			D/C,6/03	
28					4	15/07/2002	inactive			
29						22/07/2002	inactive		D/C,1/03	
30							3.6	28/03/2003	D/C,6/03	
31									4	20/05/2003
32									4.75	7/05/2003
33									5	16/06/2003
34										
35										
36									5.25	25/09/2003
37										
38										
39										
40									4.4	7/08/2003
41									4.6	23/11/2003

**Table 6: Role Functioning Scale – Outcome Measurement (cont)**

CLIENT	RFS	DATE	RFS	DATE	RFS	DATE	RFS	DATE	RFS	DATE
1	4.25	31/12/2003	3.875	06/30/04	deceased					
2	5.5	31/12/2003	5.5	30/06/2004	5.65	31/12/2004	5.38	30/06/2005		
3	6.75	31/12/2003	5.75	30/06/2004	6	31/12/2004	6.4	30/06/2005		
5	6.4	18/12/2003	6.4	30/06/2004	6.8	10/12/2004	d/c12/04			
6	4.25	31/12/2003	4.38	30/06/2004	3.375	31/12/2004	3.38	30/06/2005		
8	6.5	31/12/2003	6.13	30/06/2004	6.5	31/12/2004	6.13	30/06/2005		
9	inactive		dc							
10	4.88	23/12/2003	6.25	30/06/2004	6.6	10/12/2004	6.375	30/06/2005		
11	d/c									
12	6.1	23/12/2003	6.13	30/06/2004	6.25	10/12/2004	6.25	30/06/2005		
17	5.75	23/12/2003	6.4	30/06/2004	6.8	10/12/2004				
18	6	18/12/2003	6.25	30/06/2004	6.5	10/12/2004	5.5	30/06/2005		
20	4	23/12/2003	d/c 06/04							
23	4.63	18/12/2003	5	30/06/2004	5.4	10/12/2004	4.14	30/06/2005		
24	5.75	18/12/2003	6	30/06/2004	5.6	10/12/2004	5.87	30/06/2005		
28	inactive	4.25 7/4/04	4.75	30/06/2004	4.75	10/12/2004	4	30/06/2005		
32	4.88	19/12/2003	d/c 06/04							
33	6	31/12/2003	6.25	30/06/2004	6.37	31/12/2004	6.5	30/06/2005		
34	3.25	5/09/2003	3.25	30/06/2004	3.25	10/12/2004	inactive			
35	6.25	23/12/2003	6.5	30/06/2004	d/c11/04					
36	5.75	31/12/2003	5.63	30/06/2004	inactive		4.875	30/06/2005		
37	3.38	19/12/2003	3.63	30/06/2004	4	10/12/2004	inactive			
38	4.25	4/11/2003	4.88	30/06/2004	5.9	10/12/2004	5.75	30/06/2005		
39	4.75	23/12/2003	dc 4/04							
40	5.37	31/12/2003	6	30/06/2004	6.25	31/12/2004	inactive			
41	5.6	31/12/2003	6.13	30/06/2004	6.13	31/12/2004	6.13	30/06/2005		
42	3.88	9/01/2004	5.13	30/06/2004	d/c06/04					
43			inactive							
44			d/c 06/04							
45			6	30/06/2004	6.25	10/12/2004	d/c 1/05			
46			womens gp				outreach			
47			womens gp				outreach			
48			inactive		d/c07/04					
49			inactive		d/c07/04					
50							inactive			
51					d/c11/04					
52							4.75	30/06/2005		
53							3.5	30/06/2005		
54							2.75	30/06/2005		
55							2.75	30/06/2005		
56							4.25	30/06/2005		

\* Clients 4, 7, 11, 13-16, 19, 21, 22, 25-27, 29-31 discharged

# Life Promotion Program

Laurencia Grant: Coordinator

*Finding solutions to reduce suicide and self-harming behavior  
through collaborative partnerships across the community*

## Introduction

The Life Promotion Program is a broad non-clinical community development approach to suicide prevention. One of the greatest challenges as a new coordinator of this program has been to understand exactly what the program does and doesn't do. This has taken time to research and read about the history of the program and to talk to agencies about their understanding of the program. In this way, over time, the activity areas and responsibilities of the program have become clearer. However, it has also highlighted the enormity of the expectations of this program and the difficulty the program has in measuring its success.

It has also become clear that the program cannot respond to suicide attempts and self-harming behaviour in any real capacity unless useful data is collected to indicate the scope of the problem. Suicide attempts only come to the attention of the Life Promotion Program infrequently and as a non-clinical program, our support is limited to referral to other agencies. Workers who come in contact with people at risk of suicide are challenged with an inadequate referral pathway. ASIST Training is one tool to assist with intervention, however the next step of finding professional support that is flexible, affordable, accessible, age appropriate, culturally appropriate and ongoing is a difficult task.

During this reporting period the service plan was reviewed and out of discussions with the funding body representatives, it was agreed to alter the service plan to more accurately reflect the current objectives of the program. Also to reflect the actual work that is being done as part of the Life Promotion Program, which is keeping in line with current research, the Life Framework and identified local needs.

## LPP Steering Committee

- The Steering Committee was restabilised not long before this reporting period. The committee meets on a three-monthly basis to offer strategic direction for the program and to support the program development.
- Organisations represented include Tangentyere Council, Waltja, ASYASS, Social and Emotional Well-Being Program of CAAC, Student Support Services of DEET, Mental Health Policy of DHACS, Central Australian Mental Health Services, ESWB Program of NPY Women's Council. Lifeline, Family and Children's Services and the Reconnect Program of Gap Youth Centre.

- Achievements of the Steering committee over the last year include the development of a 12 month strategic plan for the Life Promotion Program. Development of Terms of Reference and a document reflecting the history of the program to give all members a clear picture of the origins of the program and the direction it has taken over the years.
- The committee reflects a key objective of the Life Framework that suicide prevention is a shared responsibility of Government, non-Government organisations and community representatives.
- The committee allows for partnership projects to develop.
- The committee allows the program to link in with indigenous organisations and remote communities.
- The committee ensures that the Life Promotion Program is transparent and accountable.
- The committee allows for other organisations to keep informed and up to date on Life Promotion program developments.

## **Staffing**

During this year the program was funded to employ two full-time staff based at Alice Springs. The current Coordinator of the Life Promotion Program commenced in June 2004 and this report covers her first year with the program. The full-time indigenous officer was with the program from June to October, 2004. After readvertising, the position was filled from Feb to March 2005 and was then reviewed and readvertised as two part-time indigenous positions in the hope that this would attract both a female and male worker.

One position was filled by a local indigenous woman who commenced work on 2 August 2005. Interviews took place recently to fill the other part-time role. Recruitment, orientation and training of staff have taken up a large part of the coordinators time at a time when she too was being oriented to a broad and complex program. The process of recruiting has been reviewed and the job description has been modified. Attracting indigenous males into the community sector is difficult and it is clear that the SACS award rate for this role is not considered as adequate remuneration for what is clearly a difficult and challenging position.

## **Barkly Region Life Promotion**

The program received funding approval for a part-time position to work in the Barkly region following a meeting with local organisations in Tennant Creek in December 2004. It was identified that the high incidence of suicides and attempted suicides in the Barkly Region required a coordinated response and a key worker. An office space was secured at Bradaag (Barkly Region Alcohol and Drug Treatment Service) and the position was advertised in June 2005.

## **CAYPIN And Youth Case Management Meetings**

The Life Promotion Program has had a continued link with youth organisations via the Central Australian Youth Information Network. This network meets on a bi-monthly basis and recent developments have ensured that a contact list has been updated and that agencies rotate the responsibility of the network. Youth Case Management meetings are held monthly and are an opportunity for Life Promotion to inform workers of young people at risk of suicide or self-harm and to receive information from other agencies about young people at risk. Unfortunately there is no equivalent interagency case management service for people over 20 years who are at risk of suicide.

## **Interagency Suicide Response Model**

The Interagency Suicide Response Group continues to operate under the management of the Program. Between 1 July 2004 and 30 June 2005, the Program recorded nine suicides (confirmed through the NT Police and the NT Coroners Office). The Inter-agency Suicide Response Group met in response to 6 of these deaths. The other three deaths did not come to the attention of LPP until some time after the incident. One death was not reported as a suicide by the ASH but was later reported as such by the coroner. One death occurred in the Barkly Region and one occurred in Ernabella in South Australia. LPP were not clear of their role in responding to suicides in SA and the death in the Barkly Region was responded to by the Barkly Mental Health Service. The frequency of deaths has highlighted the strengths and weaknesses of the current model of response and LPP are working to address some of these issues including the lines of communication between the Police.

Discussions have taken place with the Commonwealth funded Noosa Standby Suicide Bereavement Service and Life Promotion has indicated an interest in gaining support and training from this service in Central Australia.

## **Raising Awareness And Promoting What We Do**

- Information about the Life Promotion Program and suicide issues is disseminated to organisations when visited or on request and via e-mail networks.
- The Life Promotion Posters were developed in collaboration with the Steering Committee members and have been distributed to over 100 agencies in Central Australia and the Top End. The posters are a way of informing others about the program through visual images and basic text.
- LPP keeps agencies informed via the Steering Committee and the Youth Interagency meetings.
- During Mental health week in October 2004, LPP spoke to students at Centralian College on the issue of mental health and the Life promotion officer shared his own story from the perspective of a local indigenous man. This was an effective means of sending a positive message about mental health.
- LPP include regular updates of their program or special events in the MHACA "In Balance" newsletters and published an article in the Primary Mental Health Care Australian Resource Centre (PARC) Newsletter in November 2004.

- The Centralian Advocate published a story in January 2005 on the Bereavement Support Group (see attached)
- The LPP Coordinator was a guest speaker at the Alice Springs Interagency Meeting on 9 February 2005 and spoke to over 40 people representing a wide range of services.
- The Coordinator spoke at an evening meeting of the Alice Springs Rotary Club on 15 February 2005.
- The coordinator and a member of the Bereavement Group spoke on ABC Radio about the issue of suicide bereavement in March 2005.
- Presentation to a group of young indigenous women on mental health at a women's health workshop in Laramba in March 2005.
- Presented information about the program to the Social Work Team of the Alice Springs Hospital on 24 March 2005.
- Presented information on good practice and challenges for the Life Promotion Program at the Suicide is Everyone's Business forum in Darwin in May 2005.
- The Coordinator spoke to remote night patrol workers about the suicide intervention training options for workers at Hamilton Downs on 4 May 2005.
- Spoke to staff at a forum on depression and Young People at Anzac Hill High School on 14 May 2005
- Presented a suicide awareness talk to remote youth workers at a conference organised by Waltja at Hamilton Downs on 22 June 2005.
- Many other organisations have called or dropped into MHACA to meet with the Life Promotion Staff and to get information related to suicide prevention.

## **Professional Development, ASIST Training and IPS Training**

Over the 12 month reporting period the Life Promotion Program Coordinator attended a range of training and professional development activities. This included the following:

- Aboriginal Cultural Awareness Program
- 4WD Awareness Training
- Suicide Talk Orientation in Melbourne in July 2004
- National Planning Workshop for Suicide Prevention, Canberra – August 2004
- Indigenous Psychological Services Training in Psychological Assessment of Aboriginal Clients and Working with Suicidal and Depressed Aboriginal Clients in September 2005
- ASIST T4T in Darwin in October 2004
- Suicide is Everyone's Business Forum in Darwin in May 2005
- Representation on the NT Suicide Prevention Strategy Advisory Committee (NTSPSAC). Meetings held in July 2004 and Feb 2005

The Coordinator co-facilitated the delivery of the two-day ASIST workshop in November and April 2004. Those participating were from Central Australian Remote Health Development Service, Congress, ASYASS, the Women's Refuge, Centacare Family Services, Centacare Employment, Corrections, Alice Springs High School and Relationships Australia.

In December 2004, the LPP coordinator and a DEET psychologist arranged a meeting of interested workers to discuss the possibility of inviting Dr Tracy Westerman to Central Australia to deliver training. Over 30 people attended this meeting from a wide range of organisations. In January, the Top End Mental health Services had already made arrangements to have Dr Westerman deliver the three day workshop on depression and suicide to staff employed in the NT Government Mental Health service. It was unfortunate that the NT Government did not consult with workers prior to this arrangement being made as it was clear that many staff were interested in Tracy's work and her capacity was greater than the delivery of training to town based workers.

Through the efforts of LPP, NPY women's Council and DEET, renegotiations and additional funding ensured that workers employed outside the Government mental health service including indigenous staff from remote communities in the AP lands were able to be trained by IPS staff in June 2005.

## **Bereavement Support**

LPP established a Bereavement Support Group for those affected by suicide in collaboration with Relationships Australia NT in October 2004. A Rotary Mental Health forum held in 2004 had focused on the issue of suicide and audience members were vocal about the need for improved support for people affected by suicide. The Alice Springs Bereaved by Suicide Support Group has continued to meet on a fortnightly basis since this time. Relationships Australia continues to provide access to a meeting space, however CAMHS provides the program with a co-facilitator. A consistent group of four non-indigenous women were with the group for about six months. LPP has made efforts to inform local GP's, specialists and counsellors in order to gain more referrals.

LPP is exploring options of support for indigenous people through the Healing Centre. The program also supports individuals and families bereaved by suicide via the delivery of the bereavement support kits. These kits are not suitable for some indigenous people in remote communities unless a worker or family member is able to translate the material.

The LPP Coordinator was invited to Amoonguna by the SEWB team of Congress to talk to staff at the clinic and some family members recently bereaved by suicide in May 2005.

## **Remote Communities**

The Life Promotion Program has continued to work closely with two key agencies involved in remote work in Central Australia. LPP sent official letters to NPY Women's Council and Waltja's Committees of Management to offer a proposal for working in partnership to address the issue of suicide and self-harm. These letters were also sent to the Councils of Santa Teresa and Imanpa.

LPP visited Papunya in July 2004 as an introduction to remote Central Australia and to learn about some of the programs operating in this community. In September 2004, March and June 2005, LPP travelled to Santa Teresa with Waltja's Reconnect program to continue discussions with key agencies about LPP's involvement here. The Santa Teresa Council responded to the letter and invited LPP to speak at the council's June 2005 meeting. It has taken a year before the Coordinator was invited to Santa Teresa but this has been an important process in building trust and working through the proper procedures. This community has now indicated that they wish to work with collaborating agencies focusing on suicide prevention and support.

The LPP Coordinator engaged the support of a local artist to develop some visual aids in the form of cardboard faces for use in the delivery of talks on mental health and suicide awareness for indigenous communities.

## **Data Collection**

The Life Promotion Program continues to collect data on completed suicides received through the NT Coroner and the Alice Springs Police. LPP is continuing to work with local agencies, Government departments, the local police and local hospital to gain a better understanding of the number of incidences of attempts in Central Australia. A report released recently by the NT Police on the numbers of attempts and completed suicides in East Arnhem Land has prompted a wide ranging response from organisations and Government Departments in the Top End. A similar level of reporting in Central Australian communities would highlight the urgency of need for improved resourcing in remote communities.

# Prevention & Recovery Program

**Rangiwhiua Ponga: Co-Coordinator**

*To provide non-clinical support to people affected by an exacerbation of their mental health problems to enable them to remain in their own accommodation.*

This 18-month pilot program is being operated in a collaborative partnership between Mental Health Association of Central Australia and Central Australia Mental Health Service.

## Present Objectives

- To establish Prevention & Recovery Steering Committee to oversee development and monitoring of program
- To develop policy and practice procedures in collaboration with MHACA, Central Australia Mental Health Services and Steering Committee.
- To recruit and train four casual staff members to deliver Prevention and Recovery program.
- To develop procedures that capture statistical and evaluation data relevant to monitoring program viability.

The first four months have seen several key objectives achieved towards the development of the Prevention and Recovery program. These have culminated in the official launch of the program in early October 2005.

## Steering Committee formulation

The committee has representation of ten identified areas that are relevant to the delivery of the mental health interventions.

- Accommodation and housing
- Alcohol and other drugs
- Carer representation
- Consumer representation (2 indigenous and 2 non-indigenous)
- Centrelink beneficiary entitlement
- Cultural consultancy
- Mental Health Services: Remote indigenous and Urban indigenous
- Youth representation

There is difficulty being shown in identifying and retaining consumer representation. Two nominated consumers have withdrawn due to personal problems before the committee's first meeting. Several consumers had been approached previously and all declined to participate. There will be a need to fully support consumer representation in this program.

The Steering Committee endorses that consumer representatives are:

- i) crucial to the validity of the programs delivery,
- ii) should receive remuneration accordingly as recommended out of the steering committee meeting and
- iii) have access to an identified mentor to assist them in the functions of the committee.

Continued campaigning will ensue to assist in identifying and retaining consumer representation on the committee.

All draft documentation has been submitted for member's consideration and is due for signing in early October. An early meeting was called to expediate the reading and critiquing of drafts in readiness to sign off by managers and a nominated steering committee representative.

## **Drafting of Policy and Procedures**

There has been in-depth consultation at community and mental health levels to formulate the policy and procedures consistent to meeting the objective of the program.

The integration of clinical and non-clinical recovery based model practice standards has meant being able to determine both MHACA and CAMHS service delivery to ensure consistency and quality in what will be delivered. This is being done in consultation and observation of the services present assessment and practice procedures as well as those envisaged in the delivery of this program.

It has been important to provide step-by-step written procedures to ensure each aspect of the program is included. This is necessary to ensure safe practice procedures and delivery outcomes that will be measurable.

Although all effort is being taken to include every aspect of the programs delivery there will be some un-foreseeable gaps which will have to be added as the program progresses. The importance of a three and / or six month review in the continued evaluation of the program will reduce any major unidentified shortfalls.

At this stage there are three major MHACA documents attached to the program:

- i) Addendum to the existing Memorandum of Understanding between MHACA and CAMHS specific to the Prevention and Recovery prgm. This addendum intends to be inclusive of all allied sectors who will work directly with mental health clients in the program delivery.

- ii) Terms of Reference to Steering Committee, where by the committee will act as consultants and monitors to the delivery of both MHACA and CAMHS service delivery.
- iii) Non-clinical Policy & Practice procedures btwn MHACA and CAMHS to direct MHACA practice.

These form the body of the program and will be inclusive of an integrated Care Package of service to the client group.

Comparisons are being built around programs in existence such as the Shepparton Residential Unit in Victoria to reduce risks and provide a continuum of consistency in delivery packages. Darwin are also involved in the sub acute pilot program and have a independent staffing level to operate within giving a more independent function away from the govt. service.

## **Staff Recruitment**

There have been positive responses to advertising for casual staff from non-indigenous females and three have been duly approved (pending final police checks) for inclusion on the pool listing. Two of whom will be able to begin immediately. All three are to begin training to the programs requirements in September. Two have already participated in training offered by MHACA

There is a major gap however. The program requires the use of male indigenous to address the client group represented coming off the mental health hospital unit and the high rate of suicide risk amongst the male indigenous population. Extensive campaigning has been approached with individual contacts, community employment services and local community organizations. The lack of male indigenous staff will impact on effective delivery of the program.

This problem is not exclusive to the program. It has been identified as an issue for MHACA in general. However given that staffing is only on a casual basis for the subacute I believe this is a direct effect also and indigenous are less likely to show interest due to impacts on their benefit entitlements and financial responsibilities. This problem will be ongoing for MHACA.

## **Evaluation of Program Delivery**

Debra Rickwood of Canberra University has been contracted to provide the evaluation schedule to the Prevention and Recovery program. Debra is scheduled to meet with MHACA manager, staff, Steering Committee and both subacute coordinators during a two day visit in August.

Relevant spreadsheets and evaluation / survey questionnaires are being developed by Debra that will capture the needed information in the monitoring of the program in a

*“ pre-test, post test and follow up, with information collected from a match control group if possible...both quantitative and qualitative data will be collected from prgm participants at all levels- clients, prgm providers, other service providers including clinical services, and possibly the community. “* Rickwood, July 05.

Costing and the proposed schedule have been approved and accepted with MHACA meeting partial costs of \$5000 towards the total \$21,500 projected budget.

A standard satisfaction survey will also be completed on behalf of each client at post discharge from the program.

Statistical information is being collated by both MHACA and CAMHS in determining pre - post discharge and care planning actions. MHACA will continue to record manual and computer based stats, and CAMHS will utilize the Health of the Nation Outcome Scale (HONOS) system. Coordinators will also complete the evaluation spreadsheets provided by Debra.

## **General comments**

There has been a positive approach from both community and government sectors in the promotion of the Prevention and Recovery Program. The expectation is for step-down (pre-post discharge) to be phased in initially with the prospect of increased staffing there will then be consideration to accept referrals as step-up (pre-admission) to reduce likely admissions. I envisage that the majority of intensive monitoring would be within the step-up phase of support where there is emphasis to maintain clients in their own environment.

The discussions pertaining to a subacute residential unit for the area is very reality based and would quickly prove viable. It is important that the correct venue be researched with consideration to minimize risks for consumers, staff and the community.

The Victoria Shepparton model has been used in both step-up and step-down referrals providing a continuum of care that has the psychiatric clinical staff working directly with the unit as opposed to clients requiring hospital admissions or appointments.

The possible integration of the present Prevention & Recovery program and a subacute residential centre will benefit the Central Australian region due to the complexed nature of such a remote region.

## **Launch**

The subacute Prevention & Recovery program is due to commence in October, and it is envisaged that the launch will be officiated at by the Minister of Health, Delia Lawrie. No official date has been confirmed as yet, this will be negotiated with the Minister to identify a date suitable for her attendance.

The launch will be subject to the casual staff having completed their compulsory training components, including Mental Health First Aid Training Certificate and Triage/ Risk Assessment criteria prior to acceptance of any referrals.

