



# **Mental Health Association of Central Australia**

## **Service Report**

**July 2010 – June 2011**



# CONTENTS

<b>Program .....</b>	<b>Page No</b>
Management and Administration of MHACA Services .....	3
Pathways to Rehabilitation Program .....	22
Prevention & Recovery Program .....	29
Life Promotion Program .....	37
Training & Promotions Program .....	47
Homelessness and Transitional Housing .....	52
<b>APPENDIX 1 – FINANCIAL REPORTS .....</b>	<b>57</b>
<b>APPENDIX 2 – PATHWAYS TO REHABILITATION DATA TABLES .....</b>	<b>67</b>
<b>APPENDIX 3 – PREVENTION &amp; RECOVERY DATA TABLES .....</b>	<b>69</b>
<b>APPENDIX 4 –HOMELESSNESS AND HOUSING DATA SUMMARY .....</b>	<b>71</b>

# Management and Administration of MHACA Services

Claudia Manu-Preston: General Manager

Sue Coombs: Administrator

*To coordinate and support the program activities managed by the Mental Health Association of Central Australia*

## Overview and Analysis of the year

The 2010-11 financial year has continued to be extremely busy, particularly with the General Manager being absent for three months to undertake a Churchill Fellowship. There has been an additional workload for the all staff covering positions and particularly the senior staff who have acted in the General Manager's role.

The whole report provides a comprehensive performance report showing what we are achieving against the agreed outcomes funded through the Northern Territory Government. The process of reflecting and reporting can be very satisfying and revealing. This year we have achieved an incredible amount of work within the organisation.

MHACA has continued to develop and provide quality services for our community in Mental Health and Suicide Prevention. We have provided a range of mental health awareness and training to improve the knowledge and skills in mental health literacy for our community.

We have continued to provide one-on-one support to 183 clients across all the program areas and offered social activities, group work, training and education. One of the outcomes is that 33% of participants have achieved or retained employment. This is in line with one of the main aims for participant services that people with a mental illness have greater control of their lives.

Of interest is that our client numbers have reduced slightly from 207 in 2009-2010 to 183, a decline of 24. It should be noted that for most programs they are at the recommended level of staff-client ratio. There are various assumptions in the decline of participants, firstly the report from the clinical team of a reduction in clients to their services possibly associated with the renovations to the Mental Health Unit. More services in operation including the Peers Helpers and Mentor Services (PHAMS), Teamhealth respite, General Practice Network Northern Territory (GPNNT) who provide mental health care in remote communities. Although some of these services are new, they have improved capacity to the entire service system.

It is also assumed that MHACA has continued to develop the therapeutic relationship resulting in improved service quality, by practicing the recovery principles where clients are encouraged to develop their role in the self determination process and clarity and use of the MHACA role of providing support through a range of tools, resources to create an environment of recovery. We know that there is still a lot to be done.

We also know that people choose to stay in recognition of the benefits to their recovery or they vote with their feet. We will look at this more closely if this continues as an emerging trend.

MHACA's priorities for the coming year will be the evaluation of the current Strategic Plan and development of a new Strategic Plan which expires at the end of this year. We will continue to develop policy positions on the needs and possible solutions to improved mental health including following up the "There's No Place Like Home...There is NO PLACE" report recommendations and completion of the Suicide Story resource and Train the Trainer program.

Following is a summary of achievements for this period:

## **Achievements – 2010/11 Programs & Projects**

### **1. Quality service provision and responsive service delivery**

- Continuing surveys of participants to ensure service delivery meets their needs and expectations
- Restructure of the Day to Day Living program to better reflect the program objectives and better support the participants
- Continued monthly participant forums with participant representatives facilitating the meeting
- Continued participant representation in review processes, such as Peer Support Model development.
- Continued participant involvement in selection process for tenants in MHACA units and for new staff
- High uptake in activities, excursions and camps.
- Update of eligibility criteria for MHACA services
- Negotiation of new MoU's, Anglicare, CAMHS
- Ongoing involvement of participants and carers on Management Committee and Steering Groups on special projects
- Continuing use of WRAP and Camberwell assessment tools
- Continuing review of intake and referral systems to ensure they provide effective information

### **1. To support a community development approach to the prevention of suicide in Central Australia**

- Continued delivery of the Suicide Story training resource
- Continuation of suicide response groups both in Alice Springs and Tennant Creek
- Continuation of reference group/steering committee meetings in Alice Springs and Tennant Creek
- Ongoing delivery of ASIST and Safe Talk

### **3. Provide a quality housing support program for MHACA clients**

- Continued dialogue with the NT and Commonwealth Governments to progress the recommendations from the Housing & Support report
- Ongoing negotiation with NT Housing for additional resources for participants with higher support needs
- Rollout of new transition housing program
- Allocation of NT Housing stock for the provision of a new transition housing program
- Continuation of attendance at housing forums with other agencies to ensure participant needs are being met

- Application for funding to purchase additional independent living unit(s).
- Membership of new Housing & Homeless Reference Group

#### **4. Mental Health Awareness**

- Continuation of monthly Mental Health First Aid (MHFA) training
- Provision of participant-specific MHFA training
- Delivery of additional MHFA training to 2 organisations outside of the normal monthly courses.
- One additional staff member trained for MHFA
- Ongoing development and delivery of ASIST Training with one new staff member trained
- Production of inBalance newsletter 3 times per year
- Presentations at conferences, workshops, meetings and community agency visits
- Mental Health Week activities
- Stalls at the Alice Springs show and other activities
- Continuing provision of in-kind assistance to headspace by T&P officer one morning per week

#### **5. Management & Governance**

- Review of core and other training
- Continuation of formal staff planning days
- Continuation of Committee planning day
- Development of annual action plan from the staff planning days
- Development of risk management plan
- Ongoing review of OH&S
- Finalisation of MHACA enterprise agreement (EA)
- Review of recruitment strategies
- Participation in development of recruitment and retention strategies for indigenous staff
- Continuation of appraisal process for all staff
- Weekly intake service meetings, monthly supervision and monthly in-service training with participant rep participation
- Combined services meetings held monthly at MHACA
- Review and renewal of all NT Govt Service Agreements for 3 years

# Service Activity 1- Financial Accountability

***To provide an overall financial analysis of MHACA operations with the aim of operating with the percentage of programs having a surplus as a trend over time***

The Balance Sheet reports a current year surplus \$401,424 at 30 June 2011.

The Balance Sheet reports MHACA to have current assets of \$993,336, mainly cash at bank of \$984,544 and receivables of \$8,822. Non current assets of \$1,259,179 which comprises of bond paid \$8,532, residential units \$1,108,975, plant and equipment \$49,824 and motor vehicles \$91,348 (all amounts are written down values), plus share in Bendigo Bank at cost of \$500. Current Liabilities are \$365,590 comprised of creditors of \$121,311, unexpended grants of \$125,242 and provisions of \$119,037. Long-term liabilities total \$41,749 being employee provisions.

The Balance Sheet reports MHACA to be in a healthy financial position at 30<sup>th</sup> June 2011.

## **Statement of financial performance**

Income for the 12 months including Grants b/fwd from 2009-10 and excluding internal income is \$2,182,423. Operational Grant income \$1,833,530, and Capital Grant income \$250,426. Other income from external sources was:

- Bank interest \$37,529
- Rent and recovered costs \$76,788
- Membership fees \$ 855
- Training Income \$14,872
- Other income \$24,009

## Service Activity 2 - Governance

### ***The number of committee meetings as a trend over time and the percentage of members who attend***

The Committee is the governing body of MHACA. The MHACA administration provides support to the management committee by providing quality information to enable members to make informed decisions. This support includes the distribution of papers in a timely manner for members to consider and participate.

The MHACA Constitution was amended in October 2010 to allow for proxy representatives for both participant and organisational committee members where the elected member is unable to attend. This was done to ensure that there continues to be a strong participant voice at the committee meetings.

### ***Participant Mentoring***

An independent mentoring support person is available to participant representatives. This is to support and develop their skills and enable the members to participate. A separate meeting is held prior to the committee meeting with the mentor and participant representatives to discuss paperwork and any points needing to be raised.

There were 10 committee meetings throughout the year with an average of 71% of members attending within this period.

- July No meeting held
- August 6 committee members
- September 6 committee members
- October 7 committee members
- November 8 committee members
- December 8 committee members
- January No meeting held
- February 7 committee members
- March 10 committee members
- April 11 committee members
- May 9 committee members
- June 6 committee members

The Annual General Meeting was held on 21<sup>st</sup> October 2010 with an excellent attendance by staff, participants and general members. A number of positions on the Committee were contested with the outcome being the appointment of 3 new members to the Committee.

## 2.1 Activities Summary

<b>July 2010</b>	<ul style="list-style-type: none"> <li>• Stall at Alice Springs show</li> </ul>
<b>August</b>	<ul style="list-style-type: none"> <li>• Commencement of audit</li> <li>• Presentation of Churchill Fellowship to Claudia</li> </ul>
<b>September</b>	<ul style="list-style-type: none"> <li>• Attendance by 1 staff and 1 participant at THEMHS conference in Sydney</li> <li>• World Suicide Prevention Day</li> <li>• Attendance at Creating Future Conference in Cairns by Laurencia Grant and Valda Shannon</li> </ul>
<b>October</b>	<ul style="list-style-type: none"> <li>• Mental health week – activities</li> <li>• Visit by Prof Pat McGorry and community dinner</li> <li>• Completion of audit</li> <li>• Completion of annual report and audited accounts</li> <li>• Submission of annual acquittals</li> <li>• AGM and amendment to MHACA Constitution</li> <li>• MHACA service review by Dept of Health &amp; Families</li> <li>• Helen Glover training for staff and participants</li> <li>• Deaf Healthy Minds forum</li> <li>• Attendance at Suicide Prevention conference in Brisbane by Brian Kennedy and Warren Williams</li> </ul>
<b>November</b>	<ul style="list-style-type: none"> <li>• Melbourne Cup luncheon</li> <li>• Receipt of funding for, and purchase of additional one-bedroom unit</li> </ul>
<b>December</b>	<ul style="list-style-type: none"> <li>• Christmas functions for staff, participants and Committee members</li> <li>• Reclink cricket final – MHACA team champions</li> <li>• Notification of successful application for vehicle under the Community Benefit Gift Fund</li> </ul>
<b>January 2011</b>	<ul style="list-style-type: none"> <li>• Australia Day BBQ Alice Springs</li> <li>• New Year's Eve BBQ Tennant Creek</li> <li>• Ice skating</li> <li>• Lodgement and acceptance of MHACA Enterprise Agreement</li> <li>• First meeting of Housing and Homeless Reference Group</li> <li>• Final report on the MHACA review from NT Health &amp; Families</li> </ul>
<b>February</b>	<ul style="list-style-type: none"> <li>• Suicide Story presentation Tennant Creek and Numbulwar</li> <li>• Staff planning days</li> <li>• Bowling</li> <li>• Desert Park visit</li> <li>• Tracy Westerman training</li> <li>• Day to Day Living conference Melbourne</li> <li>• Commencement of paper on gaps in mental health</li> <li>• Commencement of paper on MHACA's position on a secure care facility for Alice Springs</li> <li>• Proposal submitted for a cluster of units in Gap Road for supported accommodation</li> </ul>
<b>March</b>	<ul style="list-style-type: none"> <li>• Golf for participants</li> <li>• Participant planning day and facilitation workshops</li> <li>• Interagency meeting</li> </ul>

	<ul style="list-style-type: none"> <li>• Peer workforce forum Sydney</li> <li>• HR conference Melbourne</li> <li>• Confirmation of sub-acute program funding through to June 2013</li> <li>• Community forum with Debra Rickwood</li> </ul>
<b>April</b>	<ul style="list-style-type: none"> <li>• OzHelp negotiations commence</li> <li>• Ormiston Gorge visit</li> <li>• A&amp;OD conference Darwin</li> <li>• Peer forum Darwin</li> <li>• MHACA social function at Alice Springs golf club</li> </ul>
<b>May</b>	<ul style="list-style-type: none"> <li>• Participation in Disabilities Expo CSC</li> <li>• Suicide Story training Mutitjulu and Alekerange</li> <li>• Visit to Simpson's Gap</li> <li>• Host Cancer Council Biggest Morning Tea event</li> <li>• Claudia heads off on her Churchill Fellowship trip</li> <li>• Creating Corporate Futures conference Melbourne</li> <li>• Meeting with Team Health Darwin</li> <li>• Participation in national conference on National Minimum Data Set for the MH sector – Sydney</li> <li>• Participation in Homelessness database training</li> <li>• Sign-off of MHACA-Anglicare MoU</li> <li>• Sign-off on OzHelp partnership agreement</li> </ul>
<b>June</b>	<ul style="list-style-type: none"> <li>• Annual Matt Deer camp</li> <li>• Bowling and golf</li> <li>• Visit to reptile centre</li> </ul>

## 2.2 MHACA Committee and Staff

### **Committee**

<i>Chairperson:</i>	Trish Van Dijk
<i>Deputy Chair:</i>	Mardijah Simpson
<i>Secretary:</i>	Maya Cifali
<i>Treasurer:</i>	Greg McIntosh
<i>Public Officer:</i>	Lee Ryall
<i>Organisational Rep:</i>	Tracey Hatchard, Carers NT
<i>Organisational Rep:</i>	Michael Johnson, Salvation Army
<i>Participant Rep:</i>	Sandi Yandell
<i>Participant Rep:</i>	John Moffat
<i>General Member:</i>	Mark Keyworth
<i>General Member:</i>	Amanda Worrall

### **Staff**

<i>General Manager:</i>	Claudia Manu-Preston
<i>Administrator:</i>	Sue Coombs
<i>Administration Assistant:</i>	Kirsten Major
<i>Services Manager:</i>	Rangi Ponga
<i>P&amp;R Officer:</i>	Peta Boon (Bianca Kelley)
<i>P&amp;R Officer:</i>	Bruce MacGregor
<i>Pathways Officer:</i>	Christine Boocock
<i>Pathways Officer:</i>	Geoffrey Miller

<i>Pathways Officer:</i>	Donna Ormsby
<i>LPP Manager:</i>	Laurencia Grant
<i>LPP Officer:</i>	Brian Kennedy
<i>LPP Officer (Tennant Ck):</i>	Larissa Knight
<i>Training &amp; Promotions Officer:</i>	Kylie Humrick
<i>D2DL Peer Support Officer</i>	Stuart James
<i>D2DL Activities Officer</i>	Kellie Georgeff
<i>Homelessness Support Officer</i>	Lizzie Dodd
<i>Homelessness Support Officer</i>	Barry Laird
<i>Suicide Story Trainer</i>	Valda Shannon
<i>Suicide Story Trainer</i>	vacant – being contracted

### **Recruitment & Retention Analysis:**

In the past six months there was a 10% staff turnover with a full year turnover of 21%.

At the end of June 2011 we had one vacancy – the Policy & Research Officer.

# Service Activity 3 - Quality Improvement Activities

*Report on quality improvement activities. The analysis of an evaluation system and outcomes on the effectiveness of interventions.*

## 3.1 Extending Range of Support

MHACA has continued to provide direct service delivery through the Pathways to Recovery, Sub-acute Care, Homelessness Housing and Support and Day to Day Living in the Community programs.

At the presentation of the last 6-monthly service report we had not received advice on the continuation of the Day to Day Living program – early in the new year we were advised that funding will be continued for a further 2 years to 30<sup>th</sup> June 2013.

Participant numbers in the Pathways and Day to Day Living programs continue to be at high levels, there is an ongoing battle for referrals for the Subacute program however we are receiving enquiries through the prison system and have provided significant respite during the year. The redevelopment of the Alice Springs Men's Hostel dropped our bed usage for the year as there was only one room available, and the redevelopment work on the Mental Health Unit at the hospital has also had an impact on client numbers. We are still constantly assessing the structure of the new Homelessness program to ensure it meets the community requirements.

The Training and Promotions roles in both Alice Springs and Tennant Creek are robust, with ongoing delivery of Mental Health First Aid training on a regular basis, together with a number of community forums and expos, and attendances at both the Alice Springs and Tennant Creek annual show days. We partnered with ADSCA to have 3 days of training with Tracy Westerman for workers in the sector, worked with Centre for Remote Health to bring guest speakers to Alice Springs to increase the knowledge base of workers in the sector as well as the general community and have worked with some of the local schools to provide age appropriate information to students.

The Life Promotions program continues to reach out to indigenous communities through the ongoing development and refinement of Suicide Story, and the continuation of training such as Safe Talk and ASIST in both Central Australia and the Barkly regions.

## 3.2 Improving Services

As a response to the departmental review undertaken in late 2010, MHACA has worked to assess unmet service criteria and develop appropriate responses and services to these gaps. This has led to a review of current policies and practices and the development of new policies and work practices. In addition the intake system is constantly monitored to ensure it meets requirements for data collection as well as being "user friendly" for new participants, and we have participated in a review (undertaken by NTCOSS) on the recruitment and retention of indigenous workers which is informing a change in recruitment practices.

- **MHACA Database**

The database was purchased late in the 2009/10 financial year, and has subsequently been installed within MHACA. We are currently fine-tuning the database to allow us to extract the information required.

- **Street to Home project**

MHACA commenced this program in November 2010, and were been allocated 3 units from NT Housing to enable us to provide assistance and training for people who may be having problems managing their tenancies, or have a past history in this area. Anglicare have assisted us with training packages for participants in the program and we are excited about this as an additional resource for our clientele.

### **3.3 Staff development**

MHACA continues to provide professional development opportunities for staff to develop skills required to work effectively within this sector. MHACA provides core training for all staff including:

#### **Core Staff Training**

- International Recovery Model – Helen Glover
- Mental Health First Aid
- ASIST
- Certificate 4 in Community Mental Health
- General First Aid
- Cultural Awareness training – through ACAP

#### **Individual Staff Training**

- Tracy Westerman
- Mental Health First Aid Train the Trainer
- Sexual Assault workshop
- Domestic violence workshop
- Safe Talk Train the Trainer
- Accidental counsellor
- AimHi
- Tenancy & Sustainability training
- Managing aggression workshop
- Building conflict resolution skills workshop
- Narrative therapy
- Safe Talk
- The Methods Level
- 4WD training
- Australian Management Colloquium – leadership training

### **CONFERENCES ATTENDED/PRESENTED AT:**

#### **THEMHS Annual Conference:**

This was held in Sydney in September 2010, and was attended by the Donna Ormsby (Pathways Support Officer) as staff representative and John Moffat as participant representative. John enjoyed the experience immensely and felt that he had benefited from attending the conference. Both John and Donna wrote articles for the inBalance newsletter on their experiences at the conference.

#### **Creating Futures Conference:**

Laurencia Grant and Valda Shannon attended this conference in Cairns in September 2010 to present the Suicide Story resource – this was well received by the audience and has led to many enquiries for copies of the training package.

**NTCOSS Alcohol & Other Drugs (AOD):**

Together with a participant from MHACA on whom the presentation was based on co-morbidity, one staff member from MHACA and another from CAMHS attended and presented the story at a conference in Darwin in April 2011.

**Asia-Pacific Region conference on suicide prevention:**

Brian Kennedy and Warren Williams presented at this conference in November 2010 in Brisbane. The main reason for attendance was to present Suicide Story – the presentation was enthusiastically accepted by the attendees and we were congratulated on the development of the resource.

**Communities in Control conference:**

Laurencia attended this conference in Melbourne in May 2010 – designed to build resilience in the NFP sector and make organisations think about what they are good at, where their strengths are, leadership within sectors, the wage disparity between government and non-government sectors etc. A write-up of the conference can be found in the May to August 2011 MHACA newsletter inBalance.

## **Service Activity 4 – Participation in NT MH quality review process**

### **4.1 Review process:**

MHACA is committed to quality assurance in the delivery of services to our participant group and participated in the NT Mental Health Program NGO Quality Standards Review in October 2010. This review was a wonderful opportunity for MHACA to undertake a self-assessment against the National Mental Health Standards as well as being reviewed by the Department of Health and Families. Our thanks go to all staff, participants, committee members and carers who made themselves available for this review.

We received the final report from the Department in January, and have revised current policies as well as created new ones in response to the findings of the review.

Out of the 79 criteria in the review there were no areas identified which were unmet and 25 which were partially met (31%). Given that such a review had never previously been undertaken, both MHACA and the Department were pleased with the outcome, and MHACA has been working with an external consultant on the recommendations from the review.

# **Service Activity 5 – Implementation of revised NMH Standards**

## **5.1 Standards implementation:**

MHACA is committed to working within the National Mental Health Standards as revised in 2010. As part of this process we are revising our Policy and Procedure Manual, participant data collection, documentation, entry and exit criteria and general service delivery. This will be an ongoing process.

## **5.2 Number of complaints, issues and resolution:**

MHACA has developed an Issues and Complaints register to monitor any recurring issues and ensure that processes are in place to manage any issues as they arise. We have always had a strong complaints mechanism and again we keep track of anything which may have an underlying theme which needs to be addressed as a wider issue rather than just as an individual complaint.

For the year 1<sup>st</sup> July 2010 to 30<sup>th</sup> June 2011 we have had three reported issues of abusive behaviour from various (different) participants towards staff. One of these issues resulted in the suspension of a participant from MHACA for a 2-week period, one resulted in a written warning, one resulted in a verbal warning.

There is a defined Code of Conduct for all participants at MHACA, when issues like these arise the leadership group of the participants is asked to raise the code of conduct at the next participant forum as a general behaviour item (not directed at specific participants), and remind all attendees of the existence of the code of conduct.

There were no complaints recorded in this period.

# Service Activity 6 - Partnerships

## 6.1 Partnership Activities

Partnership activities were undertaken within each program area. The following are the activities that administration has been responsible for.

- Central Australia Mental Health Service (CAMHS) MOU/joint training
- NT General Practice Network Mental Health Interagency Group
- NT Mental Health Coalition Ongoing attendance and contribution to discussion relating to service and sector development; organisation of Mental Health Week
- Headspace Consortium member In the Headspace Project
- Reclink, Salvation Army Activities in conjunction with the Pathways and D2DL programs
- Bindi Progression of horticulture project
- Anglicare Independent Living Skills Training
- STEPS Employment opportunities for participants
- Centrelink Assistance with income issues for participants
- NT Housing Ongoing partnership for housing for participants
- Congress access to indigenous medical services for participants
- Aged & Disability services Access to information for participants and carers
- Guardianship Board Access to information and assistance for participants
- Corrections Department – Forensics Ongoing partnership around services available

# Service Activity 7 - Advocacy

## 7.1 Advocacy

MHACA has a structured advocacy role and focus on systems-based advocacy. MHACA staff continue to refer and support participants and carers with personal complaints to the Disability Advocacy Service or the Community Visitor Program.

MHACA is represented on several local, state and national organisations and has regularly relayed information both to and from these networks. MHACA has focused at a local level on extending the range of support options for participant access to treatment, care and support.

MHACA has continued to advocate for a range of therapeutic options and expansion of community-based programs. More recently MHACA has been focussing on advocating for the recommendations of the "There's No Place Like Home....There is NO PLACE" report.

### General Advocacy:

- MHACA is a member organisation in the NT Peak Mental Health body, the NT Mental Health Coalition. MHACA provides in-kind support of 10 days to represent the peak body at the Mental Health Council of Australia.
- MHACA has continued to assist participants to 'speak out' through supporting individuals' attendance at meetings, training, events and paid participation on interview panels and forums.

The Service Manager continues to represent MHACA on the Alice Springs Homelessness Coalition and the General Manager attends the Housing and Homeless Reference Group.

### Advocacy forums MHACA participated in include:

- NT Mental Health Coalition
- NT GP Network
- Mental Health Council of Central Australia
- COAG meetings
- Alice Springs Accommodation Action group
- Interagency Alcohol and Drugs Group
- Alice Springs Homelessness Coalition

### Monthly Participant Forums

Structures such as our monthly participant forum continue to be valuable in providing information/ issues on which to form the basis of MHACA's advocacy work. The forums are followed by a participant action group meeting, and any issues are fed through the D2DL program to management for action.

The participant forums had been moved from lunchtime to evening meetings however they have now moved back to a lunchtime session due to a decrease in interest in the group – we continue to monitor this and support the participants as much as possible in raising interest and attendance however it is expected that the group will fluctuate as this has been our experience related to a range of reasons.

## **Participant Engagement**

Over this period participants have been instrumental in again updating the Participant Code of Conduct, the commencement of an orientation booklet for new participants, provided input into a range of policies, provided input into the Day to Day Living in the Community activities and have continued to be represented on the MHACA Management Committee as well as other assistance with the reception area and the drop-in centre.

## **Boards and Committees**

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

- NT Mental Health Coalition
- NT Council of Social Services (NTCOSS)

## **Organisational Membership**

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

- NT Shelter
- Mental Health Carers NT
- NT Chamber of Commerce
- National Disability Services NDS
- NT Council of Social Services

# Service Activity 8 – Participant & carer participation

## 8.1 Participant involvement:

- MHACA reserves two places on the Management Committee specifically for participant representatives and supports a mentor for the participants on the Committee to assist them to expand their knowledge and understanding of the processes
- MHACA has amended its Constitution to allow for substitute Committee representatives from the participant group to ensure that there are always at least 2 participant attendees at each Committee meeting
- MHACA calls for expressions of interest from the participant group when there is a panel convened for interviews for either job vacancies or vacancies in any of the MHACA-owned residential accommodation
- MHACA supports and assists participants to attend other agencies as representatives of the participant group – such as sitting on the CAMHS Executive etc.
- MHACA offers all participants the opportunity to gain work experience through involvement with such things as manning the drop-in centre for such times as staff planning days, staff meetings, staff training days etc, and also reception work while staff are away. These opportunities are widely advertised and we support training for participants to build up their skills in these areas.
- MHACA has worked with the MH Council of Australia and assisted 2 participants to attend a peer workforce forum in Sydney as well as 2 participants and a staff member to attend a peer forum in Darwin.
- MHACA supported a participant and a staff member to attend the annual THEMHS conference in Sydney.
- MHACA continues to mentor and support the participants to facilitate their own monthly forums etc.
- MHACA has paid for an external facilitator to run a number of participant-specific workshops during the year on facilitation of meetings, setting group terms of reference, assistance with the development of a peer support model, held a participant planning workshop and has also provided the peer group assistance in regular Skype sessions with Helen Glover to further define what it is to be a peer and “where to from here”.
- MHACA supports and encourages participants to become involved with activities such as the Alice Springs Show stall, mental health week activities etc.

## 8.2 Carer involvement:

- One of the Management Committee positions is filled by the Manager of Mental Health Carers NT Alice Springs
- MHACA invites submissions from MH Carers NT Alice Springs for our regular newsletter
- MHACA works closely with MH Carers NT Alice Springs to ensure a regular flow of knowledge and information regarding community events
- MHACA will liaise with carers of MHACA participants on an individual basis where authorised to do so by the participant

## **Service Activity 9 – Landlord Function**

***To support clients to stay in the community through the Housing Support Program; No of clients who are provided with housing support; Analysis of housing issues for clients***

MHACA's Housing and Support program provides housing for people with mental illness which is appropriate, safe, affordable, has security of tenure and is linked with support to enable the tenants to live as independently as possible. Each of the tenants receives independent support from the Pathways to Recovery Program and as well as the Admin team which acts as landlord overseeing the tenancy agreements, collection of rent and property management. MHACA's current housing stock consists of 6 x 1-bedroom flats and a 2-bedroom flat.

The vacancy rate as at 30<sup>th</sup> June 201 was nil, and the turnover in the past 12 months was nil (turnover July 2009 to June 2010 was nil).

### **Housing & Support**

MHACA continues to work with various funding bodies and government departments to ensure that the recommendations from the "There's no place like home ... there is NO PLACE" report continue to be raised and we strongly advocate for people with a mental illness to be given priority in relation to public housing. The report recognised that support is as important as accommodation, and we therefore submitted a proposal which would have given us control over a block of 8 units which would have allowed us to provide supported accommodation in a secure, homelike environment for a number of our participants – unfortunately this proposal was not accepted and the units were given to a youth housing program. We also applied for PHaMs funding to extend the support we currently offer – this funding was ultimately given to Mission Australia and we are working with them as far as possible to ensure that people with a mental illness are incorporated into the services they deliver.

### **Transition Housing Program:**

MHACA was invited to apply for funding under the NT Government's Street to Home Initiative and was successful in the application with funding commencing in September 2010.

Although the Housing report (identified above) clearly showed the need for a transitional housing program, the take-up of this has been slow, and MHACA is evaluating whether the model we are using is actually meeting the needs in the community – it may be that we need to lengthen the tenancy period from the current 3 months due to the significant lack of other accommodation options available in Alice Springs.

We currently own 7 units for long-term housing – 6 x 1-bedroom and 1 x 2-bedroom which are fully tenanted (8 residents).

We currently have 2 of the 3 transition units occupied – usage from inception to 30<sup>th</sup> June for the program was a total of 12 participants through the program.

We continue to provide respite and crisis accommodation through both the Pathways and Subacute programs for people in the Alice Springs Men's Hostel and the NT Housing unit which was allocated to the subacute program in 2007 – statistics for these are included in the subacute report.

# **Service Activity 10 – Workforce Development Strategies**

## ***An analysis on the issues related to workforce development and proposed strategies within MHACA and the sector***

The MHACA Enterprise Agreement was ratified by Fair Work Australia in January 2011, enabling us to continue to offer above award wages. This Agreement runs to 30<sup>th</sup> June 2013.

From January to June 2011 we have had a staff turnover of 10% (last year 5%), with a full year turnover of 21% (last year 28%) and we continue to work hard on finding ways to attract and retain staff.

We recruited an indigenous support officer to the organisation under the Pathways program, however he has since submitted his resignation (after the end of the financial year) so we are looking at alternative ways of filling this role as it has been an ongoing challenge for us over a number of years. One of the indigenous Suicide Story trainers has remained in our employment – the other left because of clashes with other work but has remained on as a contract trainer.

# Pathways to Rehabilitation Program

## Rangiwhiua Ponga - Services Manager

### *Service Description*

*Pathways to Recovery will provide a recovery focused rehabilitation program for people affected by mental illness. The program employs generic Support Officers to assist Participants to manage their mental illness and address associated problems. Access to the program will be according to identified criteria based on assessment and ongoing reviews. Assistance may include support with accommodation, education, employment, financial management, medication, life skills, respite, and vocational training.*

## Service Activity 1: Provision of Recovery focused rehabilitation program

### **Entry criteria:**

- diagnosed or suspected mental illness and
- functional impairment associated to their illness and be
- willing to receive support

### **1.1 Number and analysis of clients seen by age, gender and ethnicity**

Please appendices for statistical information. A total of 82 participants came through the program in 2010-11, a reduction from 127 in the previous financial year. This has been a trend over the past year, not only for MHACA but for the clinical service as well. We are monitoring the situation and believe there are a number of factors including the reduction of beds available in the Mental Health Unit because of redevelopment work, the introduction of new service providers in the region – eg Mission Australia with the PHaMs program, and possibly also because people are transitioning from the need for MHACA's services – an out come which we fully support.

### **1.2 Number of people referred internally by respective programs and external agencies, reason for referrals and diagnoses.**

74 people were provided differing levels of support during the reporting period.

In some cases no diagnosis was identified and in others there were dual-diagnosis issues eg: A&OD, forensics, non- mental health related inquiries:

#### **Diagnoses:**

**Bi-polar** 1 (1.35%), **Schizo-effective disorders** 22 (29.72%), **Depression** 8 (10.8%), **Multiple-Personality** 2 (2.7%), **Other including Disability** 16 (21.62%), **Co-morbidity A&OD** 16 (21.62%), **Forensic** 9 (12.1%), **non-identified** 13 (17.56%), referred to **counselling** 6 (8.11%)

## **Referrals between programs and other service providers.**

### **Clinical team:**

3 Ward referrals, 2 CAMHS On-Call, 1 re-referred back from another region post discharge.

### **Internal:**

1 transferred from D2DLP for respite to reduce familial stressors and increased supports.

2 transferred back from Prevention & Recovery following reduction of intensive care needs

### **Self-referred or family:**

6 for counselling referrals with GP, and accommodation needs. 1 remote family required supports for daughter who had been interstate and had dual-diagnosis which impacted on her ability to function, who subsequently returned interstate. 1 Carer has enquired about supported accommodation and clinical information on behalf of a sibling.

## **1.3 Number and reasons of exits from the service**

### **16 transfers and discharges:**

2 transferred onto HHTP from team for life skills assessing and homelessness

2 transferred to P&R Program following discharge off ward i) one at their request ii) 1 continued to remain on ward.

4 people were referred to the Homelessness and Housing program by CAMHS team members (*refer HHTP section*) from Pathways, with the intent to provide long or secured term accommodation, with life skills training. (*Note: two did not meet criteria adequately and were declined, 2 self-declined their application*)

5 failed to continue contact with service

4 have alternated between D2DLP and ongoing care needs so are supported across programs

1 has remained in prison following several days of supports and police action

## **1.4 Number of people referred and not provided with service, and identified reasons for non-provision**

21 people received minimal intervention supports from:

7 general inquiries of mental health services and networks,

5 requests for accommodation (*not mental health related*),

3 referred onto GP network for Better Outcome and MH Plan access,

3 referred onto A&OD service for service supports, following liaison with clinical teams

2 referred onto Accident & Emergency to liaison with Mental Health On-Call Team

1 family member concern referred back to Headspace for interventions/counselling

## **1.5 Analysis of overall outcome measures through aggregated data from Camberwell assessment results and identified service description areas**

Please see appendices for statistical information

7 participants of the program have no plan due to inability to function at level of recovery and have remained as long term disability with no ability to sustain structured plans,

## **1.6 Numbers and analysis of information to participants, carers and allied service providers in relation to psychosocial mental health wellness, recovery and education**

This has not been captured accurately on the database and we are unable to extract this information.

# **Service Activity 2: The provision of shared care with clinical and other services using shared individual care plans**

## **2.1 Number of Multi-disciplinary meetings**

*(Cross reference Prevention & Recovery section)*

MHACA and allied providers hold a monthly shared MDT, this consists of CAMHS, Team Health Carers, STEPS employment service, Alice Springs Men's Hostel, and invited allied visitors as required. In this period MHACA has attended all 12 meetings.

## **2.2 Number of individual case conferences for shared mental health Participants**

16 individual MHACA Wellness Care plans and or reviews were completed, and another 16 reviews were attended by staff at the mental health unit for inpatient reviews. Numbers of individual conferences are not captured accurately on system

## **2.3. Number of integrated Individual Recovery Action Plans**

15 integrated plans are recorded on files, and were updated when reviewed, plus 4 people are in receipt of Guardianship Orders and Trustee funding with two of them having their shopping allocated to MHACA to assist in ensuring sufficient food, billing accounts are directed back to the Guardian.

We are in receipt of one Aged & Disability Plan,

2 GP MH Plans are recorded; however there is some inconsistency with review dates and copies provided back to MHACA as they are not with CAMHS.

2 remain under Corrections and CAMHS provide plans to ensure medication treatment and court order compliance

1 person has remained indefinite on the mental health ward for an extended period with a request for a plan from MHACA in this reporting period.

*Reviews as above:*

Discharges: 5 people were discharged who had subsequently left the region,

Evaluations: none under taken with Participants and Carers in this reporting period.

## **2.4. Numbers referred to Allied Services**

4 people were redirected back to ADSCA for ongoing treatment and counselling, with 2 confirmations from CAMHS that they did not require mental health supports.

1 Carer was supported to refer family member back to headspace and CAMHS, with another inquiry directed to headspace for youth counselling.

2 sought counselling direction and were directed to their GP for Better Outcome approvals

## 2.5. Result of MHACA/CAMHS evaluation progress and result

There has been no further evaluation of the continued relationships between MHACA and CAMHS, other than the National MH Standard's Review which was held in 2010.

MHACA and CAMHS continuously strive towards improving a seamless process of shared case management.

Relationships have been sustained through open and clear communication in case-management, mental health ward attendance and shared monthly meetings. I am able to report that there is a **high increase in recorded Individual Recovery Plans** (15) now received from CAMHS for the majority of shared client's, they were received from a number of dedicated CAMHS staff including discharges off the ward.

The culmination of progressive consultations is eventuating in the delivery of a newly revised MOU between both services with three key deliverables; Case management, Life Promotions, and Training and Promotions, which is nearing sign off.

The primary issue for MHACA is in sustaining and maintaining cohesive working relationships to improve problems and the lack of consistent referrals. This meant MHACA offering training and promotion on individual programs to all new CAMHS staff on a regular basis, which was completed twice in the preceding period.

A key factor in lack of regular referrals can be seen as; i) CAMHS continuous staff turnover, and ii) the lack of a comprehensive orientation of staff to MHACA to improve referral streamlines.

### List of MoU's developed with other allied providers

As noted above, we are revising the CAMHS MoU, however no additional ones have been done with other providers under the Pathways program. We have signed an MoU with Anglicare related to the transitional housing program and are in negotiations for a further new one with Aboriginal Hostels – again in relation to the transitional housing program.

## **Service Activity 3: Program accessibility and appropriate to different individuals from the population i.e. people from different cultural backgrounds, gender mix, and people with problems across different life domains.**

### **3.1 Number and strategies implemented to address the needs of co-morbidity people with forensic, A&OD, disability, cognitive, physical disability and complex needs.**

There has been a flow of self-referrals from clients with primary issues that are alcohol or drug related. MHACA have attempted to encourage people to address this to look at any possible mental health needs, and have i) referred them onto DASA, and ii) consulted with CAMHS on any clinical treatments being offered to prevent gaps in supports.

This is a problematic area to improve upon due to the maladaptive behaviours of many who are known to be;

- i) actively seeking prescribed medications for addictions (declined further assessment and or treatment from CAMHS),
- ii) present with high behavioural problems as opposed to mental health needs,
- iii) resistance to accept the philosophy and ethos of self-directed recovery principles when still at a pre-contemplative stage of addressing addictive patterns (unable to work towards recovery).

MHACA has consistently ensured that the premises are non-threatening to all visitors, and alcohol and drug free, this often acts as a deterrent for any potential risk to vulnerable people and others attempting to cease substance misuse.

MHACA continues to work directly with CAMHS, DASA and ADSCA in the support of people experiencing co-morbidity problems, and complex needs (*refer 2.2 Prevention & Recovery report*)

**Under-age:** 2 people required to be referred onto headspace for counselling needs and clinical assessments of complex needs. MHACA have been unable to offer support to one young person who has proved vulnerable and unable to accept clinical treatment, the psychiatrist has to determine whether to intervene and use an Involuntary Treatment Order.

3 Cognitive and Occupational assessments have been completed around addressing complex needs and supports to ensure persons with a high level disability and needing 24/7 supports are being assessed appropriately. As there is only one staff member at CAMHS to presently assess cognitive functioning and severity of disability these are time consuming, however have proved invaluable in assisting with offering a level of supports conducive to the person's capacity to manage.

### **3.2 Number accessing for health checks and ongoing health care through identified GP, ASH – CAMHS, Emergency Dept.**

2 people have GP care plans; these are not sufficiently assessed for ongoing mental wellness as the people are no longer registered with CAMHS. There is a lack of consistency in new plans furnished to MHACA and needs to be improved against.

A total of 22 people accessed MHACA for general health checks delivered under the Day D2DL program. This includes: weight, blood sugar levels, blood pressure and general education and guidance on dietary – food balances. Diabetes was detected for one person and medical treatment has progressed for them.

### **3.3 Summary of strategies to demonstrate effective cross cultural practices**

#### ***Cross reference 2.1.b Prevention & Recovery section.***

2 long term participants have been assisted to receive home visits back to their homelands to retain familial relationships and maintain cultural links. This has required diligence on their behalf so family are able to visit when in town also.

There has been a concern re family members accessing accommodation provided to a participant and possible eviction because of this – please refer Homelessness Program.

There has been evidence of an increase in Indigenous participants with needs varying from forensic inmate releases, indefinite admission and Involuntary Treatment Orders

# Prevention & Recovery Program

## Rangiwhiua Ponga - Services Manager

### *Service Description*

*Non-clinical Support Officers employed to provide Individualised Care Packages for people affected by an exacerbation of their mental health problems to prevent an admission to hospital or to return home early with additional supports. Offer interim respite facilities that are gender appropriate and reduces admission or post discharge*

## **Service Activity 1: Provision of Individual care packages to sub-acute mental health Participants.**

### **1.1 Numbers of referrals and reasons in conjunction to CAMHS**

11 referrals were accepted between Jan-June 2011 with \*two remaining on hold, and 1 having been still supported in the December 2010 period. These referrals consisted of:

- 4 from the Forensic team at Alice Springs prison (\*two remained incarcerated)
- 1 request for transfer to region from Darwin (the second time for this person in 18 months), the placement was not secured until August this year
- 4 post discharge off the ward, both for accommodation and psychosocial integration and intensive supports
- 3 people were subject to Corrections Dept. conditions post prison release

### **1.2 Number referred internally**

1 MHACA participant was transferred internally having made it part of their own personal request and recovery needs.

### **1.3 Number of people that remained supported in their own accommodation without requiring hospitalisation or re-admission**

The internal referral felt they required more intensive supports as they had been in Pathways program post discharge off the ward, and felt less confident to self- manage at home. It was an admirable achievement to see this occur and shows the confidence of this person as they spent eight weeks receiving the extra support and did not require a readmission.

All rest were as above 1.1

## **1.4 Number of a) reviews, b) extensions of active referrals, c) discharges, d) evaluations held with participants**

6 reviews held identified that people were still experiencing difficulties in acquiring secure accommodation and had extensions of their accommodation with either Alice Springs Men's Hostel, or MHACA accommodation.

1 extension was required to assist a person who was awaiting private accommodation – this added a further 10 days to their stay.

**Discharges:** All 11 people have been discharged off the program.

2 people vacated their supported accommodation after the eight week period as they choose not to meet the costs required for longer term if remaining in the same facility.

1 person moved from the sub-acute unit at the Men's Hostel into longer term and remains there indefinitely

1 person moved interstate having received accommodation supports from the sub-acute then Homelessness programs, they have subsequently returned and are having to secure their own accommodation.

**Transfers:** 5 people were transferred across to Pathways program post-discharge, 1 remained transient between Darwin and Alice Springs

**No evaluations** were completed in this period

## **1.5 Aggregated results of the outcome measurement using the HONAS or LSP supplied by CAMHS**

No comparative data was provided by CAMHS post discharge off the program for assisting in determining any improvements to self-care and recovery.

## **1.6 Aggregated results and analysis of psychosocial Camberwell Assessment's by MHACA.**

The final analysis of the program supports has determined that of 11 recipients to the program four primary factors include:

- 7 people continued to experience psychotic symptoms for various reasons including psychological stressors, continued alcohol and or substance use and dependency, non-engagement to recovery planning and treatment, physical risks to self, family and community,
- 6 remain in positions without secure tenure of accommodation due to various problems associated to social lifestyles, personal choices to remain itinerant and/or not meet costs required to live in secure environments, regrettably 1 person remains indefinitely on the ward due to complex risks
- 2 family members remain sole carers of children as parent/s are unable to meet their parental obligations and have risks associated should they have custody
- 1 was still awaiting secure accommodation through either MHACA or NT Housing to be able to return to their community of origin
- 1 remains incarcerated due to no parole,

*The primary concern would be the continuing lifestyle choices that affect secure accommodation which contributes to continued un-wellness. 7 people were unknown to MHACA prior to referral to the program and 6 have remained to receive other supports from MHACA programs*

## **1.7 Provision of psychosocial information on mental health wellness, recovery and education to clients, carers and providers**

MHACA was able to provide educational information (alongside CAMHS case managers) to two carers, their family member and partners, this encompassed;

- planning with physical health due to being overweight and development of diet control, and exercise regime, and its impact on developing motivation to support their child and situational stressors.
- recognising and managing symptoms and stressors of living in confined accommodation and ways to combat mental fatigue by actively engaging in community,
- strategies to increase knowledge of maintaining safe, hygienic and healthy living environment

## **Service Activity 2: Program accessibility and appropriate to different individuals from the population, i.e. people from different cultural backgrounds, gender mix, and people with problems across different life domains.**

### **2.1 Report strategies implemented to ensure gender staffing balance in service provision.**

MHACA lost two female staff in a six month period, and managed to re-recruit two more, this was pivotal for this program and D2DLP as they already had male staff. Although both are non-indigenous, one person came from a strong spiritual and physical background of working intensively with Indigenous people, and so is well appreciated for the previous work experience, it has been easy for them to adapt to this specialist field of practice.

Regretfully the recruitment of a male indigenous officer was short lived with the person resigning six months into their appointment. This position is sought for various reasons as it is the only secured indigenous position to quantify supports for indigenous participants of whom we have several with permanent long term illness and dual diagnosis. The Human Resource Manager has held consultations with NTCOSS to assist in development strategies around the recruitment and retention of indigenous staffing as the program is ongoing.

### **2.2 Report strategies implemented to address the needs of people with problematic dual diagnosis and forensic population**

#### **Dual diagnosis:**

MHACA was able to support a person to take out a Voluntary Prohibition Ban Order to prevent purchase of alcohol, this worked effectively until the person travelled interstate and they self-sabotaged by purchasing alcohol to bring back to the Territory. The person re-applied for the extension of their voluntary prohibition regretfully they have reverted to using cannabis as a means to self-medicate.

As a means of recognition of their self-responsibilities; this same person was part of providing a case scenario presentation on the impact of mental health and alcohol co-morbidity through the “*no wrong door*” philosophy at a Regional NTCOSS Alcohol and Other Drug Conference in Darwin from 12th-14<sup>th</sup> April, a lot of work and commitment went into producing the presentation by the representative, a MHACA Support Officer, and two CAMHS staff. This assisted both the client and staff member to gain more confidence in public speaking and presentations.

There is a noted drop off in referrals to MHACA from DASA; this may be in direct correlation to their new transitional living accommodation facilities.

We have referred 6 people onto ADSCA and DASA as their primary issue has been alcohol or drug use, and depression being symptomatic of this (or vice versa). We collaborated with the CAMHS staff around these participants as we wanted to ensure the Alcohol and Drug related clients who may have co-morbidity issues are not abandoned.

1 person continues to be directed by the Justice Dept. to i) live where directed, ii) undergo clinical treatment, iii) abstain from THC use and receive assessment from Correction for their use and risks associated to alcohol and drug misuse. This last issue has never been adhered to by the service and makes a mockery of MHACA and CAMHS attempts to assist in the rehabilitation and management of supports to this person. They have a history of self-medicating which has been detrimental to their mental health condition and associated risk factors of assault against others, and familial problems, a matter beyond MHACA's capacity to manage due to lack of insight and addictive behaviours.

Substance misuse also impacted on 2 other people who were in receipt of MHACA accommodation, one was unresponsive to counselling from ADSCA and did not adhere to abstinence, This continued to jeopardise their supports and they were eventually evicted from private accommodation following discharge off the program.

### **Forensics:**

A close alliance has been forged with the Dept. of Corrections and Forensic Team. There has been a steady flow of referrals, mainly males requiring interim accommodation and supports post release, triage of medication which needs tight monitoring and blood testing on a weekly basis between MHACA and CAMHS. Some referrals sit for extended periods when recipients have not been approved for parole, and release conditions require Corrections approval.

Procedural issues have arisen when assisting prison court releases, people are literally "*left standing at the courtroom doors*" with no procedure to ensure their safe arrival at any accommodation.

Time frames are difficult as we are dependent on the judicial system to clear cases at a reasonable time and for staff to make their presence known. Some people have left the court and prison with nothing other than the clothes they are standing in, and no medications etc.

Matters are being resolved with all people involved ensuring plans are correlated prior to court date releases, this is improving with each release and consistent staffing ensure that plans are adhered to.

It should be noted: these prison releases are offered the same intensive supports and care as anyone discharged from the ward. Many have "burnt their bridges" with a number of accommodation facilities (evictions) prior to being imprisoned and diplomacy is required when re-advocating on their behalf with allied accommodation providers.

It is a well known fact that many people upon release will go on a drinking binge for at least three days leading in some cases to re-imprisonment, and difficulty for staff to track their whereabouts, making matters difficult to monitor their transition back into the community

Noted concern has been inflexibility of some Correction referrals, when the department has an expectation clients can be directed to attend MHACA programs. It has been a problem for some staff at Corrections to accept that MHACA is a non- government organisation and all referrals have right to voluntarily decline engagement at MHACA

## Service Activity 3: Provision of respite accommodation for clients to reduce an admission or post discharge off ward.

### 3.1 Number and analysis of clients accessing respite in lieu of hospital admission and/or post discharge

Total non- subacute referrals accessing MHACA respite accommodation:

ASMH	Jan:	Feb:	Mar:	Apr:	May:	June:	Totals
No of people	1	3		1	3	4	1
Length of stay	1 Night	13 Nights		2 8 Nights	12 Nights	18 Nights	3 52
Musgrave	0	0	0	0	0	0	0

**10 (non sub-acute) referrals:** required the services of supported accommodation to reduce an admission of 48hr respite, this was however subject to misuse by the clinical teams by having people remain longer without a referral to the subacute program eg: 3 extensions of up to 5 nights each without adequate referral information and shared supports, these people continue to have ongoing problems in secure accommodation due to complex needs, and as agreed by providers require 24/7 supported accommodation.

Regretfully one person had to be evicted due to the continuing complexity of their mental health, welfare and associated risks to others

Protocols have been tightened by the hostel to avoid this problem, and improve sub-acute referrals appropriately.

Total sub-acute referrals accessing MHACA accommodation:

ASMH	Jan:	Feb:	Mar	Apr:	May:	June: 0	Total
	2	3	2	2	1		10
	32 nights	18 nights	58 Nights	31 Nights	9 Nights		148
Musgrave St.	1	1	1				3
	30 nights	25 nights	30 nights				85

#### Musgrave Street:

1 person was able to access the women's sub-acute accommodation to allow her and family private time, this assisted to reduce the stress on the grandparent's 1 bedroom unit during periods of her daughter being on the ward and post discharge and involved the grandparent caring for the persons daughter (4yr old)

- the person continued to remain on ward for sporadic periods of time due to continued psychosis, and possible risk to child

1 person continued to place family members at risk, was on low rating for priority listing with NT Housing, and required A&OD counselling. Subsequently: discharged, received private rental and were eventually evicted (*refer 2.2*)

**Men's Hostel:**

6 men accessed subacute under the hostel: 3 forensic transfers, 1 MHACA internal, 2 off the ward.

### **3.2 Number and analysis of clients unable to access respite options due to lack of respite beds**

This has not been a problem, during renovations at the Men's Hostel, MHACA only had 1 bed available for a period of time, this however did not affect the level of referrals, or accessing alternate accommodation at the hostel.

It is noted that there continues to be under-usage of these facilities.

## **Service Activity 4: The provision of shared care with clinical and other services using shared individual care plans**

### **4.1 Number and analysis of multi-disciplinary meetings, case conferences and actions for shared mental health participants**

MHACA and allied providers hold a monthly shared MDT, this consists of CAMHS, Team Health Carers, STEPS employment service, Alice Springs Men's Hostel, allied visitors as required.

Individual case conferences were unable to be accurately recorded off the database system.

### **4.2 Number of integrated Recovery Action Plans with a) reviews, b) discharges, c) evaluations, undertaken with participants and carers in service provision**

All referrals were subject to CAMHS ICP's.

**9 plans were developed** and implemented with 2 of these being in conjunction with the mental health ward, pre and post discharge. 1 person remained in jail so no plan was completed and awaits parole board hearing, 1 plan not completed pending return to region from Darwin, 1 person made efforts to return to employment but left after a while and moved interstate for a period.

Providers included in these plans included consults with;

*CAMHS clinical teams, Corrections, Forensics, 2 Carer, 1 partner, Salvation Army Hostel and Transitional housing reps, Team Health Carers, 2 Interstate Real Estate agents, client employment provider, Darwin clinical team, Grog Mob, Sexual abuse Counselling, Alcohol & Drug Services, DASA - Arunda House*

- all 11 referrals have been subsequently discharged
- one evaluation with a carer identified that her and her daughters needs continue to be problematic, and was appreciative of the extra time in respite to reduce accommodation stressors for all three people involved.

# Life Promotion Program

## Laurencia Grant

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

### **Service Activity 1: Create and strengthen links between key Government departments, non-government agencies, health services, and community groups to support a whole of community approach to suicide prevention**

#### **1.1 Life Promotion Program Steering Committee – Alice Springs**

Currently 30 Organisation and Government Department representatives:

- Tangentyere Council Social Services
- Salvation Army
- Catholic Care
- Community Corrections, Department of Justice
- Headspace
- Waltja
- ASYASS (Alice Springs Youth Accommodation Service)
- Social and Emotional Well-Being Program and Men's Health of CAAC
- Student Support Services of NT Schools – Department of Education and Training
- NPY Women's Council
- General Practise Network NT
- Lifeline
- Alice Springs Police
- NT Government Department of Health and Families
- Central Australian Mental Health Services
- Suicide Prevention Coordinator, Mental Health Policy
- Alcohol and Drug Services of Central Australia

- Remote Health
- Family and Children's Services
- DASA – Drug and Alcohol Services Association
- Mt Theo Program, Yuendumu
- FAHCSIA
- Cross Border Program
- Centrelink
- Nganampa Health
- Relationships Australia
- MacDonnell Shire Council
- MOSS Plus service – child trauma
- Bush Support Service, CRANA
- Private psychologist

#### **Meetings held and numbers attending**

The Steering Committee meets on a three monthly basis to offer strategic direction to the program and to support program development. There have been 4 meetings from July 2010 to June 2011 – 10th August 2010 (13 external agencies), 9th November 2010 (7 external agencies), 10th February 2011 (9 external agencies) and 11 May 2011 (9 external agencies). All representatives receive minutes from meetings and other relevant information related to suicide prevention across the Territory and Australia.

Issues raised and information provided at the February 2011 and May 2011 meetings.

MHPN webinar on Adolescent Mental Health: Depression, Suicidality and Cyber-bullying

ABS data on Suicide Rates based on 2009 indicated that 38 people died by suicide in the NT

Discussion re higher incidence of youth suicide in the NT and the possibility that the generation of young people who have had an experience of suicide can experience risk.

Centre for Remote Health provided an evaluation report on Suicide Story Training

LPP received copy of CARPA manual re section on suicide response

Valda Shannon developed codes of conduct for workers to better understand what occurs in sorry camp after a death by suicide.

Paul Hills – Mental Health Practitioner (Nganampa Health Council) was a guest speaker on “Suicidal behaviour in Aboriginal communities”. Paul talked about Narrative Therapy strategies that could help diffuse the anger that often leads to Suicidal ideation.

Michelle Williamson (Shelby) of the Centre for Health Policy, Programs and Economics at The University of Melbourne attended the May meeting re Community Planning for the prevention and containment of Suicide Clusters. She later met separately to consult further on these guidelines.

Sarah reported that the NT Budget had put an extra \$2.4 million dollars into the Suicide Prevention area.

The Menzies School of Health Research has been asked to do research into deaths by suicide in the under 18 age bracket.

Lifeline relinquished its management of Living Works in Australia at the end of June 2011. Bryan Tanney, one of the founders of Living Works Education in Canada, will run things in Australia from Perth and will be assisted by Bruce Turley the former Lifeline Manager and developer of Living Works in Australia.

MHACA and OzHelp formally entered into a partnership agreement to work on the development of the Train the trainer component of Suicide Story and the intellectual property of the materials linked to the training.

Suicide Story Training delivered in Numbulwar, Mutitjulu and Alekerange between Feb and May 2011

LIFE news distributed on a regular basis

Suicide Prevention Australia position papers distributed on a regular basis

We present this information in a way that invites feedback from the committee so they can offer insights about how things might work better in the local context.

## **1.2 Barkly Life Promotion Reference Group**

Current organisations represented:

- Julalikari
- Catholic Care NT
- Anyinginyi Stronger Families
- Tennant Creek Police
- NT Schools
- Tennant Creek Women's Shelter
- Red Cross
- Frontier Services
- St John's Ambulance Service
- Council of Elders and Respected Persons
- NT Government Department of Health and Families
- Barkly Mental Health Services
- Suicide Prevention Coordinator, Mental Health Policy

- Family and Children's Services
- Braadag – Barkly Region Drug and Alcohol Service
- RFDS
- Sexual Assault Referral Centre
- Legal Aid
- STEPS employment
- Barkly Shire Council
- FAHSCIA

Meetings were held in August and September 2010 and February and April 2011 with 5 external agencies attending the February meeting and seven in April.

**Issues raised and discussed:**

These meetings were about re-establishing the committee and reminding representatives of the purpose of the committee and the response to suicide function

Suicide Story Training update

Reminder of the Action Plan for Suicide Prevention in the NT

Code of Conduct – Re death by Suicide in Aboriginal Communities

Training for Reference Group Members in ASIST, Safe Talk, MH First Aid

Update on the PHaMs program in Tennant Creek

## **Service Activity 2: Coordinate the Alice Springs and Tennant Creek Interagency Suicide Response**

### **Response meetings held after suicide**

There were five reported suicides in Central Australia from July to December 2010 and a further two between 1 Jan 2011 and 30 June 2011. A Suicide Response Meeting was held on the 23rd Feb relating to a death of a young woman in Willowra. Life Promotion was able to accommodate the telephone link up of the Clinic Manager and Audrey Kitson from Willowra and Larissa and Pat Braun from Tennant Creek. The meeting was very useful identifying the full details of this incident, the commitments of agency workers and the possibilities for preventative measures for young people.

Life Promotion facilitated a suicide response meeting on 29th June related to a death of a young man in Mutitjulu. This meeting generated a lot of interest from the community and the clinic Doctor and a local indigenous woman phoned in. Laurencia recorded this meeting in a document that was circulated to relevant people. It outlined the interest of workers in long term initiatives.

A Suicide Response Meeting was held in Tennant Creek in response to a death that occurred in Mt Isa of a man from the Barkly region

## **Service Activity 3: Provision of relevant training in Suicide Intervention Skills**

### **Education and training workshops**

Brian and Laurencia travelled to Tennant Creek to deliver ASIST on the 1st and 2nd Feb 2011 and to chair and present at the Barkly Reference Group Meeting. Only a small group of participants enrolled in ASIST including Warren H Williams. It clashed with an important Alcohol Management Plan meeting. The training was very valuable however, especially for the Tennant Creek Hospital Social Worker.

Brian delivered Safe Talk on the 28th Feb to staff from Corrections and Anyinginyi in Tennant Creek.

Valda attended Aboriginal Mental Health First Aid Training in Alice Springs on the 22nd and 23rd March 2011. She found it very helpful in her role with MHACA and on a personal level.

Brian Kennedy and Amanda Worrell delivered Mental Health First Aid training on 19th and 20th April a group of trainees from CASA, Salvation Army, Team Health, WAHAC, MacDonnell Shire and Frontier Services.

Laurencia delivered Safe Talk (half day suicide awareness training) to staff of OLSH (Our Lady Sacred Heart School) in collaboration with Lifeline. Approximately 90 staff participated thanks to the efforts of Karen Revel and Heather Bunting (OLSH school counsellor).

Larissa and Valda attended Lifeline's Accidental Counsellor Workshop held in Tennant Creek and assisted in arrangements for this and the ASIST Tune-up with Karen Revel.

Larissa participated in Safe Talk train the trainer in Darwin in June 2011. This was facilitated by Simone Dayer over two days. This involved preparation of a section of the training, a thorough explanation of the steps involved in SafeTALK and the importance of specific wording and structure. On the second day all participants delivered their sections of the training and concluded with smiles and relief all around.

Larissa and Brian co-presented Safe Talk training in Alice Springs on the 30th June 2011.

## **Service Activity 4: Raise awareness of suicide related issues through WSPD (World Suicide Prevention Day), media, local activities and information sessions.**

### **Media**

InBalance News and MHACA website - Regular updates on the Life Promotion Program are provided in the MHACA newsletter on a quarterly basis. The Life Promotion Team also regularly provides photos and feature articles on special events. These are posted on the website also as are all of our resource.

### **Events**

Larissa's role in Tennant Creek involves mental health promotion. Opportunities in this reporting period included a New Year's Eve bbq, youth week in April 2011 and Women's sexual awareness month. Valda attended the opening of the BRADAAG Outreach Program Offices and gave a talk to staff on suicide prevention and the Life Promotion Program.

# **Service Activity 5: Provision of Suicide Story Training for Remote and Urban based Indigenous People and the development of strategies to address suicide threats.**

## **Suicide Story Training**

### **Numbulwar Suicide Story Training – 14th to 18<sup>th</sup> Feb 2011**

Brian, Laurencia, Valda and Christine Palmer travelled to Darwin, to Groote Eylandt and then on a chartered flight to Numbulwar. Unfortunately Warren was unable to attend and Christine was able to fill in at the last minute. Approximately 20 people received certificates although it was challenging to keep all the trainees in the training space for the full time. This was due to other services visiting the community, meetings at the school that staff needed to attend, funerals and possibly the heat on the first day. The training was well received, some claiming that this was the best training they had ever had in the community. This community experienced a death of a 14 year old girl last year. They were grateful for the training not only in having better skills and better awareness, but to address their own healing and sadness.

### **Yulara Suicide Story Training - 4th to 6<sup>th</sup> May 2011**

Brian, Laurencia, Valda, Christine Palmer and Warren H Williams delivered Suicide Story Training at Nyangatjatjara College, Yulara in the first week of May. Brian and Laurencia also did a pre-visit in April 2011 to generate interest, put up promotional flyers 13 participants arrived on the first day of training, 17 on the second day and 13 on the last day. Among these participants were Keith Todd and Brenton Tainsh (of OzHelp in ACT) and three Aboriginal Mental Health workers from NT Government, Social Worker from GPNNT, Medical Practitioner from Mutitjulu Clinic, Youth Workers from NPY Women's Council, four respected elders from Mutitjulu, a young couple from Imanpa and Kathy Tozer, an interpreter of Pitjantjatjara.

Some of us resided in the dorm rooms of the college. Claire was hired as a cook and Larissa was a much appreciated second hand in the kitchen. This was the first time we had full interpreting of the program. It was a rich experience for all of us to hear from the women through their own language and to witness the difficulties of translating these concepts into an indigenous language. There is a dilemma that stands out in this training. Elders know that there was a way of life that worked well and their longevity and strength and resilience (despite hardship) is evidence of this. They are not considered a risk group for suicide (chronic disease maybe, but not suicide). They want young people to know this life and see this as the solution to suicidal thinking. But young people have lived a very different life already. The solution is not so straight forward; the life that was led by their elders is not as accessible and not as appealing.

### **Alekerange Suicide Story Training –17th to 19<sup>th</sup> May 2011**

In Alekerange 20 participants attended over the course of the week. Mostly from the Barkly Shire Council Night Patrol Team with a rep from Anyinginyi Health and FAHCSIA, Indigenous Coordination Council. All our Indigenous trainers had a strong connection to this country. Valda and Warren went to school here before heading off to Secondary school and Christine Palmer had many relatives here. Phillip Pedersen helped out as a Traditional owner for this country and Eddie Taylor encouraged his team to attend. Larissa was our cook extraordinaire for the week along with Michael, the second chef.

- Valda finalised the Cultural Codes of Conduct for the purpose of assisting others to respond appropriately to suicide bereavement in Indigenous families and at sorry camp.

### **OzHelp**

MHACA and OzHelp have formally entered into a partnership agreement to work on the development of the Train the trainer component of Suicide Story and the intellectual property of the materials linked to the training. They will also be assisting to take Suicide Story to a National audience.

### **Suicide Threats**

Paul Hills – Mental Health Practitioner (Nganampa Health Council) was a guest speaker on “Suicidal behaviour in Aboriginal communities”. Paul talked about Narrative Therapy strategies that could help diffuse the anger that often leads to Suicidal ideation. This has led to further discussion about developing Paul’s ideas for use in communities to work with suicide threat behaviour.

Laurencia worked together with Michelle Williamson during the consultation on the Document on Containing and Preventing Suicide Clusters. These consultations have provided information related to suicide threats and the final document will prove useful in dealing with this behaviour after a suicide in a community.

## **Service Activity 6: Collection of data on completed suicides**

Life Promotion collects information on completed suicides provided by the police at the time of the incident. This information is developed into annual excel spread sheets and is provided to NT Government and other relevant organisations on request. From January to June 2011, there were two reported deaths in Central Australia.

# Training & Promotions Program

Kylie Humrick – Mental Health Training & Promotions Officer

*To provide training opportunities and help raise community awareness  
about mental health issues*

## Service Activity 1: Organise activities for key relevant mental health promotional events

### 1.1 Number of activities and locations

#### Alice Springs

- Australian of the Year/Mental Health Week Dinner – October
- Mental Health Week Helen Glover Forum – October
- Mental Health Week Deaf Healthy Minds Forum – October
- Mental Health Week Expo & BBQ – October
- Interagency Meeting – March

#### Tennant Creek

- New Year's Eve Community BBQ - December
- Youth Week Opening Ceremony - April
- Youth Week Disco – April
- Youth Week Closing Ceremony – April
- Women's Groups Alekareng

### 1.2 Number of people attending

#### Alice Springs

The Australian of the Year Dinner attracted 200 people which was capacity for the location at the Crowne Plaza. The dinner attracted a wide variety of attendees from across the Alice Springs community (Mental Health workers, carers and teachers).

The Helen Glover Forum attracted approximately 30 people from organisations across the community sector.

The Deaf Health Minds forum attracted approximately 20 people from organisations across the community sector.

Approximately 100 people attended the Mental Health Week expo & BBQ which was supported by CAMHS, Catholic Care & Lifeline

Approximately 40 people from a range of community sector agencies attended the interagency meeting hosted by MHACA in March 2011. These meetings are organised by NTCOSS and hosted by a different community organisation each time.

## Tennant Creek

The New Year's Eve community bbq organised by Larissa attracted approximately 80 people. The Youth Week opening ceremony, Youth Week Disco and Youth Week closing ceremony were attended by approximately 60-80 young people. The women's groups run at Alekarenge community had approximately 15 attendees per session.

### **1.3 Issues Identified and actioned**

Data not captured

### **1.4 Partnerships Developed**

MHACA continues to work closely with CAMHS, NT Mental Health Carers, and NTCOSS on organising and promoting events. A new connection was made with the Australia Day Council NT. MHACA has also developed partnerships with the Centre for Remote Health for the purpose of providing speakers on mental health topics to the community.

In Tennant Creek MHACA has worked closely with Barkly Mental Health, Lifeline, SARC Women's Shelter and the Red Cross. Larissa has also worked hard to establish new relationships with the Youth Providers Network, Anyinginyi Congress Aboriginal Medical Service, the council of Elders and Respected Persons and Alekarenge Community.

# **Service Area 2 – Provision of Mental Health First Aid Training, coordination of the network of trainers and support for other relevant Mental Health and MHACA Training**

## **2.1 Development of a Mental Health First Aid calendar.**

The Mental Health First Aid training calendar for 2011 was developed at the end of 2010 in consultation with the available trainers. A meeting of Mental Health First Aid trainers was held in January of 2011 to advise trainers of the schedule and for trainers to volunteer which sessions they would be available for.

## **2.2 Number of training sessions held annually**

From July 2010 to June 2011 there were 14 Mental Health First Aid courses held. Ten were regular scheduled monthly courses (February to November each calendar year). Four were additional courses provided to organisations upon request.

## **2.3 Number of individuals trained and organisations represented**

- 20-21 July 2010 – 13 people
- 3-4 August 2010 – (Replacement for June 2010 course) 3 people
- 17-18 August 2010 – 7 people
- 21-22 September 2010 – 12 people
- 19-20 October 2010 – 16 people
- 28-29 October 2010 – 5 people (MHACA participant course)
- 16-17 November 2010 – 10 people
- 8-9 December 2010 – 9 people (Life Without Barriers)
- 15-16 December 2010 – 10 people
- 15 – 16 February 2011 – 3 people
- 15 – 16 March 2011 – 11 people
- 19 – 20 April 2011 – 9 people
- 17 – 18 May 2011 – 8 people
- 16 – 17 June 2011 – 17 people

A total of 133 people received Mental Health First Aid training from July 2010 to June 2011. Some organisations represented are listed below.

- |                                   |                              |                               |
|-----------------------------------|------------------------------|-------------------------------|
| • Frontier Services               | • NT Police                  | • CASA                        |
| • AS Women's Shelter              | • Witness Assistance Service | • Ngurratjuta Accounting Svcs |
| • Salvation Army                  | • Macdonnell Shire           | • Jobfind                     |
| • JASP Security                   | • Mt Theo Program            | • STEPS Employment            |
| • Department of Health & Families | • ASYAS                      | • Centralian Senior College   |

- Tangentyere
- Bindi Inc
- Team Health

## **2.4 Partnerships established through co-training**

In this period MHACA co-trained with workers from CAMHS and CAYLUS.

## **2.5 Participant evaluations results analysis**

Response from participants of the MHFA courses is positive. Participants consistently rate the material as easy to understand, well presented and relevant to them. Overall responses to the course include:

- “Helpful. Am now more aware of how to approach dealing with someone with mental illness”
- “It gave me insight into areas of mental health previously unknown to me”
- “Happy that I have taken part in the course and feel more confident now if a case arises”
- “I would strongly recommend for anyone who has experienced depression, anxiety, etc.”
- “Interesting & educational”
- “Interesting and held a lot of needed information”

The course continues to fill up approximately 4 weeks in advance, and is generally recommended by employers and community organisations. Participant feedback is collected and reported to Orygen Youth Health which auspices the Mental Health First Aid training.

## **Service Area 3 – Development of consistent corporate identity, promotional tools and sourcing of mental health resources.**

### **3.1 The publication of three inBalance newsletters per year**

An ongoing major promotional strategy continues to be the MHACA newsletter, *inBalance*, now produced every four months. From July 2010 to June 2011 three editions were produced – *Edition 22: May – August 2010, Edition 23: September – December 2010 and Edition 24: January to April*. 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; participant and carer stories, self-help information, resources and conference articles. MHACA continues to receive positive feedback about *inBalance*

### **3.2 Number of MHACA information sessions delivered**

MHACA hosted and Alice Springs Inter-agency meeting on March 2, 2011. NTCOSS Alice Springs organise the meetings which are an excellent way for services to connect and learn from each other. The MHACA presentation was well received.

### **3.3 MHACA merchandise and publicity tools**

A complete update of MHACA promotional merchandise was completed in 2011. MHACA program brochures were also updated.

### **3.4 Number of Articles in local publications**

MHACA continues to be featured in local publications including the Centralian Advocate. MHACA has contributed both advertising and articles for events including Schizophrenia Week. MHACA Tennant Creek office provided two “Mind Yarn” articles for the Tennant Creek Times.

### **3.5 Up-to-date resources and website information available at all events and activities**

The MHACA website has continued to be regularly updated. It is a user-friendly resource and provides a broad range of information on both MHACA services and activities and mental illness in general.

### **3.6 Provision of resources relevant to Indigenous populations**

MHACA continues to produce and source relevant materials for Indigenous populations. Training and Promotions support is also provided to the life promotions program for the Suicide Story resource.

### **3.7 Number of local Mental Health Resources Developed**

MHACA continues to produce resources relating to mental health, including flyers and brochures for use at promotional events. Two of the most frequently used resources are the Alice Springs Service Directory and Acronyms Around Town. A Tennant Creek Acronyms Around Town and a Tennant Creek Service Directory were also developed in the last 12 months.

# Homelessness and Transitional Housing

## Rangiwhiua Ponga - Services Manager

### *Service Description*

*Work alongside participants experiencing mental illness to focus on developing housing and living skills to assist them in accessing and maintaining their housing and broader psychosocial needs. The program may offer short-term housing where training in situ will be provided with a focus on tenancy management*

## **Service Activity 1: Provision of accommodation.**

### **1.1. Number of clients exiting health or correctional institutes**

2 were direct referrals following admissions off the ward, with one post discharged from Subacute.

1 Prison referral had a brief respite in the Men's Hostel and re-offended which led to immediate reimprisonment.

*Note:* 1 referral was unaccepted to the program as the person was being detained in the mental health ward indefinitely, and would return to homelessness on discharge if accepted, or have to be returned to the ward.

### **1.2. Number of clients for crisis accommodation**

1 person received two weeks respite to reduce familial stressors for themselves and extended carers, subsequently returning home. The option of a carer also having time was not accepted.

### **1.3. Number for transitional housing**

3 people received transitional life skills supports, with 3 having been housed in the HHTP units.

1 had waited for a long period on priority housing with Territory Housing listing, with 1 extension required to avoid homelessness and was subsequently allocated a secured unit.

The latter person is still awaiting housing and has been discharged to Mission Australia for longer term transitional housing options.

### **1.4. Number of signed tenancy agreements**

2 people signed tenancies agreements.

## **Service Activity 2: Support Worker Roles**

### **2.1 Total number of individual clients in reporting period**

There were 14 referrals to the program for the year:

- 3 provided Transitional Life Skills housing,
- 1 provided two weeks respite for family/Carer
- 1 with continued supports from previous period in Dec 2010 with outreach services
- 2 self-declined following referral (1 remained living with family at own volition, 1 objected to meeting personal costs for food etc)
- 2 declined as unable to meet level of self-care due to degree of disability, and under Trustee and Guardianship, one eventually accepted transitional housing following eviction from the men's hostel.
- 1 remains indefinitely on the mental health ward
- 1 transferred to Prevention & Recovery due to repeat admissions to MH unit, did not meet criteria
- 2 were unprocessed due to being detained back in prison

### **2.2 Monthly caseload numbers** *(refer appendices)*

### **2.3 Number of indigenous/non-indigenous** *(refer appendices)*

### **2.4 Demographics – gender** *(refer appendices)*

### **2.5 Provision of training:**

4 people received transitional life skills with one being unresponsive to the need to improve their skills, rejected financial and hygiene guidance and was subsequently evicted from their tenancy. 2 received Certificates of Achievement at having been able to demonstrate varying levels of skills based on the Anglicare and NT Territory Tenancy Sustainability criteria.

1 person relinquished their right to remain in the transitional life skills program as they felt alienated from family after successfully spending four weeks on the program.

### **2.6 Number of rough sleepers/primary homelessness:**

Of the 14 referrals received, 10 people remained in differing states of homelessness, and these varied from remaining in:

Continued Institutional care, Men's Hostel, Prison, living transitory between their family groups in Community or Territory Housing, one eventuated in a return to complete homelessness following eviction and they left the region, one remains with family member as their carer for self and child

The majority of these people remain supported at different levels from MHACA and CAMHS

## **2.7 Numbers receiving Outreach support**

As per above 2.1, one person rejected outreach supports and was evicted from a real estate tenancy.

One person has subsequently received a month's further outreach following transition to permanent housing with Territory Housing.

## **Service Activity 3: Provision of shared care with clinical and other services using shared individual care plans.**

### **3.1 Number of referral/s, diagnosis, reason for internal and external referrals**

6 dual diagnosis of A&OD co-morbidity, 2 mental health and associated prison charges, 6 severe and persistent schizophrenia related diagnosis, A&OD related behavioural associated risks.

All were related to risk of homelessness due to inability to maintain management of private housing either shared or independently with evictions due to poor mental health management.

### **3.2 Number and reasons of exits from the service**

Refer 2.1. With the addition of two successfully completing the program

### **3.3 Number referred and not provided with service, identified reasons for non-provision**

Refer 2.1, reasons varied from i) cognitive inability - confirmed with Occupational assessments, ii) behavioural risks and potential if in unsupported accommodation, iii) un-readiness for rehabilitation, iv) incarceration, v) unwillingness to engage.

### **3.3 Number of MDT meetings**

Refer 4.1 Prevention & Recovery: MHACA shared 6 MDT meetings with CAMHS

### **3.4 Number of case conferences**

16 individual case conferences were recorded by the program in meeting the objectives of its referrals.

### **3.5 Number of integrated Wellness Recovery Plans – reviews / discharges**

Not applicable, the four people in receipt of supports were in with CAMHS Recovery Plans. All four have been subsequently discharged and referred back onto Pathways, with one having since left the region.

### **3.6 Numbers referred to allied services**

Refer 1.3: Mission Australia.

## **Service activity 4: Ongoing quality improvement of the program**

### **Quality Improvement:**

#### **Key factors and addition to program improvement:**

Due to the complex nature of “cultural norms” for indigenous participants and their families, the challenge for service providers is in managing “squatting and excessive use of the person’s finances and material resources”, and wilful damage to properties MHACA leases from Territory Housing.

This was resolved through consultation with CAMHS and Territory Housing who were in agreement that MHACA should issue Trespass Orders against squatters in these properties. This has since assured safety and reduced damages to MHACA units. One person involved was amicable for this to occur. Coupled with this has been the approval of Guardianship to safeguard their finances, which again has meant a deterrent against exploitation.

### **4.1 Number and analysis of self-assessment exit surveys completed**

One case study example:

*“One client came into the program with low-level skills, was on listing for NT Housing for considerable period of time. Moved into MHACA unit, worked intensively with the support officer, received achievement certificate, priority housing application finalised and has now shifted into this unit. Has learnt skills around tenancy management in regard to family, humbugging etc and is now communicating more effectively with service providers. Has transitioned into MHACA Pathways to Recovery program”*

### **4.2 Analysis of overall outcome measures through aggregated data from Camberwell assessment:**

Refer to statistical data in appendices.

#### **Key factors:**

9 people continue to require more secure accommodation and live transitory lifestyle due to their vulnerability. 7 remaining unable to retain self-care, hygiene and eventually will require a degree of supported or permanent supported accommodation. 12 continue to experience severe levels of symptoms and are in CAMHS continued service for treatment. 7 experience problems in financial mismanagement with exploitation from others and 2 are under financial Guardianship to protect this.

**Role Functioning Scale:** Not applicable; participants not ready to return to work.

## APPENDIX 1 – FINANCIAL REPORTS:

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC  
MANAGEMENT & ADMINISTRATION STATEMENT  
[FOR THE YEAR ENDED 30 JUNE 2011](#)

	2011	2010
	\$	\$
<b>INCOME</b>		
Grant - Dept Health & Community Services	104,353	101,363
Surplus carried forward		12,688
Surplus transferred		50,491
Interest	37,529	21,883
Membership fees	855	680
Fundraising income	15,030	500
Administration fees	324,025	238,037
Hire of vehicle	57,333	52,000
Profit on Sale of Asset	8,979	2,902
Recovered costs	13,203	6,262
	<b>561,307</b>	<b>486,807</b>
<b>EXPENDITURE</b>		
Accounting and audit fees	4,300	4,231
Advertising expenses	1,342	1,996
Bank charges	432	492
Bookkeeping	665	1,503
Computer support	2,909	5,444
Cleaning	11,684	16,082
Conferences	932	
Consultancy	1,950	11,300
Consumables	805	3,157
Depreciation	53,467	50,867
Electricity	955	1,505
Equipment purchase - minor	4,208	2,124
Insurance	15,745	14,103
Legal fees	1,655	
Library	365	689
Loss on disposal of asset		1,485
Motor vehicle expense	4,522	3,002
Newsletter	2,070	2,427
Postage expenses	425	760
Program costs	13,136	10,991
Professional development expenses	8,046	13,582
Promotions	1,567	351
Rates	898	1,259
Recruitment costs	3,068	
Rent expense	38,257	40,780
Repairs and maintenance - gardening	974	2,857

Repairs and maintenance – Buildings & equipment	2,551	2,623
Security expenses	535	942
Staff wellbeing	970	1,590
Stationery expenses	4,900	11,426
Storage costs		909
Subscriptions	4,370	5,290
Superannuation	18,473	17,957
Telephone expenses	4,845	5,094
Travel expense	7,403	10,132
Workers compensation	3,215	2,248
Wages and salaries	225,588	220,273
	<b>447,227</b>	<b>469,473</b>
Surplus	114,080	17,334
ACQUITTAL ADJUSTMENTS		
Capital - Motor vehicles	45,259	16,273
Capital - Office equipment	5,184	2,545
OPERATING SURPLUS/ (DEFICIT)	63,637	(1,483)

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC

PATHWAYS OPERATING STATEMENT  
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	\$	\$
<b>INCOME</b>		
Grant - Dept Health & Community Services	290,388	258,197
Transfer to Training & Promotion	(12,250)	
Other Income	475	-
	<b>278,613</b>	<b>258,197</b>
<b>EXPENDITURE</b>		
Administration expenses	52,355	50,770
Advertising		563
Cleaning	2,925	655
Computer support	1,605	109
Conferences	586	
Consultancy expenses	11,237	
Consumables	99	101
Counselling	530	1,606
Depreciation	730	897
Electricity	1,071	1,080
Equipment purchase - minor	1,915	454
Library		94
Motor vehicle expenses	10,616	5,854
MV lease expense	16,000	16,000
Newsletter	2,070	2,427
Postage & freight	385	223
Program costs	4,131	2,244
Professional development	1,389	2,379
Promotions	1,567	
Recruitment costs	886	1,180
Rent expense	12,000	11,000
Repairs and maintenance	1,149	294
Stationery	3,140	1,113
Staff wellbeing	504	578
Superannuation	9,768	12,902
Telephone expenses	2,561	3,084
Travel expenses	3,053	1,949
Wages and salaries	120,016	138,822
Workers compensation	1,928	1,823
	<b>264,216</b>	<b>258,197</b>
Surplus	14,397	-

ACQUITTAL ADJUSTMENTS

Capital - Office equipment

3,452

-

OVERALL SURPLUS/ (DEFICIT)

10,945

-

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC

LIFE PROMOTIONS OPERATING STATEMENT

FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	\$	\$
<b>INCOME</b>		
Grant - Dept Health & Community Services	277,901	355,718
Surplus c/fwd - LPP Tennant Creek		27,507
Transfer to Tennant Creek	(43,248)	
Recovered costs		1,359
	<b>234,653</b>	<b>384,584</b>
<b>EXPENDITURE</b>		
Administration fees	50,022	64,085
Advertising	432	1,468
Computer support	1,059	109
Conferences	1,721	2,705
Consultancy		6,000
Consumables	691	726
Depreciation	1,208	1,316
Electricity	1,071	1,798
Employee housing costs		5,575
Equipment purchase -minor	649	3,403
Insurance		271
Library	55	298
Motor vehicle expenses	7,286	14,477
MV lease expense	10,000	20,000
Newsletter	2,070	2,427
Postage and freight	427	233
Program costs	1,519	4,441
Professional development and training	4,466	7,045
Promotions	1,567	1,355
Rent expense	12,000	16,280
Repairs and maintenance	168	139
Staff wellbeing	1,154	1,602
Stationery	4,079	3,995
Subscriptions	50	125
Superannuation	8,755	15,916
Telephone	2,647	6,793
Travel expenses	5,753	13,087
Workers compensation	1,499	2,270
Wages and salaries	99,010	184,243
	<b>219,358</b>	<b>382,179</b>
Surplus	15,295	2,405

ACQUITTAL ADJUSTMENTS

Capital - Office equipment	<u>2,180</u>	<u>          </u>
OPERATING SURPLUS/ (DEFICIT)	<u>13,115</u>	<u>2,405</u>

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC  
SUB-ACUTE OPERATING STATEMENT  
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	\$	\$
<b>INCOME</b>		
Grant - Dept Health & Community Services	337,083	327,424
Other income	2,715	700
	<b>339,798</b>	<b>328,124</b>
<b>EXPENDITURE</b>		
Administration	61,164	59,062
Advertising expenses		563
Bank charges		10
Cleaning	627	1,020
Computer support	1,434	55
Consultants	18,972	-
Consumables	72	182
Depreciation	659	316
Electricity	1,743	1,787
Equipment purchase - minor	1,625	103
Insurance	380	155
Motor vehicle expense	5,343	3,665
MV lease expense	8,000	8,000
Newsletter	2,070	2,427
Postage and freight	385	167
Professional development and training	958	1,640
Program costs	2,161	1,359
Promotions	1,567	-
Recruitment costs	920	4,512
Rent expense	36,398	33,877
Repairs and maintenance	2,602	1,039
Staff wellbeing	1,355	853
Stationery expenses	2,006	1,125
Superannuation	14,347	10,484
Telephone expenses	2,597	2,680
Travel expense	2,673	707
Workers compensation	1,627	1,823
Wages and salaries	160,468	126,296
	<b>332,153</b>	<b>263,906</b>
Surplus	7,645	64,218
<b>ACQUITTAL ADJUSTMENTS</b>		
Capital - Office furniture	4,120	
Surplus transferred		50,491
<b>OPERATING SURPLUS/ (DEFICIT)</b>	<b>3,525</b>	<b>13,727</b>

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC  
MENTAL HEALTH TRAINING AND PROMOTION OPERATING STATEMENT  
FOR THE YEAR ENDED 30 JUNE 2011

	2011	2010
	\$	\$
<b>INCOME</b>		
Grant - Dept Health & Community Services	169,939	103,860
Surplus c/fwd Tennant Creek	16,132	
Transfer from Life Promotions	43,248	
Transfer from Pathways	12,250	
Grants – Mental Health Week	2,000	
Training income	14,872	12,499
Other income	12,109	-
	<u>270,550</u>	<u>116,359</u>
<b>EXPENDITURE</b>		
Administration	38,709	16,526
Advertising expenses	2,858	864
Computer support	1,168	343
Consultancy		8,380
Consumables	1,029	385
Depreciation	1,286	503
Electricity & gas	864	
Employee housing costs	704	
Equipment purchase - minor	4,122	689
Legal fees	2,237	
Motor vehicle costs	8,416	
Motor vehicle lease	10,000	
Newsletter	1,035	
Postage and freight	231	14
Professional development and training	7,490	3,184
Program costs	21,913	6,183
Promotions	2,344	5,851
Recruitment costs	3,298	977
Relocation costs		1,164
Rent expense	5,760	
Repairs and maintenance	46	
Staff wellbeing		295
Stationery expenses	1,503	136
Superannuation	10,735	4,811
Telephone expenses	2,904	215
Travel expense	7,995	6,778
Venue hire	1,734	3,573
Wages and salaries	128,025	52,886
Workers compensation	1,438	814

	<u>267,844</u>	<u>114,570</u>
Surplus	<u>2,706</u>	<u>1,790</u>
<b>ACQUITTAL ADJUSTMENTS</b>		
Capital - Office equipment	2,706	1,790
<b>OPERATING SURPLUS/ (DEFICIT)</b>	<u><u>-</u></u>	<u><u>-</u></u>

MENTAL HEALTH ASSOCIATION OF CENTRAL AUSTRALIA INC

HOMELESSNESS HOUSING & SUPPORT OPERATING STATEMENT  
FOR THE YEAR ENDED 30 JUNE 2011

	2011
	\$
<hr/>	
<b>INCOME</b>	
Grant - Dept Health & Community Services	247,705
Rent received	3,781
	<hr/>
<b>EXPENDITURE</b>	
Administration	45,267
Bank charges	15
Computer support	1,034
Consultancy	6,975
Depreciation	1,578
Electricity	1,237
Equipment purchase - minor	13,134
Insurance	366
Motor vehicle expense	4,661
Motor vehicle lease	5,333
Newsletter	1,035
Postage and freight	138
Professional development and training	1,814
Program costs	977
Promotions	1,567
Recruitment costs	2,219
Rent expense	13,372
Repairs and maintenance	2,632
Staff wellbeing	73
Stationery expenses	1,069
Storage costs	477
Superannuation	6,010
Telephone expenses	1,687
Wages and salaries	76,462
Workers compensation	1,141
	<hr/>
	<b>190,273</b>
	<hr/>
Surplus	61,213
	<hr/>
<b>ACQUITTAL ADJUSTMENTS</b>	
Capital - Equipment	6,804
	<hr/>
OPERATING SURPLUS/ (DEFICIT)	<b>54,409</b>
	<hr/>

## APPENDIX 2 – PATHWAYS TO REHABILITATION DATA TABLES:

SERVICE ACTIVITY KPI's	Jan	Feb	March	April	May	June	Totals
<b>1. Provision of recovery focused rehabilitation program</b>							
1.1 Number of analysis by Age and Gender							
1.2 Internal transfers	1			1		1	3
1.3 External referrals and reasons	6	2	1	2	3	1	14
1.4 Number and reasons for exits	3	1	6	1	1	4	16
1.5 Numbers referred and not provided services	2		7	2	6		17
<b>1.6 Analysis of aggregated results:</b>							
- Camberwell	2	3	2	2	1	4	14
- Role functioning scale	3	1	1	1	1	5	12
- Recovery plans			1	3		2	6
1.7 Numbers and analysis of info re MH, recovery and educational material	*	*	*	*	*	*	
<b>2. Provision of shared care with clinical and other services using shared individual recovery plans</b>							
2.1 Number of MDT	1	1	1	1	1	1	6
2.2 Number of individual case conferences	5	2		3	1	5	16
2.3 Number of integrated recovery plans	5	2		3	1	4	15
- Reviews - ward reviews (16)							
- Discharges	1	2	1			1	5
- evaluations							
2.4 Number referred to allied providers	*	*	*	*	*	*	
2.5 Shared evaluation progress results	*	*	*	*	*	*	
2.6 List of MOU developed with allied and copies							
<b>3. Program accessibility and appropriate different individuals from population</b>							
3.1 Number and strategies implemented to address the needs of co-morbidity eg: Forensics, A&OD, Disabilities, Cognitive, Physical, Complex needs	3	2	3		2		
3.2 Numbers accessing health checks eg: GP, CAMHS, D2DLP		4	7	8		3	
3.3 Strategies for effective cross cultural practices							
<b>3.4 – Additional: Number of Inquiries</b>	4	4	6	4	2	1	21
<b>3.5 - Additional: Respite care access and options</b>	1	2		2	3	4	12
<b>3.6- Additional: Accommodation inquiries</b>	2		3	3	3		11

- 15 Integrated plans
- 6 MHACA plans
- 2 GP – Mental Health Plans
- 1 Age & Disability Plan
- 1 Ward Discharge Plan
- 1 Indefinite on Ward
- 24 incomplete Plan/ CANs / RFS
- Total: 50

Gender ratio. 38 male 36 female

ATSI: 12 male 6 female

CALD: 3 male 3 female

## APPENDIX 3 – PREVENTION & RECOVERY DATA TABLES

Service Activity KPI's	Jan	Feb	Mar	Apr	May	June	Total
<b>1. Provision of Individual Care Packages to P&amp;R Participants</b>							
1.1 .Number of referrals and reasons externally / CAMHS	3	2		1	1	1	8
1.2 Number of internal referrals	1	1	1				3
1.3 Number that remained supported in own accommodation without admission			1				
1.4 Number of reviews	1						1
1.5 Number of extensions of active referrals	1		1	1			3
1.6 Number of discharges		2	1		1		4
1.7 number of evaluations	1						
1.8 Aggregated results of HONs supplied by CAMHS							
1.9 Aggregated results of Camberwell by MHACA	*	*	*	*	*	*	
1.10 Provision of psychosocial educational information on MH	*	*	*	*	*	*	
<b>2. Program accessibility and appropriate to different individuals from the population; cultural backgrounds, gender mix and different life domains</b>							
2.1 Report strategies implemented to ensure gender staffing balance in service provision							
2.2 Report strategies implemented to address dual diagnosis and forensic	2	1	1		1		
<b>3. Provision of respite accommodation for clients to reduce admission of post discharge off ward</b>							
3.1 number and analysis accessing respite in lieu of hospital admissions ( <i>ref Pathways</i> )	1	2		2	3	4	12
3.2 Number post discharge and analysis		3	1	1	1		
3.3 number unable to access due to lack of bed	n/a	n/a	n/a	n/a	n/a	n/a	
<b>4. Provision of shared care with clinical and other services using shared individual care plans</b>							
4.1 number of MDT, case conference	1	1	1	1	1	1	6
4.2 number of integrated plans	3	3	1	1		1	9
4.3 Number of reviews		8				4	12
4.4 number of discharges and <b>or transfer to other program area</b>	1	2	2	1	1		7
4.5 Evaluations under taken with Client, Carer, in service provision	*	*	*	*	*	*	

Shared CAMHS ICP or Discharge Plan: 10                      Gender: 5 male    6 female  
 MHACA Recovery Plan: 1                      ASTI: 2 male    1 female  
 Remains on ward: 1 CALD: male 1 female  
 Transfer into Pathways / D2DLP /HHTP: 5  
 Prevention & Recovery pre- Jan 2011 caseload: 1  
 Referrals Jan – June: 10  
**Total =11**



## APPENDIX 4 –HOMELESSNESS AND HOUSING DATA SUMMARY:

Service Activity – Key Performance Indicator	Jan	Feb	March	April	May	June	Totals
<b>1. Provision of accommodation</b>							
1.1 exit health or correctional institutes	1		1				2
1.2 crisis accommodation						1	1
1.3 transitional housing			3			1	4
1.4 signed tenancy agreements			3			1	4
<b>2. Support Worker Role/s</b>							
2.1 Total number of individual clients referred in	8	2	2	0	0	2	14
2.2 Monthly caseload numbers	1	1	2	2	2	3	
2.3 Number of Indigenous / Non – Indigenous	5 Indig. 3 Non	2 Non	2 Indig.			2 Non	7 Indig. 7 Non
2.4 Demographics – gender	7 m 1 f	1 m 1 f	1 m 1 f			2 m	11 male 3 female
2.5 Provision of training		1	2	1	1	2	
2.6 Number of rough sleepers / primary homelessness	6	1	2			1	10
2.7 Numbers receiving Outreach support		1					1
<b>3. Provision of shared care with clinical and other</b>							

<b>services using shared individual care plans.</b>							
3.1 Referral/s, diagnosis, reason for internal and external referrals	7 +1internal	2internal	2external			2 internal	
3.2 Reasons of exits from the service	0	1	0	1	0		
3.3 Referred and not provided with service, identified reasons for non- provision	8	1	0	0	0	0	
3.4 Number of MDT meetings	1	1	1	1	1	1	
3.5 Number of case conferences	2	1	1	5	6	1	16
3.6 Number of integrated Wellness Recovery Plans – reviews / discharges		1	2	0	0	1	4
3.7 Numbers referred to allied services	*	*	*	*	*	*	
<b>4. Ongoing quality improvement of the program</b>							
4.1 Number and analysis of self-assessment exit surveys completed - case study examples				1		1	
4.2 Analysis of overall outcome measures through aggregated data from Camberwell assessment							
4.3 Role Functioning Scale				1			
4.4 Tenancy and Sustainability Training Program				1			