# Rockingham


Integrated Systems of Care to support people with mental health, alcohol and other drug issues (ISC)

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## Community Engagement and Co-Design Workshop Report

2017

# Executive Summary: Rockingham Area

[Rockingham population: 125,114]

Richmond Wellbeing, in collaboration with consortium partners, has been commissioned by WA Primary Health Alliance (WAPHA) to develop an integrated system of care program to support people with mental health, alcohol, and drug issues in the Perth South Primary Health Network region from April 2017 to June 2018. The purpose of this activity is to improve the health and wellbeing of people who are living with co-occurring AOD (alcohol and other drugs) and MH (mental health) conditions.

The Richmond Wellbeing (RW) ISC engagement team conducted outreach into communities in this location to listen to community member's experiences, concerns, issues and ideas regarding problematic mental health and AOD use in the community. The RW team heard from community members who experienced these issues themselves, and from people who are carers, families, friends and supporters of people experiencing problematic AOD and MH issues.

Mental health services, AOD services and other service providers in the area were also contacted by the RW team to gather information on issues and concerns of the organisations. Ideas on ways to provide better access to services for vulnerable and disadvantaged community members and better integrate AOD and MH services were discussed in this engagement process.

Feedback from the local community was collated to provide themes for place-based co-design workshops attended by local community members and service providers working together on solutions to address these issues.

**ROCKINGHAM AREA:**

| CONSULTATION AND ENGAGEMENT | |
|---|---|
| Community Members | Service Providers |
| 17 | 8 |
| WORKSHOP ATTENDANCE | |
| Community Members | Service Providers |
| 13 | 8 |

# Co-design Workshop

## Workshop Themes:

- **Provide more options for rehabilitation and following rehabilitation provide ongoing support.**

  Follow-up support, access to one-on-one peer support workers to provide mentoring assistance with transition needs such as housing, run life skills programs that look at whole of life environments and stressors to increase coping skills, run peer support groups to build positive social networks.

- **Increase opportunities for employment.**

  Employ local peer workers with lived experience to reduce stigma of seeking help, provide volunteer opportunities to engage with the community.

- **Provide more support for homeless people.**

  Provide more outreach workers on the streets, increase access to social services for people at high risk to prevent them from becoming homeless, open access to a drop in centre where people can go for help or to talk - like Crew.

- **Enhance access to AOD and MH services.**

  Increase community awareness of local services available, accept self-referrals, involve family, provide more community education to increase knowledge about MH and AOD issues to reduce stigma and support early intervention.

A co-design workshop was held in Rockingham on Nov 24th 2017 for community members and service providers. This workshop provided an opportunity for service providers and local community to come together to co-design local service activity.

## Workshop Findings:

The co-design workshop identified six key findings to be considered by the Project Management Group:

1. Employ two community engagement workers (one peer outreach, one administration) to provide holistic support services.
2. Provide more transitional housing with support during and after care, including employment of assertive outreach workers to support homeless people and facilitate opportunities for employment and skill development.

3. Increase opportunities for local Aboriginal people to be peer support mentors by adopting flexible employment policies and working in partnership with employment agencies.
4. Expand Step Up Step Down (SUSD) services to NGOs and bring Solid Ground Groups to Rockingham.
5. Increase outreach services that focus on supporting those with co-occurring conditions and actively promote these services to increase community awareness.
6. Introduce new processes to improve integration, coordination and communication between services to reduce the need for people to keep telling their story over and over, such as having one counsellor to do all initial and ongoing assessment.

## Solutions to Address Key Findings:

### 1. Employ two community engagement workers (one peer outreach, one administration) to provide holistic support services.

**Identified need:**

- Need people in services making connections with community.
- Need to provide social activities to ensure people in the community are involved and engaged.

**How to do it:**

Community engagement officers to be:

- Non-judgemental;
- Skilled across areas; and
- Resourceful.

Assertive outreach worker:

- To be a peer worker (lived experience);
- Not necessarily goes by the book in terms of employment and processes;
- Provide support prior to leaving rehab – referrals for these two workers;
- Consultation with Department of Housing re: improving transitional housing;
- Provide transport to appointments;
- Assistance with obtaining ID to access services e.g., the Beacon, food barn;
- Finding clothes – particularly nice ones for interviews;
- Assistance with haircuts;
- Information about local services;
- Go to some of the places some organisations see as too hard;
- Take services to the person and vice versa; and
- GP appointments/advocacy at the appointment.

Office-based administration worker:

- Does the admin;
- Helps get set up/provide life skills (bank accounts, cooking etc.);

- Getting identification;
- Assisting with Centrelink; and
- Organising mail.

Both positions help deliver and coordinate workshops, groups and activities:

- Parenting;
- Communication;
- Goal setting;
- Banking;
- Cooking (household skills);
- Accommodation;
- Peer support groups (youth, older);
- One on one support; and
- Provide community family fun days – holistic family health focus where families can network with the services in the local area where the aim is to have the opportunity to connect with multiple services and organisations, not just limited to AOD and MH but greater wellbeing.

## 2. Provide more transitional housing with support during and after care, including employment of assertive outreach workers to support homeless people and facilitate opportunities for employment and skill development.

**Identified need:**

- Getting into transitional housing is really hard – need to make it easier so people do not have to be in crisis to be eligible.
- Need outreach workers to help those currently homeless or between housing services.

**How to do it:**

Need specific housing support for:

- Youth 16-20 years;
- Single parents;
- Females only; and
- Non-Australian citizens.

Develop partnerships:

- Approach Homes West and Community Housing Limited; and
- Work with Mission Australia and Outcare for more support during and after initial transitional housing – council on board.

Increase access:

- Expand range of accommodation options;
- Making referral forms easier;
- Re-home immediately – volunteers in community who are screened offer spare rooms to rent; and

- Assertive outreach workers to be based within local services to help homeless and those in transitional housing before and after accommodation.

Assertive outreach workers to facilitate opportunities for employment and skill development:

- Big Issue;
- Registered Training Organisation (RTO) discounted driver license – pay for four lessons and get one for free from some driving schools;
- Help with job applications (CVs, confidence building, interview tips, role playing);
- Employment – find local employers willing to provide paid position work experience that leads to a real job;
- Link with in Centrelink – advocacy support;
- Find out what has worked in past in Rockingham;
- Petition our MP for funding; and
- Find accessible empty buildings to increase availability of accommodation services.

### 3. Increase opportunities for local Aboriginal people to be peer support mentors by adopting flexible employment policies and working in partnership with employment agencies.

**Identified need:**

- To access services you need money, to get money you need employment – need more opportunities.
- Need more peer support workers to support AOD and MH recovery.
- Need to increase opportunities for mentoring - mentoring roles enable those with life experience to have employment opportunities but also builds hope for individuals who are currently facing similar issues and barriers.
- Need more flexible HR policies to break down barriers to employment - by waving criminal records and making exemptions for some convictions many individuals may have more opportunity to gain employment.
- Need to increase support for those returning to the community from prison or rehabilitation to find meaningful employment.
- Currently receive little to no support from employment agencies - need to build and develop job networking opportunities to open doors for the community to access work.
- Need to open doors for those who have worked to change themselves - individuals work hard to change their life and move away from the lifestyle which resulted in them wanting to change.

**How to do it:**

Provide mentoring/peer support opportunities for those with lived experience to:

- Support those coming out of prison or rehabilitation; and
- Focus on the rehabilitation for individuals once they leave prison or rehab.

HR policies to be more flexible to reduce barriers:

- Exemptions from criminal checks – ensure opportunities for those who have charges and criminal records to still gain employment;
- Have criminal checks waved, based on the sentence/charge and also dependent on the job position; and
- Youth worker – need to have clear check from abuse, neglect or child/under 21 related changes/convictions.

Develop partnerships and networks:

- Work alongside and develop the employment (disability) agencies and job networking (Centrelink) services to ensure that individuals are receiving the correct type of help from the services;
- Access prisons and rehabs to link in with Outcare; and
- Gain/build relationships with services and organisations to ensure clients have the best service available - network with employment agencies and job networking.

Create positions and revise policies:

- Create job positions for mentoring roles on a permanent basis for those who have been in prison – not having some sort of employment at the end is more harmful than good – it is instant rejection;
- Develop criteria for the mentoring roles;
- Who can apply for jobs – need life experience;
- Wave the restrictions of criminal records - depending on the conviction and what position they are applying for - if there are convictions where abuse or harm occurred towards another individual the criminal record may not be waved; and
- Be supportive of disclosing history – many frightened will impact employment.

Develop the program:

- Mentoring programs to be totally individual based and to support those with employment who are returning to the community from prison or rehab;
- Assist in building self-care outside of employment (holistic approach); and
- Ensure funding for positions lasts for years – not for short period.

### 4. Expand Step Up Step Down (SUSD) services to NGOs and bring Solid Ground Groups to Rockingham.

**Identified need:**

- Need to increase capacity of local Step up Step Down services.
- Need to provide more individual and family support.

**How to do it:**

- Open Step up Step Down Service provision to AOD.
- Currently 10 spaces (1 unit) in Rockingham.
- Expand spaces/units in local area.
- Operated in local area – need to find out who.

- Train staff to be MH/AOD aware.
- Source funding to expand (approaching Mental Health Commission).
- Increase promotion of SUSD services available to increase community awareness.
- Bring Solid Ground to Rockingham - Wungening Aboriginal Corporation (previously AADS).
- Provide community forums on local services supports (how family can support).
- Talk to Mental Health Commission (MHC).
- Look for locations.
- Separate AOD and MH locations.
- Talk to NGOs about picking Step Up Step Down (SUSD) approach.
- Employ qualified staff (possibly funded by MHC; need to administer medications).

### 5. Increase outreach services that focus on supporting those with co-occurring conditions and actively promote these services to increase community awareness.

**Identified need:**

- Need to increase outreach services – take more services to the community, especially to Baldivis.
- Need to better educate community on what is available (including service providers and GPs)  Need to reduce stigma by increasing public awareness of AOD and MH issues.

**How to do it:**

Outreach services to:

- Focus on dual diagnoses;
- Co-locate in local services;
- Based in Palmerston or Salvation Army;
- Outreach worker to be trained and skilled in AOD and MH to Include Aboriginal outreach worker; and
- Provide support while on wait lists.

Increase awareness of AOD and MH issues and services available:

- Run radio campaigns; and
- Service directories.

Establish a working group with local agencies and stakeholders to establish and oversee service:

- Palmerston;
- Salvation Army;
- Mental Health Services (Step Up Step Down etc.);
- City of Rockingham;
- Consumer Advisory Group;
- Peer representative;

- 360 Health and Community;
- GROW;
- Headspace;
- Anglicare;
- Ruah; and
- Neami.

### 6. Introduce new processes to improve integration, coordination and communication between services to reduce the need for people to keep telling their story over and over, such as having one counsellor to do all initial and ongoing assessment

**Identified need:**

- Need to build better therapeutic relationships with consistency and continuity.
- Need to stop being asked to repeat story – this reinforces the trauma cycle.
- Processes need to prevent anger, distress and minimise harm.

**How to do it:**

- Provide one counsellor that does a detailed initial assessment and new assessment every 12 months - record stories and get consent for future use.
- People with expertise need to hear the story first hand – frames the experience – but this should not have to be told over and over the individual.
- The individual to tell story once; story is documented and shared (with consent from individual).
- Counsellors to read case notes – timeline of events – rather than asking same questions.
- Your story can change over the recovery journey – the issues change – but important that the whole picture is explained once and only once.