

# SNAP Gippsland

2014  
Annual  
Report

working together for  
better mental health



Recovery means more than the absence or management of symptoms. Recovery represents the unique and personal journey taken by an individual as they work towards regaining their sense of identity and achieving meaning and purpose in their lives.

Recovery embraces a person's capacity for taking responsibility for their own life based on their values and goals.

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### 'Living with a mental illness shapes but does not define me'

Living with a mental illness should not preclude a person from leading a meaningful and fulfilling life based on their individual values and goals. Recovery involves regaining hope, re-connecting to the community,

taking responsibility for one's own life and being able to participate in education, employment, recreational, social and other meaningful activities. SNAP Gippsland partners with individuals in their recovery journeys.

*SNAP deeply respects the privacy of our clients. The photographs used in this publication include our valued workers and contractors.*

# Our Vision, Purpose and Values

## Vision

Working Together for Better Mental Health.

## Core Purpose

SNAP is committed to excellence, equity and quality in mental health. It achieves this by forming partnerships that generate hope, meaning, self-identity and responsibility.

## Values

Equity, Honesty, Respect, Integrity, Quality, Excellence, Transparency.

## About Us

SNAP Gippsland is a Community Managed Mental Health Service delivering psychosocial rehabilitation, recovery services and educative programs to adults with a severe and persistent mental illness, their families and carers.

Established in 1992, SNAP Gippsland delivers services throughout East Gippsland, Wellington, South Gippsland and Bass Coast, offering a range of services that are recovery oriented and meet the individual needs of clients. SNAP Gippsland also manages the bed-based Gippsland Prevention and Recovery Care (PARC) service located in Bairnsdale in collaboration with Latrobe Regional Hospital-Mental Health Services.

In addition to service outlets located in Bairnsdale, Sale, Yarram, Orbost and Leongatha,

SNAP Gippsland works in collaboration with other community based organisations and health services to ensure its programs and services are accessible to remote rural and other hard to reach groups and communities.

Research validated and evidenced-based practices together with a well-developed service model are the core strengths that have enabled SNAP Gippsland to take a lead role in policy and service development in the Gippsland region and beyond. The organisation is highly regarded for its service delivery framework that responds to the individual's stage of recovery.

In the 2014 recommissioning of Mental Health Community Support Services (MHCSS) in Victoria, SNAP was one of 15 successful organisations.

SNAP Gippsland has established strong partnerships with universities and research organisations to validate and further 'practice-develop' its models of service.

SNAP Gippsland works with people with a mental illness and their families to overcome barriers regain hope, reconnect with their communities and realise their goals, providing services which are based around collaboration, inclusion and self-management.

## Acknowledgments

SNAP Gippsland acknowledges the traditional custodians and Elders past and present of the land where we deliver our services.

We wish to thank and gratefully acknowledge our funders for their continued support.



# Governance & Management

SNAP Gippsland has had an extraordinary year of achievement and growth. The work done in previous years of building our organisational capabilities along with our reputation for delivering evidence-based services has provided us with a solid foundation for success. Our understanding and care of the individual and diverse needs of our clients, their families and carers has driven innovative planning responses in collaboration with our partners and connections resulting in the delivery of responsive, high quality, individualised, recovery oriented mental health services.

We have been successful in securing National Partnership funding that assists adults who are homeless or living in tenuous housing situations; the Federally funded Partners in Recovery for adults with very complex circumstances that require assistance to co-ordinate their care; nomination as the lead agency for the East Gippsland Mental Health Initiative, a Victorian Government investment of one million dollars in the mental health of East Gippslander's until June, 2017 and the greatest success of the past year was becoming one of the 15 Victorian Mental Health Community Support Services (MHCSS) as a result of the recommissioning of Victorian community managed mental health services.

We also received with great enthusiasm the announcement by Federal Minister for Health, Peter Dutton, in October that a Headspace would be funded for Bairnsdale in 2016-17. SNAP will show leadership in this initiative and actively participate in the planning and development to ensure that it responds to the diversity and challenges of the catchment.

SNAP is a partner in the successful bid for Services Connect in Outer Gippsland. This initiative is funded by the Victorian Department of Human Services and aims to connect people with the right support, address the whole range of a person's or family's needs and help people build their capabilities to improve their lives.

We have also registered to receive referrals from the Transport Accident Commission and will soon be registering with the Victorian WorkCover Authority.

We have extended our reach and now deliver services in Yarram and we have opened an office in Orbost co-locating with Orbost Regional Health.

Our workforce has been restructured to create depth and a career pathway. Teams consist of a Team Leader, Senior Recovery Support Worker, Recovery Support Workers, Assistant Recovery Support Workers and Peer Workers.

We have also created a dedicated position to assist people exiting from our service to ensure a smooth transition with supported referrals into community.

Coaching has been implemented throughout SNAP's services. All staff including management staff participate in coaching. We also have two Peer workers trained in the delivery of coaching.

An organisational wellbeing plan is being developed by Alex Couley in collaboration with staff in response to the inordinate amount of change being experienced both internally and externally.

In June, 2014 Quality Innovation Performance reviewed our accreditation and we met both the Health and Community Service Standards and the National Standards for Mental Health services (2010).

Our information management systems and capabilities have been enhanced through the excellent and responsive support of Data Central and Wild Bamboo NZ.

Our Board of Governance has commenced development of the 2015-2018 Strategic Plan, which includes SNAP's preparation for the National Disability Insurance Scheme (NDIS) by July, 2016 and the Bairnsdale Headspace.

Dr Anton Isaacs is leaving our Board after 6 years. During Anton's 6 years of service to the Board he held the position of Chair, Vice-Chair, Secretary and Public Officer. He also participated in the Governance and Finance Audit and Risk Management Committees. We are very grateful for Anton's contribution to the governance, leadership and development of our service and thank him most sincerely.

This is an exciting time for mental health services and the success experienced by SNAP has come about by "Working Together for Better Mental Health" through the dedication, care and commitment of our Board, CEO and staff, our contractors, our partners and through the support of VMIAC (Victorian Mental Illness Awareness Council) in particular Tony Salter. We would like to thank you all for your contribution and it is a privilege to work with you.



**David Loadman**  
Chair



**Chris McNamara**  
CEO

# Strategic Directions 2012-2015

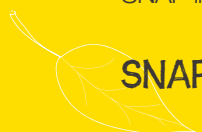
## Key Messages

SNAP partners with its clients in individualised holistic recovery that provides outcomes in:

- regaining self-dependency
- mental health self-management
- social inclusion.

Through evidence based interventions, and joined up support, across a range of interprofessional approaches and community based programs that can involve carers and families.

SNAP innovates in the development and implementation of a framework of evidence based practice in a rural environment.



## SNAP Gippsland is a sustainable organisation

### Our Goals

Every person with a serious mental illness will have access to a service from SNAP Gippsland

We will achieve this through:

- strengthening the branding of SNAP as the Gippsland provider of individualised holistic recovery services
- strengthening our relationship with Latrobe Regional Hospital-Mental Health Services
- providing services to Aboriginal people
- increasing our presence in far east Gippsland
- improving the access of Culturally and Linguistically Diverse (CALD) and refugee communities to mental health services.

To be the rural leader in evidence based mental health recovery practice

We will achieve this by:

- increasing the evidence base for effective practice
- being recognised as a rural centre of excellence in mental health recovery practice.

SNAP has the capacity to provide a consistent, innovative, sustainable and holistic service that responds to the changing needs of consumers

We will achieve this by ensuring that:

- we have an appropriately skilled workforce founded on a “learning organisation” culture
- we develop and strengthen our operational relationships with key professional and community support services.

To be a strong dynamic and sustainable organisation

We will achieve this by:

- having an informed and engaged board that meets the requirements of good governance
- having strong financial and risk management systems
- having effective and appropriate business and support systems
- having flexible and efficient infrastructure
- preparing for future leadership sustainability.

## Our Services and Models of Care

SNAP Gippsland delivers a set of services which are easy for our client's, their carers and families to navigate.

As a recovery oriented service, our focus is on outcomes in relation to physical and emotional health, social participation, education and employment.



We work with people with a mental illness and their families to overcome barriers, regain hope, reconnect with their communities and realise their goals.

Our services are based on collaboration, inclusion, self-management and a commitment to delivering the most up-to-date, recovery oriented, evidence based and research validated models of service and care available.

## Our Services

### Prevention and Recovery Care (PARC) Services

PARC Services are delivered in collaboration with Latrobe Regional Hospital – Mental Health Services. Gippsland PARC is a short-term (7-28 days), residential treatment service located in the community that provides recovery oriented support to clients of Latrobe Regional Hospital - Mental Health Services and SNAP Gippsland. PARC assists clients to transition from acute inpatient services, continue on their recovery journey and resume their role in the community. For individuals who are becoming unwell and at risk of experiencing a crisis, PARC aims to provide the support needed to avoid admission to acute mental health facilities and develop strategies to cope better at home and continue the recovery journey.

The Optimal Health Program and Action Over Inertia are delivered daily and are key components of the PARC service Model of Care.

#### *Data from PARC exit interviews 2013/14:*

The average length of stay at PARC is 2 weeks. 70% of people who stay at PARC describe the experience as very good. The top three responses to the 'feel' or culture of PARC are supportive, friendly, and recovery oriented. The top 3 answers with respect to staff are that they are friendly, helpful and caring. 96% of clients understood the goal setting process with 76% of clients achieving their goals during their stay at PARC. 80% of clients considered the Optimal Health Program beneficial to very beneficial to them upon their return home. 92% of people considered their stay at PARC achieved its purpose

### Mental Health Support for Secure Tenancies (MHSST)

MHSST is an innovative service that aims to break the cycle of homelessness by supporting people with a severe and enduring mental illness to live independently in the community, obtain secure

housing, improve their independent living skills and address their physical and mental health needs. MHSST utilises a flexible outreach approach that is integrated and links to the broader health and community service system.

We work collaboratively with homelessness services, clinical mental health services, primary and allied health, housing services, drug and alcohol services and other community support services to assist the person to access and maintain stable housing.

#### *A SNAP shot of the Program*

The majority of our clients have been homeless or living in tenuous housing situations for up to 5 years. 63% of the client group are women and 37% men. The majority of clients are aged between 31 and 50 years old with 16 to 20 year olds being the next prominent grouping. The overwhelming majority have never had a referral to a Mental Health Community Support Service such as SNAP. Of the 18 people who have exited the program 10 were living in stable accommodation, 5 were not and 3 it was not known if the person was in stable accommodation.

### Partners in Recovery

Partners in Recovery is a national program for people with severe and persistent mental illness with multi-service needs. The aim is to provide a 'wrap around' service tailored to the person's individual needs and for services to be co-ordinated and work collaboratively.

Clients of Partners in Recovery are often reported to have 'fallen through the gaps' and require more intensive support to effectively address the complexity of their needs.

SNAP has been funded via the lead agency, Gippsland Medicare Local, as a Support Facilitation Organisation to employ 5 Support Facilitators to provide Care Co-ordination and planning in Leongatha, Sale, Orbost and Bairnsdale with an additional position Based in Bairnsdale for the Aboriginal community.



The ultimate aim of the program is to improve the system response and outcomes by facilitating better co-ordination of clinical and community support services; strengthening partnerships and service linkages; improving referral pathways and promoting recovery oriented services.

## East Gippsland Mental Health Initiative (EGMHI)

Prior to the 2010 Victorian Election the Liberal Party made a pledge to commit \$1m to infrastructure to develop a wellbeing centre in Bairnsdale.

The East Gippsland Mental Health Initiative was established in 2011. Discussions took place with Minister Wooldridge about the need for services rather than infrastructure. After considerable consultation with service providers, consumers and communities a proposal was developed and tested in East Gippsland. As a result of this process we are now ready to implement a set of community capacity building programs that will assist young people, engender faith and hope and promote resilience in East Gippslanders in more remote communities.

Members of the Initiative:

- Bairnsdale Regional Health Service
- Barrier Breakers
- Gippsland and East Gippsland Aboriginal Co-operative
- Gippsland Lakes Community Health Service
- Gippsland Medicare Local
- Latrobe Regional Hospital – Mental Health Services
- Mental Illness Fellowship
- Orbost Regional Health
- Ramahyuck Aboriginal Corporation

SNAP Gippsland has been nominated by members of the Initiative as the Lead agency.

The State Government funded the Initiative in the 2013-2014 State budget for 4 years 1st July 2013 to 30th June, 2017.

There are 4 components to the Initiative:

1. Targeted Intensive Care Co-ordination for 16-21 year olds with Department of Human Services who have a mental illness and co-existing complexities. Encouraging cross sector co-ordination and practice, involving and consulting with Spectrum (clinical service for people with Borderline Personality Disorders) building the capacity of services to work with young people
2. Aboriginal Care Co-ordination for 16-21 year olds with Department of Human Services who have a mental illness and co-existing complexities. The Aboriginal Community Controlled Health Organisations will partner with SNAP in the delivery of service
3. Building capacity for spiritual work and wellbeing in community mental health support service delivery. Building on the work of Spiritual Health Victoria developing chaplaincy and pastoral care services in mental health services
4. Building mental health support and community capacity through the provision of preventative and educative programs aimed at farmers and their families and building partnerships with Victorian Farmers Federation & Beyond Blue.

### *Our focus is to:*

Maximise sustainability, apply a comprehensive and integrated place-based approach. To target remote communities and strengthen partnerships between EGMHI partners, service providers within local communities, communities and people with a mental illness, families and carers. To avoid duplication of coordination or capacity building efforts in East Gippsland but rather value adding, to and of, other East for Gippsland capacity building efforts.

## Our Models of Care

### Optimal Health Program

The Optimal Health Program (OHP) is a gateway to service and is designed to help individuals achieve optimal health outcomes (a balance of physical, psychological and social health and wellbeing). OHP has three core components: Education (factors that influence your mental health), Coping Strategies (actions and strategies to manage and reduce stress) and Skills Development (tools and techniques to help you achieve and maintain long term optimal health).

SNAP utilises the Optimal Health Program to manage its wait list. Rather than people receiving no service SNAP assesses the client's needs after the referral is received from Central Intake and invites the person to participate in the Optimal Health Program, a program that is delivered weekly for 8 weeks and is designed to teach self-management skills.

### Action Over Inertia Program

The Action Over Inertia Program supports individuals in overcoming the barriers preventing them from deriving meaning and enjoyment from the wide range of activities that make up daily life. The program utilises occupational therapy techniques and helps participants

realise the health and wellbeing benefits associated with taking part in meaningful activities.

SNAP also utilises Action over Inertia to manage its waitlist. The program is delivered weekly for 10 weeks and is designed to get balance back into the activities of daily life.

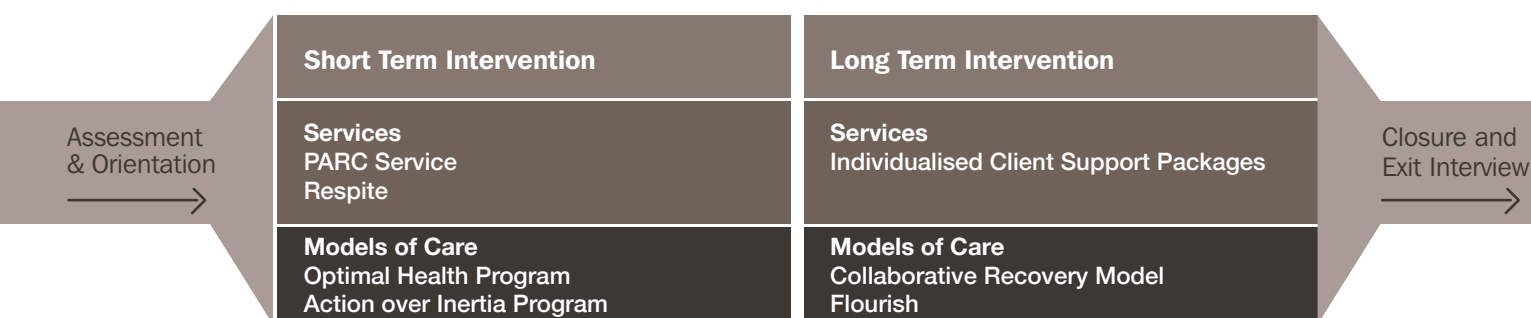
### The Collaborative Recovery Model

The Collaborative Recovery Model (CRM), developed by the University of Wollongong Illawarra Institute for Mental Health, focuses on achieving positive outcomes and is founded on the principles of recovery; individual process, collaboration and autonomy support. CRM is delivered in a coaching style and takes a value based approach to setting life goals and managing illness experience.

### Flourish

Developed by the University of Wollongong Illawarra Institute for Mental Health, Flourish is a peer facilitated recovery based self-development program that focuses on personal growth and responsibility. The program helps participants identify their goals and provides them with the tools they need to achieve them. Flourish is not an illness management program but is designed to help individuals take responsibility for making positive changes in their life.

## Framework of Service



## The Way We Work A Case Study

*We will call this gentleman, Mr Jones.*

Mental Health Community  
Support Services (MHCSS)

Individualised Client  
Support Packages

South Gippsland, Bass Coast,  
East Gippsland and Wellington Shires





## Referral

Mr Jones is a 43 year old gentleman who has been diagnosed with schizophrenia, he has been referred from Central Intake and registered on SNAP's Service Co-ordination database. Following a telephone call from the Service Co-ordinator, an appointment is made for assessment at Mr Jones current residence; a Supported Residential Service (SRS) in an isolated seaside community with no public transport to speak of. Mr Jones has very little contact with his ageing parents who live in Melbourne and declines the invitation to have a carer present at the appointment. Three days after the initial referral, the Senior Recovery Support worker meets with Mr Jones at the SRS in order to assess his eligibility for service, identify his individual needs and to start a conversation about his hopes and dreams for the future.

## Assessment

When Mr Jones meets with the Service Recovery Support Worker he appears disinterested and dishevelled. There are no activities or stimulation at the SRS apart from a television in the dining hall. Most of the other residents are older than Mr Jones whose only privacy is in his small single room.

The Senior Recovery Support Worker provides information about her role, about SNAP's services and the assessment process. Mr Jones understands that participation is entirely voluntary and is engaged and encouraged by the Senior Recovery Support Worker who explains that his package of care will be tailored to his individual needs and that SNAP's energies will be directed to strengthening his confidence and resilience, supporting him to address his unmet needs in a manner that is suitable to him and proactively working towards planning for his discharge from SNAP's services.

## Rights and Responsibilities

Confidentiality and Privacy is reviewed and a Service-user Rights and Responsibilities brochure that includes the Victorian Human Rights Charter is provided. Mr Jones is informed that there is a monthly Service-user forum convened by the Victorian Mental Illness Awareness Council (VMIAC) which he is welcome to attend if he has any issues in relation to his rights and care. Advocacy can be accessed through VMIAC.

Documentation and information is provided to Mr Jones about how SNAP stores and collects health information. Mr Jones gives SNAP the authority to collect relevant health information.

## Comprehensive Assessment

A Comprehensive Assessment is undertaken with Mr Jones.

### *Mental Health*

Mr Jones cannot describe how his mental illness affects him. He has no understanding of the medication that has been prescribed for him, how it can help him or how to manage it. The staff at the SRS give him his medication morning and night and his Case Manager comes to the SRS every fortnight to give him an injection. Mr Jones describes managing his mental illness by drinking excessive amounts of alcohol, frequently spending all of his Disability Support Pension purchasing alcohol. Mr Jones has a dual diagnosis and self-medicates to deal with his psychosis. His multiple admissions to the inpatient unit result primarily from his failure to take his medication. He moves frequently from place to place, his chronic homelessness often resulting from his having no money to pay his rent.

### Physical Health

The Physical Health screening reveals that Mr Jones cannot remember when he last had a physical health check with a GP despite having repeatedly received stitches after falls and brawls. His diet is poor; he smokes, requires dental work and has difficulty with balance.

### Living Skills

Mr Jones describes his living skills as poor in all areas; budgeting, shopping, cooking, cleaning, personal hygiene, social connections, advocating for himself and accessing community resources.

### Accommodation and Housing

Mr Jones is content to stay where he is because he receives regular meals and has a bed. However, he feels restricted because he can't drink on the premises and the SRS is isolated with no public transport available.

### Drugs and Alcohol

In relation to the Dual Diagnosis screening Mr Jones does not believe that his drinking is a problem despite discussion on the impact that drinking has had on family relationships, homelessness, lack of money and impact on his mental health. However, he does agree to complete the Alcohol Smoking Substance Involvement Test (ASSIST). Mr Jones rates as a high risk with a rating of more than 27. It is recommended he seek intensive intervention with further assessment and consultation to take place with an Alcohol and Other Drugs service.

### Risk Assessment

A Risk Assessment is undertaken in relation to:

- non-concordance with medication
- disinhibition of alcohol
- self-neglect/harm
- decline in physical health and risk of falls
- homelessness.

A strong protective factor in all of these identified risks is Mr Jones accommodation at the SRS. In this environment medication is taken as prescribed, alcohol is not allowed, decent shelter and regular meals and standards of self-care are insisted upon.

### Identified Needs

Mr Jones has multiple service needs involving at least seven services: Clinical Mental Health Services, MHCSS, GP, Dental, Neurological Testing, Training and Employment, Financial Counselling and Housing services.

### Recovery Outcome Measurement

Mr Jones completes the Stages of Recovery Instrument (STORI) outcome measurement and is identified as being in the 'Moratorium' stage, citing no hope for the future, loss of identity and dependence. This is contrary to his desire to get some sort of employment and find more stable and affordable housing. The STORI will be reviewed again in 3 months.



## Confirmation of Rights

SNAP's Complaints Policy and Procedure is explained and a copy of the documentation is provided. All information about programs and services and copies of Rights and Responsibilities, Consent, Complaints and other relevant procedures are contained within a presentation folder to be kept by Mr Jones.

## Acceptance for Service

Mr Jones is accepted for service and a worker skilled in working with people with a dual diagnosis is allocated to work with him to complete further assessments, the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), to develop a Recovery Care Plan by using the Collaborative Recovery Model and LifeJET and develop an Individual Client Support Package for him.

An invitation to an Orientation to SNAP's services (delivered by Peer workers) is provided along with the dates and the location of the next Optimal Health Program and Action over Inertia Program.

### Introduction of Worker

The allocated Recovery Support Worker is introduced to Mr Jones by the Senior Recovery Support Worker and work begins on the CANSAS.

## Recovery Care Planning

### Completion of the CANSAS

The completion of the CANSAS presents an opportunity for Mr Jones to have a full and frank discussion with his worker regarding his circumstances and the multiple domains of his

unmet need: Looking after the home, Self-care, Daytime activities, Physical Health, Psychotic Symptoms, Information on Condition or Treatment, Psychological Distress, Safety to Self, Alcohol, Company, Transport and Money and met needs in the areas of Accommodation and Food. The CANSAS results correlate with that of the assessment and the Key Recovery Care Planning Domains:

- mental health self-care and self-management
- daily living skills
- physical health
- housing
- relationships
- social connectedness
- education, vocational training and employment.

### Immediate Needs Addressed

Given Mr Jones lack of transport and isolation, the worker provides assistance in having his more pressing needs met prior to the development of the Recovery Care Plan combined with the CRM and LifeJET.

- appointment with a GP for a physical health check and to discuss falls and balance issues
- waitlisted for appointment with Public Dental service
- meeting with Case Manager accompanied by a worker to discuss medication and Mr Jones self-medication through the use of alcohol
- participation in Orientation to SNAP's services delivered by Peer workers
- participation in the first session of the Optimal Health Program.

## Supported Referrals and Care Co-ordination

### *Alcohol and Other Drugs:*

Further discussion takes place between Mr Jones and his worker about a supported referral to the Alcohol and Drug service. Mr Jones has tried it before and does not believe that it is going to help. Because most of his pension is going on rent at the SRS he hasn't been drinking as much.

### *Homeliness:*

Mr Jones does not wish for a referral to be made to the Mental Health Support for Secured Tenancies program at this point. His preference is to stay at the SRS in the short term.

### *Employment:*

Mr Jones does not want a referral to go ahead for employment at this time because he doesn't feel ready.

### *Partners in Recovery:*

Due to Mr Jones multiple and complex needs, Mr Jones Support Worker provides information in relation to Partners in Recovery and their role of Care Co-ordination. Mr Jones does not want a referral to be made to PiR, preferring to wait and have SNAP take on that role.

## The Collaborative Recovery Model

*Use of LifeJET (Life Journey Enhancement Tools), the CAMERA, COMPASS and MAP*

### *Completion of the CAMERA - Identifying Values and Strengths*

The worker explains to Mr Jones the purpose and process of using the CAMERA. Whilst Mr Jones needs have been discussed when completing the CANSAS, CAMERA focusses on valued directions, strengths and the things that are really important to him. This is not something that Mr Jones has thought much about before. The worker asks him to think about times and situations where he has had to draw on his strengths to get through hardship and to think about the things that are dear to him. Mr Jones has never had conversations like this before. He is asked to start to write these strengths and values on the outside of the lens of the picture of the CAMERA. He writes: Good Health, Secure Housing, Friendship, Family, To go to Work, Good Mental Health, Looking After Myself. These values align with the key domains of the Recovery Care Plan and are consistent with the results of the CANSAS.

Mr Jones is asked how well he has been living these strengths and values in the last month and to rate them. In focus - close to the centre of the lens of the CAMERA or out of focus – from the centre to the edge of the lens of the CAMERA. The worker explores why he has rated his values and strengths in the way that he has, with discussion focussed on how he would like his life to be and a life vision.

## Completion of the COMPASS (aka Recovery Care Plan)

The worker shows Mr Jones the COMPASS document and talks about the COMPASS as a plan for the future, as an opportunity to think about the bigger picture and what he would like his life to be like – a big vision, a life vision. The worker asks Mr Jones to identify three of his seven strengths and valued directions; these are the three things that are most important to him, the three things that he values the most. He chooses Good Mental Health, Family and Looking after myself. He writes them down on the COMPASS. All values connect with the key domains of Recovery Care Planning.

Mr Jones is then asked to identify a goal relating to each of the three valued directions and strengths and rate the importance of the three goals out of ten.

Strengths & Valued Direction	Goal	Rate of importance
Good Mental Health	Learning more about my medication	3
Family	Visit my parents in Melbourne	3
Looking after myself	Make an appointment with a Drug and Alcohol Counsellor	4
<b>Total</b>		<b>10</b>

### Setting a Life Vision

Mr Jones is asked to think about and describe what his life might look like if he was to achieve his valued directions. He decides that his life vision is 'To be a Happy Person' and he writes this on the top line of the COMPASS.

### Benefits of Goal Setting

Discussion takes place between the worker and Mr Jones about the usefulness of goal setting; it provides direction, motivates, helps measure achievements. Achieving goals can depend on a range of factors and circumstances that are not always within our control.

### Confidence in Achieving Goals

Mr Jones is asked how confident he is, out of 100, of achieving his chosen goals. Mr Jones feels that if he works at the goals little by little he can be 70% sure of achieving all of his goals. He writes 70 on the 'targeted goal cell'. The worker explains that if he is less than 70% confident then he could choose something he was more confident in achieving. Mr Jones is sure that he can do this with support and encouragement.

Establishing goals for a Recovery Care Plan using the CRM and LifeJET is a very detailed process. Each step along the path is checked and checked again for confidence and validation and the client is completely involved in the process with the worker acting as the coach.

Each goal is broken down into small actions and documented on the MAP (Member Action Plan). The worker and client discuss the barriers and benefits of achieving these small actions and a confidence rating of achievement set. A new MAP is set every week for the client to work on between visits from the worker.

Every three months the COMPASS is scored for achievement and the CANSAS, CAMERA and COMPASS are reviewed and new goals are selected as the client grows in confidence and strength. If goals are achieved before the scheduled review the Review is brought forward.

Not all valued directions will be addressed and incorporated into a goal planning process; some are interdependent and will resolve due to other actions. The working alliance that exists between the worker and client is vitally important and that there is a striving to achieve.

The Individualised Client Support Package developed with Mr Jones address his complex individual needs:

### *Mr Jones: Individualised Client Support Package*

<b>Program</b>	<b>Purpose</b>	<b>Duration</b>
The Optimal Health Program	Develop coping skills, appreciation of overall health, early warning signs of deterioration of mental health	8 weeks x 90 minutes per week
Action Over Inertia	Get more balance in daily activities	12 weeks x 90 minutes per week
Collaborative Recovery Model - Incorporating Recovery Care Plan	Setting direction, establishing Recovery Care Plan and working to achieve goals	2 hours per week until goals that meet valued directions achieved
Men's Shed	Social connectedness	½ day per week
Participation in Community Kitchen	Improving Living skills	½ day per week
Service User Forum	Information and contribution	monthly x 2 hours
Health and Wellbeing Program	Participation, knowledge and improved physical health	2 hours per week
Transportation to and from activities due to no public transport	To access activities	

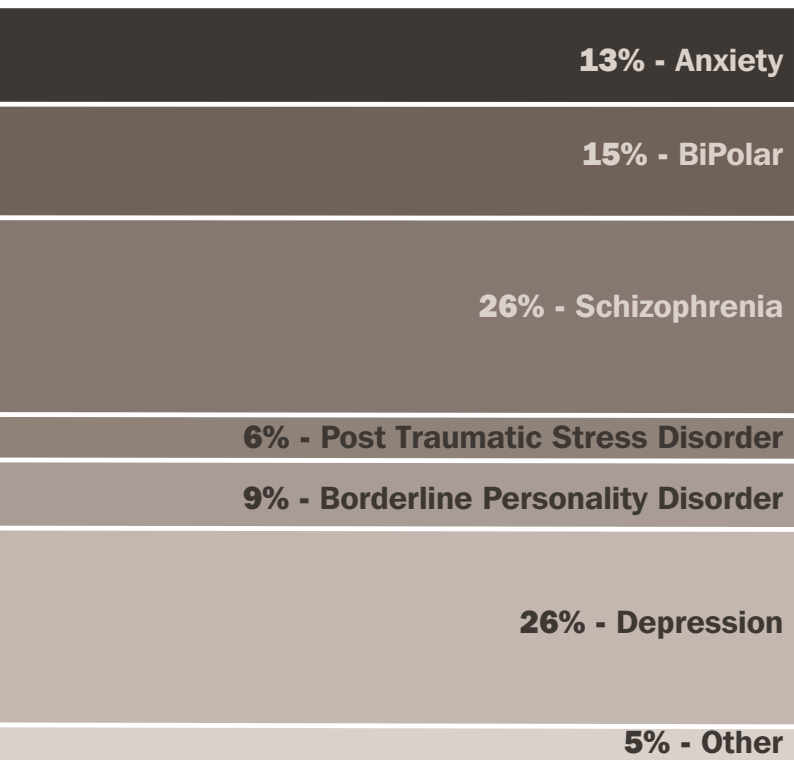
## Governance and Organisational Structure





## Data

### Our clients - Gender



# Diagnosis

## Our clients - Age range



## Referrals

45% - Area Mental Health Service

21% - GP's

18% - Community Service Organisations (CSO's)

10% - Self/Carer or Family

6% - Other

## Board of Governance 2013-2014



**David Loadman**  
(Chair)

Lawyer and retired Magistrate, David was a member of the Northern Territory Mental Health Review Tribunal and Chaired the Tribunal for one year.



**Janice Chesters**  
(Vice Chair)

Janice is a retired academic and health research consultant. She has extensive board experience and is a life member of SNAP Gippsland.



**Chris McNamara**  
(Secretary)

Chris participated in the establishment of SNAP Gippsland, she has worked in mental health for the past 22 years and is a Board member of Vicserv and the Women's Mental Health Network Victoria.



**Betty Trayling**  
(Treasurer)

With over 30 years experience in corporate financial and administrative roles Betty brings extensive strategic and operational management skills to the Board. She holds a Bachelor of Business with a Major in Accounting.



**Monica Gilbert**

Monica has worked as a clinician and researcher in mental health and drug and alcohol dependency for over 25 years. She has extensive experience in leading large research projects in health behaviour change.



**Dr. Anton Isaacs**

Public health physician, researcher and lecturer, Anton works in the area of mental health and wellbeing with Aboriginal communities in rural Victoria.



**Cathy Johnson**

Cathy has a business and nursing background. She is a Coach and trainer in the Collaborative Recovery Model and brings considerable 'practice knowledge' to the Board.

**Graeme Coull**  
(resigned November 2013)

Certified Practicing Accountant, Graeme is new to Gippsland and keen to contribute to the community.

**Dr. Eleanor Mitchell**  
(resigned September 2013)

Researcher and lecturer, Eleanor assists academics and health professionals in East Gippsland to establish their own research and program evaluations.

**Jeanette Severs**  
(resigned September 2013)

Newspaper journalist, editor, author, social researcher and media trainer, Jeanette is a strong advocate for the improvement and advancement of rural women's issues.

Board of Governance meetings are convened on alternate months and there are now three standing committees.

The role of the Governance Committee is to ensure that the Board fulfils its legal, ethical and functional responsibilities through governance policy development, recruitment strategies, training programs, monitoring of Board activities and the review of the Board's performance.

The Finance Audit and Risk Management (FARM) Committee has been split to form two separate sub-committees, the Finance and Audit Committee and the Risk Management Committee. This was done to provide a greater emphasis on Risk Management and in particular clinical risk.

Board Member Management	Board Meeting	Governance	Finance and Audit	Risk Management
Janice Chesters	4/6	4/5		
Graeme Coull (Resigned November 2013)	2/6		1/3	
Monica Gilbert	4/6			1/1
Anton Isaacs	4/6	3/5		
Cathy Johnson	2/6			
David Loadman	5/6	5/5		1/1
Chris McNamara	4/6	4/5	2/3	1/1
Eleanor Mitchell (Resigned September, 2013)	1/6	1/5		
Jeannette Severs (Resigned September 2013)	1/6	1/5		
Betty Trayling	4/6		2/3	

## Financials

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## SNAP GIPPSLAND INC.

### Board of Governance Declaration 30<sup>th</sup> June 2014

In the Board of Governance's opinion:

- the incorporated association is not a reporting entity because there are no users dependent on general purpose financial statements. Accordingly, as prescribed in note 1 to the financial statements, the attached special purpose financial statements have been prepared for the purpose of complying with the Associations Incorporation Reform Act 2012
- the attached financial statements and notes thereto comply with the Accounting Standards as described in note 1 to the financial statements.
- The attached financial statements and notes thereto give a true and fair view of the incorporated association's financial position as at the 30 June 2014 and of its performance for the financial year ended on that date; and
- there are reasonable grounds to believe that the incorporated association will be able to pay its debts as and when they become due and payable.

On behalf of the Board of Governance

A handwritten signature in black ink, appearing to read 'Janice Chesters', is written over a horizontal line.

Janice Chesters Vice  
Chair

Dated: 22-10-2014  
Bairnsdale

*Note: The following financial statements have been extracted from the audited accounts, a copy of which is available to members on request.*

## Statement of Profit or Loss and other Comprehensive Income for the Year Ended 30 June 2014

	2014 (\$)	2013 (\$)
Revenue from operating activities	2,837,442	2,661,044
Revenue from non-operating activities	48,123	47,689
Employee Benefits	(2,069,174)	(1,640,965)
Expenses from continuing operations	(830,546)	(675,839)
<b>Net Result before Capital &amp; Specific Items</b>	<b>(14,155)</b>	<b>391,928</b>
Depreciation	(30,922)	(42,794)
Net Loss on Sale of Non-Current Assets	(6,211)	(3,168)
<b>Net Result for the year</b>	<b>(51,288)</b>	<b>345,966</b>
Other Comprehensive income	-	-
<b>Total Comprehensive income</b>	<b>(51,288)</b>	<b>345,966</b>

## Statement of Financial Position for the Year Ended 30 June 2014

	2014 (\$)	2013 (\$)
<b>Current Assets</b>		
Cash Assets	2,139,375	514,818
Receivables	24,596	91,413
Prepayments	7,491	4,472
Other Financial Assets	-	750,000
<b>Total Current Assets</b>	<b>2,171,462</b>	<b>1,360,703</b>
Property, Plant and Equipment	457,109	380,995
<b>Total Non-Current Assets</b>	<b>457,109</b>	<b>380,995</b>
<b>Total Assets</b>	<b>2,628,571</b>	<b>1,741,699</b>
Payables	992,601	109,149
Other Liabilities	33,265	33,265
Employee Benefits	187,249	149,595
<b>Total Current Liabilities</b>	<b>1,213,115</b>	<b>292,009</b>
Employee Benefits	35,612	18,562
<b>Total Non-Current Liabilities</b>	<b>35,612</b>	<b>18,562</b>
<b>Total Liabilities</b>	<b>1,248,727</b>	<b>310,571</b>
<b>Net Assets</b>	<b>1,379,844</b>	<b>1,431,128</b>
Accumulated Surplus	1,379,844	1,431,128
<b>Total Equity</b>	<b>1,379,844</b>	<b>1,431,128</b>

## Statement of Cash Flows for the Year Ended 30 June 2014

	2014 (\$)	2013 (\$)
Operating grant receipts	2,694,612	1,565,729
Fees and charges	1,074,658	923,558
Interest received	48,123	47,689
Sundry receipts	3,089	23,909
Payments to suppliers and employees	(2,837,443)	(2,502,420)
GST - Net collected/(paid)	4,765	3,185
<b>Net cash provided by Operating Activities</b>	<b>987,803</b>	<b>61,649</b>
Plant & equipment and motor vehicle purchases	(130,246)	-
Proceeds from sale of assets	17,000	48,500
Term Deposits	750,000	-
<b>Net cash provided by/(used in) investing activities</b>	<b>636,754</b>	<b>48,500</b>
<b>Net increase/(decrease) in cash held</b>	<b>1,624,557</b>	<b>110,149</b>
Cash at the beginning of the year	481,552	371,404
<b>Cash at the end of the year</b>	<b>2,106,110</b>	<b>481,552</b>

## Statement of Changes in Equity for the Year Ended 30 June 2014

	Retained Surpluses (\$)
<b>Balance 1 July 2012</b>	<b>1,085,166</b>
Total Comprehensive Income	345,966
<b>Balance 30 June 2013</b>	<b>1,431,128</b>
Total Comprehensive Income	(51,288)
<b>Balance 30 June 2014</b>	<b>1,379,844</b>

## INDEPENDENT AUDITOR'S REPORT

To the Members of SNAP Gippsland Inc.

We have audited the accompanying financial report, being a special purpose financial report of SNAP Gippsland Inc, which comprises the statement of financial position as at 30 June 2014, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the statement by members of the committee.

### Committee's Responsibility for the Financial Report

The members of the committee are responsible for the preparation of the financial report that gives a true and fair view and have determined that the basis of preparation described in Note 1 to the financial report is appropriate to meet the requirements of the *Associations Incorporation Reform Act 2012* and the needs of the members. The responsibility of the members of the committee also includes such internal control as the members of the committee determine is necessary to enable the preparation of a financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

### Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the association's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the association's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the members of the committee, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### Independence

In conducting our audit, we have complied with the independence requirements of Australian professional ethical pronouncements.



## Opinion

In our opinion the financial report gives a true and fair view of the financial position of SNAP Gippsland Inc as at 30 June 2014 and of its performance and its cash flows for the year ended in accordance with the *Associations Incorporation Reform Act 2012*.

## Basis of Accounting

Without modifying our opinion, we draw attention to Note 1 to the financial report, which describes the basis of accounting. The financial report has been prepared to assist SNAP Gippsland Inc to meet the requirements of the *Associations Incorporation Reform Act 2012*. As a result, the financial report may not be suitable for another purpose.

Crowe Horwath Vic

## CROWE HORWATH VIC



## MARY WINTER

Partner

Warragul

Date: 29 October 2014



**SNAP**

gippsland inc.

*Working together for  
better mental health*

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