NT Housing Support Program (the Program) Service Model

NORTHERN TERRITORY GOVERNMENT

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Contents

1. Introduction

The Northern Territory Housing Support Program (the Program) service model will guide establishment of this initiative. It will channel development of strong and effective partnerships between primary health care services, specialist Mental Health AOD services, housing and other accommodation providers, and the Program in supporting the recovery of people with mental illness who require support to maintain stable housing.

The Program will provide all stakeholders with clear information designed to provide consistency in the delivery of services to participants.

NT Health will commission suitable organisation(s) to provide recovery-oriented psychosocial supports to complement clinical supports delivered by health services, for adults with mild to moderate mental illness with episodes of more severe symptoms. Organisations will work with NT Mental Health Services, GPs, housing providers and other relevant stakeholders to support clients to sustain suitable housing.
The Program allows for direct psychosocial supports to be provided, and for service navigation supports to enable access to the community and clinical services, links to education, vocational training and employment. Participants will also be assisted to prepare assessment requests to the National Disability Insurance Scheme (NDIS), where their needs for assistance are chronic and persistent.

An appropriate program name (embodying key principles of community, shelter and wellness) will be developed by the successful organisation.

2. Aim and Objectives

The aim of the Program is to support people experiencing mild to moderate mental illness and related psychosocial disability who experience episodic deterioration of condition(s) to live independently in the community through:

- The provision of psychosocial rehabilitation and support services that are flexible and responsive to an individual's needs.
- Supporting access to clinical mental health care which is individualised and recovery focused.
- Supporting access to programs and services for people to improve their life skills and capacity to live as independently as possible in the community.
- Avoiding or reducing hospital admissions and the need to access crisis services through prompt detection of early warning signs of a mental health crisis and providing early intervention.
- Transition to sustainable permanent housing where appropriate and possible.

3. Key Service Principles

- Planned and coordinated approach to service delivery.
- Culturally responsive and safe service delivery, with particular focus for Aboriginal Territorians as outlined in the NT Health Aboriginal Cultural Security Framework 2016-2026.
- Effective and efficient use of evidence based practice in the provision of trauma informed, recovery focused, and person centred services.
- Improve cross-sector collaboration and opportunities to address social determinants that may impact on an individual's wellbeing.

4. Service Model

The Program is a voluntary program where a Wellbeing and Recovery Worker works to support people experiencing mental illness maintain and sustain suitable and safe accommodation. Workers will help design supports to meet individual needs and recovery goals. Each person's unique journey of recovery will be supported to the degree they are able to participate in the following:

- Improved management, moving towards effective self-management, of their mental illness and associated substance misuse disorder (as appropriate).
- Partnership with their housing provider (TFHC and others), the Program provider, primary health care providers and clinical mental health services (NT Health and others).
- Engagement in activities to support the individual with living, learning, social, vocational and recreational aspects of their lives.
- Development of aspirations, goals and milestones.
- Regular review of the service and other supports to better meet their recovery needs.

Carers and family members are encouraged and supported, where the person is in agreement, to be involved with plans for the care of their family member.

The service model will be a flexible recovery-based approach that includes elements of all major approaches for people with enduring mental illness including:

- Flexible intensity supports
- Assertive community treatment
- Critical time intervention.

4.1. Psychosocial support

The Program provider will provide structured, goal focused, strengths based and individually tailored non clinical rehabilitation and support services at a level of intensity and duration appropriate to the person's needs. The hours of support will be flexible depending on the person's needs e.g. if a person becomes unwell the level of support provided may increase from medium to high intensity.

The range of psychosocial supports may be across the spectrum of:

- Self-maintenance needs such as self-care, insight and management of illness, home management, (including shopping, cooking, cleaning as needed), medication management and, physical and dental health care needs, e.g. diabetes management. The program supports an Equally Well approach to care.
- Provision of support to assist with maintaining sustainable living arrangements including liaising with the housing provider regarding tenancy management issues.
- Community connection and social inclusion supports to build stronger interpersonal connections through networks and recreation. Intervention strategies will connect with broader community services wherever possible. Meet the needs of people from culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander people, people with physical impairment and intellectual disability.
- Where other options are available (such as NDIS Supported Independent Living packages) personal assistance with homecare such as shopping cooking and cleaning will be provided through those packages.

These services will be available up to seven days a week, within extended hours depending on the person's needs in the program.

4.2. Access criteria

Inclusion criteria:

- Voluntarily consents to being part of the program and willing to engage with non-clinical support services as needed in recovery planning and regular support visits.
- Aged 16 years and over (until aged related frailty / illness affects person's ability to engage in the program)
- Diagnosis of serious mental illness, +/- secondary substance use disorder, and complex needs due to functional impairment caused by their illness (for younger person formal diagnosis may be absent).
- Be homeless or at risk of homelessness, including living in unsuitable, inadequate or unsustainable housing.
- Living in social or private housing, which may be at risk.
- Requiring coordination of services and extended care package to obtain and /or maintain adequate and appropriate community living arrangements.
- Case managed by specialist mental health services (includes consumers care managed by the Forensic mental health teams and parents with mental illness with dependent children in their care).
- Living in the greater urban areas of Darwin or Katherine.

People in receipt of a Homelessness Support Service funded by DTFHC or other appropriate supports may still be eligible to be referred to the service for 'top-up' care.

Exclusion criteria:

- Persons eligible for the National Disability Insurance Scheme (NDIS) and where this scheme fully meets their psychosocial needs. The Program can work in conjunction with the NDIS to support any unmet psychosocial needs.
- Persons less than sixteen years of age (this criteria will be flexible if a person is determined to need the service).
- A person who does not consent to participate.
- Persons whose primary diagnosis is not mental illness, and who have a medium to high functioning capacity.

4.3. Referral and intake assessment

Referrals can be made by:

- Specialist mental health clinicians and teams.
- Mental health specific NGO[1]'s, primary health care providers and GP's who are providing ongoing mental health care coordination for the referred person, as long as there is evidence that the

[1] Mental health service providers that also offer psychosocial supports would only refer if they were at full capacity or cannot meet the needs of the client

person has a diagnosed mental illness that impacts on their overall functioning. The referring service must be willing to remain involved as the primary mental health care contact (Program partner) for the duration the person is in the program.

The referring clinician / service, together with the person being referred, will complete the referral form and consent form (for sharing information) and forward it to the Program coordinator. Any other relevant information should be included – existing care or recovery plans, risk assessment, recent Health of the Nation Outcome Scales (HoNOS) score and other relevant outcome measures, Occupational Therapy/ functional assessment etc.

Referrals received will be reviewed by the Program provider to ensure eligibility criteria has been met.

An intake assessment process will be coordinated by the Program provider where information needed to determine acceptance into the program will be gathered. This will include the referred person, involved mental health care clinician/ service, housing provider, other involved supports services providing wrap around care, and any nominated carers/family the referred person requests to be involved.

There will be reasonable timeframes established from time of referral to the decision regarding acceptance into the program being made (nominally within 2 weeks). There will be timely feedback and communication regarding the referral and intake assessment process to the consumer and other involved services.

Possible Outcomes:

- Referral accepted and participant is able to progress to the comprehensive assessment stage.
- Referral accepted but no places available in the program so participant placed on a wait list.
- Not accepted, feedback on reasons provided back to the referrer along with other referral pathways for consumer.

4.4. Assessment and recovery planning

Comprehensive assessment of participant's current functioning and support needs using evidence based and validated assessment processes / tools will be completed as soon as practical following entry to the program. This assessment will inform the participants Individual Recovery Plan (IRP).

Program participants will have an IRP developed with them by the Program provider that documents individual support needs and the support to be provided from each partner. The Program provider will provide a copy of the IRP to the individual, specialist mental health service and any other person/ service as determined by the participant, to ensure that care is complimentary and coordinated.

The IRP will contain at a minimum information on the following:

- Participants identified recovery goals e.g.
  - Physical health and self-care goals e.g. engagement with primary health care.
  - Support with increasing independent living skills.
  - Support accessing broader community networks and services.
  - Increased participation in vocational or work opportunities.
  - Increased social connection and positive interpersonal relationships.
- How to manage their mental health by identifying any triggers that may make them become unwell (leading to deterioration of condition and higher needs).
- The level and type of support to be provided through the Program. What, how and how often. This includes moderate to intense level in-reach/out-reach services for periods of higher need.

- Details of other agencies that will provide any other services including clinical mental health services and accommodation support services.
- What happens if the person's needs decrease or increase and what strategies are in place to deal with this situation e.g. a relapse and crisis / emergency plan.
- What happens if the person loses the legal ability to give consent? E.g. ensure that there is a crisis management plan in place in consultation with the primary mental health provider / case manager.
- Contact information about carer, and / or guardian, and next of kin.
- Addresses significant lifestyle issues e.g. alcohol and other drug (AOD) issues that may need to be addressed by the person. It may also list strategies to assist the person to manage these issues e.g. attending AOD counselling.
- Any specific supports which may assist the person to better manage their accommodation.
- Any special needs e.g. using an interpreter.
- Provision for quarterly reviews.

4.5. Care intensity and length of service

The general length of time a participant will access the program will be 12 months, although some participants may move on from the program more quickly, and others may need a degree of flexibility regarding exiting the program.

Care will be offered to participants dependent on their level of need in their current circumstances, noting this will vary over time. Participants may move back and forth between the support levels as their level of need changes over the time they are in the program. The following provides a guide to the hours of care provided by the Program provider, noting that this care will be one component of the overall care being provided to the participant. In partnership with the clinical provider and the housing provider, and actual combined hours of care will be higher. The hours of support provided should be regularly reviewed to ensure the participants needs are being met and any emerging risk issues or deterioration in functioning are identified early, and support hours varied accordingly. Support provided will vary with individual circumstances from low daily or weekly support, to moderate to intense daily in-reach/out-reach services.

1. *High/intensive support* – 10 - 20 hours per person per week

   High intensity support will be required for people experiencing a significantly high level of impairment relating to serious mental illness, and who are unlikely to maintain their tenancy agreement without intensive psychosocial support. Among this group are people with more frequent complex needs, who may be experiencing unpredictable and challenging behaviours in relation to their illness. This group will prioritised for entry into the program and provision of care.

2. *Medium/flexible support* – between 5-10 hours per person per week

   A medium level of support will be required for people who have a diagnosed mental illness and are functioning at a satisfactory level most of the time but are experiencing periods of impairment. This cohort will require support in household tasks living skills, property care and good neighbour behaviour, as well as accessing community services and activities.

3. *Low/flexible support* – up to 5 hours per person per week (1-10 hours per fortnight)

   A low and flexible level of support will be required for people with lower levels of functional disability. This group will be functioning reasonably independently, but may need shorter periods of support to maintain their wellness, or when they are experiencing periods of un-wellness or stress which is having a negative impact on their ability to sustain their tenancy.

5. Care coordination within a stepped care model

The Program provider is responsible for working closely with the individual, carers and other Program partners to enable the person to reach the recovery goals identified in the IRP.

This process will include:

- Responding to any new developments or changes in the individual's situation and amending the IRP where necessary.
- Regularly reviewing the recovery process with the individual and other parties.
- Working closely with program partners to ensure services provided are integrated and targeted.
- Monitoring mental state and medication management and compliance.

All Program partners need to work flexibly with each other to provide person-centred care throughout each participants program. Should the person be admitted to an inpatient facility (whether acute, sub-acute or rehabilitation), the Program provider will remain in contact with the individual and assist with their transition back to accommodation upon discharge.

The referring mental health case manager / team, or primary health care provider / mental health NGO are responsible for providing, or supervising, mental health clinical care for the individual while they are participating in the Program. This includes responding to requests by the Program provider for review of mental state and risk (during business hours) if required, and assisting in the development of clear after hours relapse / crisis plan for each participant.

6. Discharge

A person will be ready for discharge from the program when:

- The Program partners, together with the participant, agree that recovery goals have been reached (this may mean the participant is able to sustain their original accommodation, or the participant has successfully moved to more appropriate sustainable accommodation).
- The participant no longer wants to engage with the program / withdraws consent.
- The participant shifts to the NDIS or other similar support program where accommodation and sufficient psychosocial support services are included.

There may be a period of transition upon discharge from the program where the Program provider remains involved for a short period while the participant safely engages with ongoing supports / services.

7. After hours and crisis support

All participants will have a relapse and crisis plan developed with them as part of their IRP, identifying the contact mental health clinician/ service who can respond to deterioration or relapse of mental illness during business hours/after hours when required.

After hours (or business hours when identified contact person is unreachable) crisis support will be provided via the NT Mental Health Line. TEMHAODS staff will undertake assessment of mental state and determine the person's risk status and arrange for follow up psychiatric assessment where required. Specialist NT mental health staff will also arrange admissions to inpatient facility as per their usual protocols if and when required.

In emergencies where there is imminent risk to the participant or others, 000 should be used.

8. Responsibilities

8.1. Responsibilities of the program staff

- Negotiating the IRP (complimentary to the specialist mental health care plan) with the individual and mental health care clinician/ service, in consultation with all program partners, to identify the person's best care plan for stable health and continuing community living.
- Coordinating the care and support provided to an individual in consultation with program partners and in line with the IRP.
- Monitoring changes in the person's situation that may affect their mental health care plan, support contract or services provided by other agencies.
- Keeping relevant program partners informed of any relevant accommodation issues.
- Leading and participating in joint reviews of the mental health recovery plan with relevant service providers, the individual and/or carer or significant other, where relevant.

8.2. Responsibility of Mental Health service partners

- People referred to the Program will be consumers of community mental health services or primary health care services providing or coordinating their ongoing mental health care, e.g. NT Health specialist mental health staff, non-government mental health services, General Practitioners etc.
- Mental health service partners will work in partnership with the Program provider to ensure the participant receives safe holistic wrap around care by:
    - Contributing towards the development and review of the persons IRP.
    - Providing or coordinating ongoing mental health care for the participants.
    - Being available to the Program provider for advice and consultation regarding participants mental health care, including when participant mental health needs increase due to deterioration and crisis.

8.3. Responsibility of housing providers

- The majority of participants of the Program will be living in public housing provided by the DTFHC, however some may be in private rental or other social housing.
- The DTFHC and other housing providers will provide tenancy management services to Program participants residing in public housing dwellings. Managing tenancy includes ensuring that Program participants understand their rights and responsibilities under their signed Tenancy Agreement.
- The DTFHC, with consent, will refer any public housing tenant who appears to have mental illness to the program through Specialist NT mental health services.
- People may wish to move from their accommodation, either due to no longer needing the level of support provided by the Program, or because they wish to move locations. The Program provider will work with people and the other partner agencies to assist people to access secure long term housing, where possible.

9. Informed consent and sharing of information

All individuals referred to the service will have signed a Program consent form. The consent form will include consent for sharing of information between all Program partners (Mental Health Services, Program provider, DTFHC or housing provider, and NT Health) and other service / carers nominated by the participant.

It is important that individuals who wish to participate in the Program initiative have a clear understanding of their right and those of their carers to:

- Receive and understand information about how their information is being shared.
- Make informed consent, including withdrawing consent at any time.
- At any time, amend who they want their information shared with.
- Have their decisions respected.

Program participants will be expected to consent to the following:

- The individual understanding that the Program provider will need to provide information to service providers (and all partners) to support the individual.
- The Program provider may seek information from other providers about the person in order to inform the intake and comprehensive assessment, and IRP.
- If consent is withdrawn from sharing information with one of the partners, the person will be withdrawn from the program.
- De-identified care information being provided to the NT Health for the purposes of monitoring and evaluation and with the aim of improving the Program model. If consent is withdrawn to participate in the evaluation component of the program they can still receive the service.

Informed consent may be verbal or in writing. Should verbal consent be given, this should be documented and witnessed in the event that consent is contested.

10. Duty of care

There are some circumstances where professional judgement by the Program provider will be required and there may be a requirement to share some information with other parties even without consent. These circumstances could include:

- When the person is in danger of harming themselves or others.
- When the person may be at risk of harm from others, or from the environment around them.
- When information about illegal activity has been disclosed.
- Mandatory reporting requirements under legislation.

The participant should be made aware that their information may be required to be shared with others, such as emergency services (police or ambulance), depending on the circumstances and nature of the information.

11. Critical incidents

The Executive Director of Mental Health Alcohol and Other Drugs Branch, NT Health or their nominated representative, must be notified by phone of any critical incidents immediately or as soon as possible following the incident. These include, but are not limited to; deaths or serious injury (including from self-harm) on the premises, criminal behaviour in or associated with the service, serious inappropriate

behaviour, environmental or building hazards at the site and/or any other matter that might affect the safe and efficient delivery of this service or generate significant public or media concern.

The Program provider must provide a written report of the critical incident to NT Health via the Mental Health Branch in line with the timelines provided in the document: *Non-Government Organisation Guidelines for Reporting Critical Incidents to Department of Health MHAODB.*

12. Data collection and performance reporting

The Program provider will provide specific information at regular intervals to NT Health through progress reports (qualitative and quantitative).The data will consist of risk and issues identified and any quantitative data collected. The provider is responsible for their program commitments, and to individually and collectively undertake regular monitoring of program and individual outcomes as per this framework.

Data requirements will be set out in the contract for services and the following table is indicative of reporting requirements:

Data Type	Data Item
Activity	Age range, gender identity, region
Activity	Number of people currently in program
Activity	Number of people entering program
Activity	Number of people exiting program
Activity	People on the waiting list
Activity	Referrals received for program from specialist mental health services
Activity	Referrals received for program from other sources such as GPs or AHHCO's homeless shelter
Activity	Type of package provided – high medium or low and hours provided
Activity	Hours of support provided to participant from other partners
Activity	HoNOS scores at entry to the program and then quarterly thereafter
Activity	K-10 and K-5 Scores at entry to the program and then quarterly there thereafter
Activity	Living in the Community Questionnaire Survey at entry to the program and then quarterly thereafter
Activity	Hospital Admissions at entry to the program and then quarterly thereafter
Activity	Sub-Acute Service Admissions
Activity	Carer engagement
Activity	Partnerships developed
Activity	Number of NDIS applications supported

Data Type	Data Item
Activity	Number of clients accepted by the NDIS

13. Safety and quality

Successful Program providers will need to demonstrate that they are an appropriately accredited organisation.

The Program provider will provide a safe and high quality environment for consumers, carers and staff. A recovery focused, trauma informed style of support will guide all practice and interventions. Practice will be evidence based, and staff will be accountable and work within their scope of practice. Ongoing quality improvement activities and staff development will ensure the program consistently provides safe and quality care.

14. Legislation and standards

The following legislation and standards will be followed:

National Frameworks and Legislation

- National Standards for Mental Health Services
- National Disability Strategy
- National Disability Service Standards
- National Disability Insurance Scheme Act
- Privacy Act and Principles
- Health and Community Services Complaints Act
- Framework for Recovery Orientated Mental Health Services
- Anti-Discrimination Act
- Australian Charter of Healthcare Rights
- Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standard 2; Partnering with Consumers
- The Code of Health & Community Rights & Responsibilities
- Ombudsman Act
- Sex Discrimination Act
- Racial Discrimination Act
- Disability Discrimination Act
- Age Discrimination Act
- Australian Human Rights Commission Act
- Disability Services Act
- Work Health and Safety Act.

Northern Territory Frameworks and Legislation

- Mental Health and Related Services Act
- Medical Services Act
- Disability Services Act
- Domestic Violence Act
- Child Protection Act
- Anti-Discrimination Act

- Adult Guardianship Act
- Carers Recognition Act
- Care and Protection of Children Act
- Freedom of Information Act
- Health and Community Services Complaints Act
- Health and Community Services Complaints Regulations
- NT Residential Tenancies Act
- NT Housing Act
- NT Disability Service Standards
- NT Domestic and Family Violence Act
- NT Care and Protection of Children Act
- NT Health Aboriginal Cultural Security Framework 2016-2026
- NT Carers Charter.

Any other relevant national and Northern Territory legislation and/or standards

15. Dispute resolution

Participant disputes, Complaints and feedback

Sometimes a person will disagree with their treatment or support. The Program provider, and other stakeholders will use their existing compliments and complaints mechanisms for resolving this type of dispute.

Neighbourhood disputes

On occasion disputes will arise between the Program participant and their neighbours. In these instances the housing provider will use their usual mechanisms for resolving neighbourhood disputes, including talking to both parties, negotiating agreed behaviour or actions between the parties, mediating a meeting between parties and where appropriate more formal processes, including local council, Public Housing Safety Officer (PHSO) or police involvement.

Partner Disputes

In circumstances where a difference of opinion or dispute arises between the Program provider, housing provider, or mental health services, it is expected that the parties adopt a staged approach to resolving the dispute amicably and professionally.

There will be occasions where decisions may not be able to be resolved. In this situation the following actions are to be taken:

- The individuals directly involved in the care and support of the person, usually the mental health care provider and the Program key worker, will meet to work through the issues and negotiate a solution as a part of the ongoing working partnership. Additional input may be sought from each party's supervisor/team leader and/or manager, executive manager who may assist with meetings, negotiations and solutions.
- If a dispute is not resolved using the above method, the matter should be raised with the NT Health as the commissioning agency.

Definitions and acronyms **The following acronyms and definitions are used in this document**	
Acronyms	**Full form**
AOD	Alcohol and Other Drugs
CALD	Culturally and Linguistically Diverse
Case management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost effective outcomes. The case manager often takes the lead role in care coordination or it can be a function of the non-government organisation.
Carer	The Northern Territory Carers Recognition Act specifically recognises carers of people with mental illness.
Care coordination	Care coordination is the deliberate organisation of care between two or more parties and the person with a mental illness so that appropriate and relevant care is delivered by the right person and at the right time ensuring that all parties including services providers are aware of what care is being provided at what times.
Cultural responsiveness	Describes the capacity of a health professional, health service and health system to respond to the health care issues of individuals and provide person-centred care (taking into account cultural, linguistic, spiritual and socio-economic background).
Cultural safety	Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the individual's experience of care they are given, and the ability to access services and the confidence to raise concerns.
Cultural security	Fundamental to closing the gap in health outcomes for Aboriginal Territorians. Cultural security is a commitment to the principle that the construction and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. Cultural security refers to the embedded structures, policies, workforce attributes and other elements enabling participants to experience cultural security.
Critical incident	Critical Incident (also known as a reportable incident) includes any adverse event that causes mild to moderate harm to any person related to the NT HASI program and has occurred during an aspect of the programs delivery. It differs from a sentinel event where serious harm or death occurs as a result of, or during the delivery of supports to a participant.
DTFHC	Northern Territory Department of Housing and Community Development

Definitions and acronyms **The following acronyms and definitions are used in this document**	
Acronyms	**Full form**
Forensic client	Relates to a person with mental illness in the criminal justice system. In the Northern Territory, this usually is restricted to clients that are on Part IIA orders of the Criminal Code, a small cohort of complex prisoners and a small number of recidivist clients through the local court (section 77 of the Mental Health and Related Services Act).
IRP	Individual recovery plan
Mental illness	A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar affective disorder, eating disorders, and schizophrenia Mental Illness is a health problem that may significantly affect how a person thinks, feels thinks, feels, behaves and interacts with other people. It describes a group of illnesses that are diagnosed according to standardised criteria.
MHAT	Top End Mental Health Services Mental Health Access Team.
MH CA&BR	Mental Health Central Australia and Barkly Region
NDIA	The agency responsible for implementing the National Disability Insurance Scheme
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NT Health	Northern Territory Health
Psychosocial disability	Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities, used to describe the experience of people with impairments and participation restrictions related to mental health conditions It is estimated at any one time 0.3% of the population has a severe mental illness that results in psychosocial disability. This cohort is targeted for the NDIS. In the Northern Territory it is estimated to be four hundred and twenty people.
Primary Health Care (PHC)	Primary Health Care is the front line of Australia's health system and is comprised of service providers from the public, private and non-government sectors. Services provided are broad and include health promotion, prevention, screening, early intervention, treatment and management. PHC providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal health workers.
Public housing	Public Housing is delivered through the DTFHC for individuals who meet eligibility criteria.
Strengths approach	A model of intervention that shifts the focus of work with clients from power-over to power-with, from deficits to capacities, from expert-focussed to the-client-as-expert (Hammond; 2010).
TEMHAODS	Top End Mental Health Alcohol and Other Drugs Service
Relapse prevention plan	A plan designed with the participant to prevent an episode of illness.

Definitions and acronyms **The following acronyms and definitions are used in this document**	
Acronyms	**Full form**
Recovery	The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers, outlines that there is no single description or definition of recovery because recovery is different for everyone. It notes that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing free of stigma and discrimination.
Social and emotional wellbeing	Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.
Stigma (mental illness)	People with mental illness face stigma at all levels of society. Stigma occurs whenever there are negative views and stereotypes about someone with a mental illness. These negative views result in the participant being excluded, de-valued and disrespected and have a negative impact on the person's health and wellbeing.
Social inclusion	Is the opportunity for people to participate in society through employment and access to services; connect with family, friends, personal interests and the local community; deal with personal crises; and have their voices heard.
Tenancy support services	Tenancy Support Services (TSS) funded by DHCD provides services to individuals and families living in public housing or on the public housing waitlist who need support to maintain their tenancy. The TSS provides case management and support to public housing tenants in the NT to maintain their housing and prevent homelessness.
Tenancy management	Monitoring of all rental payments and managing rental arrears. This includes negotiating schedules of repayments and monitoring arrangements and providing the person with appropriate documentation regarding their accommodation and its management, including policies and processes for disputes and complaints. DHCD may also provide to the client rental documentation on request.
National Standards for Mental Health Services	Standards that assist in the development and implementation of appropriate practices, and guide for continuous quality improvement across the broad range of mental health services including the government, non-government sector and private sectors.
Wraparound care	Individualised and integrated services provided through a single coordinated process to comprehensively meet a person's needs. One plan is developed for the individual and/or family. One person is nominated to facilitate the planning