INTERIM NARRATIVE REPORT FOR EXTERNAL ACTIONS OF THE EUROPEAN UNION

1. Description

1.1 Name of beneficiary of grant contract:

Goshen Trust Mental Health Services Samoa ("Goshen")

1.2 Name and title of the Contact person:

Savea Tutogi Soi Too Arundell

1.3 Name of partners in the Action:

N/A

1.4 Title of the Action:

Delivery and promotion of safe community-based mental health care programmes in Samoa

1.5 Contract number:

14-13-3-3-2

1.6 Start date and end date of the full reporting period:

Start date for the full reporting period: 5 October 2013
End date for the full reporting period: 2 April 2015

This interim narrative report is for the period 5 October 2013 to 31 January 2015 (16 months). A final narrative report will be provided for the full 18 month contract period (5 October 2013 to 2 April 2015) by end of April 2015.

1.7 Target country(ies) or region(s):

Target Region: Pacific
Target Country: Samoa

1.8 Final beneficiaries&/or target groups (if different) (including numbers of women and men):

Final beneficiaries/target groups:

(a) Mental health consumers in Samoa;

(b) Families of mental health consumers in Samoa; and

(c) Mental health sector (Government and NGO) in Samoa.

1.9 Country(ies) in which the activities take place (if different from 1.7):

N/A

2. Assessment of implementation of Action activities

2.1 Executive summary of the Action

(Please give a global overview of the Action's implementation for the interim reporting period (no more than ½ page)

The overall aim of the action is to improve community-based mental health services for Samoa. The specific objectives involve delivering community-based mental healthcare through a coordinated programme of activities. There are four activities involved: (1) the continuation of a community-based residential mental health respite care programme for consumers of low-level mental health disorders in Upolu; (2) delivery of a new step-down bed programme for Samoa mental health consumers whose case is not acute enough to be held in the acute MHU unit and not low-risk enough to be housed together with other respite residential consumers; (3) continuation of a community-based family support service for mental health consumers in Upolu; and (4) delivery of a new public mental health destigmatisation campaign in Samoa.

All four activities were implemented during the reporting period. Three of the four activities were well implemented throughout the reporting period. The fourth activity faced implementation challenges. The main challenge was lack of staff time available to organise meetings at the national level with MOH and NHS staff on the development of the destigmatisation campaign. However, much needed literature, such as the production of brochures relevant to the Samoa context were produced and distributed nationally.

The first activity has not been modified. It saw stable average numbers of consumers accessing the service. There was also an increase in number of activity topics available. Positive feedback about the service has been received from all stakeholders. Of all the four activities of this action, this was the most comprehensively implemented.

The second activity is a new activity and has not been modified. The building of the unit was successfully completed and would not have been possible without this EU support. Consumers have been referred to the service as planned through MHU. This activity has the full support of the MHU and NHS Social Services. Discussions towards the

establishment of a memorandum of understanding with the Ministry of Police and Prisons (MPP) for this service are still progressing.

The third activity has not been modified. The results have been challenged by the availability of only one licensed driver. Moreover, more intensive work with families of consumers with severe mental health conditions outside of the Apia Urban Area has happened during the reporting period compared with previous reporting periods.

2.2 Activities and results

There are four Activities for this Action as per the contract. All four are reported on below.

Activity 1:

Title:

To continue to provide a professional 24-hour low security residential respite care programme for low level clinically diagnosed mental health consumers in Upolu.

Topics/activities covered

This activity involved the delivery of a respite care programme for mental health consumers. The topics covered in the programme are noted in Table 1 below. All of these topics were able to be continued or were introduced for the first time and implemented as a result of this EU action. There are 11 activity topics in total. The shaded cells illustrate when and for how long the activity topic has been running over the 16 month interim reporting period.

Table 1: Residential Respite Care Activity Topics by Month

Activity Topic	***Oct '13***	***Nov***	***Dec***	***Jan '14***	***Feb***	***Mar***	***Apr***	***May***	***Jun***	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***	***Jan '15***
1: Prayers & Worship																
2: Hygiene																
3: Respect for Self																
4: Literacy																
5: Communi-cation Skills																
6:																

Physical Exercise																
7: Cooking																
8: Garden-ing																
9: Arts & Crafts																
10: Farming animals																
11: Sewing																

As highlighted in Table 1, three new activity topics were introduced in March 2014 and continued through to the end of the reporting period: "Arts & Crafts", "Farming Animals" and "Sewing". Activity topics 1-6 are designed to help consumers learn personal life skills that could help them look after themselves when they return to their families and villages. These activity topics stress the importance of knowing how to care for their mental, physical, social and spiritual needs. They also emphasise the importance of building respectful relationships with peers, staff, family and community members. They include guidance in the performance of basic tasks such as answering the telephone and responding to peers and staff in respectful tones using words of respect as per Samoan culture and custom. (See pictures in appendix 1 of consumers engaging in the activity topics mentioned above)

All of the 11 activity topics were delivered at a very basic level of instruction with consumer participation dependent on their respective levels of mental and physical wellness.

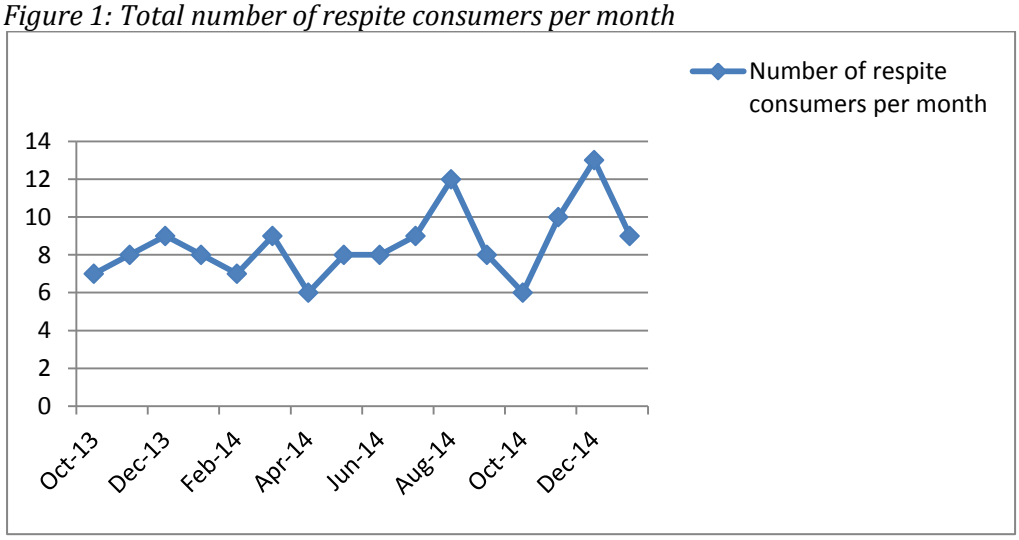
The activity topics were designed and implemented by Goshen staff, with the assistance of volunteers from JICA, Samoa Deportee Programme, SUNGO and Project Abroad.

At the start of the interim reporting period there were seven (7) staff members involved in this activity: six (6) full-time respite care staff and the other a volunteer from JICA. By the end of the interim reporting period (Jan 2015), there were still seven (7) staff members (the same ratio of six full-time staff and one volunteer from JICA). Respite care staff experienced two turnovers over the 16 month period. The main reasons for the turnovers were: one staff member taking maternity leave and the other two taking up new vocations/employment opportunities. These three (3) staff members were subsequently replaced by three (3) new staff members. Staff to consumer ratio is ideally 1:3, depending on severity of mental illness.

Figure 1 records the number of consumers accessing the activity from October 2013 to January 2015. Overall, despite fluctuating numbers, there has been an increase in total

number of consumers involved in this activity over the 16 months. The highest number of 13 consumers in respite care for one month was in the month of December 2014. A minimum number of six (6) consumers were in respite care in the months of April and October 2014. These monthly totals suggest an average of 8 consumers engaged in the activity across the reporting period. This is in line with general budgetary forecasts made at the beginning of the activity. It also aligns with total numbers for respite care consumers in previous years (e.g. between July 2012-July 2013 Goshen respite care service averaged between 7-8 consumers per month).[1]

Figure 1: Total number of respite consumers per month

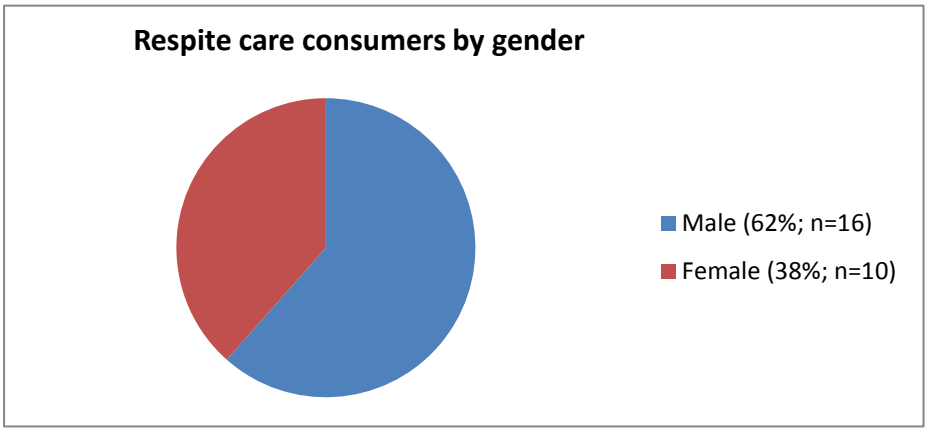


As is the nature of a respite care service, consumer stays are short not long term. Respite care stays usually average 6 weeks. However, depending on MHU diagnosis and treatment plan, consumer respite stays may be extended or shortened accordingly.

The demographic (gender, age and village/district of usual family residence) and diagnosed mental illness profiles of consumers involved in this activity are noted in figures 2 to 5 below. There were 26 different respite service users or consumers who accessed the service during the 16 month reporting period.

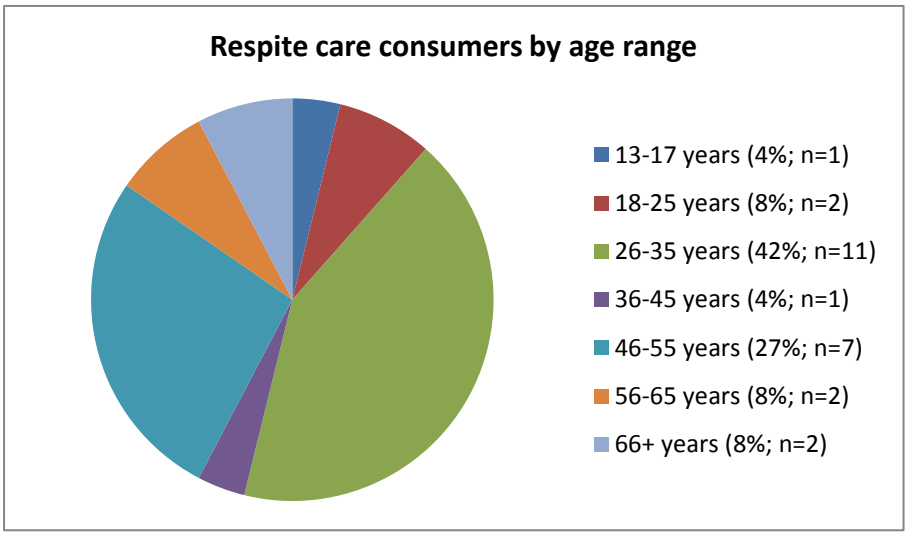
[1] See Goshen Progress reports to CSSP for periods Sept-Dec 2011; July-Dec 2012; and Jan-July 2013.

Figure 2: Respite care consumers by gender



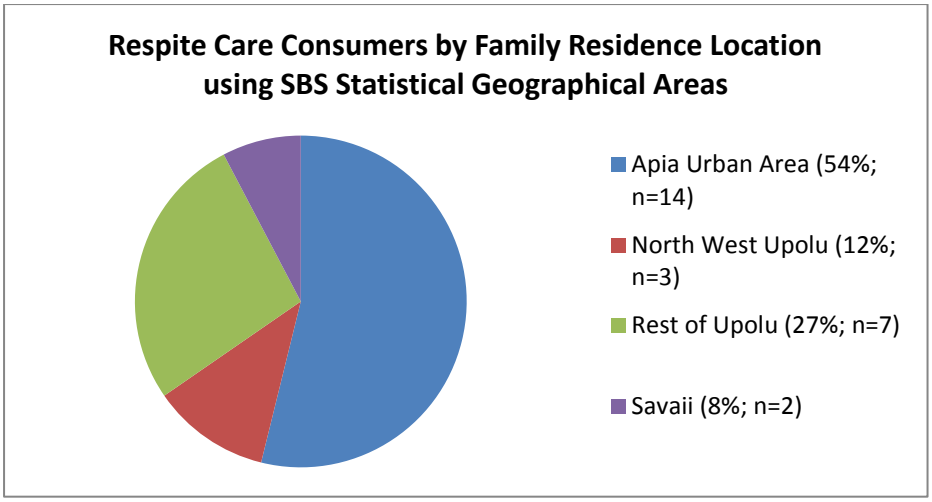
Most (62% or 16 out of 26) of the respite care consumers were males. However, an increasing number of females have been accessing the service since the start of the activity. In October 2013 there were only 2 females accessing the service. By December 2014 up to 10 females had accessed the service. The overall increase in female consumers was enabled by the employment of two regular female staff members, which in turn was as a result of EU support for this activity.

Figure 3: Respite care consumers by age range



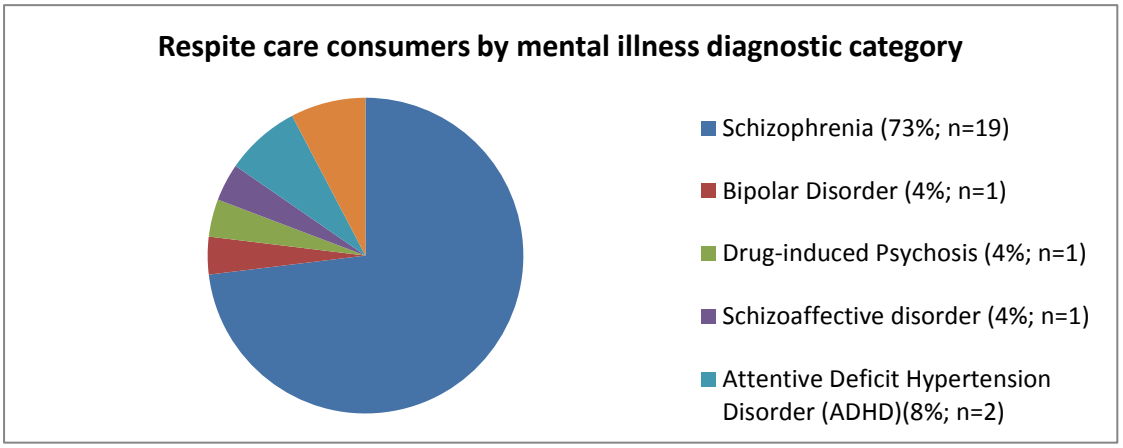
Over half (54%; 14 out of 26) of respite care consumers were 35 years old or younger. The youngest consumer during this period was between 15-16 years. The next largest group were between 46-55 years, with only 1 consumer aged between 36-45 years and 4 consumers aged 56 years plus. Goshen respite care service does not take children (under 13 year olds) and only under exceptional circumstances will it take adolescents. Because Samoa does not as yet have special services for elderly (post 65 years) with mental health problems, Goshen at present will take on 65 plus year olds in respite care providing they are clients also of the MHU.

Figure 4: Respite care consumers by usual residence using SBS Statistical Geographical Areas



Using the Samoa Bureau of Statistics census population and dwelling areas[2], most of the respite care consumers accessing the activity during the reporting period are usually residents of the Apia Urban Area (AUA). The next largest group come from the North West Upolu (NWU) area, followed by the Rest of Upolu (ROU) area and then Savaii. The two Savaii consumers came to the attention of Goshen via the Mental Health Unit (MHU).

Figure 5: Respite care consumers by diagnosed mental illness



NB: Dual Diagnosis categories are: Bipolar & Schizoaffective Disorder; and Schizophrenia & Historic Personality Disorder (these are based on MHU diagnoses as recorded in Goshen referral forms)

Most (73%) of the respite care consumer group were diagnosed (by MHU) as suffering from Schizophrenia. Diagnoses for the remaining consumers varied: ADHD, bipolar disorder, schizoaffective disorder, historic personality disorder and drug-induced psychosis. In two cases, consumers were diagnosed as suffering from two (dual) mental health disorders. Many of these consumers also have physical illnesses, such as diabetes and epilepsy. And some have an intellectual disability. These mental and physical illness conditions affect the consumer's ability to participate in the activities and place a caveat

[2] Samoa Bureau of Statistics. 2012. *Population and Housing Census 2011: Tabulation Report v.1*. Apia, Samoa: Samoa Government.

on staff expectations. However, with individual care plans consumers and staff are able to design, work towards and evidence progress at the individual consumer level. All consumers engaged to some degree in one or more of the topic areas noted in Table 1 over the reporting period. Staff daily progress sheets and care plans document consumer engagement in the 11 activity topics.

This community residential respite care activity, with its safe and nurturing physical environment, and its tailoring of different activity topics to meet consumer skill levels and interests, has, despite staffing and resource constraints, seen positive improvements in consumer wellbeing from time of entry to time of exit. Positive family feedback received by staff from family members during family visits include improved levels of engagement with family members, consumer desire to stay longer at home, consumers engaging more in doing chores around the family home, consumers are more sociable and well mannered, a decrease in unwell episodes at home, and consumer's knowing when they become unwell and asking to return to Goshen for support. All these indicate positive improvements as a result of the activity.

From the above data the general profile of consumers accessing the respite care service is mostly those under 40 years old, male, from the Apia Urban Area, with schizophrenia. This profile is subject to service delivery restrictions especially the location of the service (which is in Moamoa, Apia) and resource constraints (including staff).

Any modifications to or problems with the programme?

No modifications were made to his activity. There was an increase in activity topics as noted in Table 1. This was enabled by the action.

There have been no unexpected problems implementing this programme.

<u>Results</u> of this activity (please quantify these results, where possible; refer to the various assumptions of the Logframe)

Results for this activity are provided in figures 1-5 and table 1 above. The activity/programme was delivered in close association with the MHU and NHS social services. An external evaluation report on this activity will be provided in the final report for this action.

Staff have attended two mental health training courses offered by the Ministry of Health in 2014. One of these courses focused specifically on teaching participants how to restrain consumers safely.

All consumer have care plans in place. These care plans involve, by and large, Goshen working together with MHU staff and consumer family members to facilitate keeping the consumer well and, wherever possible, keeping the consumer in a safe and stable

living environment, preferably at home. This involves working with families and the consumer/s to ensure that they are able to identify when the consumer gets unwell, what they need in terms of treatment, and who they need to see to receive it.

Activity 2:

Title:

To provide professional 24-hour high security residential 'step down bed' rehabilitation programme for mental health consumers in Upolu.

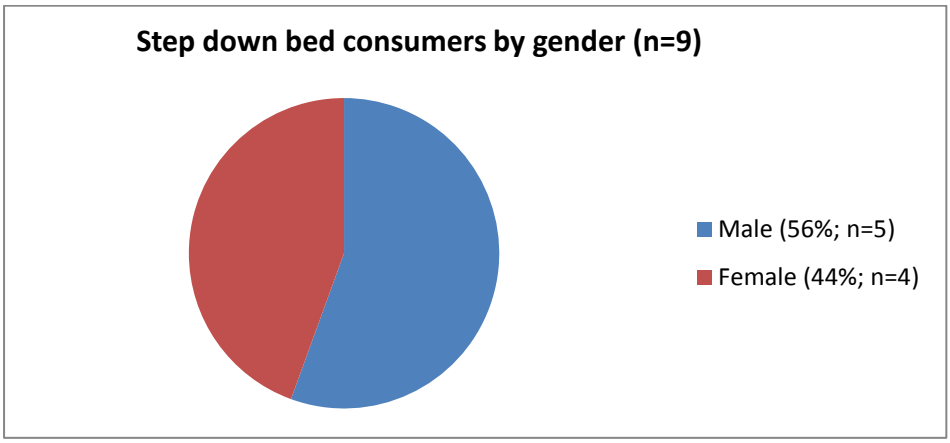
Topics/activities covered

This activity involved the provision of a high security (i.e. policed) residential 'step-down bed' facility that would house consumers who cannot be accommodated in the MHU Acute Unit but whose mental health status was too severe to be placed in Goshen's respite care services. The object of the activity is to ensure that there is a facility that consumers who suffer from an acute mental illness can be placed temporarily, with 24 hour security, without them having to go to Tafaigata prison or to be kept in a Police station holding cell.

To implement this activity it was necessary to renovate the bottom area of House 100 so that a separate locked two room unit with office and bathroom could be built for use as a step-down bed facility. The necessary building work was completed in early April 2014. Immediately upon completion the facility was formally blessed and the programme was ready to receive consumers (see appendix 2 for newspaper article on the opening of the step-down bed unit).

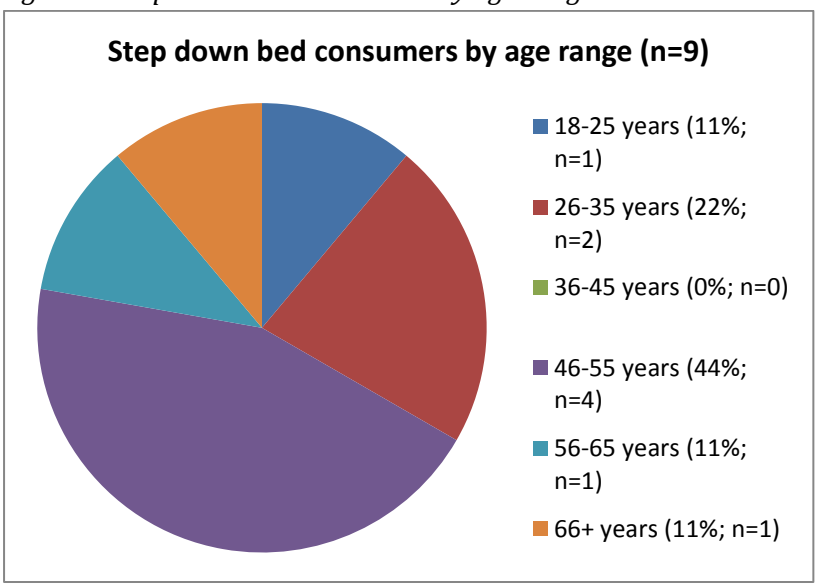
A total of nine (9) consumers have accessed this activity during the reporting period. All were referred from MHU. Just over half, five (5) were male, and four (4) were female.

Figure 6: Step-down bed consumers by gender



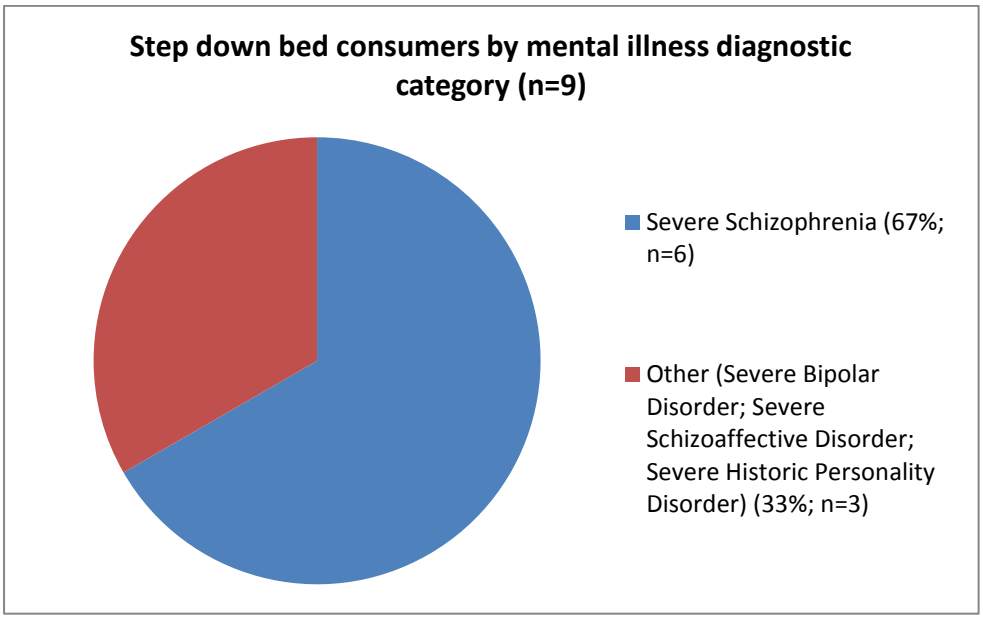
These nine consumers ranged across all age brackets: one (1) between 18-25 years; two (2) between 26-35 years; four (4) between 46-55 years; one (1) between 56-65 years; and one (1) 66 years plus.

Figure 7: Step-down bed consumers by age range



Most (6/9) were diagnosed with severe schizophrenia; the rest (3/9) were diagnosed with bipolar disorder, historic personality disorder, and schizoaffective disorder.

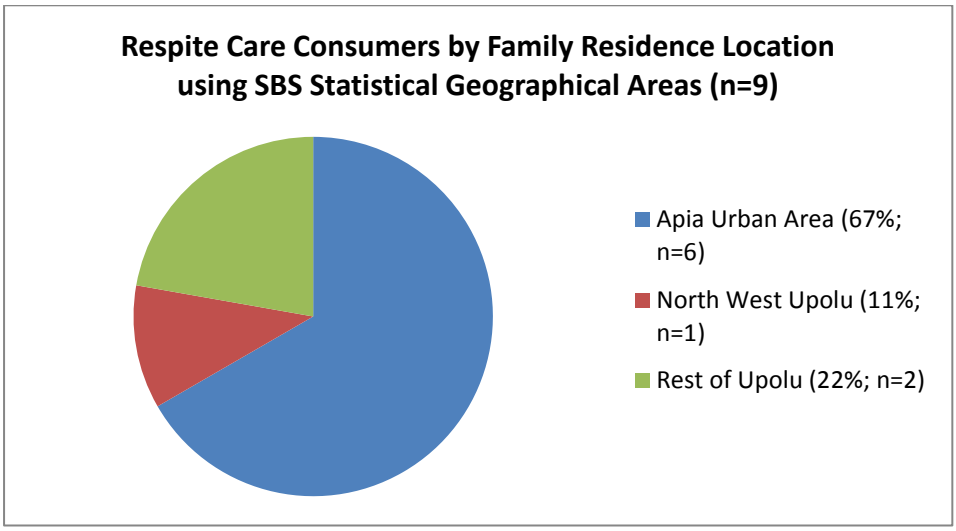
Figure 8: Step-down bed consumers by diagnosed mental illness



Except for one, all step-down bed consumers (8/9) also accessed respite care service either before or after their step-down bed stay.

All of the step-down bed residents normally reside in Upolu. Most of the step-down bed consumers are usual residents of the Apia Urban Area (6/9). One is usually a resident of the North West Upolu area and the remaining two are from the Rest of Upolu area.

Figure 9: Step-down bed consumers by SBS Statistical Geographical Areas



Any modification to or problems with the programme? Why did they arise and how were they solved?

Implementation of the programme over the reporting period depended on good cooperation between Goshen, the MHU and Ministry of Police and Prison (MPP). With the signing of the MOU between Goshen and the National Health Service (NHS), within which the MHU sits, cooperation between Goshen and MHU has been excellent (see copy of support letter by MHU Registrar in appendix 3). All step-down bed referrals are from MHU. Discussion on MOU with MPP continuing.

<u>Results</u> of this activity (please quantify these results, where possible; refer to the various assumptions of the Logframe)

See narrative above.

Activity 3:

Title:

To continue to provide regular home visitations to community/family-based mental health consumers in Upolu and to set up infrastructures to provide same service for Savaii-based consumers and their families

Topics/activities covered

There are two main activity topics in this activity. First is to visit in person or by phone with families of consumers who access Goshen respite or step-down bed services and/or families of consumers referred to Goshen by the MHU for family support work. The second is to provide these families with educational information relating to the mental illness/s suffered by their mentally unwell family member.

Over the reporting period there were a total of 161 actual family visits conducted under this activity. When the number of visits conducted are counted across the relevant months over the reporting period, there is a clear indication of how the service is operating. The spread of visits to these families over the reporting period was as follows:

Table 3: Number of family visits conducted by month/year

Month/Year	**No. of family visits**	**Talking therapies & Educational services delivered**
Oct 2013	12	√
Nov	8	√
Dec	9	√
Total for 3 months (2013)	*29*	
Jan 2014	18	√
Feb	5	√
March	8	√
April	10	√
May	15	√
June	12	√
July	6	√
Aug	17	√
Sept	11	√
Oct	8	√
Nov	14	√
Dec	5	√
Total for 12 months	*129*	
January 2013	3	√
Total for 1 month	3	√
Total number of visitations for reporting period (29+129+3)	***161***	

Educational services delivered included verbal explanations of:

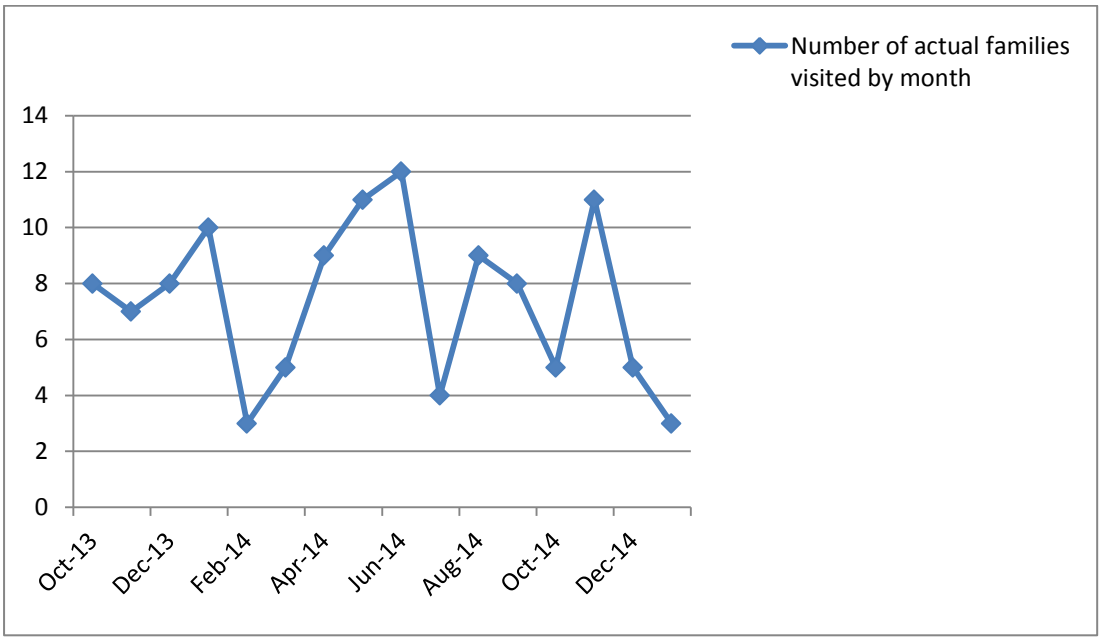
- the usual mental illness symptoms associated with the mental illness that their unwell family members suffered from;
- the treatment advised by the MHU;

- the medication prescribed and it's side-effects.

Education services were delivered by the CEO and trained senior community programme staff members. Staff within this programme attended training in basic mental health knowledge and care (which included information on interventions and medication side-effects) delivered by the Samoa Ministry of Health at the end of 2013 and middle of 2014.

Over the reporting period the number of actual families supported by this activity fluctuates each month. This is evident within figure 10. In 2013 a total of 24 actual families were visited by Goshen. In the three reporting months of October to December 2013, 7-8 families were visited and supported. In 2014 a total of 21 actual families were visited by Goshen. The numbers of actual families supported by Goshen in this activity per month for the year fluctuated considerably between a maximum of 12 and a minimum of three (3) families as illustrated in figure 10. In January 2015 only three (3) families were supported for that month.

Figure 10: Number of actual families visited by month



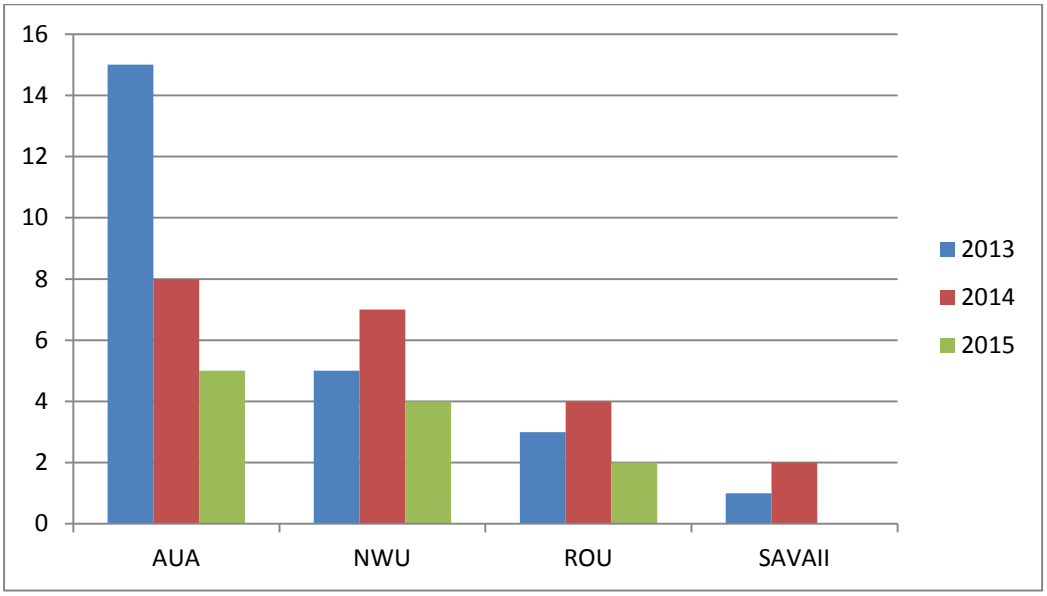
The fluctuation in numbers per month of actual families visited and actual visits per family was due largely to a combination of (a) the loss in May 2014 of the second licensed driver who assisted the CEO with driving duties for this activity; (b) the shortage of staff to cover the respite service so that the CEO (the remaining driver) could carry out the community visits; and (c) staff shortages over the Christmas/New Year holiday period, especially in December 2014-January 2015.

Almost all of the visitations took place in Upolu, with only two visits to Savaii for one family with two consumers. To provide as accurate an indication of trend over the

reporting period, the figures below are provided for two full years (Jan-Dec 2013 and Jan-Dec 2014) and only the month of January in the year 2015 is counted.

As illustrated in figure 11, in 2013 most of the families supported by Goshen in its community support programme resided in the Apia Urban Area (15/24). In the following year (2014) only 8 out of 21 families residing in AUA were visited. In the month of January 2015 this number decreases further to only 3 out of 12 families. The trend for visits to families residing in the other three geographical areas however shows an increase. The main reason for this increase was the increase in consumers of the respite and step-down bed activities whose families resided in those areas and who required intensive work as part of their mental health consumer's care and/or rehabilitation plan.

Figure 11: Number of families visited by geographical area for Jan 2013-Jan 2015



During visits with families Goshen's community support teams stressed the importance of properly monitoring their consumer's medication and wherever possible keeping the consumer gainfully occupied. As noted in Table 3 Goshen's community team conducted talking therapy sessions and/or gave educational literature on mental illnesses during all their family visits. These visitation sessions also provided opportunities for families to give Goshen verbal feedback about Goshen's service and to raise any questions or concerns about the progress of their mentally unwell family member.

Overall family feedback given verbally to staff during these visits has been overwhelmingly positive. The independent formal evaluation to be reported on in the final report will provide family member feedback on the community visits.

Any modification to or problems with the programme? Why did they arise and how were they solved?

No modification to the programme.

Results of this activity (please quantify these results, where possible; refer to the various assumptions of the Logframe)

See narrative above.

Activity 4:

Title:

To develop and facilitate a destigmatisation of mental health media campaign in Samoa

Topics/activities covered

This activity was to involve working together with NHS and MOH to develop and facilitate a national destigmatisation media campaign.

Liaison work on the destigmatisation campaign with NHS, MHU and MOH (Health Alliance) was initiated by Goshen's CEO. This began in November 2013. Contact was also made with three New Zealand mental health services who engage in the "Like Mine Like Minds" New Zealand campaign – a national destigmatisation campaign targeting mental illness: Penina Health Trust (see copy of confirmation letter from Penina Trust in appendix 3), Vaka Tautua Trust and Takanga a Fohe, Waitemata District Health Board Pacific Mental Health and Addictions Service in the same month. Follow up visits, email and/or phone conversations were held over the reporting period with these organisations for this activity.

Art therapy and mental health workshop, April 2014, was held at Tiapapata. Goshen attended along with MHU and others from social services at NHS. This saw the start of a productive relationship between Tiapapata Arts Centre and Goshen.

Goshen celebrated the World Mental Health Day on the 10th October 2014 by running a special art session with Tiapapata Art Centre. The following week on October 16th, Tiapapata Arts Centre ran another art therapy and mental health workshop on their premises. This was also attended by Goshen, along with other mental health organisations, including the technical mental health officer from the Fiji WHO office. These events have been recorded, along with the art work of Goshen consumers produced on the day, and interview comments by Goshen's CEO in a digital video documentary produced by Tiapapata Arts Centre titled "Expressions of Emotion" (2014, Paradigm Documentaries, Apia, Samoa).

There's very positive narrative on the DVD by artist Wendy Percival about the art therapy work at Goshen by consumers.

Tiapapata Arts Centre was also contracted to produce Goshen "Loto Gatasi" (meaning "One Heart" – a suggested Samoan equivalent for the "Like Mine Like Minds" slogan) brochures in the Samoan language, together with English language brochures about Goshen's activities – the family support services, respite care rehabilitation services, step-down bed service and the mental health destigmatisation campaign. (See copies of the brochures and banner in appendix 4).

Goshen has also promoted its message at local health forums, association meetings and international conferences. These include the Samoa Medical Association Meeting held in Apia, 2014, the Partnerships in Health 7th Annual Health Sector Forum meeting held in Samoa on the 4th & 5th of November, 2014, and the Small Island Developing States Conference held in Samoa, September 2014.

Any modification to or problems with the programme? Why did they arise and how were they solved?

The programme was modified in that it was reduced to two topic activities: production of destigamatisation brochure; and participation in mental health national health forums and international conferences.

<u>Results</u> of this activity (please quantify these results, where possible; refer to the various assumptions of the Logframe)

Results of this activity are provided above.

2.3 Please list activities that were planned and that you were not able to implement, explaining the reasons for these.

All activities were implemented. Three were and continue to be implemented fully. The fourth, i.e. the national destigmatisation campaign, was only partially implemented. It is believed that this activity is long-term and will continue to be developed post the action.

2.4 What is your assessment of the results of the Action so far?

(Include observations on the performance and the achievement of outputs, outcomes and impact in relation to specific and overall objectives, and whether the Action has had any unforeseen positive or negative results (please quantify where possible; refer to Logframe indicators)

Given the constraints mentioned in section 2 above, the outputs, outcomes and impact of the action thus far has been very good.

Please list potential risks that may have jeopardized the realisation of some activities and explain how they have been tackled. Refer to logframe indicators.

Staffing is the main challenge to full implementation and forward progress on activities. This affected the fourth activity the most. Goshen believes that the fourth activity will continue to be implemented post-action.

If relevant, submit a revised logframe, highlighting the changes.

N/A

Please list all contracts (works, supplies, services) above 10,000€ awarded for the implementation of the action during the interim reporting period, giving for each contract the amount, the award procedure followed and the name of the contractor.

N/A

2.5 Please provide an updated action plan.

See appendix 5.

3 Partners and other Co-operation

3.1 ***How do you assess the relationship between the formal partners of this Action (i.e. those partners which have signed a partnership statement)?***

Please provide specific information for each partner organisation.

N/A

3.2 How would you assess the relationship between your organisation and State authorities in the Action countries? How has this relationship affected the Action?

Excellent.

3.3 Where applicable, describe your relationship with any other organisations involved in implementing the Action:

- *Associate(s)(if any)*

The following organisations were instrumental in the successful implementation of the action:

- NHS MHU and Social Services
- Ministry of Police and Prison
- Tiapapa Arts Centre
- JICA Volunteers
- Project Abroad Volunteers

Goshen's working relationship with these organisations has been excellent. Goshen is grateful for their ongoing support.

- *Sub-contractor(s) (if any)*

Two subcontractors were procured for this action during the interim reporting period:

- Carpenter for the building of the step-down bed unit: Mr Laupepa Aloniu; and
- Media services for the production of destigmatisation brochure and Goshen banner: Tiapapata Arts Centre.

Goshen's relationship with the two subcontractors has been very good.

One more subcontractor is to come. This is the evaluator, who will conduct an independent formal evaluation of the four activities. The final report for the evaluation will be submitted with the final report for the action.

- *Final Beneficiaries and Target Groups*

Goshen has received positive verbal and written support from consumers, families of consumers and the mental health sector. See letter of support from the MHU Registrar in appendix 3. The formal evaluation findings will include independent feedback from consumers, their families and other stakeholders.

- *Other third parties involved (including other donors, other government agencies or local government units, NGOs, etc)*

JICA has been very supportive in providing volunteers and provision of gardening resources. Project Abroad have also provided excellent volunteers who have assisted in the implementation of this action. New Zealand mental health organisations, as mentioned above, have also been very supportive.

3.4 Where applicable, outline any links and synergies you have developed with other actions.

N/A

3.5 If your organisation has received previous EU grants in view of strengthening the same target group, in how far has this Action been able to build upon/complement the previous one(s)? (List all previous relevant EU grants).

N/A

4 Visibility

How is the visibility of the EU contribution being ensured in this Action?

At all media, conference or other public presentation events in which Goshen have participated representatives have highlighted the fact that it was through EU funding that this action was possible.

The European Commission may wish to publicise the results of Actions. Do you have any objection to this report being published on the EuropeAid website? If so, please state your objections here.

No, there is no objection.

Name of the contact person for the Action: Savea Tutogi Soi Too Arundell

Signature: _____

Location: 100 Ausetalia Road, Moamoa, Apia, SAMOA.

Date report due: 27 February, 2015

Date report sent: 25 February 2015

Appendix 1: Activity One – Images of Respite Care Service Activities

Gardening & Cooking Activities:

Learning about physical health & hygiene:

Arts & Crafts Activity:

Dancing & Other Craft Activities:

Appendix 2: Samoan Observer Newspaper Article of Step-Down Bed Unit Opening

www.samoaobserver.ws

Goshen Trust sets up mental health unit

Goshen has learnt from recent unfortunate events that Samoa could do better by way of offering facilities manned by trained staff to safely house high maintenance patients with violent presentations.

PR - Goshen Trust Samoa a registered charitable trust since 2000 celebrated the opening of a third service available to the community Wednesday evening at their Moamoa residence.

Their first service was in opening a Respite Care Home in 2010 which provides 24 hour residential housing and when needed a further 24 hour weekend care.

All referrals come from the Mental Health Unit (M.H.U.) at Moto'otua.

Their second service is in offering Family Support in the Community, this is twofold in that Goshen liaises between families and our M.H.U. at Moto'otua.

They also provide an educative role with information about Mental Health issues in partnership with M.H.U. staff.

The third service which opened this past Wednesday offers a Step-Down Bed facility.

Goshen has learnt from recent unfortunate events that Samoa could do better by way of offering facilities manned by trained staff to safely house high maintenance patients with violent presentations.

Our best answer then, was Tafaigata.

It was the appropriate direction that Goshen needed to head to urgently.

The newly opened Step-Down Bed facility offers: 24 hr 1:1 supervision, lockable single rooms, daily clinical checks by M.H.U. staff at Moto'otua, implementation of intensive talking therapy, 24 hr updates to M.H.U. and the 'stair-casing' of care from Step down to Respite.

Goshen is proud to offer this service in partnership with NHS and Ministry of Police.

Goshen Trust Samoa remains grateful to all its supporters both local and international.

Goshen Trust Samoa is indebted to the European Union (E.U.) from whom their 2013-2014 operating budget was financed from.

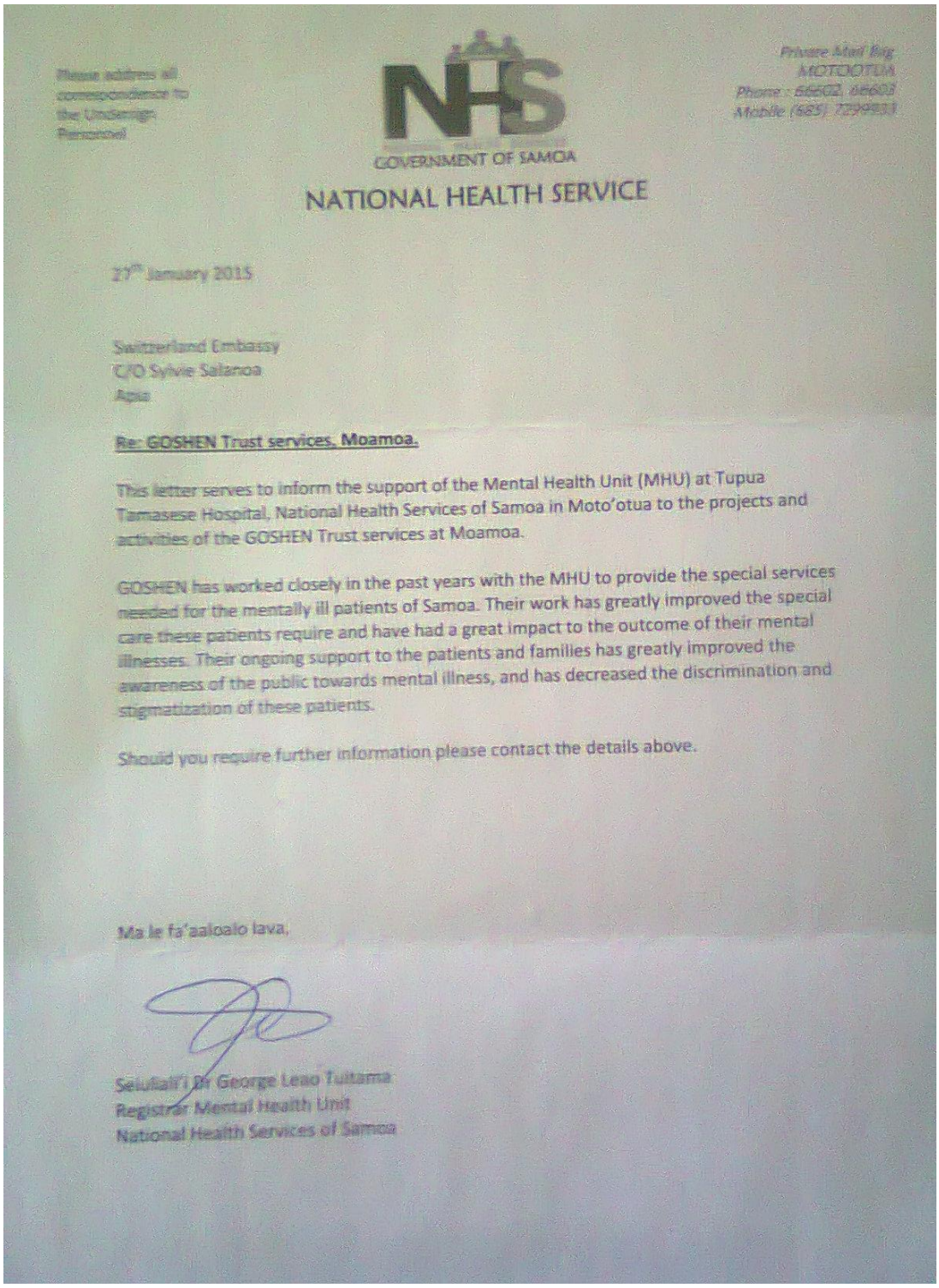
SAT $20,000 from their E.U. funded SAT $300,000 grant was earmarked for this Step-Down Bed project.

The trust thanked John Stanley of E.U. for making this project a reality.

This will go a long way in ensuring that Mental Health care in Samoa moves towards meeting international best practice in providing safety and treatment for high maintenance consumers.

GRATEFUL: Goshen Trust Samoa's Patron, Board Chair & Trustees, C.E.O., staff and most importantly their consumers and families, thank the Government of Samoa, Ausaid and E.U. their generous donors, and many friends for their continued support.

Appendix 3: Support Letter by MHU Registrar & by Penina Trust (NZ)



Please address all correspondence to the Chief Executive

GOVERNMENT OF SAMOA

NATIONAL HEALTH SERVICE

Private Mail Bag
MOTOOTUA
Phone : 66602, 66603
Mobile (685) 7259931

27th January 2015

Switzerland Embassy
C/O Sylvie Salanoa
Apia

Re: GOSHEN Trust services, Moamoa.

This letter serves to inform the support of the Mental Health Unit (MHU) at Tupua Tamasese Hospital, National Health Services of Samoa in Moto'otua to the projects and activities of the GOSHEN Trust services at Moamoa.

GOSHEN has worked closely in the past years with the MHU to provide the special services needed for the mentally ill patients of Samoa. Their work has greatly improved the special care these patients require and have had a great impact to the outcome of their mental illnesses. Their ongoing support to the patients and families has greatly improved the awareness of the public towards mental illness, and has decreased the discrimination and stigmatization of these patients.

Should you require further information please contact the details above.

Ma le fa'aaloalo lava,

Selufiali'i Dr George Leao Tuitama
Registrar Mental Health Unit
National Health Services of Samoa

Penina Health Trust

Our peoples, our pearls

25th November, 2013

Board of Trustees
Goshen Trust

Dear Chair,

Re: Attendance at our annual 'Step-down Beds – Residential Rehabilitation Service Training'

I write to confirm the attendance of Savea Tutogi Soi Too-Arundell at our annual training held on the week beginning the 18th of November, 2013.

Unfortunately I was on leave for my fathers' funeral, however the Service Manager reported to me that they had a very focused and productive training.

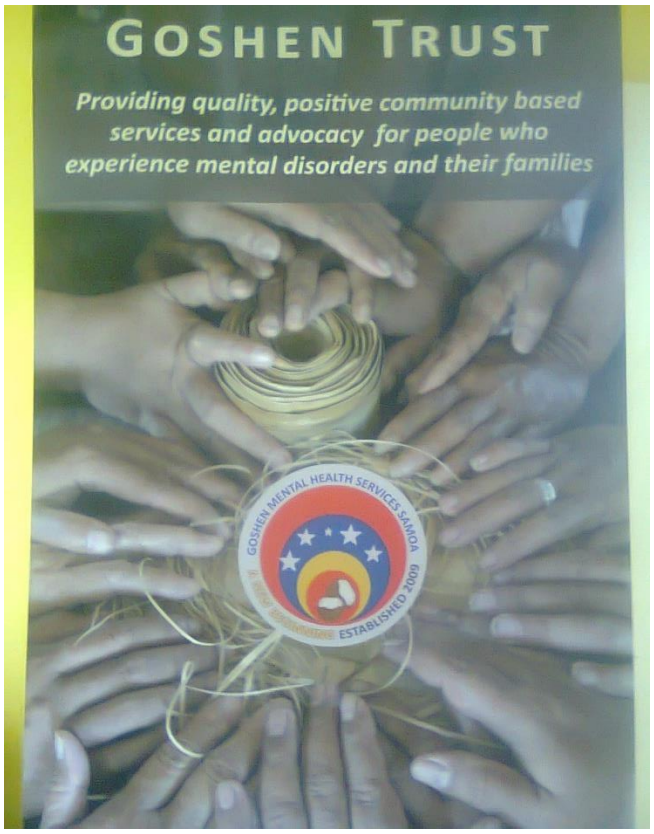
I look forward to coming out in April to work on our collaborative training surrounding the destigmatisation and antidiscrimination work. This is a critical area of development for Samoa and as the original Pacific consultant on the project within New Zealand, it is wonderful to see Samoa embrace this important initiative. This initiative will go a long way in helping improve the quality of life of those who experience mental illness and their families.

I look forward to seeing you then,

Kind regards,

Roine Lealaiauloto
(Chief Executive for Penina Health Trust)

Appendix 4: Photographic copies of Brochures and Banner



Art Therapy Workshop at the Tiapapata Art Centre, 16 October 2014

WORDS OF ENCOURAGEMENT

"I can do all things through Christ which strengtheneth me"

Philippians 4:13

He shall call upon me, and I will answer him: I will be with him in trouble; I will deliver him, and honour him.

With long life will I satisfy him, and shew him my salvation.

Psalm 91: 15-16

CONTACT US:

Location: Waisirisi
Street: Australia Road
Telephone: 23487
P.O Box: 3033
Mobile: 7207363
Email: goshentrust@solomon.net

GOSHEN TRUST

Goshen Trust formally began operations in September 2010 with its Family Community support services. Since its humble voluntary beginnings, Goshen has developed to provide a wide range of services including services in residential rehabilitation.

Mission, Philosophy and Values

"Provide quality, positive community based services and advocacy for people who experience mental disorders and their families"

Goshen's philosophy of Care

"Goshen is committed to the principle of recovery. Goshen exists to support people on their journey through illness and towards recovery. Recovery for Goshen is about enabling people to take control of their own lives with a view to achieving their full potential. Goshen will support people towards recovery through the delivery of timely, appropriate and safe services delivered by professional competent staff whilst respecting the dignity and human rights of all those that they serve"

LOTO GATASI

O le galuega a lenei polokalame:

Fa'asalalauina fa'alauaitele mataupu tau i le soifua malōlōina fa'a le mafaufau.

Feso'ota'iga vāvālalata ma isi fa'alapotopotoga o lo'o galulue fo'i i lea vaega o le soifua malōlōina ma ia malamalama i le autu ma le fa'amoemoe o lenei polokalame ua fa'aigoaina o le **"Loto Gatasi"**. Una'ia le te'ena o uiga ma amioga fa'amāasiasi ma le fa'ailoga tagata e fa'asaga i ē ua a'afia i le gasegase o le mafaufau.

Fe'au tāua:

Taofi nei loa le fa'ailoga tagata.

E mo'omia:

- le tagolagosua a le āiga
- le galulue vāvālalata ma Ekalesia
- le vave ona sa'ili togafitiga
- le amana'iaina o āiā tatau a tagata ua maua i le gasegase o le mafaufau.

FA'AMAFANAFANAGA

"Ia foa'i atu fo'i ia te outou e le Atua o ia e tupu mai ai le onosai ma le fa'amafanafanaga, ina ia gatasi ai o outou loto e tusa ma le finagalo o Keriso Iesu." (Roma 15: 5)

"Ia outou [illegible]" (Iakopo 1:22)

CONTACT US:

Location: Moamoa
Street: Australia Road
Telephone: 27487
P.O Box: 9013
Mobile: 7207362
Email: goshentrust@samoaonline.ws

LOTO GATASI

O le **"Loto Gatasi"**, o se polokalame na muaa'i fa'alauiloaina i le tausaga 1996 mai i fa'amaumauga Ripoti e ta'ua o le Mason Report, i Aukilani, Niu Sila.

O matāupu na fa'aālia i lea Ripoti, o le fa'asinosino lima ma le fa'amāasiasiga o uiga ia o le fa'ailoga tagata i ē o lo'o a'afia i le gasegase o le mafaufau. O le talitonuga o Kosena (Goshen), o lo'o tupu fo'i lea fa'afitauli i totonu o Samoa.

O le Loto Gatasi ma A'u

O le sini autu "O le Loto Gatasi ma A'u", o le fa'atitino lea o le fa'ailoga tagata ma le fa'amāasiasi i ē ua a'afia i le gasegase o le mafaufau.

Appendix 5: Updated Action Plan

The duration of the action will be 18 months. The update to the action plan is the removal of the Traditional Healer group from the preparation and execution of the activity, and the insertion of New Zealand mental health organisations involved in the 'Like Mine Like Minds' programme. The revisions are highlighted yellow.

Year 1													
	Semester 1						Semester 2						
Activity	1	2	3	4	5	6	7	8	9	10	11	12	Implementing body
Example	E.g.												Example
Preparation Activity 1 Delivery of respite care programme	G ME	G ME	G	G	G	G	G	G	G	G	G	G	G=Goshen Planning is ongoing and is informed by findings from internal process evaluations ME=design of monitoring & evaluation framework
Execution Activity 1 Delivery of respite care programme	G M1 F1	G M1 F1	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	G M1 F1 ME	Goshen = implements care plan activities M1=MHU = provides clinical assessment when needed F1=Families – they assist with individual care plans ME=implement monitoring & evaluation work

Preparation Activity 2 Delivery of "step-down bed" programme	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	Planning is ongoing Goshen M1=MHU =provides clinical care MPP = M2=provides security care F1=assists with care plan ME=design monitoring & evaluation framework
Execution Activity 2 Delivery of "step-down bed" programme													
Preparation Activity 3 Delivery of family support programme	G ME	G ME	G F2	G F2	G F2	G F2	G F2	G F2	G F2	G F2	G F2	G F2	Planning is ongoing Goshen F2=work as cooperative to promote family needs and perspectives ME=design
Execution Activity 3 Delivery of family support programme	G	G	G ME	G ME	G ME	G ME	G ME	G ME	G ME	G ME	G ME	G ME	Goshen (darker shade highlights work on Savaii database and scoping exercise) ME=implement

Preparation Activity 4 Development and implementation of national media destigmatisation campaign	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ F2 ME	G M1 M3 N NZ T ME	Planning is ongoing Goshen M1 M3=MOH N=NHS NZ = NZ Mental Health F2 ME=design
Execution Activity 4 Development and implementation of national media destigmatisation campaign							G M1 M3 N F2 ME	G M1 M3 N F2 ME	G M1 M3 N F2 ME	G M1 M3 N F2 ME	G M1 M3 N F2 ME	G M1 M3 N F2 ME	Goshen M1 M3 N F2 ME=implement
Year 2													
	Semester 3												
Activity	1	2	3	4	5	6							Implementing body
Example	E.g.												Example

Preparation Activity 1 Delivery of respite care programme	G	G	G	G	G	G							Goshen Planning is ongoing and is informed by findings from internal process evaluations ME=design impact evaluation
Execution Activity 1 Delivery of respite care programme	G' ME	G ME	G ME	G ME	G ME	G ME							Goshen MHU = provides clinical assessment when needed F1 ME=implement impact evaluation
Preparation Activity 2 Delivery of "step-down bed" programme	G M1 M2 F1	G M1 M2 F1	G M1 M2 F1	G M1 M2 F1	G M1 M2 F1	G M1 M2 F1							Planning is ongoing Goshen M1= provides clinical care M2 = provides security care F1 ME=design impact evaluation
Execution Activity 2 Delivery of "step-down bed" programme	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME	G M1 M2 F1 ME							Goshen M1= provides clinical care M2= provides security care F1 ME=implement

Preparation Activity 3 Delivery of family support programme	G F2	G F2	G F2	G F2	G F2	G F2							Planning is ongoing Goshen F2 ME=design
Execution Activity 3 Delivery of family support programme	G F2 ME	G F2 ME	G F2 ME	G F2 ME	G F2 ME	G F2 ME							Goshen F2 ME=implement
Preparation Activity 4 Development and implementation of national media destigmatisation campaign	G M1 M3 N ME	G M1 M3 N ME	G M1 M3 N	G M1 M3 N	G M1 M3 N	G M1 M3 N							Planning is ongoing Goshen M1 M3=MOH N=NHS F2 ME=design impact
Execution Activity 4 Development and implementation of national media destigmatisation campaign	G M1 N M3	G M1 N M3	G M1 N M3 ME	G M1 N M3 ME	G M1 N M3 ME	G M1 N M3 ME							Goshen M1 M3 N F2 ME=implement

Appendix 6: Financial Report for the Reporting Period (excel spreadsheet attached)

NB:

1. EU fund total provided for action = $300,000.00; first instalment = $240,000.00 received Oct 2013; Goshen provided $25,350.00 in Oct 2013. This provides the total operating amount of $265,350.00 for the reporting period.

2. The difference between $265,350.00 that went into the action and actual amount spent as at end of Jan 2015 on the action of $218,987.58 is $46,371.42. This is the actual sum remaining from the action as at end of reporting period.

Appendix 7: Copy of Financial Auditor's Report for Year ending 30 June 2014 (photocopy attached)