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**Part C2:**

**Mental Health Respite: Carer Support Activity under the**

**Targeted Community Care (Mental Health) Program**

**April 2013**

**Preface**

These guidelines provide the framework for the implementation and administration of the Mental Health Respite: Carer Support Activity under the Targeted Community Care (Mental Health) Program (the Program).

The Australian Government Department of Social Services (**DSS** or the **Department**) has a suite of documents (the **Program Guidelines Suite**) which provide information relating to the Program. The Program Guidelines Suite provides the key starting point for parties considering whether to participate in the Program and form the basis for the business relationship between DSS and the funding recipient.

The Program Guidelines Suite consists of the following documents:

**Part A: Targeted Community Care (Mental Health) Program Guidelines**,whichprovide an overview of the Program and the activities relating to the Program.

**Part B: Information for Applicants**,which provides information on the Application, assessment, eligibility, selection and complaints processes; and financial and funding agreement arrangements.

**Part C1 ‐ Personal Helpers and Mentors Activity Guidelines**,whichprovides specific information on the activity, selection processes, performance management and reporting. This part should be read in conjunction with the [Standard Terms and Conditions.](http://www.dss.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement)

**Part C2 - Mental Health Respite: Carer Support Activity Guidelines**,whichprovides specific information on the activity, selection processes, performance management and reporting. This part should be read in conjunction with the [Standard Terms and Conditions.](http://www.dss.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement)

**Part C3 - Family Mental Health Support Services Activity Guidelines**, whichprovides specific information on the activity, selection processes, performance management and reporting. This part should be read in conjunction with the [Standard Terms and Conditions.](http://www.dss.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement)

DSS reserves the right to amend these documents from time to time by whatever means it may determine in its absolute discretion and will provide reasonable notice of these amendments.

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**1. TCC Program Overview**

The Targeted Community Care (Mental Health) Program (TCC Program or the Program) commenced in 2006 following a Council of Australian Governments (COAG) agreement to a whole-of-government approach to mental health. The original measures (over five years to 2010–11) are now fully implemented and the three activities under the Program are well established and achieving good outcomes for people with mental illness, their families and carers.

The three activities funded under the TCC Program are:

* Personal Helpers and Mentors (PHaMs)
* Mental Health Respite: Carer Support (MHR:CS), and
* Family Mental Health Support Services (FMHSS).

The TCC Program is contributing towards the Government’s mental health agenda, by providing services that are designed around the support needs of people with mental illness, their families and carers, and that work together to help people with a mental illness live well in their communities.

The services delivered under the TCC program are seen as an important component of the broader mental health service system, complementing other Commonwealth and state clinical and non‑clinical services that aim to increase the ability for people with severe mental illness to be fully participating members of their communities. Ongoing feedback from community mental health sector stakeholders has confirmed the importance of these community-based programs in areas of prevention, early intervention and targeted support. Each activity makes a substantial contribution through increasing access to services and improving service pathways and social inclusion.

In the 2011–12 Budget, the Australian Government announced a significant investment for a major expansion of all three TCC Program activities, building on the successes of the previous five years. The Australian Government allocated a total of $269.3 million in its Mental Health Reform Budget measures that will see new services rolled out over five years from 2011–12 to 2015–16. The number of FMHSS will double, the PHaMs workforce will increase by almost 50 per cent, and respite and carer support will be available for more than 1,000 additional carers of people with mental illness. The Government also introduced a new component of the PHaMs activity to provide personal helpers and mentors to specifically help people with mental illness on, or claiming income support or the Disability Support Pension, who are also engaged with employment services.

In implementing the Budget measures, DSS will be:

* Increasing the number of intensive support services for people with severe and persistent mental illness who have complex care needs, along with their carers
* Targeting support to areas and communities that need it most, such as Indigenous communities and socioeconomically disadvantaged areas that are underserviced, and
* Helping to detect potential mental health problems in early years, and supporting children and young people and families who struggle with mental illness.

**1.1 TCC Program Outcomes**

This program provides accessible, responsive, high-quality and integrated community-based mental health services that improve the capacity of individuals, families and carers to manage the impacts of mental illness on their lives and improve their overall wellbeing.

**1.2 TCC Program Objectives**

The objective of the TCC Program is to implement community mental health initiatives to assist people affected by severe mental illness and their families and carers to manage the impact of mental illness. The TCC Program will provide accessible, responsive, high-quality and integrated community mental health services that improve the lives of people affected by severe mental illness, provide support for families and carers of people with a mental illness, and intervene early to assist families with children and young people affected by, or at risk of, mental illness.

**2. Mental Health Respite: Carer Support**

**2.1 Overview**

Mental illness in households can have devastating impacts on families and carers. Research shows how important carers and families are in supporting people living with mental illness, and assisting them in their recovery journeys. The MHR:CS activity provides a range of flexible support options for carers of people affected by severe mental illness.

In 2007, direct approaches were made to the 55 organisations funded to operate Commonwealth Respite and Carelink Centres, to broker respite services for carers of people with mental illness or an intellectual disability[[1]](#footnote-1), in all Home and Community Care (HACC) regions across Australia. Between late 2007 and early 2009, additional providers were selected through competitive and direct approach processes to deliver respite and other carer support services.

In 2011–12, a total of 190 MHR:CS services, funded for $50.3 million, assisted over 28,000 carers of people with mental illness or intellectual disability in Australia.

In 2011, the Australian Government launched the [National Carer Strategy](http://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/national-carer-strategy), the second element of the Australian Government’s [National Carer Recognition Framework](http://www.health.gov.au/nationalcarerstrategy).  Along with the [*Carer Recognition Act 2010*](http://www.comlaw.gov.au/Details/C2010A00123), the National Carer Strategy strengthens the Government’s commitment to recognise and respond to the needs of carers so they have rights, choices, opportunities and capabilities to participate in economic, social and community life.

The National Carer Strategy outlines six important priority areas for action – recognition and respect, information and access, economic security, services for carers, education and training, and health and wellbeing.  Collectively, these priority areas outline how the contribution of Australia’s carers will be better valued, supported and shared.

The 2011–12 Budget allocated an additional $54.3 million over five years to 2015–16, to extend carer support to an additional 1,100 carers and families of people with mental illness.

It is clear from carer feedback that they want services that take a whole-of-family recovery approach and are targeted to meet their individual and evolving needs and circumstances. Carers are seeking flexible, individually tailored, carer-centred and carer-driven support that recognises the episodic nature of mental illness.

Support provided by MHR:CS services can be broadly grouped into three types:

* **Relief from the caring role**
* breaks from the caring role through short-term in-home or out-of-home respite[[2]](#footnote-2), and
* social and recreational activities[[3]](#footnote-3) that provide carers with a break from their caring roles.
* **Carer support**
* Counselling, including assistance to develop strategies and plans for coping in difficult times
* Practical assistance to address issues that are impediments to carers sustaining their caring roles and their own physical and mental wellbeing[[4]](#footnote-4)
* Social and recreational activities, including activities that keep carers connected to their communities
* Advocacy services[[5]](#footnote-5)
* Peer support and mentoring, and
* Case management, including development, review and revision of carer support plans, and tracking the progress of carers against carer support plans.
* **Education, information and access**
* Information about, and referral or access to, relevant services, community groups and activities
* Carer education and training, including carer wellbeing programmes or formal training to help carers transition to employment
* Education for families about mental illness and its impacts
* Mental health promotion in the broader community, including efforts to de‑stigmatise mental illness, or marketing of services to ensure services are accessible and widely known, and
* Activities that assist carers to remain connected with the community, or help them to live active and fulfilling lives, including personal development opportunities that could lead to voluntary or paid employment.

Services are delivered directly by the funded MHR:CS providers, arranged through referrals to other agencies or by brokering services from other agencies.

In selecting providers for new MHR:CS services, the Department will be seeking organisations with the ability to deliver carer-centred services that offer a range of flexible supports to meet the needs of carers of people with mental illness, along with their families. The providers would be expected to develop carer support plans in collaboration with carers, to provide a continuum of support for carers and their families, involving a range of assistance to suit their circumstances at different points in time.

New or expanded MHR:CS services focus on improving access to a broader range of carer support options that account for the episodic nature of mental illness and the need for carer support services that respond to changing circumstances. New services are expected to deliver services from all the three types listed above. The balance between types will reflect the particular needs identified in a service’s coverage area.

**2.****2 Mental Health Respite: Carer Support Aims and Objectives**

The aim of the MHR:CS activity is to assist carers of people with mental illness to sustain their caring roles and maintain connection with their communities, by increasing access to flexible, innovative carer support services.

The key objective of MHR:CS is for carers to make progress towards addressing those things that prevent them sustaining their caring roles. This includes maintenance or improvement of their physical and mental health and wellbeing.

The Department is seeking the following outcomes:

* Carers are better able to sustain their caring roles
* Carers have increased confidence, capacity and choices; and
* Improved wellbeing for families and carers of people with mental illness.

**3. Selection processes for providers of MHR:CS**

There are no selection processes currently open. There are also no open selection processes planned for the remainder of 2012–13. When opportunities to apply for funding become available, they will be announced on the [DSS website.](http://www.dss.gov.au/)

**4. MHR:CS activity in detail**

**4.1 MHR:CS client eligibility and target groups**

The primary focus of MHR:CS is assistance for carers of people with mental illness to help them maintain their caring roles and improve their wellbeing. Services funded prior to 2011–12 will continue to deliver carer support as outlined in their funding agreements. This includes assisting carers of people with intellectual disability, who may make up to 25 per cent of each service’s client base.

Carers[[6]](#footnote-6) will undergo an eligibility assessment and a needs assessment to determine eligibility and access priority. Where a carer needs alternative care for the care recipient as a form of respite from the caring role, the care recipient’s needs will also be assessed to determine the most appropriate service and the specifics of care needed.

Assessment criteria and processes ensure that the carers’ total circumstances are taken into account. They ensure that consumer rights, including privacy, are recognised and protected. Processes include review and re‑assessment of the care situation, and referral plans where appropriate.

Carers may be asked to make a small contribution to the cost of some services (not more than 10 per cent), however carers unable to contribute will not be denied services.

**4.1.1 MHR:CS client eligibility criteria**

To be eligible to receive MHR:CS services the carer must be providing care to a person because of his/her mental illness[[7]](#footnote-7). Highest priority will be given to carers without access to similar respite or carer support through other government-funded services (e.g. state disability services or the National Respite Carer Program).

**4.1.2 How to access MHR:CS services**

To access MHR:CS services, contact either a Commonwealth Respite and Carelink Centre on 1800 052 222 or a [respite service provider](http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/publications-articles/mental-health-respite-carer-support-guidelines-part-c2/locating-a-respite-service-provider) directly.

**4.1.3 What participants can expect**

Carers and their families can expect support to be provided according to MHR:CS practice principles listed in paragraph 4.5.2. In addition:

* services for carers will be prioritised based on carer need, relative to other carers
* service providers will endeavour to provide equity of access for carers, such that funding is used to provide service to as many carers as possible
* where service providers are unable to deliver the services needed by the carer they will provide information about, and facilitate access to, other appropriate services, and
* carers receiving MHR:CS services may be asked to participate in a Client Survey each year.

**4.1.4 Ineligible persons**

Carers who are not eligible for MHR:CS funded services are:

* paid carers whose vocation is providing personal care services to the person with a mental illness, in return for wages or salary, and
* self-carers, because MHR:CS is intended to support people who provide care to another person[[8]](#footnote-8).

**4.1.5 Participant rights and responsibilities**

***Rights*:** [Standard 6 of the *National standards* *for mental health services*](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10) lists rights applying to consumers of mental health services. They include that clients must be treated with respect, have their privacy protected, and receive services appropriate to their needs in a safe and healthy environment.

***Responsibilities*:** Carers have a responsibility to provide accurate information about their needs and circumstances so that they can receive quality services, are required to comply with the rules and regulations for engaging with services (e.g. no smoking in service premises) and behave in a manner that does not compromise the health and safety or privacy of others.

**4.1.6 Exiting MHR:CS**

As this service is voluntary, carers may exit the service at any time by declining any further participation.

Service providers will ensure that carers exiting MHR:CS have adequate alternative supports in place should they require them. This may include access to relevant mainstream services, family support, and strategies in place to deal with crises should they occur. The carers should be given assurances they can seek to return to MHR:CS at a later time, if appropriate.

**4.2 Funding for the MHR:CS activity**

Funding for MHR:CS services varies according to demand for services within the coverage area, and the types of services delivered. The coverage areas for MHR:CS services are generally HACC regions, aligning with the coverage of the Commonwealth Respite and Carelink Centres.[[9]](#footnote-9) From 2011–12, smaller Local Government Areas have been used to define coverage to allow new services to better target service gaps in high-need locations.

MHR:CS service providers are funded under funding agreements of up to three years duration. Funding is adjusted each year in line with the indexation rate applying to the TCC Appropriation. Payments under the agreements are generally six-monthly, in January and July each year.

Over $200 million has been allocated to MHR:CS services across Australia from implementation in 2007 to 30 June 2011.

Additional funding was provided for MHR:CS through the 2011–12 Budget. The Australian Government announced $54 million over five years to June 2016 to extend carer support to an additional 1,100 carers and families of people with mental illness.

The first new MHR:CS services commenced in late 2011–12. The major rollout of funding for new or expanded services will occur in 2013–14 and all new services will be established by 2014–15.

Service providers will be funded to:

* manage entry to MHR:CS through assessment of carer eligibility
* develop carer support plans with carers, to ensure the services provided meet their needs and the needs of their families[[10]](#footnote-10), including care recipients where necessary
* deliver the types of support listed in Section 2 MHR:CS Activity Overview
* coordinate carer support services and help carers navigate the mental health and community sectors
* promote MHR:CS services in the community
* liaise and work with other stakeholders to make and receive appropriate referrals for carers of people with mental illness, and
* develop, support and supervise staff, including peer support workers and volunteer workers.

**4.3 Eligible and ineligible MHR:CS activities**

**4.3.1 Eligible activities**

MHR:CS funding may be used for:

* staff salaries and on-costs, which can be directly attributed to the provision of MHR:CS in the identified service area as per the Funding Agreement
* employee training for paid and unpaid staff, Committee and Board members, that is relevant, appropriate and in line with the delivery of MHR:CS
* brokerage, or purchasing services on behalf of client carers
* materials and equipment directly relating to service delivery
* marketing of services
* costs of service evaluation
* operating and administration expenses directly related to the delivery of MHR:CS, such as:
* telephones
* rent and outgoings
* computer/IT/website/software
* insurance
* utilities
* postage
* stationery and printing
* accounting and auditing
* travel/accommodation costs[[11]](#footnote-11), and
* assets as defined in the [Terms and Conditions](http://www.dss.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement), including motor vehicle purchase or lease. Acquittals for all assets must be in accordance with the Australian Accounting Standards.

The Terms and Conditions outline how funds must be spent, acquitted and repaid (if necessary).

**4.3.2 Ineligible activities**

Funding **will not** be provided for the following categories of costs:

* Costs that are not directly related to MHR:CS service delivery
* Overseas travel
* Costs incurred in the preparation of an Application or incurred in providing information additional to the information in an Application, or
* Profits, dividends, etc. to directors or other stakeholders.

**4.4 Activity links and working with other agencies and services**

To achieve the best outcomes for carers and their families, and to ensure a wide range of flexible support options are offered to carers, service providers must develop relationships and have referral processes in place with a wide range of mental health, family support, community and other support services. This should include other services funded under the TCC Program: PHaMs for people with severe mental illness; and, FMHSS for children and young people with, or at risk of, mental illness, and their families.

Organisations applying to deliver MHR:CS must demonstrate how well established they are in local community networks. Funded organisations are required to maintain and foster relationships with the full range of community, welfare and mental health sector organisations necessary to comprehensively cater to the needs of carers and their families.

In keeping with the Australian Government’s emphasis on improving social and economic participation for vulnerable Australians, providers are also encouraged to develop and maintain close links with Centrelink, housing, employment and other family support services that can assist families and carers to achieve greater social inclusion, safety and stability. MHR:CS services must also work closely with local clinical and mental health specialist services.

Commonwealth Respite and Carelink Centres in each HACC region provide an information service that maintains a database of local disability services and supports. Centres can be contacted on Freecall 1800 052 222 during business hours. Location details are at: <http://www9.health.gov.au/ccsd/usr_general/find_centre_01.cfm?section=centre>

Another useful source of support for carers of people with mental illness or intellectual disability is Carers Australia and its state and territory associations. Contact information is at: <http://www.carersaustralia.com.au/publications/publications/>.

Commonwealth and Commonwealth supported initiatives that would be useful for families and carers of people impacted by mental illness include:

* [Personal Helpers and Mentors](http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/personal-helpers-and-mentors)
* [Family Mental Health Support Services](http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/family-mental-health-support-services)
* [Family Support Program](http://www.fahcsia.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program)
* [National Respite for Carers Program](http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-carers-nrcp.htm)
* [National Carer Counselling Program](http://carersaustralia.com.au/how-we-work/national-programs/national-carer-counselling-program/)
* [Young Carers Respite and Information Services Program](http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/program-services/young-carers-respite-and-information-services-program)
* [Commonwealth Respite and Carelink Centres](http://www9.health.gov.au/ccsd/index.cfm)
* [Mental health services in Australia](http://mhsa.aihw.gov.au/home/)
* [headspace](http://www.headspace.org.au/)
* [beyondblue](http://www.beyondblue.org.au)
* [Support for Day to Day Living in the Community](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-d2dl) Program
* [Partners in Recovery](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir) Program
* [National Disability Insurance Scheme](http://www.ndis.gov.au/)
* [Mental Health Professionals Network](http://www.mhpn.org.au/)
* [Reconnect Program](http://www.fahcsia.gov.au/our-responsibilities/housing-support/programs-services/homelessness/reconnect) that uses community‐based early intervention services to assist young people aged 12 to 18 years who are homeless, or at risk of homelessness, and their families, and
* [Money Management services](http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/jobs-money-business/money-management-information-education) that provide practical and essential support to help people build longer‐term capability to manage their money better and increase financial resilience.

More information can be found on the [Department of Social Services](http://www.dss.gov.au/) and [Department of Health](http://www.health.gov.au/) websites.

**4.5 Specialist requirements for MHR:CS**

Funded organisations are required to deliver carer support services in accordance with relevant legislation and industry standards. There are a number of special requirements of MHR:CS providers as follows.

**4.5.1 Targeted groups/special needs groups**

MHR:CS Program identifies a number of groups of carers facing additional disadvantage including:

* Indigenous carers, including Stolen Generations and Indigenous kinship carers
* carers with culturally and linguistically diverse backgrounds, including humanitarian entrants and recent migrants
* older parent carers
* young carers
* carers needing urgent assistance or support, including those at risk of homelessness, or
* special needs group carers specific to the MHR:CS coverage area, such as:
* carers in rural and remote communities
* Forgotten Australians[[12]](#footnote-12), and/or
* lesbian, gay, bisexual, transgender and intersex carers.

Consideration must be given to the needs of carers in special needs groups so they receive appropriate information and services. Those services should be accessible and delivered in a sensitive and appropriate manner. MHR:CS service providers should be aware of the full range of needs within their region and ensure that their client base reflects the region’s demographics.

**4.5.2 MHR:CS practice principles**

All MHR:CS services must subscribe to a set of practice principles that underpin delivery of support to carers and their families. The principles are:

* Respect, trust and understanding – rights and dignities of carers and their families are protected and promoted, including cultural sensitivities.
* Privacy and Confidentiality – the right to privacy, dignity and confidentiality in all aspects of carers’ lives are recognised and respected.
* Accessibility – services are promoted to carers and other community and clinical organisations. Providers ensure priority access for carers of people with high-dependency needs, complex-care needs and challenging behaviours.
* Flexibility, Choice and Appropriateness – service providers promote choice for carers, and take a partnership approach to developing carer support plans that are driven by carers’ needs and preferences. Carer support plans are flexible to respond to emergency situations. Service providers recognise the broader needs and inter-relationships of the family as a whole.
* Cultural competency – services are culturally appropriate.
* Appropriate staff – MHR:CS staff have appropriate attitudes, backgrounds, experiences and qualifications to deliver support services to carers and families in their site. Staff, both paid and unpaid, receive appropriate training, support and supervision.

**4.5.3 National Standards for Mental Health Services**

MHR:CS is delivered in accordance with the [*National standards for mental health services*](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10)*,* applying to all mental health services, including government, non-government and private sectors across Australia. The National Standards were endorsed by the Commonwealth and state and territory Health Ministers in 1996. They have since been revised with a particular focus on their implementation in the community mental health sector. The national standards focus on recovery and are based on values related to human rights and dignity. They promote the empowerment of consumers of mental health services, their carers and families. They emphasise practices which support continuous improvement in service quality.

**4.5.4 Incident reporting**

Service providers must notify DSS of any incidents such as accidents, injuries, damage to property, errors, acts of aggression, etc. that may adversely impact the delivery of services to carers, or on the Department. Incident reporting can also contribute to service improvement through analysis of critical incidents to inform the implementation of preventative measures and responses to adverse events.

**4.5.5 Compliance with relevant legislation**

Service Providers funded under the MHR:CS will ensure that services are delivered in accordance with the [Carer Recognition Act 2010](http://www.comlaw.gov.au/Details/C2010A00123) and all other relevant Commonwealth and state and territory legislation (refer to **Section 2.3** in **Part A** of this guideline suit for more detail).

Service providers should be aware of any case‐based law that may apply or has an effect on their service delivery. Providers must ensure that the services meet health and safety requirements and all licence, certification and/or registration requirements in the area in which they are providing services.

**4.5.6 Service agreements for brokering / subcontracting MHR:CS services**

DSS acknowledges that service providers who are funded to broker services on behalf of carers use subcontractors to provide the services specified under the Activities in the Funding Agreement. DSS therefore authorises service providers to engage subcontractors or purchase goods/services from them without seeking approval. Service providers should note that subcontracting services does not relieve them of their obligations to provide services specified in their Funding Agreements.

Providers are strongly advised to seek their own legal advice before subcontracting services. This is to ensure that subcontracted services have appropriate ‘duty of care’ arrangements in place.

The obligations of a subcontractor must be consistent with the obligations of the DSS service providers under their funding agreements. This includes any provisions relating to confidentiality, permitted disclosure, insurance requirements and privacy information.

**4.5.7 Peer support and peer support workers**

Peer support, in the context of MHR:CS, is social, emotional and/or practical support, provided by people who have prior experience caring for someone with mental illness. Peer support has proven effective in achieving outcomes for participants in community mental health programmes.

It is mandatory that new MHR:CS services funded from 2011–12, engage[[13]](#footnote-13) at least one peer support worker with lived ex*p*erience of caring for a person with mental illness. The role of the peer support worker within the service can vary and be tailored to the particular service. Peer support workers both paid and unpaid, must receive appropriate training, support and supervision.

This requirement supports Action 26 in the[*Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014*](http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-pubs-f-plan09) *:* an increase in consumer and carer employment in clinical and community support settings.

**4.5.8 Carer representation in governance arrangements**

In line with the intent of th*e* [Carer Recognition Act 2010*,*](http://www.comlaw.gov.au/Details/C2010A00123) DSS expects organisations funded to deliver MHR:CS services, to include appropriate carer representation in their decision-making and governance structures. This will ensure the views and concerns of carers of people with mental illness are considered in planning, implementation and delivery of MHR:CS services.

**4.5.9 Volunteer workers**

The [National Volunteering Strategy](http://pandora.nla.gov.au/pan/142935/20130923-1458/www.notforprofit.gov.au/volunteering/strategy.html) was released in 2011. It sets out the vision for volunteering, including supporting those who are currently volunteers and encouraging more Australians to participate in their communities through volunteering. The Strategy will set the direction for volunteering in Australia for the next ten years and will support organisations to adapt to changes in the ways that Australians want to volunteer.

Where service providers engage volunteers, they are required to have operational policies and procedures in place for volunteer involvement. The policies and procedures need to be understood, implemented and maintained at all levels of the organisation. The [National Standards for Involving Volunteers](http://www.volunteeringaustralia.org/volunteering-resources/volunteer-managers/) available on Volunteering Australia’s website provide a sound basis for the engagement of volunteers and should form the basis of the operational policies and procedures developed by MHR:CS services. They cover the following elements:

* the work of volunteers is documented and regularly reviewed
* the work of volunteers is controlled and supported by agreed processes and procedures
* information is gathered about work satisfaction
* appropriate support is available, including access to professional debriefing
* effective channels of communication with volunteers are established, and
* appropriate processes are established to monitor, identify and address all health, safety and work satisfaction issues.

**4.5.10 Information technology (IT)**

Services will receive telephone and email support on IT matters and data collection activities to assist them in complying with DSS reporting requirements. The Mental Health Helpdesk [mentalhealth@dss.gov.au](mailto:mentalhealth@dss.gov.au) is closely monitored to ensure prompt responses to requests for IT assistance. Service providers will be advised of the expected timeframes for responses if they are likely to take more than two working days.

A **Targeted Community Care Collaborative Workspace** has been set up on Govdex to facilitate collaboration and share information. Access details will be provided to all funded TCC Program service providers.

**4.5.11 Activity performance and reporting**

DSS will notify service providers electronically when reports are due and provide reporting templates. Reports are to be submitted electronically. Providers should therefore ensure they have internet access and compatible IT[[14]](#footnote-14) (Windows 2000 or later and Adobe Reader 7.0.5 or later).

Reporting includes:

* biannual progress reports (using a SMARTFORM submitted online)
* an annual financial report (as prescribed in funding agreements), and
* other reports requested by the Department.

Templates may be provided. Reports will be required on the due dates as specified in the Funding Agreement unless otherwise negotiated with DSS and approved in writing.

The following TCC Program Key Performance Indicators apply to the MHR:CS services:

* Percentage and number of clients, families and carers maintaining progress against individual goals
* Percentage and number of clients who report that they are satisfied that the service they received was appropriate to their needs[[15]](#footnote-15)
* Percentage and number of clients from Indigenous, and culturally and linguistically diverse backgrounds
* Proportion of participants assisted from priority target groups, and
* Number of participants accessing support services.

DSS is currently reviewing the TCC Program Performance Framework.

**5. Contact Information**

For enquires regarding current grant agreements, service providers should contact their grant agreement manager. For general program enquiries contact [Program.help@dss.gov.au](mailto:Program.help@dss.gov.au) or phone 1800 020 283.

Website: [www.dss.gov.au](http://www.dss.gov.au)

**6. Glossary**

**Applicant** – an organisation submitting an Application for funding for a new or expanded MHR:CS site.

**Application** – an application for funding for a new or expanded MHR:CS site.

**Application Form** – the form that Applicants are required to use when submitting an application for funding for a new or expanded MHR:CS site.

**Autism –** autism spectrum disorders have been variously classified as mental illness, intellectual disability, or as a classification of their own. For the purposes of MHR:CS, autism spectrum disorders are considered a subcategory of mental illness.

**Brokerage –** purchasing services from a third party on behalf of carer clients.

**Carer –** For the purposes of MHR:CS, a carer is an individual who provides personal care, support and assistance to a person who needs it **because** that person has a mental illness or intellectual disability.

An individual is **not a carer** in respect of care, support and assistance he/she provides:

* under a contract of service or a contract for the provision of services
* in the course of doing voluntary work for a charitable, welfare or community organisation, or
* as part of the requirements of a course of education or training.

To avoid doubt, an individual is **not a carer merely because** he or she:

* is the spouse, de facto partner, parent, child or other relative of an individual, or is the guardian of an individual, or
* lives with an individual who requires care.

A carer is not necessarily related by marriage or biologically related to the person for whom they are caring. Foster carers and kinship carers, caring for a person because of the person’s mental illness, are eligible for MHR:CS services. Carers do not necessarily live with the person with mental illness.

**Carer needs assessment –** an assessment of the carer’s need for support because of his/her personal circumstances. Assessment will consider other family support available to carer, other family responsibilities, income status, carer’s health and health of other family members, and carer’s emotional wellbeing and state of personal relationships.

**Carer support plan –** a plan jointly developed by a service provider and a carer that details how the service provider will support the carer and his/her family to help them maintain their caring roles for a person with mental illness. The carer support plan will be driven by the carer and will reflect his/her preferences for any of a broad range of supports that will best meet his/her needs at different times.

**Commonwealth Respite and Carelink Centres –** Commonwealth Respite and Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability services and other support services available locally, interstate or anywhere within Australia. DSS funds the organisations operating the Centres to deliver a range of carer supports specifically for carers of people with mental illness.

The network of 55 [Commonwealth Respite and Carelink Centres](http://www9.health.gov.au/ccsd/usr_general/find_centre_01.cfm?section=centre) has around 65 'walk-in' shopfronts throughout Australia. Many shopfronts are located near, or within, shopping centres.

**Community capacity building –** community development activities to improve community wellbeing through collaborative projects with community groups such as promoting mental health awareness and first aid, or stigma reduction. This can also include establishing relationships and trust in communities to allow services to be delivered most effectively.

**Comorbidity –** condition or disorder co-occurring with another medical condition or disorder, e.g. alcoholism and bipolar disorder are common comorbidities.

**Cultural competence –** an ability to interact effectively with people of different cultures, particularly in the context of non-profit organisations and government agencies whose employees work with persons from different cultural/ethnic backgrounds.

**Culturally and Linguistically Diverse (CALD) –** people who identify “…as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home, or because of their parents’ identification on a similar basis”[[16]](#footnote-16)

**Cultural sensitivity –** the quality of being aware and accepting of other cultures and cultural beliefs.

**Family –** in the context of MHR:CS, family is anyone with a family-like relationship with the carer of the person with mental illness.

**Indigenous –** a person, who is of Aboriginal or Torres Strait Islander descent, identifies himself or herself as an Aboriginal person or Torres Strait Islander and is accepted as such by the Indigenous community in which he or she lives.

**Intellectual disability –** conditions associated with impairment of mental functions, difficulties in learning and performing certain daily life skills and limitation of adaptive skills in the context of community environments compared to others of the same age.

**Mental illness –** a diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The brochure ‘[What is mental illness?](mailto:http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-w-whatmen)’ on the Department of Health and Ageing website provides more information.

**Peer support** **worker** **–** (in the context of MHR:CS) a worker with a lived experience of caring for a person with mental illness, who is able to support and mentor other carers.

**Program Guidelines** – the guidelines applicable to the MHR:CS application processes. The Program Guidelines have three parts – Part A (title), Part B (Information for Applicants) and this Part C2. Applicants should read all parts.

**Recovery approach –** a recovery approach to assist people whose lives are severely affected by mental illness aims to build personal resilience and sustainably manage the impacts of mental illness on their lives. The four key objectives are:

1. increased access to appropriate support services at the right time
2. increased personal capacity, confidence and self-reliance
3. increased ability to manage daily activities, and
4. increased community participation (both social and economic).

**Respite –** temporary relief/break from the usual caring role.

**Terms and Conditions** means the terms and conditions of the standard funding agreement between the Department and successful Applicants. For further details see [http://www.DSS.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement](http://www.fahcsia.gov.au/grants-funding/general-information-on-funding/terms-and-conditions-standard-funding-agreement).

1. The inclusion of people with an intellectual disability recognises that in 2003, according to the Australian Bureau of Statistics, around 57 per cent of Australians with an intellectual disability also had a mental or psychiatric illness. [↑](#footnote-ref-1)
2. These could be planned breaks or support provided in an emergency. [↑](#footnote-ref-2)
3. Social and recreational activities can be provided for either the carer or the care recipient, but are primarily for the benefit of the carer. [↑](#footnote-ref-3)
4. An example is one-off assistance to help clean or tidy the house or yard to meet housing inspection requirements, where the loss of stable housing would severely impact the carer’s ability to continue caring. [↑](#footnote-ref-4)
5. This includes advocacy to help a carer maintain his/her caring role, e.g. supporting a carer who wants to be more involved in a care recipient’s treatment plan, or advocacy to secure or maintain adequate and affordable housing for the carer. [↑](#footnote-ref-5)
6. As defined by the *Carer Recognition Act 2010* (see **Glossary**). [↑](#footnote-ref-6)
7. Except where a carer makes up part of the 25 per cent maximum allowed for carers of people with an intellectual disability. [↑](#footnote-ref-7)
8. A person with mental illness may be entitled to other government-funded support services such as PHaMs or Day to Day Living. [↑](#footnote-ref-8)
9. See Overview in Section 2. [↑](#footnote-ref-9)
10. Carer support plans should include strategies to help carers and families deal with crises and emergencies, and a broad range of supports to assist carers and families maintain their caring roles and their own wellbeing. [↑](#footnote-ref-10)
11. Including accommodation costs that may be incurred where MHR:CS workers are required to travel to distant or remote locations to service carers, or costs for staff travelling to attend training or personal development activities. [↑](#footnote-ref-11)
12. People raised in institutional or other out-of-home care in Australia in the 20th century. [↑](#footnote-ref-12)
13. The peer worker can be engaged on a paid or voluntary basis. [↑](#footnote-ref-13)
14. Note that in paragraph 4.3.1 ‘computer/IT/software’ expenses are eligible uses of MHR:CS funding. [↑](#footnote-ref-14)
15. A representative sample of carers will be asked to complete a Client Survey each year. [↑](#footnote-ref-15)
16. Victorian Multicultural Strategy Unit (2002) in Australian Psychological Society Ltd 2008. [↑](#footnote-ref-16)