Australian Government

Department of Families,
Housing, Community Services
and Indigenous Affairs

Resource Kit
New Family Mental Health Support Services Activity
under the Targeted Community Care (Mental Health) Program
February 2013

Preface

This Resource Kit provides additional information for parties considering whether to participate in the New Family Mental Health Support Services (FMHSS) Activity under the Targeted Community Care (Mental Health) Program. It also provides information to assist with the ongoing development and operation of already established New FMHSS (funded through the 2011–12 Budget and established from 2012).

The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA or the Department) has a suite of documents (the Program Guidelines Suite) which provide information relating to the Targeted Community Care (Mental Health) Program. They provide the key starting point for parties considering whether to participate in the Program and form the basis for the business relationship between FaHCSIA and the funding recipient.

This additional information expands on and complements the information provided in the Part C3 of Program Guidelines Suite – Application Information for the New Family Mental Health Support Services Activity.

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1. New FMHSS Framework and Practice Principles

1.1 Introduction

The Targeted Community Care (Mental Health) Program (TCC Program) commenced in 2006 following a Council of Australian Governments (COAG) agreement to a whole-of-government approach to mental health.

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).

There are two distinct groups of FMHSS:

- **FMHSS established before 2012**: those FMHSS funded and established prior to the 2011–12 Budget, and
- **New FMHSS**: those FMHSS funded through the 2011–12 Budget, and established from 2012, including those FMHSS providers selected through the current selection process.

This Resource Kit refers to New FMHSS. Consultation with providers and other key stakeholders has guided the design and development of the New FMHSS. Further detail on the consultation outcomes is at **Attachment A**.

Key themes that have emerged from consultations and that have been built into New FMHSS include:

- There are few services available for children, young people and their families who are at the early stages of being at risk of experiencing poor mental health outcomes. Many current services focus on supporting families who are already experiencing multiple and complex needs, and these services often have waiting lists
- There are few services that focus first on the needs of children and young people. Many services give more prominence to the needs and goals of adults
- Child-centred services are needed to ensure the voices of children and young people are heard and responded to
- It is essential to always work with the family[1] of the children and young people as this will improve their long term mental health outcomes. Work with families should be strengths based and build resilience
- Service delivery needs to be flexible and innovative to meet the wide range of needs of children, young people and their families. This includes considering how technology can be used effectively to engage and work with New FMHSS participants

[1] The definition of 'family' in this Resource Kit is: a group of people identified by the participant as their family. This includes all familial arrangements, such as same-sex relationships, kinship, de facto, etc.

- It is essential services be well linked with other relevant services in the local area to promote better integrated service delivery and ensure children and families do not fall through the cracks, and
- Communities need to be supported to better understand mental health issues for children and young people and be assisted to respond effectively.

These key considerations have guided the development and operation of New FMHSS.

As at December 2012, there were a total of 52 FMHSS (including pre 2012 and New FMHSS) operating in geographically defined sites across Australia, including in two remote sites.

The 2011–12 Budget allocated an additional $61 million over five years, to 2015-16 for 40 new FMHSS to support an additional 32,000 children and young people (aged up to 18 years) at risk of or affected by mental illness.

New FMHSS, funded through the 2011-12 Budget, are intended to deliver support to children (aged 0-12) and young people (aged 13-18) at risk of or affected by mental illness and their families. If a provider chooses to focus their service on a subset of this group, based on local knowledge and available services, for example children aged 8 -12 years, the provider must still be open to receiving referrals for children and young people across the whole age spectrum.

Service delivery model:
The service delivery model for New FMHSS has three elements, all of which must be delivered by each provider:

- Intensive, long term, early interventions specifically for children and young people, and practical whole-of-family assistance to improve the long-term outcomes for vulnerable children and young people at risk of, or affected by, mental illness. This can include targeted therapeutic group work.

- Information and referral for families requiring short-term immediate assistance, and

- Community outreach, mental health promotion/education and community development activities to increase local capacity to understand and respond to children or young people at risk of or affected by mental illness. (This includes general group work with children, young people and their families/carers).

Target numbers:

Each of the three elements has a specific target in terms of numbers:
- Intensive and long term - minimum of 50 children or young people each year
- Short term information or referral - minimum of 100 families each year, and
- Community outreach and general group work - minimum of 150 children, young people and families each year.

Delivery of New FMHSS in each location must include:

- A primary focus on children and young people while working with them in a whole of family context
- Capacity to respond quickly and early to make a difference in achieving outcomes for children, young people and families
- Flexible use of funding to provide practical assistance tailored to the needs and situation of each child, young person and family, and
- The establishment of partnerships and linkages with other services to establish good referral pathways into and out of the New FMHSS to reach vulnerable children, young people and families who may not otherwise engage with the mental health or children's service sector.

1.2 Practice Principles

Through consultation with currently funded FMHSS and other key stakeholders, a number of practice principles have been identified that underpin the service delivery of all FMHSS providers.

The following expands on the principles set out in Part C3 of Program Guidelines Suite – Application Information for the Family Mental Health Support Services Activity. Providers are required to use these principles to guide the development and operation of New FMHSS.

Principle 1: Early Intervention – *an approach that ensures support is offered early in life to children and young people, and early in a situation where mental health risk factors may be emerging for a child or young person. This approach seeks to address personal, family and environmental factors to reduce the risk of onset, or the impact, of mental illness.*

- Service providers have knowledge and understanding of the risk factors and protective or positive factors that impact on the development of mental health issues in children and young people.
- Service providers support their staff to remain skilled in and committed to an early intervention approach to their service delivery.
- Service providers establish and maintain strong links with first-to-know agencies to promote early intervention and not rely on referrals from more specialised or clinical agencies.

Principle 2: Child and young person centred – *services place children and young people at the centre of the service delivery model and ensure their voices are heard and responded to:*

- Participants and potential participants are clear that the service is primarily directed to meeting the needs of children and young people.
- The voices of children and young people are heard in the development of Family Action Plans which are living documents and remain the property of the children and young people.
- Service providers use the Common Approach to Assessment, Referral and Support (CAARS), to ensure the service delivery remains child-centred, family focused, strengths based and holistic.

- Service providers establish and maintain close links with children's universal services and agencies, and take advantage of relevant resources such as KidsMatter to encourage an ongoing focus on children.
- Service providers ensure their staff are skilled in working with children and support their staff to access ongoing professional development and training to keep up to date with research about children's and young people's mental health and wellbeing issues.

Principle 3: Family Focus – *while children and young people are at the centre of the service delivery model, it is also required that services work within a family context. It is essential to acknowledge that different members in a family have different perspectives and needs, and may require different responses. The family focus needs to be strengths-based and build resilience in the family.*

- Service providers work to ensure families feel comfortable in accessing the service and set up their premises to be welcoming for different types of families in the area.
- Service providers ensure any promotion of the service clearly articulates the family focus.
- Service providers are aware of and respond to any specific cultural or religious practices or sensitivities of families in the local area.
- Service providers employ and/or train staff to work with the range of different families represented in the local area.
- Service providers promote tolerance and respect for different cultural needs and circumstances.

Principle 4: Flexibility – *an approach that ensures services meet the broad needs of children, young people and families and offer a range of tailored supports to achieve this. Support should take into account an individual's cultural and lifestyle context. Flexibility can be supported through outreach, variable working hours and technology.*

- Service providers actively seek to fit services round the person, rather than the person into services.
- The individual needs, strengths, goals, and steps to achieve these goals are reflected in the Family Action Plan, which is developed with each individual child, young person and family member, and becomes a living document that is able to be reviewed and changed on a regular basis.
- Service providers operate outreach as a way to contact hard to engage children, young people and families.
- Service providers consider how their operating hours promote or hinder flexibility in their service delivery. If necessary, providers establish variable working hours to encourage flexibility.
- Service providers actively consider how the use of technology and social media may increase their flexibility, especially in terms of working with young people.

- Service providers link with local services to give greater flexibility to the options that can be offered to children, young people and their families.

Principle 5: Accessibility and responsiveness – *services should be accessible to children, young people and their families according to their needs and capacity, provided in ways that reduce the stigma of mental illness and be responsive to individual circumstances.*

- Service providers design and deliver services in such a way as to reduce the stigma of mental illness in the community.
- Services are mindful of the range of cultural and lifestyle contexts represented in the local community and design and promote their service accordingly.
- Service providers employ and/or train staff to ensure the service is responsive to the range of lifestyle and cultural experiences of participants.
- Services have mental health crisis information readily available for participants and the general public.
- Service providers ensure they are able to offer individually tailored support to participants.

Principle 6: Partnerships – *includes working with children, young people and families to plan and deliver services that meet their needs. Working in partnership requires a good understanding of the local service system and capacity to engage constructively and collaboratively. It also requires sound and collaborative working relationships with other organisations to ensure there is a 'joined up' service system to meet the wide range of needs identified for children, young people and families.*

- Service providers use approaches, such as the Family Action Plan, to work collaboratively with children, young people and their families, and to keep these voices at the forefront of service delivery.
- Service providers have processes in place to ensure staff maintain a focus on the individual needs of participants and work together with children, young people and families to meet their needs.
- Service providers establish and nurture formal and informal working relationships with first-to-know agencies and other relevant services in the local area to promote a joined up service system.
- Service providers work particularly hard to establish strong partnerships with services that deliver support to vulnerable and disadvantaged people in the local community, including those from an Indigenous and CALD background.

Principle 7: Integration – *providers ensure that support delivered for children, young people and families is 'joined up' and linked with other services to ensure an holistic approach to their support needs. This includes ensuring that any services are culturally appropriate through behaviour and language.*

- Service providers use their partnerships with FMHSS participants and other services to deliver tailored and holistic support to participants.

- Service providers use their knowledge of local services and their partnerships to promote improved integration of local services across the coverage area.

Principle 8: Continuous Improvement and quality of service – *FMHSS providers are required to engage in an ongoing process of reviewing and refining their service delivery to achieve positive outcomes, to meet the intent of their funding, and to ensure their services are high quality and appropriate for the local area. Services must meet standards of quality appropriate to the service type, as specified in legislation, by professional associations, and in the funding agreement.*

- Service providers have procedures for complaints handling and participants are aware of these.
- Service providers encourage FMHSS participants to raise, and have resolved without fear of retribution, any issues, dissatisfaction, complaints or disputes they may have about the service provider or the service they receive.
- Service providers take complaints and feedback seriously, investigate and address them, and use this process to improve ongoing services.
- Service providers have quality management and financial systems in place to ensure standards of service are met and optimal outcomes for participants are achieved.
- Service providers have mechanisms in place, including a flexible and learning culture, to ensure improved outcomes for participants.
- Service providers identify and address any issues and risks that might impact on service delivery.
- Service providers have strong and effective leadership to provide strategic direction and uphold and exemplify the FMHSS principles and standards.
- Service providers perform effectively against goals and standards, and annual service plans.
- Service providers are accountable for their decisions and actions and comply with legislation, policies, guidelines, instructions and standards.
- Service providers ensure their activities are being delivered effectively, efficiently, lawfully and in a fair and reasonable way.

1.3 Practical assistance

Sometimes children, young people and families who access the New FMHSS may be in need of practical assistance to support them to meet their goals articulated in their Family Action Plans. For example the goal for an eight year old boy may be to join a local sport team, but his family might not have the financial means to purchase the required uniform or equipment. New FMHSS providers may be able to offer some assistance in these sorts of situations.

It may be appropriate for New FMHSS to dedicate a small part of their budget (up to 10 per cent) to support program participants and families to access practical and material assistance if:

- All other options have been exhausted

- The assistance required is to meet the goals identified in the relevant Family Action Plan, and
- The purchase relates to a CAARS life domain.

It is not the intent of New FMHSS that it becomes an emergency relief measure and New FMHSS are not to use their funds to purchase services from another provider.

2 Cultural Competence and Special Needs Groups

2.1 Cultural Competence

Cultural competence is the ability to interact effectively with people across different cultures. It has four main components:

- Being aware of one's own cultural worldview (one's own assumptions and biases that could affect decision making and actions)
- Having a positive, respectful and accepting attitude towards cultural differences
- Having knowledge of different cultural practices and world views, and
- Having good cross-cultural communication skills.

A person who is culturally competent can communicate sensitively and effectively with people who have different languages, cultures, religions, genders, ethnicities, disabilities, ages and sexualities. Culturally competent staff strive to provide services that are consistent with a person's needs and values.

2.1.1 Culturally Competent Services

In delivering culturally competent services, service providers:

- Seek to identify and understand the needs of specific special needs groups (Indigenous, CALD, humanitarian entrants etc.) within the site
- Investigate, understand and take into account a participant's beliefs, practices or other culture-related factors in designing services
- Are respectful of a participant's cultural beliefs and values at all times
- Ensure that the work environment and practices are culturally inviting and helpful
- Ensure that services are flexible and adapted to take account of the needs of specific special needs groups and individual participants
- Provide access to culturally specific training and supports to improve team understanding of the local community groups and effective communication methods
- Regularly monitor and evaluate cultural competence of the service and staff (including obtaining input from participants and the community), and
- Use information and data about specific special needs groups to inform planning, policy development, service delivery, operations, and implementation of services.

2.1.2 Organisational Cultural Competence

It is important that cultural competence is valued and is a key consideration at the organisational level. Consideration of the following will assist to improve organisational cultural competence.

- Is the organisation's governing body educated about cultural competence?
- Are community members represented on the governing body and advisory committees?
- Does the organisation have both formal and informal alliances and links with local community representative groups?
- Are regular reports provided to key stakeholders on the cultural competence activities undertaken?
- Is cultural competence embedded in the philosophy, mission statement, policies and key objectives?
- Does the organisation have formal cultural competence-related policies (that were formulated with input from the community) regarding staff recruitment and retention, training and staff development, language, access and communication, cultural competence-related grievances and complaints?
- An effective complaints mechanism is important to all participants that are vulnerable and should also be easily accessible and useable by CALD or Indigenous Australians with specific cultural needs.
- Does the organisation have processes in place to obtain participant, community and staff input in the development of cultural competence-related plans?
- Does the organisation regularly self-assess cultural competence?
- How can the organisation collect client-level cultural competence-related information, conduct regular community needs assessments and evaluate cultural competence-related activities? How will this data inform service quality improvement activities?
- How are Family Action Plans developed with participants where English may not be a first language?
- What types of culturally appropriate materials are required to communicate effectively? Is signage and key written materials available in the language(s) of the local community and appropriate to the literacy level of your community? This can be expensive so are there alternative strategies that can be used?
- Can the organisation recruit staff with suitable skills and experience that are connected with the local community and can provide appropriate support? Are there any cultural issues in doing this?

2.2 Target Groups

New FMHSS identifies groups of children and young people that face additional disadvantage and risk factors for poor mental health outcomes as special needs groups.

Special needs groups for New FMHSS include but are not limited to:

- Indigenous Australians
- People from CALD backgrounds, including humanitarian entrants and recently arrived refugees and migrants
- Children in contact with the child protection system
- Young people leaving out-of-home care, and

- Children and young people in families experiencing homelessness, unemployment, drug and alcohol abuse, domestic violence, history of trauma etc.

2.2.1 Indigenous Australians

An Indigenous person is defined as "someone of Aboriginal or Torres Strait Islander descent, who 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."

2.2.2 People from Culturally and Linguistically Diverse backgrounds (CALD) - including humanitarian entrants and recently arrived refugees and migrants

People from CALD backgrounds are defined as 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"[2].

Humanitarian entrants are defined as people who are subject to substantial discrimination amounting to gross violation of their human rights in their home country, are living outside their home country and have links with Australia http://www.immi.gov.au/visas/humanitarian/).

Refugees are defined as people subject to persecution in their home country.

Over the past 50 years, over half a million refugees and displaced people have resettled in Australia.

2.2.3 Children in Contact with the Child Protection System

State governments have the responsibility and services to meet the needs of children and young people who are 'under the care of' the child protection system. This is when the parental responsibility for that child or young person is shared with or totally delegated to the Minister or Chief Executive of the relevant department. These children are not eligible for FMHSS as they already have a state agency responsible for their care.

However, there are many children, young people and families who may be reported to, or be in contact with, the child protection system but who are not assessed as requiring formal statutory intervention, in terms of parental responsibility being delegated to the State. In this case, these children, young people and families may need further support if they are at risk of or affected by mental illness, and would therefore be eligible for FMHSS.

In instances where a New FMHSS is working with a child who subsequently comes under the care of the child protection system, it is anticipated that the New FMHSS would work closely

[2] Victorian Multicultural Strategy Unit (2002) in Australian Psychological Society Ltd 2008

with the child protection agency to determine which supports and services would be best for the child or young person and their family, and gradually withdraw New FMHSs assistance in a planned way.

2.2.4 Young People Leaving Out of Home Care

The 'young people leaving care' target group refers specifically to young people who have been in the formal care of the state and are in the process of transitioning to independence.

The nationally consistent approach to 'leaving care planning' recognises the transition from out-of-home care to independence as a process occurring along a continuum, commencing no later than age 15 years and continuing up to age 25 where the young person needs and/or desires ongoing assistance.

Out-of-home care refers to foster care, kinship care and therapeutic residential care. It focuses on those children and young people with Children's Court ordered care arrangements, where parental responsibility for the child or young person has been transferred to the Minister/Chief Executive. It does not refer to young people who just happen not to be living at home.

Therefore young people leaving care have been identified as a particularly vulnerable group of young people. They are eligible for support through New FMHSS if they are at risk of having poor mental health outcomes and have an adult family member who is able and willing to work with them and the provider to support them in meeting their goals as reflected in a Family Action Plan.

2.2.5 Children, Young People and Families Experiencing Significant Risk Factors

We know that children who live in families where there are significant risk factors such as homelessness, unemployment, drug and alcohol abuse, domestic violence and/or history of trauma have a higher risk of experiencing poor mental health outcomes later in life. These risk factors all contribute to vulnerability and disadvantage experienced by children, young people and families.

Such children and young people are regarded as vulnerable and disadvantaged and are regarded as special needs groups for the purposes of New FMHSS.

2.3 Service Access for Special Needs Groups

2.3.1 Access Issues for Special Needs Groups

There are a range of issues which can create barriers to accessing services for special needs groups. These include:

- Complex administration processes and procedures
- Costs – perceived or actual (out of pocket expenses however small may deter people)

- Shame and stigma (fear of being judged)
- Prior negative experiences (e.g. with particular organisations or institutions)
- Inflexible approaches (e.g. requiring particular attendance or appointment times in set locations)
- Communication/cultural or linguistic barriers
- Fear of authorities (vulnerable people may have experienced difficult situations with authority figures and fear possible consequences of seeking help – e.g. their children might be taken away or they could lose their income support payments from Centrelink)
- Lack of knowledge of entitlements, and
- Lack of support or social networks.

2.3.2 Overcoming Access Issues

Service providers are required to prioritise and actively target special needs groups. The following considerations will assist with promoting and targeting services to special needs groups.

- Become known in the community – people need to understand the service provide and see the value in accessing the service.
- Being accessible – having an open door approach, using outreach not just drop-in or appointment services.
- Being accepting – not stigmatising or devaluing further - being acceptable and relevant to the local community and reflecting its ethnic and cultural values.
- Providing good 'case management' – by using bottom up approaches to planning and service delivery based on the needs and strengths of individual participants.
- Continuity – providing long-term support and enabling a relationship with a named worker.
- Co-ordination – having a comprehensive assessment, monitoring and review process for individuals. Coordinating with other workers or agencies on behalf of an individual to ensure that their needs are met.
- Flexibility – one size doesn't fit all - varying approaches to suit the individual child, young person or family rather than making individuals fit the service.

3 Screening, Assessment and Data Collection

3.1 Overview

FaHCSIA has developed a range of templates to assist provides with screening and assessment processes. These are included as attachments to this resource kit. An online data collection system has a minimum requirement for service providers. Providers must update client level and aggregate data on the online system every three months. FMHSS data specifications are at **Attachment D**

3.2 What is 'Screening' in New FMHSS?

In New FMHSS, screening is defined as:
"The initial process by which a service determines if FMHSS is the right service for the child or young person and their family, and broadly what type of support they may require as a first step. This screening is a point in time and does not in any way prohibit further assistance or a change in the support offered".

Screening occurs as soon as someone walks in off the street, rings up the service or turns up as a result of a referral. Many people have to be quite courageous to approach a service, so it's important to recognise this and get them the help they need as soon as possible.

Screening is designed to fairly quickly determine if the person is eligible for New FMHSS and if New FMHSS is the most appropriate service for the particular child, young person and family.

New FMHSS providers are able to intake procedures already in place in their organisation.

Use of their existing intake/duty system for New FMHSS has three provisos:

- aggregate numbers of children/families who present at the service and receive information or referrals and one-off support are captured as per the FMHSS data collection system, and
- a child-cantered, family focused approach to any new referrals, consistent with the intent of the New FMHSS the CAATRS approach as outlined in the section below.

There is a screening template at **Attachment B,** but providers may choose to design their own version to link in with their other documentation.

It is expected that FMHSS providers have their own systems in place to ensure they have the necessary permission from parents or guardians to work individually with the child or young person.

Common Approach to Assessment, Referral and Support (CAARS **)** - Providers are required to use the CAARS approach to underpin all interactions. The approach is child-centred, family focused, holistic and strengths based. The CAARS tools which include the 'wheel',

questionnaires and conversation prompts, may be used from the time of assessment to support the work of practitioners and to assist with recording and entering data in the online reporting system.

3.3 The CAARS 'wheel' and its Six Life Domains

New FMHSS providers are required to use the CAARS approach which accurately reflects the intent and focus of New FMHSS. Using the CAARS tools is encouraged as the tools support the focus of the New FMHSS, facilitate holistic and creative practice, provide a common language, and assist with on line reporting requirements. FaHCSIA ensures that all New FMHSS providers are trained and supported in the use of the CAARS approach and tools.

The primary tool for New FMHSS is the 'wheel' at **Attachment C**. The 'wheel' is not prescriptive. It is a conversation tool, not an assessment, screening or outcomes tool. Practitioners are encouraged to use the 'wheel' flexibly in combination with any other tools and resources they are already using. New FMHSS providers have found the CAARS approach and the 'wheel' can be implemented across their agency to encourage consistent language across different programs and range of staff.

In New FMHSS, the CAARS wheel is designed to assist practitioners work with children, young people and their families to identify their needs across six life domains.

The six domains are:

1. Physical health
2. Mental health and emotional wellbeing
3. Relationships (including social networks and relationships, and family relationships and functioning)
4. Material wellbeing (including housing and self-care and living skills)
5. Learning and development (including school attendance/learning and sport/recreational activities), and
6. Safety (including child and family safety).

Practitioners need to align the issue they are working on with the child, young person or family into one or more of the life domains to assist with online reporting requirements.

3.4 Information, referral or one off assistance

If the result of screening is information/referral or one off assistance, rather than going on to an assessment, 'aggregate' or 'summary' data is collected at this point. This may occur because this is the most appropriate support or because the service is at capacity.

Providers collect a range of data and information in order to meet the reporting requirements in the New FMHSS online reporting system. The data to be collected at this point covers:

- Number of individuals seeking support
- Indicate the number of family members in each category who received assistance (number of parents/carers, number of children/young people, number of extended family or friends)
- Why the family did not progress to assessment
- Referral source – where was the family referred from? and
- Referral destination – where was the family referred to?

The data can be submitted at any time and will be aggregated in each reporting period of three months.

3.5 Assessment process

In New FMHSS, assessment refers to:

"An initial process, after screening has occurred, to determine the reason a child or young person has come to the service, to gain a preliminary understanding of the life circumstances of a child or young person and their family, and to gain a level of insight into the needs and strengths of the child or young person and their family."

Assessment follows the initial screening process where a determination has been made that the child/young person meets the eligibility for entry into New FMHSS.

The assessment begins the process of working with the child, young person or family to identify goals and start to develop a Family Action Plan. The Department assumes practitioners consider a range of risk and protective factors or issues that are relevant for mental health outcomes (see **Attachment E**), but you are not be expected to report against them all. However given the intent of the program, it is important that FaHCSIA can report on those priority risk factors or issues that link to mental illness. Identification of these issues and factors and their inclusion in the Family Action Plan enables tracking of any improvement in these particular issues and factors during the reporting period. The tracking is largely done through reporting related to the Family Action Plans.

It is during the assessment process that providers are encouraged to use the CAARS tools. The tools can be used to have a conversation with a child or young person or family, to begin to name needs and strengths across the range of six life domains listed in the CAARS wheel. Data is collected to indicate if the CAARS tools were used for the assessment, and which ones.

During the assessment process, practitioners discuss and record risk factors, protective or positive factors and what the child, young person and family want to work on. This leads to developing a Family Action Plan.

3.6 Consent to provide data to FaHCSIA

The participant (or adult family member) must complete the FaHCSIA provided data transfer/consent to collect information form (**Attachment F**) which allows the transfer of data from funded service providers to FaHCSIA. This form must be completed before the assessment information is collected or recorded. Participants are to be reassured that information provided is de-identified (that is – data may be about them but FaHCSIA can't identify who they are – FaHCSIA does not see the participant's name or address).

This consent form is a legal requirement and cannot be used for any other purpose and cannot be altered by service providers. The wording on the form has specific legal meaning and can't be changed. A copy of the signed consent form must be kept on the participant's file.

Service providers need to develop their own consent forms for use where they want to make a referral to another service and require the participant's consent to share information.

3.7 Assessment reporting and data

The assessment process needs to capture and record the following data for reporting purposes:

- Demographic information about the family and young person or child
- Referral source
- Main presenting issue/s
- If the child or young person has had contact with the child protection system
- If the young person is under the care of the child protection system and is transitioning from out-of home care (This process usually starts from the age of 15.), and
- Assessment outcome.

There is also some data collected specifically about the child or young person:

- Who the child is living with
- Sex of the child
- Date of birth of the child
- Is the child Aboriginal or Torres Strait Islander?
- Does the child's mother identify as Aboriginal or Torres Strait Islander?
- Does the child's father identify as Aboriginal or Torres Strait islander?
- Is the child in contact with the child protection system?
- If the young person is under the care of the child protection system are they transitioning form out of home care?

Following the assessment process not all participants will continue on to receive intensive, long term assistance and be involved in the development of a Family Action Plan. The practitioner may decide through the assessment to make a referral or offer short term assistance to the family.

3.8 Outcomes of assessment process

As a result of the assessment process, children, young people and families have one of three outcomes:

1. No further support
2. Accepted for short term support (can include general group work), or
3. Accepted for intensive support (can include targeted/therapeutic group work)

If there is no further support, the reason for this is recorded as:

- Does not meet eligibility criteria
- Participant choice or decision not to proceed, or
- Other reason, specify…….

3.9 Accepted for short term support

If the outcome of the assessment process is that the child or young person and their family require short term support this is recorded through the online data system. An example of short-term assistance is if a family is functioning well but a primary school aged child seems to be finding it difficult to go to school (early sign of anxiety?) and the parents need a couple of sessions to discuss ways to manage this situation. In this case, the parents or carers would have been assessed as having the capacity to take the ideas discussed and implement them successfully at home to assist their child to manage their anxious feelings and resume consistent school attendance.

This level of support requires only a few sessions (up to six), need not be part of a Family Action Plan, and the data collected relates to the family overall.

The data covers:

- Dates the support commenced and ended
- What sort of support was provided?
- If the family was referred to other services - what were they?
- The numbers of family members in different categories who received support, and
- In which life domains did the family receive support by your service?

3.10 Accepted for intensive long term support

If the outcome of the assessment process is that the child or young person and their family requires intensive long term support there are some extra data items that need to be collected, even though much will already have been collected during the assessment process itself.

Please note this category includes children, young people or families referred to targeted intensive group work. The provider needs to work with these children, young people and families to develop a Family Action Plan to ensure any intervention is based on the expressed opinions of the individuals involved.

Data to be collected includes:

- Date Family Action Plan was developed
- Rates for the family in each of the six life domains (rate is based on the Outcomes Star, see section 4.1)
- Exit date, and
- Main reason for exit

3.11 End of reporting period

At the end of the reporting period, or when a family exits the service, there is a requirement to collect data to capture a summary of their experience in the service.

This data is designed to assist FaHCSIA be informed about the outcomes being achieved through the New FMHSS for children, young people and their families.

The data collected includes:

- Number of family members who received support through the reporting period
- In which of the six life domains was this support provided?
- If relevant, where was the family referred to?
- Updated rating for the family in each of the six life domains (rating is based on the Outcomes Star)
- Date of the most recent review of the Family Action Plan. (Needs to be reviewed at least every three months.)

3.12 Exiting participants

When a child, young person or family exits FMHSS, the service provider must complete the required data as per section 3.1. This information forms part of the regular reporting obligations to FaHCSIA.

As outlined at *4.1.7 of Part C3: Application Information for the Family Mental Health Support Services Activity*, FMHSS providers ensure that participants exiting the service have adequate alternative supports in place should they require them.

3.13 Data for Community Events or Groups

The defining principle for recording people attending community events is – has the particular New FMHSS engaged with and delivered a service to a person or group of people in terms of the intent of New FMHSS?

If a provider organises an event/activity that is about mental health issues, especially related to children and young people, then all participants can be counted.

If a provider participates in an event organised by another service or agency, then they should not count people who may approach them at that event, unless they are subsequently provided with a New FMHSS service and counted in direct service data.

The on line reporting system is set up to collect the number of participants at an event or in a group and the number of times an event or group may have been conducted.

If a participant attends a group jointly organised by a New FMHSS and another agency, such as a school, the New FMHSS is still able to record the numbers attending as FaHCSIA is interested in the total reach of New FMHSS, even if the other agency also counts the numbers.

4 Family Action Plans

The Family Action Plan (FAP) is central to the effectiveness and success of New FMHSS. It is the tool used to plan, record and review each participant's aspirations, goals, activities, achievements and progress.

Every participant in New FMHSS receiving intensive and long term support must have a FAP tailored to reflect their needs.

Service providers operating in some sites or who are providing services to CALD participants may need to arrange to have the FAP drafted in the participant's first language or develop other suitable arrangements to ensure participants actively engaged in any changes to the content of their FAPs.

4.1 What is a Family Action Plan?

The Family Action Plan (FAP) is used to record the goals, needs, strengths and progress of the referred child or young person, and each significant person in their family who is also be working with the provider. The goals, or what issues will be worked on, is recorded against the six CAARS life domains used in the New FMHSS online system:

1. Physical health

2. Mental health and emotional wellbeing
3. Relationships (including social networks and relationships, and family relationships and functioning)
4. Material wellbeing (including housing and self-care and living skills)
5. Learning and development (including school attendance/learning and sport/recreational activities), and
6. Safety (including child and family safety).

The child, young person or family member is asked to rate how they are currently managing the issue/s in the nominated domain/s. The FAP also records progress made with the issues in the domain/s.

The rating levels, related to the Outcomes Star (Outcomes Star Australia), are:

1. stuck - feeling out of control but might have moments of awareness
2. accepting help - reaching out for help and engaging with people who can help me
3. believing - it's scary but I want things to change and will try
4. learning - feeling better and able to manage the ups and downs a bit better
5. self-reliant - managing better and know how to use support if I need it
6. not known.

The FAP has at least two sections – one for the child or young person and one for each of the significant other family members who is working with the provider to support the child or young person.

The FAP is linked with the data collection and reporting system through recording:

- When the FAP was first developed
- The review date
- CAARS domains which are the focus of the work (the service is not expected to work on all the identified issues, but to work with the child or young person or family member to choose the two or three most important issues)
- Starting rating point for each relevant domain (six point scale - see above), and
- Progress rating against each relevant domain (six point scale).

The rating of the domains is designed to inform the child, young person or family member, the practitioner and the Department that progress is being made with the issues the child, young person or family member wanted to work on. It would be useful to know for example that 60% of children who wanted to work on their school attendance had improved their attendance rate over the first three months of service from the New FMHSS.

The FAP is not intended to replace detailed notes kept by the practitioner.

4.2 Family Action Plan Principles

The following principles must be followed when working with participants (children, young people and families) to develop their FAPs.

- The child or young person is central to all planning processes and their voices must be heard and recorded in the FAP.
- Discussions between the participants and their New FMHSS worker should be based on the participants' life goals, not on what other people think should be their goals.
- The FAP should focus on the participants' goals, aspirations and preferences and affirm the strengths, talents and capacities of the person.
- Other participants (e.g. family members) involved in the development of the FAP need to be willing to discuss their goals in relation to outcomes for the child or young person.
- The FAP is a living document and can and should be regularly reviewed. It should be updated three monthly at a minimum.
- The FAP is owned by the participants and not the New FMHSS. It is considered as 'Mary's FAP' rather than 'the FAP for Mary'. The participants should always be able to have a copy of their FAP and know exactly what is in it. Nothing should be in the FAP that the participants did not agree to.
- The FAP should use the participants' language or way of expressing their needs and goals, and not service or clinical language.
- The process of planning and developing a FAP is a shared responsibility between a New FMHSS worker and the participants. It is not something prepared without the participants.

4.3 Developing a Family Action Plan

A FAP template is provided at **Attachment G**. This template is simple and can be modified to make it more interesting and engaging for participants, depending on their age, cultural background and other personal interests.

FaHCSIA asks providers to base their modified FAPs on the template contained in this document. There are some key elements that should be contained in any FAP that is used for New FMHSS. These essential elements are:

- Date the Plan was developed
- What the person wants to work on - and which of the six CAARS life domains this fits in
- How the person rates themselves in this domain (six point scale), and
- Date for review (FAPs must be reviewed at least once every three months).

FaHCSIA does not expect providers to work on all the issues identified by a child or young person or family member but to focus on the two or three highest priority issues.

If appropriate, a FAP can also include:

- The person's strengths
- What they can do to help themselves
- Which other people can help them and how
- Which other people don't really help them
- How will they know they are finding it easier to manage their issues
- How will they know they are finding it more difficult to manage their issues
- What can they do if they start finding it more difficult to manage their issues, and what do they want other people to do.

5 Service Coverage Areas

5.1 Defined service coverage areas

Each New FMHSS is allocated a site with a defined service coverage area, usually a single Local Government Area (LGA) or adjoining LGAs. The service coverage area is specified in the funding agreement. As a principle, FaHCSIA expects services to provide access to children, young people and families living within their defined site coverage area.

5.2 Servicing participants outside of the site's coverage area

It is possible to service someone living outside of the defined site coverage. Up to 10 per cent of a service provider's participant 'caseload' can come from outside a site's coverage area. These participants are referred to as out-of area participants.

There may be times when a decision is required on whether to provide services to an out-of-area participant. This decision may be required when a participant applies to access a New FMHSS or because they move out of the site's coverage area. Servicing someone from outside the site's coverage area should be considered on a case-by-case basis and consideration should be given to the following:

- First and foremost, what is in the best interest of the child or young person and their family in the long term?
- Is there another New FMHSS provider, or appropriate community service, that could support the participant?
- What is the site's capacity to service this participant and what, if any, impact could this have on servicing participants from within the designated site's coverage area?
- How difficult will it be to service that individual (e.g. if there are long distances for workers to travel to service that individual, then will that individual actually receive the quality of service expected – would they be better serviced by another provider)?

There is no need to seek permission from a FaHCSIA funding agreement manager to service one-off participants from outside the site's defined coverage area.

A service provider must seek the approval of a FaHCSIA funding agreement manager to service more than 10 per cent of their caseload outside their defined coverage area.

5.3 Servicing areas that are allocated to another New FMHSS

Service providers can negotiate with one another to support participants that reside in areas that are not allocated to them. There may be circumstances in which it is easier for another provider to service a particular area rather than the provider that has been allocated the area.

Service providers should request a permanent change to their coverage area if they believe they have a good reason to cease servicing part of their coverage area. FaHCSIA will consider the requested change and, if agreed, will vary the Funding Agreement accordingly. This will ensure accurate information is available on New FMHSS service coverage for participant referrals.

6 New FMHSS staff roles, skills and qualities

Implementing and delivering New FMHSS requires staff that are highly skilled and experienced in working with children and young people. It also requires staff with a range of personal and professional qualities to ensure the service delivers high quality support to vulnerable children, young people and families. It is envisaged that New FMHSS will engage teams will consist of three full time equivalent workers.

6.1 Personal qualities

Service providers are expected to employ staff for New FMHSS with a range of backgrounds, qualifications, skills and knowledge, relevant to working with children and young people at risk of or affected by mental illness and their families.

All New FMHSS team members should have the following attributes, personal and professional skills, and knowledge:

- Compassion, patience, ability to empathise and treat people with dignity and respect
- Genuine commitment to supporting children and young people and a capacity to remain focused on their issues
- Ability to think and act calmly and deal sensitively with distress, unpredictable behaviour and complex situations, while balancing the right to privacy and confidentiality with duty of care
- Knowledge of the development of mental illness, and skills in working with a wide range of children, young people and families
- Ability to promote the rights of vulnerable children, young people and families
- Effective listening and communication skills, non-judgemental practice and creativity in their approach to problem solving
- Cultural competence
- Knowledge of, and capacity to engage with, local community resources
- Knowledge of when to seek help or supervision and how to work in a team environment
- Understanding and promotion of mental health issues in the community, and
- Ability to work safely.

6.2 Roles

There are no defined roles in the New FMHSS but each provider must ensure their staff composition guarantees the service is capable of delivering the three elements of the service delivery model. It is particularly important to employ staff with the skills and experience to work with children and young people. If staff do not already have these skills it is important to train them as soon as possible to reduce the risk of the service focussing on the adults in

the family.

Designated roles in the team or accessible by the team, must cover:

- Work with children
- Work with young people
- Work with families
- Group work (both therapeutic/targeted and general), and
- Community development and outreach.

Providers may also find it works well to employ a project manager in the early stages of implementation who can take responsibility for managing the myriad of issues and challenges that arise, such as stakeholder engagement and recruitment, and to harness resources required across the organisation.

6.3 Team Leader Role

Ideally, the Team Leader of the New FMHSS should be the most qualified and/or experienced member of the team as it is their responsibility to provide direction and support to the whole team and to facilitate team connections with local community and clinical services.

7 Establishment Plans

New FMHSS providers are required to submit an Establishment Plan (template at **Attachment H**) to the FaHCSIA funding agreement manager within six weeks of signing their funding agreement. The plan will include how providers intend to implement and deliver the New FMHSS to achieve the required outcomes over the life of the funding agreement, and steps they will take in the first 12 months to implement New FMHSS in their site to ensure the target numbers are met and the three elements of the model are in place.

8 Privacy and Handling Complaints and Incidents

8.1 Confidentiality and privacy

New FMHSS workers develop relationships with vulnerable children, young people and families and as part of these relationships a New FMHSS worker will have access to very personal and sensitive information. Personal information should only be shared with the consent of participants and it should be kept safe and secure from access by others. The confidentiality and consent form is to enable de-identified data to be submitted by the provider and accessed by FaHCSIA.

It is very important service providers understand privacy and confidentiality obligations. FaHCSIA also expects providers to meet their obligations under the *Privacy Act 1988* and any relevant state or territory privacy legislation.

8.2 Handling complaints

A complaint is defined as: "Any expression of dissatisfaction with a product or service offered or provided".

Complaints, queries and feedback are considered a valuable opportunity for New FMHSS providers and FaHCSIA to review and improve processes and the quality of services provided.

Service providers must have an internal complaints procedure in place and it must be prominently displayed. The procedures should allow confidentiality of participants in order for participants to express concerns without any fear of their complaint impacting on the support or assistance they receive. New FMHSS complaints handling procedures must:

- Have commitment from all levels of the organisation
- Be fair to all concerned, including the complainant, your organisation and the person complained about
- Allow for the involvement of advocates
- Ensure the complainant does not suffer retribution or intimidation
- Be accessible – promoted internally and externally, in English and other languages as appropriate
- Have flexible methods of making complaints, with assistance available to complainants as necessary. This is particularly important for a service dealing with a vulnerable and disempowered children, young people and families
- Be responsive – a full impartial and timely process with fair and reasonable remedies
- Be effective – must address individual complaints, use information to improve overall service delivery and inform planning decisions
- Be open and accountable so participants can judge for themselves whether the system is working effectively
- Afford privacy, dignity and confidentiality

- Provide information about alternative avenues for any complaint that cannot be resolved internally (including referral to FaHCSIA)
- Be provided free of charge, and
- Refer the complaint to the FaHCSIA Contact Person as named in the Funding Agreement if the participant does not receive satisfactory resolution of their concerns.

8.3 Handling incidents

While TCC Program providers strive hard to ensure their services are safe and supportive places for participants and staff, there can be times when incidents occur that result in someone not feeling safe or supported. Such incidents can include:

- Death, injury or abuse of a participant while in the care of the provider
- Death, injury or abuse of staff or volunteers undertaking TCC Program tasks
- Inappropriate conduct between a participant and employee
- Significant damage to or destruction of property impacting service delivery
- Adverse community reaction to TCC Program activities, and
- Misuse of TCC Program funding

Incidents should be reported to the FaHCSIA funding agreement manager within 24 hours of occurrence or discovery.

Information supplied to FaHCSIA should be de-identified. Names and addresses may be requested if FaHCSIA becomes involved in judicial proceedings as a result of the incident.

The TCC Program Incident Report Form at **Attachment I** should be completed by the Site Manager and forwarded to their FaHCSIA funding agreement manager for the activity involved.

9 Communication and Promotion

An important part of New FMHSS is to communicate and promote the service and the importance of mental health and wellbeing for children, young people and their families. However, these activities should avoid creating unrealistic expectations in the community about the resources allocated to FMHSS.

9.1 New FMHSS Promotional Products

Providers are free to name or brand their particular New FMHSS in such a way that it is relevant and welcoming for children, young people and families in their local area.

However there is a requirement that the name “Family Mental Health Support Services” is included in any advertising or promotion of the service, and that it is acknowledged the funding is from the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

For example:
“(Name of the organisation) is launching our new Family Mental Health Support Service called (own brand name). This service is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.”

10 Contacting FaHCSIA

We encourage service providers to contact their New FMHSS Funding Agreement Manager (as named in the Funding Agreement) in FaHCSIA whenever the need arises.

Service providers may request a meeting with Departmental representatives to address specific issues or concerns that may arise in relation to New FMHSS.

The FaHCSIA National Office can be contacted via email at: mentalhealth@fahcsia.gov.au

Phone: 1300 653 227 (Calls are charged at a local rate except from mobile phones, where higher call costs are incurred)

Street Address:	Mental Health Branch Department of Families, Housing, Community Services and Indigenous Affairs CW1, Tuggeranong Office Park Soward Way (cnr Athlon Drive) Greenway ACT 2900
Postal Address:	Mental Health Branch Department of Families, Housing, Community Services and Indigenous Affairs PO Box 7576 Canberra Business Centre ACT 2610
Website:	www.fahcsia.gov.au

Locations and contact details of New FMHSS providers can be viewed at the FaHCSIA website.

Further Reading and References

Children and young people – mental health

Special Needs Groups

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Attachment A Summary of consultation outcomes

Background

In the 2011-12 financial year, FaHCSIA provided funding to eleven non-government organisations to deliver the first 13 new Family Mental Health Support Services (FMHSS).

The new FMHSS included eleven mainstream services and two remote services all of which were located in Local Government Areas assessed as high need. The remote services were in the APY Lands in South Australia and the Lower Gulf region of North Queensland. Four mainstream services were located in NSW, two in Queensland, three in Victoria, one in South Australia and one in Western Australia.

To assist the service providers with the implementation of FMHSS, FaHCSIA held three workshops – an initial workshop was held in Canberra in early August 2012, a second workshop was held in Sydney in October 2012, and a final workshop was held in Sydney in early December 2012.

Managers and newly recruited staff from all thirteen services attended these workshops as well as staff from the FaHCSIA State Office network and staff from FaHCSIA National Office with responsibility for the rollout of the FMHSS.

Following the October workshop, FaHCSIA engaged a consultant, to assist providers during the early implementation phase for the new FMHSS until the end of January 2013.

The consultant's primary role during this period was to provide individualised support, clarification and guidance for FMHSS providers as they planned and implemented the delivery of new FMHSS in their local area. The scope of work required the consultant to meet with the FMHSS managers to gain an insight into the challenges they had experienced during the implementation phase as policy translated to 'on the ground' service delivery.

The work included identifying strategies that had been put in place by the service providers to address the challenges they faced and to identify best practice examples for future implementation of FMHSS.

Two primary objectives of the December 2012 FMHSS workshop were to:

- obtain feedback and advice from providers on amendments and changes which could potentially be incorporated into the 2013 rollout of FMHSS; and
- consider any refinements to the current FMHSS guidelines to ensure they reflect the intent and implementation of the new FMHSS.

This document brings together the information and feedback collected from all three workshops, the findings of the visits and discussions with FMHSS providers and issues identified during discussions with FaHCSIA National and State Office staff.

The following factors have contributed to building a successful FMHSS service in 2012-13:

- Managers and team leaders who are experienced, highly motivated, knowledgeable and are able to provide strong leadership and guidance;
- The ability of the provider to build a strong team and create high team morale in a complex and demanding environment;

- Strong relationships with other service providers and the ability of the provider to build collegiate and collaborative partnerships in the region and state;
- A high degree of support for the FMHSS from auspicing bodies, child protection authorities and the community in general;
- The 'parent' body and/or auspicing body has a good reputation and is preferably established in the community;
- The ability of the provider to effectively recruit staff with the necessary skills, experience and personal attributes required to work in a challenging and complex environment;
- Proven experience in the delivery of similar complex services in high need communities; and
- Proven ability to deliver outcomes in a complex service delivery environment.

Intent of FMHSS

The 11 providers funded under the new FMHSS model in 2011-12 Budget, were required to broaden the assistance provided to children aged 0-18 years and to strengthen the focus of FMHSS on early intervention support for children and young people and their families to improve mental health outcomes.

A risk for the Department is that providers may revert to working with adult members of the family, particularly if this is the age cohort that staff have had the most experience working with, and that the focus on early intervention and prevention is dissipated. To mitigate this risk it will be important that the Department (and in particular the STO network) continually monitor the services being delivered and the strategies being put in place by FMHSS providers.

It will also be important for providers to ensure they engage staff who are comfortable working with children and young people, that their staff have the necessary skills and attributes and that appropriate training is provided to ensure this objective of FMHSS is met.

Recruitment and Staff Development

One of the most significant challenges experienced by the New FMHSS providers has been recruitment. Several providers needed to go to the market a second and third time to find suitably qualified staff and staff with the right skills, attributes and attitudes to work effectively in the FMHSS service. Providers noted that the highest priority should be given to recruitment in the establishment phase of any future FMHSS roll out and highlighted the importance of getting the documentation right and to clearly articulate roles and responsibilities as well as the skills, capabilities and personal attributes required to work in an FMHSS.

This is an area where support and mentoring from the current providers would be useful for new FMHSS providers. The opportunity to learn from their experiences, particularly in similar regions and to have access to documentation, job advertisements, job descriptions etc would provide the additional support has been recommended by the current providers.

Engagement with Local Service Providers

The ability of FMHSS providers to engage with and build effective partnerships with other service providers in their local region is a key factor for the success of the FMHSS model.

Given the significant demand for the support that is provided through FMHSS the majority of providers have been welcomed and strongly supported by other service providers in their region. A small number of FMHSS providers however experienced some resistance and a degree of scepticism from other service providers. This was generally put down to the fact that many of these providers did not have an understanding and full appreciation of the intent of FMHSS and the approach that would be taken by FMHSS providers to work in partnership with other services to deliver an holistic approach to providing support for the parents, children and young people.

Implementation

A key observation at the December workshop was that the majority of FMHSS providers had under-estimated the time it takes to develop and implement the FMHSS. This in turn created a tension for providers between meeting FaHCSIA targets and implementation timeframes and taking the time to 'get it right'. A number of service providers said that with the benefit of hindsight they would have engaged a project manager in the very early stages of implementation (following advice from FaHCSIA of a successful tender application) to manage the myriad of challenges that arise and to harness the resources required across their organisation. Using the approach outlined above would go some way to reducing the tensions experienced by the current providers and would also assist with shortening implementation timeframes.

Implementation plans should also include consideration of key stakeholders and communication strategies.

Rural and Remote Service Provision

There is a clear need to expand the FMHSS to regional Australia where there are significant challenges for children and in particular young people. Moreover, the delivery of FMHSS in remote and rural locations presents a number of additional challenges including increased costs to deliver services, significant demand for assistance across a diverse and expanded geographic area, increased occupational health and safety risks and the services and the ability to recruit and retain suitably qualified and experienced staff. These issues warrant further consideration in establishing any future FMHSS services in rural locations.

Indigenous Service Delivery

Issues associated with the delivery of services in remote Indigenous communities are even more complex and challenging than those in rural Australia.

It was clear from feedback and discussions with the providers that there is no one model for remote indigenous service delivery that is can be applied universally. The key to successful service delivery is to tailor the service to the specific needs of the community and to ensure the community is involved in its development and has a high degree of ownership in how the service is delivered.

Key observations from discussions with the remote Indigenous service providers are:

- Experience shows that the most successful non-clinical services in Indigenous communities are those that have been co-created with local people.
- Future service providers for FMHSS would preferably have a documented and demonstrated history of a community development approach not only to service delivery but also to service design.

- Having endorsement from indigenous communities themselves would add additional credibility to any funding applications; the degree of flexibility in the FMHSS model presents the risk of the program going off course. It will be important that the intent and purpose of the FMHSS is highlighted within any Indigenous service delivery model and that it is at the centre of any implementation plans;
- The partnership, trust and working relationship between FaHCSIA and the service provider in any remote Indigenous location is crucial to its success. This partnership provides support, information sharing, monitoring of the 'intent' in developing initiatives, and in putting forward reportable outcomes for government consideration.

Other factors that appear to have contributed to successful delivery of FMHSS in remote Indigenous communities include:

- Having the appropriate mix of mental health professionals and youth workers in the FMHSS;
- Ensuring local staff are engaged and that the provider has a strong commitment to building capacity and capabilities in the community;
- Ensuring appropriate supports are in place for staff engaged to work remotely; these supports include access to professional and cultural/local supports as well as access to personal support networks;
- The ability of the provider to engage effectively with the local community and gain the support of Indigenous leaders and community councils and that they understand the model and intent of FMHSS;
- The ability of the provider to work effectively with and build cooperative relationships with other providers working in the community and the region;
- The need for providers to gain an understanding of what local people are already doing in the community along with other providers;
- The provider has a strong understanding of the culture, traditions and protocols for the community.

Attachment B Screening template

Question	Response	Comment/s
1. Does the referral concern a child or young person between the ages of 0 and 18 years?	Yes/No	
2. Is there at least one adult family member or carer willing to work with the child or young person and the service?	Yes/No	
3. Does the child or young person live within the coverage area for this particular service?	Yes/No	
4. Does an adult think the child or young person is at risk of or affected by mental illness?	Yes/No	
5. Who is that adult? • Parent or care giver? • Health professional? • Educational professional? • Friend or informal contact?		
6. Is there a presenting issue for the child or young person which may increase their risk of having poor mental health outcomes later in life?	Yes/No	
7. Is the child or young person under the care of the state child protection agency? (That is, does the state child protection agency have total or shared parental responsibility for the child?)	Yes/No	
8. Is the child or young person in contact with the child protection system?	Yes/No	
9. If the young person is under the care of the child protection system, are they transitioning from out-of-home care? (This process usually starts from the age of 15.)	Yes/No	
10. What is the expressed request of the child or young person and their family? • For information or one-off support? • For ongoing assistance?	Information or one-off support/ ongoing assistance	
11. If the child or young person and their	Yes/No	

family are accepted into the service do they consent to their information collected by this provider being disclosed in a de-identified form to FaHCSIA for the purposes of New FMHSS data collection? (See **Attachment F**)		

For a child or young person to be accepted for further support, there should be a 'yes' answer to questions 1, 2, 3, 5 and 6. The answer to question 7 should be 'no'.

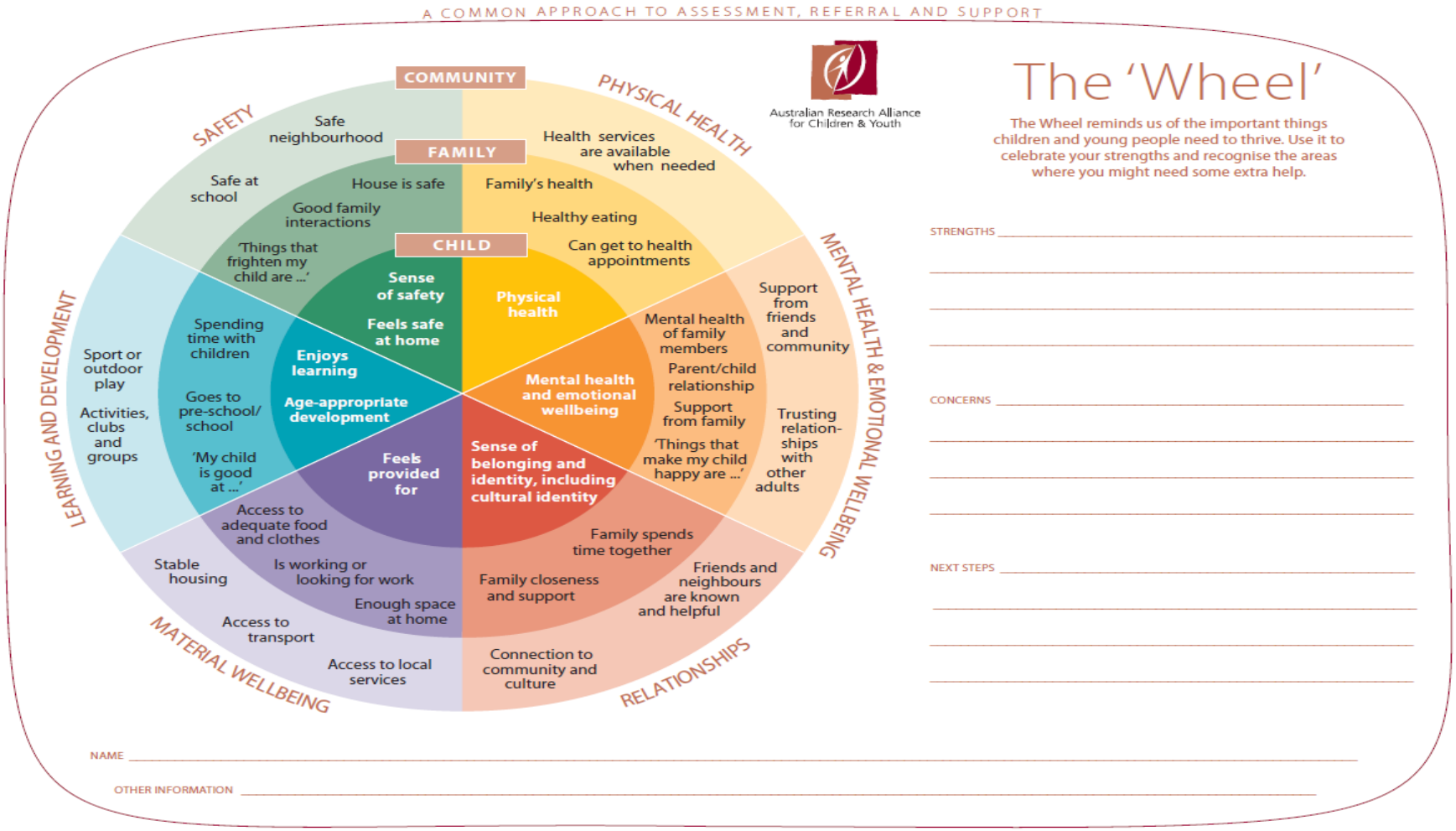
If the answer to question 7 is 'yes' and they are a child or young person aged under 15, they are only able to receive information or one-off support. (It is not appropriate for FMHSS to provide ongoing support for these children or young people as it is the responsibility of the state child protection agency to do this.)

If the answer to question 7 is 'yes' and they are a young person aged 15 or over transitioning to independence from out-of-home care and wanting to work with their family of origin or carer/s to improve their mental health outcomes, then they may be eligible for this service.

The answer to question 8 can be 'yes' or 'no' - it will be recorded through the assessment data for the child or young person.

The answer to question 9 can be 'yes' or 'no' – it will be recorded through the assessment data for the child or young person.

Attachment C – CAARS Wheel



Attachment D FMHSS data system specifications

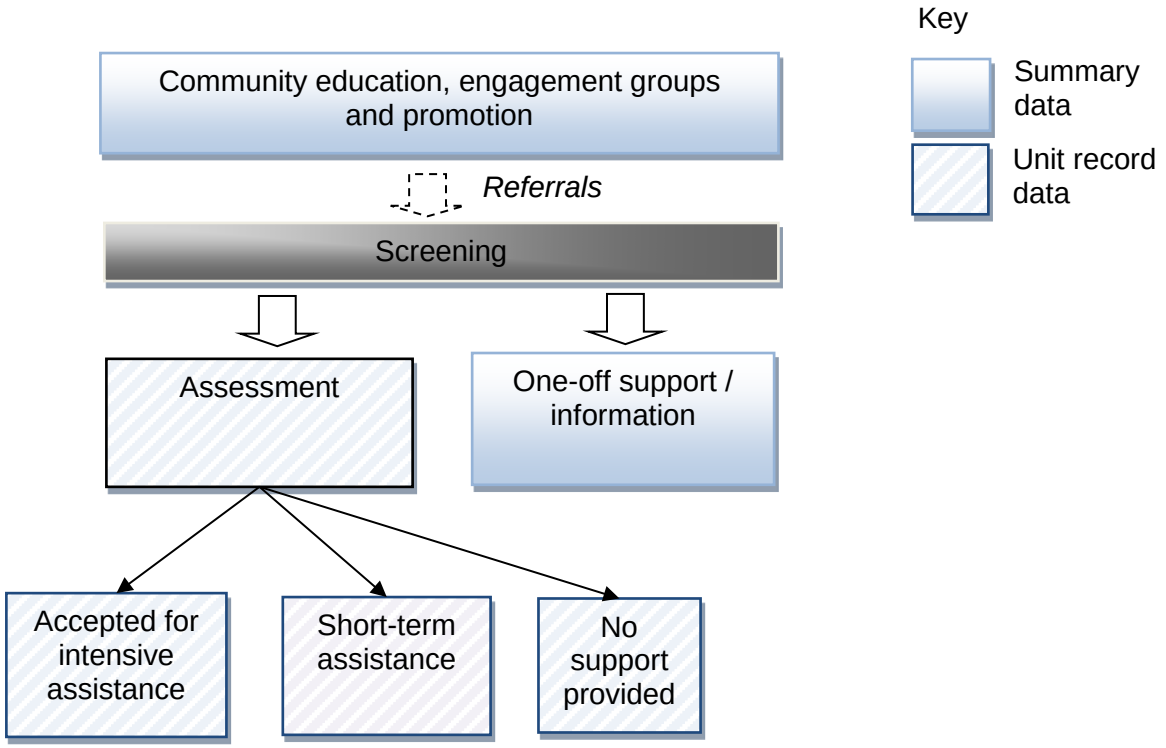
The first step in developing a data system for FMHSS is to set up specifications for what data needs to be collected for whom at what stage.

The basic assumptions about how service providers will work with clients are that:

- Service providers are expected to undertake some general activities that are not directly related to supporting individual clients. These activities are mainly about engaging with communities. Summary data on the number of activities and the number of people reached is sought.
- Enquiries and referrals (including self-referrals) are subject to an initial screening, which will result in either
  - one-off information referrals, strategies, resources only (summary data collected)
  - a more thorough assessments of need (unit record data collected)
- There are three possible outcomes from assessments
  - no support provided
  - limited short-term support (including info, strategies, referrals and groups)
  - intensive assistance (including groups)
- Different sets of data are required depending on the assessment outcome.
- For groups, the following rules apply:
  - Where groups are run for engagement and information purposes, only aggregate data is needed
  - Where groups have a therapeutic purpose, unit record data is required for all group participants. It is assumed that the participants in such groups have gone through assessment and are either subject to "short-term support" or "intensive support". Participating in groups is simply one part of their support.

Figure one over the page shows a simple picture of processes. It focuses on data collection points rather than client pathways. The following sections show what data will be collected at each stage.

Figure 1. Processes and data collection events



0.1 Community activities and engagement groups

Only summary data is collected for community and engagement activities. Where groups have an intervention or therapeutic focus, they should not be included here and unit record data would then need to be collected on participants of those groups. Reporting unit record data looks simple, but requires service providers to have a record keeping system to be able to produce the summary numbers.

0.1.1 Summary data on Community education, engagement groups and promotion

Data item	Categories
Indicate number of activities and persons attending for each category (confirm range of options)	1) Information sessions 2) Education programs 3) Community events 4) Newsletter/ promotion 5) Support groups

0.2 Summary data on one-off support

The data provided in this section is of individuals or family units seeking information or support from the service but do not progress to assessment. These families may receive information and referrals but the support is one-off.

This section should only include families that have individually sought support. If families have only participated in "community activities and engagement groups" (see above) they should not be counted here. If families have participated in "community activities and engagement groups" and individually sought support, then they may be counted both here and in the previous section.

Data item	Categories
Number of instances of one-off support.	Number
Who has one-off support been provided to—indicate number for each category	1) Number of parents/ carers 2) Number of children/ young people 3) Number of extended family or non-family individuals
Number of families receiving types of one-off support—indicate number for each category	1) Referral to other services 2) Information 3) Advice and assistance
Why families did not progress to assessment—indicate number of families for each category	1) Only wanted information 2) Child/ young person outside target group 3) Service at capacity (no capacity to provide more than information) 4) Other, specify
Referral source—indicate the referral source of the number of families referred from each referral source.	1) Child Protection Service 2) Mental Health Service/ provider 3) Drug/ alcohol service 4) Domestic violence service 5) Law/ Justice system 6) General Community support service 7) Health Practitioner 8) Housing Service 9) School 10) Early Childhood 11) Personal Helpers and Mentors service 12) Respite service 13) Another FMHSS 14) Financial Service 15) Self referral (no referral source) 16) Centrelink 17) Other, specify:_____

Referral destination—indicate the number of families referred to each referral destination.	1) Child Protection Service 2) Mental Health Service/ provider 3) Drug/ alcohol service 4) Domestic violence service 5) Law/ Justice system 6) General Community support service 7) Health Practitioner 8) Housing Service 9) School 10) Early Childhood 11) Personal Helpers and Mentors service 12) Respite service 13) Another FMHSS 14) Financial Service 15) Centrelink 16) Other, specify:_____

0.3 Assessment

It is expected that families who request support, or are assessed by the service provider to require support, are assessed for eligibility and need. For all families who go through assessment, mainly demographic data is required. Importantly, the assessment outcome is recorded, which determines what further data is collected.

Full names will not be used in the data system in order to protect anonymity. Instead, unique client IDs will be used. The family ID will uniquely identify the family. The system will also include a voluntary "service provider's family ID" that can serve as a link to other service provider data systems/ records as needed.

If possible, IDs used in other FaHCSIA data systems (constructed out of names) will be used in this system. Although, this may be difficult as the client is a family rather than individual.

0.3.1 Data about the family

It is assumed that most often support will be provided to a family. One or more members of the family may actively receive support. This first section refers to the family unit.

Data items	Categories
Family ID	Text (this is an umbrella ID capturing work done for the whole family, including child)
Service provider's family ID	Text
Date assessment began	Date
Postcode where family lives (primary residence)	Number
Does the family speak a language other than English at home?	1) Yes 2) No 3) Not known
Main language spoken at home	1) English only 2) Indigenous language 3) Italian 4) Greek 5) Arabic 6) Cantonese 7) Mandarin 8) Vietnamese 9) German 10) Spanish 11) Tagalog (Filipino) 12) Croatian 13) Macedonian 14) Dari 15) Other , specify
Does the family require interpreter services	1) Yes—for spoken language other than English 2) Yes—for non-spoken communication 3) No

Data items	Categories
Main sources of family Income	Full time employment Full-time and/ or part-time employment (including casual) Financial assistance from the Government
Referral source—indicate from where the family was referred.	1) Child Protection Service 2) Mental Health Service /provider 3) Drug/ alcohol service 4) Domestic violence service 5) Law/ Justice system 6) General Community support service 7) Health Practitioner 8) Housing Service 9) School 10) Early Childhood 11) Personal Helpers and Mentors service 12) Respite service 13) Another FMHSS 14) Financial Service 15) Self referral (no referral source) 16) Other, specify:_____
Indicate how many family members/ persons in the following categories were actively involved in the assessment	1) Number of parents/ carers 2) Number of children/ young people – siblings 3) Number of extended family or friends
Main presenting issue for the child /young person(s) which may increase their risk of having poor mental health outcomes later in life. (select all that apply).	1) Parenting practices –2) Relationship with parents 3) Family member with mental illness 4) Substance abuse in the family 5) Domestic violence in the home 6) Inconsistent or poor attendance at school 7) History of trauma for the child or young person e.g. child abuse or neglect 8) Family stress or trauma 9) Chronic or serious physical health condition 10) Family instability 11) Peer problems e.g. bullying 12) Academic problems 13) Homelessness 14) None of the above
Did you use any of the CAARS tools with this family?	1) Yes 2) No
If yes above, which tools did you use	1) Wheel pad 2) Family Questionnaire 3) Children Questionnaire 4) Professional Judgement Reference Points 5) Discussion Prompts - Children 6) Discussion Prompts - Families
Assessment outcome	1) No support provided 2) Accepted for short-term assistance 3) Accepted for intensive assistance
If assessment outcome above is 1 above What was the reason for not accepting family	1) Does not meet eligibility requirements 2) Client decision/ choice not to proceed 3) Other reason, specify:_____

0.3.2 Data about the child/ young person(s) in the family

It is assumed that in most cases support sought is related mainly to one child. The data in this section relates to that child. If there is more than one child in the family and the support is relating to both, then data for more than one child can be entered.

Data items	Categories
Who the child/ young person is living with (select all that apply)	1) Parent(s) (including shared care) 2) Extended family 3) Formal out-of-home care 4) Informal out-of-home care 5) Supported accommodation e.g. refuge 6) Friends 7) Other
Sex of the child/ young person	1) Male 2) Female 3) Not known
Date of birth of the child/ young person	Date
Is the child/ young person of Aboriginal or Torres Strait Islander origin?	1) Aboriginal but not Torres Strait Islander origin 2) Torres Strait Islander but not Aboriginal origin 3) Both, Aboriginal and Torres Strait Islander origin 4) Neither Aboriginal nor Torres Strait Islander origin 5) Not known
Does the child/ young person's mother identify as Aboriginal or Torres Strait Islander?	1) Yes 2) No 3) Not known
Does the child/ young person's father identify as Aboriginal or Torres Strait Islander?	1) Yes 2) No 3) Not known
Is the child or young person in contact with the child protection system?	1) Yes 2) No 3) Not known
If the young person is under the care of the child protection system are they transitioning from out-of-home care? (This process usually starts from the age of 15)	1) Yes 2) No 3) Not known

0.4 Data items if family is accepted for short-term assistance

Short-term assistance refers to services not provided under a family plan, usually involving no more than a handful of sessions. The data in this section refers to the family overall.

Data items	Categories
Date support commenced	Date
Date support ended	Date
What sort of short-term assistance was provided (select all that apply):	1) Information 2) Referral other service(s) 3) Strategies 4) Resources 5) Group(s)
If the family or family members were referred to other services, indicate which services (indicate all that apply)	1) Child Protection Service 2) Mental Health Service/ provider 3) Drug/ alcohol service 4) Domestic violence service 5) Law/ Justice system 6) General Community support service 7) Health Practitioner 8) Housing Service 9) School/ Early Childhood 10) Personal Helpers and Mentors service 11) Respite service 12) Another FMHSS 13) Financial Service 14) Other, specify:_____
Indicate the number of family members in each category who received assistance	1) Number of parents/ carers 2) Number of children/ young people – siblings 3) Number of extended family or friends
In which domains did the family receive support by your service	1) Physical health 2) Mental health and emotional wellbeing 3) Relationships (including social networks and relationships, and family relationships and functioning) 4) Material wellbeing (including housing, and self-care and living skills) 5) Learning and development (including school attendance/learning and sport/recreational activities) 6) Safety (including child and family safety)

0.5 Questions if family is accepted for intensive assistance (case managed)

For case managed clients there is some data that is provided once and some that needs to be updated six-monthly for as long as support is provided to a family. One family may participate over many months and over more than one 6 month reporting period. There is a need to further consider how we capture what the support needs of families are and what progress they make in different areas. At present there are key issues and priority areas.

0.5.1 Data items provided once for each case-managed family

Data items	Categories
Date Family Action plan was first developed	Date
Rate the family in each area. In each area, select one of the following: 1 – Stuck 2 – Accepting help 3 – Believing 4 – Learning 5 – Self reliant 6 – Not known	1) Physical health 2) Mental health and emotional wellbeing 3) Relationships (including social networks and relationships, and family relationships and functioning) 4) Material wellbeing (including housing, and self-care and living skills) 5) Learning and development (including school attendance/learning and sport/recreational activities) 6) Safety (including child and family safety)
Exit date	Date
Main reason for exit	1) Goals achieved (planned closure) 2) Family stopped engaging (unplanned closure) 3) Family relocated 4) Death or sickness 5) Other, specify:_____

0.5.2 Data items provided at the end of each reporting period (or at exit) while the family is case-managed

Data items	Categories
Number of family members in each category who received assistance in this reporting period	1) Number of parents/ carers 2) Number of children/ young people – siblings 3) Number of extended family
In which domains did the family receive support by your service in this reporting period (for each category, no support, some or extensive)	1) Physical health 2) Mental health and emotional wellbeing 3) Relationships (including social networks and relationships, and family relationships and functioning) 4) Material wellbeing (including housing, and self-care and living skills) 5) Learning and development (including school attendance/learning and sport/recreational activities) 6) Safety (including child and family safety)
Where, if anywhere, was the family referred in this reporting period (indicate all that apply)	1) Child Protection Service 2) Mental Health Service/ provider 3) Drug/ alcohol service 4) Domestic violence service 5) Law/ Justice system 6) General Community support service 7) Health Practitioner 8) Housing Service 9) School 10) Early Childhood 11) Personal Helpers and Mentors service 12) Respite service 13) Another FMHSS 14) Financial Service 15 Centrelink 16) Other, specify:_____ 17) No referral
Rate the family in each area. In each area, select one of the following: 1 – Stuck 2 – Accepting help 3 – Believing 4 – Learning 5 – Self reliant 6 – Not known	1) Physical health 2) Mental health and emotional wellbeing 3) Relationships (including social networks and relationships, and family relationships and functioning) 4) Material wellbeing (including housing, and self-care and living skills) 5) Learning and development (including school attendance/learning and sport/recreational activities) 6) Safety (including child and family safety)
Most recent formal review of the Family Action Plan (action plans should be reviewed at least once every 6 months)	Date

0.6 System feedback

Service providers will be asked to provide formal feedback about the data collection and reporting system. This feedback will be collected once per reporting period through the online system.

Data items	Categories
It is important that we provide data on the activities that we are funded to provide	1) Agree 2) Mostly agree 3) Mostly disagree 4) Disagree
It was easy to collect the required data	1) Agree 2) Mostly agree 3) Mostly disagree 4) Disagree
An online system is my preferred way to provide this data	1) Agree 2) Mostly agree 3) Mostly disagree 4) Disagree
The online system adequately explained what I needed to do	1) Agree 2) Mostly agree 3) Mostly disagree 4) Disagree
It was easy to use the online system	1) Agree 2) Mostly agree 3) Mostly disagree 4) Disagree
If you disagreed about any of the statements above, please briefly explain why	Text
Any other comments about the data collection	Text

Attachment E Risk and Protective Factors for Mental Illness

A document produced by the Australian Government National Mental Health Strategy (2000), *Promotion, Prevention and Early Intervention for Mental Health – A Monograph* (Monograph) provides factors generally accepted by practitioners and research as important contributors to the development of mental health problems and illness. These identified risk and protective factors build on the work of Fuller and McGraw (1996) and Blum and Resnick (1996), and provide a common set of risk and protective factors for multiple health risks including: mental illness; alcohol and other drug (AOD) abuse; violence; anti-social behaviour; crime and offending; school disengagement; and youth pregnancy.

These risk and protective factors may be used to identify risk and protective factors for intervention, towards mental health and wellbeing.

Table 1: Protective Factors

Individual Factors	Family/Social Factors	School Context	Life Events and Situations	Community and Cultural Factors
Easy Temperament Adequate nutrition Attachment to the family Above average intelligence School achievement Problem solving skills Internal locus of control Social competence Social skills Good coping skills Optimism Moral Beliefs Values Positive self-related cognitions	Supportive caring parents Family Harmony Secure and stable family Small family size More than two years between siblings Responsibility within the family (for child or adult) Supportive relationship with other adult (for a child or adult) Strong family norms and morality	Sense of belonging Positive school climate Pro-social peer group Required responsibility and helpfulness Opportunities for some success and recognition of achievement School norms against violence	Involvement with significant other person (partner/mentor) Availability of opportunities at critical turning points or major life transitions Economic Security Good physical health	Sense of connectedness Attachment to and networks within the community Participation in church or other community group Strong cultural identity and ethnic pride Access to support services Community/Cultural norms against violence

Table 2. Risk Factors

Individual Factors	Family/Social Factors	School Context	Life Events and Situations	Community and Cultural Factors
Prenatal brain damage Prematurity, Birth injury Low birth weight, birth complications Physical and intellectual disability Poor health in infancy Insecure attachment in infant/child. Low Intelligence Difficult temperament Chronic illness Poor social skills Low self esteem Alienation Impulsivity	Having a teenage mother Having a single parent, Absence of father in childhood, Large family size Anti-social role models in childhood Family violence and disharmony Marital discord in parents Poor supervision and monitoring of child Low parental involvement in child's activities Neglect in Childhood Long-term parental unemployment Criminality in parent Parental substance misuse Parental mental disorder Harsh or inconsistent discipline style Social isolation Experiencing rejection Lack of warmth and affection	Bullying Peer rejection Poor attachment to school Inadequate behaviour management Deviant peer group, School failure	Physical, sexual and emotional abuse School Transitions Divorce and family break up Death of family member Physical Illness or Impairment Unemployment, homelessness, Incarceration Poverty/Economic Security Job Insecurity, Unsatisfactory workplace relationships Workplace accident/injury Caring for someone with an illness or disability Living in nursing home or aged care hostel War or natural disasters	Socio- economic disadvantage Socio or cultural discrimination Isolation Neighbourhood violence and crime Population density and housing conditions Lack of support services including transport, shopping, recreational facilities

Attachment F Consent to Collection, Use and Disclosure of Information Form

Family Mental Health Support Services

I, _____, *[insert name of participant or guardian]* consent to information about_____ *[me/insert name of participant if this form is being signed by a guardian or other responsible person]* being collected and used for the purposes of the Family Mental Health Support Services (FMHSS).

I also consent to the information collected by *[insert name of organisation providing services]* _____ being disclosed to and used by:

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) state and territory governments, or another agency contracted to FaHCSIA, for IT support, reporting, research and statistical purposes.

I understand that personal information about _____ *[me/insert name of participant if this form is being signed by a guardian or other responsible person]* that is related to the operation and outcomes of the FMHSS will be recorded and disclosed in accordance with the *Privacy Act 1988*.

Signature of Participant	Signature of Guardian/ Person responsible for the participant
Print Name	Print Name
Date	Date

Signature of representative of organisation providing services

Print Name	Date

I ALSO UNDERSTAND THAT MY FMHSS WORKER MAY, IN SOME CIRCUMSTANCES, DISCLOSE INFORMATION HELD ABOUT_____ [ME/INSERT NAME OF PARTICIPANT IF THIS FORM IS BEING SIGNED BY A GUARDIAN OR OTHER RESPONSIBLE PERSON] TO OTHER ORGANISATIONS, FOR THE PURPOSES OF REFERRAL TO OTHER ORGANISATIONS FOR ASSISTANCE. I UNDERSTAND THAT MY FMHSS WORKER WILL DISCUSS ANY DISCLOSURE OF INFORMATION WITH _____ [ME/INSERT NAME OF PARTICIPANT IF THIS FORM IS BEING SIGNED BY A GUARDIAN OR OTHER RESPONSIBLE PERSON] PRIOR TO THIS DISCLOSURE.

Attachment G Family Action Plan template

Providers are not required to use this exact template, they can develop their own to suit their local participants and target groups etc. See section 4.3 for more information on Family Action Plans.

FAMILY ACTION PLAN - TEMPLATE

NAME OF CHILD OR YOUNG PERSON (FIRST NAME ONLY REQUIRED):……

DATE THE PLAN WAS DEVELOPED:……..

AREAS OF NEED IDENTIFIED IN ASSESSMENT (THE THINGS I WANT TO WORK ON):

FOR PRACTITIONER - WHICH OF THE SIX CAARS DOMAIN DOES THIS FIT IN?

1. PHYSICAL HEALTH;
2. MENTAL HEALTH AND EMOTIONAL WELLBEING;
3. RELATIONSHIPS (INCLUDING SOCIAL NETWORKS AND RELATIONSHIPS, AND FAMILY RELATIONSHIPS AND FUNCTIONING);
4. MATERIAL WELLBEING (INCLUDING HOUSING AND SELF-CARE AND LIVING SKILLS);
5. LEARNING AND DEVELOPMENT (INCLUDING SCHOOL ATTENDANCE/LEARNING AND SPORT/RECREATIONAL ACTIVITIES); AND
6. SAFETY (INCLUDING CHILD AND FAMILY SAFETY).

WHAT I'M GOOD AT OR WHAT I DON'T NEED HELP WITH:

WHERE I AM UP TO NOW WITH THE THINGS I WANT TO WORK ON (6 POINT SCALE):

1. STUCK - FEELING OUT OF CONTROL BUT MIGHT HAVE MOMENTS OF AWARENESS
2. ACCEPTING HELP - REACHING OUT FOR HELP AND ENGAGING WITH PEOPLE WHO CAN HELP
3. BELIEVING - IT'S SCARY BUT I WANT THINGS TO CHANGE AND WILL TRY
4. LEARNING - FEELING BETTER AND ABLE TO MANAGE THE UPS AND DOWNS A BIT BETTER
5. SELF-RELIANT - MANAGING BETTER AND KNOW HOW TO USE SUPPORT IF I NEED IT.
6. NOT KNOWN

WHAT I CAN DO TO HELP ME MANAGE MY ISSUES MORE EASILY:

PEOPLE WHO CAN HELP ME WITH MY ISSUES:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARENT, TEACHER, COUSIN ETC)	WHAT I NEED THEM TO DO

PEOPLE WHO DO NOT HELP ME WITH MY ISSUES:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARENT, TEACHER, COUSIN ETC)	WHAT I NEED THEM TO DO

HOW I WILL KNOW IF I AM FINDING IT EASIER TO MANAGE MY ISSUES:

WHAT I CAN DO IF I START TO HAVE MORE DIFFICULTIES IN MANAGING MY ISSUES:

WHAT I WANT OTHER PEOPLE TO DO IF I START HAVING MORE DIFFICULTIES IN MANAGING MY ISSUES:

THINGS I CAN DO FOR MYSELF:

DATE THIS PLAN WILL BE REVIEWED:

NAME OF PARENT/CARER OR ADULT PERSON WHO WILL BE WORKING WITH THE CHILD OR YOUNG PERSON (FIRST NAME/S ONLY REQUIRED)……

DATE THE PLAN WAS DEVELOPED:

AREAS OF NEED WERE IDENTIFIED IN THE ASSESSMENT (THE THINGS I WANT TO WORK ON TO HELP THIS CHILD/YOUNG PERSON MANAGE THEIR ISSUES MORE EASILY):

FOR PRACTITIONER - WHICH OF THE SIX CAARS DOMAIN DOES THIS FIT IN?

1. PHYSICAL HEALTH;
2. MENTAL HEALTH AND EMOTIONAL WELLBEING;
3. RELATIONSHIPS (INCLUDING SOCIAL NETWORKS AND RELATIONSHIPS, AND FAMILY RELATIONSHIPS AND FUNCTIONING);
4. MATERIAL WELLBEING (INCLUDING HOUSING AND SELF-CARE AND LIVING SKILLS);
5. LEARNING AND DEVELOPMENT (INCLUDING SCHOOL ATTENDANCE/LEARNING AND SPORT/RECREATIONAL ACTIVITIES); AND
6. SAFETY (INCLUDING CHILD AND FAMILY SAFETY).

WHAT I'M GOOD AT OR WHAT I DON'T NEED HELP WITH AS THE PARENT OF THIS CHILD OR YOUNG PERSON*:*

WHERE I AM UP TO NOW WITH THE THINGS I WANT TO WORK ON TO HELP THIS CHILD OR YOUNG PERSON (6 POINT SCALE):

1. STUCK – FEELING OUT OF CONTROL BUT MIGHT HAVE MOMENTS OF AWARENESS
2. ACCEPTING HELP – REACHING OUT FOR HELP AND ENGAGING WITH PEOPLE WHO CAN HELP
3. BELIEVING – IT'S SCARY BUT I WANT THINGS TO CHANGE AND WILL TRY
4. LEARNING - FEELING BETTER AND ABLE TO MANAGE THE UPS AND DOWNS A BIT BETTER
5. SELF-RELIANT - MANAGING BETTER AND KNOW HOW TO USE SUPPORT IF I NEED IT.
6. NOT KNOWN

WHAT I CAN DO TO HELP THIS CHILD/YOUNG PERSON MANAGE THEIR ISSUES MORE EASILY:

PEOPLE WHO CAN HELP ME TO SUPPORT THIS CHILD/YOUNG PERSON:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARTNER , FRIEND, SUPPORT WORKER ETC)	WHAT I NEED THEM TO DO

PEOPLE WHO DO NOT HELP ME TO SUPPORT THIS CHILD/YOUNG PERSON:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARTNER, FRIEND, SUPPORT WORKER ETC)	WHAT I NEED THEM TO DO

HOW I WILL KNOW IF THIS CHILD/YOUNG PERSON IS FINDING IT EASIER TO MANAGE THEIR ISSUES:

WHAT I CAN DO IF I START TO NOTICE THE CHILD OR YOUNG PERSON IS FINDING IT MORE DIFFICULT TO MANAGE THEIR ISSUES:

WHAT I WANT OTHER PEOPLE TO DO TO SUPPORT ME IN HELPING THIS CHILD/YOUNG PERSON:

THINGS I CAN DO FOR MYSELF IF I START TO FEEL THAT I AM NOT HELPING THIS CHILD/YOUNG PERSON ENOUGH:

DATE THIS PLAN WILL BE REVIEWED:

NAME OF SIBLING OR OTHER CHILD/YOUNG PERSON WHO WILL BE WORKING WITH THE CHILD OR YOUNG PERSON (FIRST NAME/S ONLY REQUIRED)……

DATE THIS PLAN WAS DEVELOPED:…….

AREAS OF NEED WERE IDENTIFIED IN THE ASSESSMENT (THE THINGS I WANT TO WORK ON TO HELP THIS CHILD/YOUNG PERSON MANAGE THEIR ISSUES):

FOR PRACTITIONER - WHICH OF THE SIX CAARS DOMAIN DOES THIS FIT IN?

1. PHYSICAL HEALTH;
2. MENTAL HEALTH AND EMOTIONAL WELLBEING;
3. RELATIONSHIPS (INCLUDING SOCIAL NETWORKS AND RELATIONSHIPS, AND FAMILY RELATIONSHIPS AND FUNCTIONING);
4. MATERIAL WELLBEING (INCLUDING HOUSING AND SELF-CARE AND LIVING SKILLS);
5. LEARNING AND DEVELOPMENT (INCLUDING SCHOOL ATTENDANCE/LEARNING AND SPORT/RECREATIONAL ACTIVITIES); AND
6. SAFETY (INCLUDING CHILD AND FAMILY SAFETY).

WHAT I'M GOOD AT OR WHAT I DON'T NEED HELP WITH AS A SIBLING OR FRIEND OF THIS CHILD OR YOUNG PERSON:

WHERE I AM UP TO NOW WITH THE THINGS I WANT TO WORK ON TO HELP THIS CHILD OR YOUNG PERSON (6 POINT SCALE):

1. STUCK - FEELING OUT OF CONTROL BUT MIGHT HAVE MOMENTS OF AWARENESS
2. ACCEPTING HELP - REACHING OUT FOR HELP AND ENGAGING WITH PEOPLE WHO CAN HELP
3. BELIEVING - IT'S SCARY BUT I WANT THINGS TO CHANGE AND WILL TRY
4. LEARNING - FEELING BETTER AND ABLE TO MANAGE THE UPS AND DOWNS A BIT BETTER
5. SELF-RELIANT - MANAGING BETTER AND KNOW HOW TO USE SUPPORT IF I NEED IT.
6. NOT KNOWN

WHAT I CAN DO TO HELP THIS CHILD/YOUNG PERSON MANAGE THEIR ISSUES BETTER:

PEOPLE WHO CAN HELP ME TO SUPPORT THIS CHILD/YOUNG PERSON:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARTNER , FRIEND, SUPPORT WORKER ETC)	WHAT I NEED THEM TO DO

PEOPLE WHO DO NOT HELP ME TO SUPPORT THIS CHILD/YOUNG PERSON:

WHO (NAME)	WHAT PART DO THEY PLAY IN MY LIFE? (EG PARTNER, FRIEND, SUPPORT WORKER ETC)	WHAT I NEED THEM TO DO

HOW I WILL KNOW IF THIS CHILD/YOUNG PERSON IS FINDING IT EASIER TO MANAGE THEIR ISSUES:

WHAT I CAN DO IF I START TO NOTICE THE CHILD OR YOUNG PERSON IS FINDING IT MORE DIFFICULT TO MANAGE THEIR ISSUES:

WHAT I WANT OTHER PEOPLE TO DO TO SUPPORT ME IN HELPING THIS CHILD/YOUNG PERSON:

THINGS I CAN DO FOR MYSELF IF I START TO FEEL THAT I AM NOT HELPING THIS CHILD/YOUNG PERSON ENOUGH:

DATE THIS PLAN WILL BE REVIEWED:

Attachment H Establishment Plan template

Establishment Plan (please refer back to your original proposal for information).

Name of service provider:
State:
Site (Local Government Area):
Address of service (street address):
Period covered:
Name of person in the organisation submitting this plan:
Date the plan was submitted:

Please indicate target dates for each of the elements listed below:

Elements of your Plan	**Target date** (When you anticipate the task will be completed)
Service operational: • When will you accept your first clients: o groups o short-term assistance o intensive • When do you expect your service to be fully operational ie fully staffed and with all procedures and processes in place?	
Service at capacity: • When do you anticipate being at capacity ie having a full case load?	

Please outline your plan for managing or achieving the elements listed below

Elements	Plan
Service at capacity • How are you planning to stage your implementation to reach full capacity by your target date?	
Targets: • What are your targets for the number of clients you will have assisted by: o End of first 6 months of operating o End of the first 12 months of operating	• Intensive ongoing assistance • Short-term assistance • Community engagement/group work
Staffing • How will you structure your team? - roles of each staff member	
Service model: • Please confirm what your service model will be. (Note any changes from your application for funding and ensure you include enough detail to enable FaHCSIA to use this document when discussing service delivery with you)	
Coverage • Details of where you will be delivering services from. Please include any outreach locations.	

Target groups • Which particular vulnerable groups will you be targeting within your area?	
• Which age cohort/s will you prioritise in your service?	
Promotion • Key strategies to promote your service to ensure you are able to reach children, young people and families who may be eligible?	• • •
Working with other agencies/services • Key strategies to establish strong and effective partnerships with local service providers?	• • •
Evaluation and continuous improvement • What will you put in place to review and improve your practice?	

Name of Department's representative accepting and approving this Establishment Plan:

Name: _____

Signed: _____

Date Approved: _____

Attachment I Incident Report Form

TARGETED COMMUNITY CARE (MENTAL HEALTH) PROGRAM

INCIDENT REPORT

ORGANISATION: _____

SERVICE ACTIVITY (PHAMS, MHR:CS OR FMHSS):_____

SITE:_____

DETAILS OF INCIDENT

DATE OF INCIDENT:_____TIME OF INCIDENT:_____

NO. OF INDIVIDUALS INVOLVED: _____GENDER OF INDIVIDUALS INVOLVED:_____

AGE OF INDIVIDUALS INVOLVED: _____STATUS OF INDIVIDUALS INVOLVED (STAFF, PARTICIPANTS ETC):_____

WHERE DID THE INCIDENT TAKE PLACE?_____

WHAT OCCURRED? (DESCRIPTION OF INCIDENT)_____

_____
_____
_____
_____
_____
_____
_____

RESPONSE TO THE INCIDENT:_____

_____
_____
_____
_____

ACTION THAT HAS BEEN TAKEN OR CAN BE TAKEN TO PREVENT THE INCIDENT FROM HAPPENING AGAIN:_____
_____
_____
_____

HAS THERE BEEN OR IS THERE LIKELY TO BE MEDIA COVERAGE OF THE INCIDENT;_____
_____

NAME OF SITE MANAGER:_____DATE:_____

SIGNATURE OF SITE MANAGER: _____

GUIDELINES FOR REPORTING INCIDENTS

INCIDENTS SHOULD BE REPORTED TO YOUR FAHCSIA FUNDING AGREEMENT MANAGER WITHIN 24 HOURS OF OCCURRENCE/DISCOVERY INCLUDE:

- DEATH, INJURY OR ABUSE OF A CLIENT WHILE IN YOUR CARE
- DEATH, INJURY OR ABUSE OF STAFF OR VOLUNTEERS UNDERTAKING TCC PROGRAM (FMHSS) TASKS
- INAPPROPRIATE CONDUCT BETWEEN A PARTICIPANT, ESPECIALLY A CHILD OR YOUNG PERSON, AND EMPLOYEE
- SIGNIFICANT DAMAGE TO OR DESTRUCTION OF PROPERTY IMPACTING SERVICE DELIVERY
- ADVERSE COMMUNITY REACTION TO TCC PROGRAM (FMHSS) ACTIVITIES
- MISUSE OF TCC PROGRAM (FMHSS) FUNDING.

INFORMATION SUPPLIED TO FAHCSIA SHOULD BE DE-IDENTIFIED,. NAMES AND ADDRESSES MAY BE REQUESTED IF FAHCSIA BECOMES INVOLVED IN JUDICIAL PROCEEDINGS AS A RESULT OF THE INCIDENT.

THE TCC PROGRAM INCIDENT FORM SHOULD BE COMPLETED BY THE SITE MANAGER AND FORWARDED TO YOUR FAHCSIA FUNDING AGREEMENT MANAGER FOR FMHSS.