



Australian Government

Department of Social Services

**Early Intervention Support for Vulnerable Families
with Children and Young People who are
Showing Early Signs of, or are at Risk of
Developing, Mental Illness –
Family Mental Health Support Services (FMHSS)
Operational Guidelines**

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1. Information

These Operational Guidelines provide the operational framework for the Family Mental Health Support Services (FMHSS) component of the Sub-Activity 'Early intervention support services for vulnerable families with children and young people who are showing early signs of, or are at risk of developing, mental illness'. These guidelines form the basis of the business relationship between the Department of Social Services (DSS) and the service providers.

These Operational Guidelines should be read in conjunction with the Disability, Mental Health and Carers Programme – Community Mental Health Guidelines, and the Grant Agreement.

DSS reserves the right to vary any aspect of, or replace these Operational Guidelines from time to time by whatever means it may determine in its absolute discretion.

Amendments made to these Operational Guidelines will be notified by email to the contact person named in the Grant Agreement within 20 business days of any change. DSS will ensure that the most current version of the Operational Guidelines is located within the Literature Tab of the DSS Online Funding Management System (FOFMS).

It is the responsibility of each service provider to ensure that they are familiar with the content and requirements of these Operational Guidelines as detailed in the current version maintained in FOFMS.

2. Role of the Sub-Activity 'Early intervention support services for vulnerable families with children and young people who are showing early signs of, or are at risk of developing, mental illness'

2.1 Activity and Sub-Activity Roles

'Early intervention support services for vulnerable families with children and young people who are showing early signs of, or are at risk of developing, mental illness' is one of four Sub-Activities funded under the Community Mental Health Activity of the Disability, Mental Health and Carers Programme.

The Community Mental Health Activity provides early intervention and other support through community-based initiatives to assist people with mental illness and their families and carers to develop their capabilities, increase their wellbeing and actively participate in community and economic life. The Activity will provide accessible, responsive, high-quality and integrated community mental health services that improve the lives of people with severe mental illness, provide support for families and carers of people with a mental illness, and intervene early to assist families with children and young people affected by, or at risk of, mental illness.

2.2 Objectives

Services support children and young people who are showing early signs of, or are at risk of developing, mental illness, to improve their wellbeing and enable them to better participate in their communities and reach their full potential.

3. Sub-Activity Overview

3.1 Services provided

Services provide a range of flexible, responsive, non-clinical mental health support services to meet the needs of children and young people affected by, or at risk of, mental illness, and their families and carers.

Services work with children, young people and their families or carers to address risk factors and strengthen protective factors. Examples of risk and protective factors are provided in **Attachment A**.

The Department is seeking the following outcomes from this Sub-Activity:

- children and young people have improved emotional health and wellbeing
- children and young people can better manage the different aspects of their lives
- families and carers are helped to support their children and young people, and
- communities have a better understanding of, and response to, mental health issues that affect children and young people.

3.2 Minimum requirements

The FMHSS component of the Sub-Activity funds organisations to deliver a service model which includes three levels of support each provider must offer:

1. Intensive, long-term, early intervention support for children, young people and their families which may include: Assessment and identification of needs; practical assistance and home-based support; linking with other relevant services; and, targeted therapeutic groups.
2. Short-term immediate assistance for families which may include: Assessment of needs; information or referrals; and, limited direct support.
3. Community outreach, mental health education and community development activities which may include: organisation of, and participation in, community events; and, general group work in the community.

Targets required for each of the three elements are:

- Intensive and long-term support – minimum of 50 children or young people each year
- Short-term assistance, information or referral – minimum of 100 families each year
- Community outreach and general group work – minimum of 150 children, young people and families each year.

FMHSS are required to work with children, young people and their families and carers, to identify and develop supports to address significant risk factors that may be impacting on

their lives. Services must also identify and strengthen the protective factors in their lives to reduce the impact of issues that may produce poor mental health outcomes later in life.

Service delivery 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 service in order to reach vulnerable children, young people, families and carers who may not otherwise engage with the mental health or children's service sector.

3.3 Service Provider Eligibility

The following entity types meet the eligibility requirements to apply for a grant for this Sub-Activity:

- a. Incorporated Associations (incorporated under State/Territory legislation, commonly have 'Association' or 'Incorporated' or 'Inc.' in their legal name)
- b. Incorporated Cooperatives (also incorporated under State/Territory legislation, commonly have 'Cooperative' in their legal name)
- c. Companies (incorporated under the *Corporations Act 2001* – may be a not-for-profit or for-profit proprietary company (limited by shares or by guarantee) or public companies)
- d. Aboriginal Corporations (incorporated under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*)
- e. Organisations established through a specific piece of Commonwealth or State/Territory legislation (public benevolent institutions, churches, universities, unions etc.)
- f. Partnerships, and
- g. Trustees on behalf of a Trust.

The following entity types may be invited in special circumstances:

- h. State and territory governments, and
- i. Local governments.

3.4 Service Delivery Principles

All services must operate according to the principles outlined in the '[National standards for mental health services 2010](#)' and the '[National practice standards for the mental health workforce 2013](#)'. In addition, the following principles relating to FMHSS, apply:

- **Early Intervention** – an early intervention approach ensures support is offered as early as possible in life, to children and young people where mental health risk factors can be identified.

- **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.
- **Family Focus** – while children and young people are at the centre of the service delivery model, services work within a family context. Different family members have different perspectives and needs, and may require different responses.
- **Flexibility** – services take a flexible approach that ensures they meet the broad needs of children, young people and families and offer a range of tailored supports.
- **Accessibility and responsiveness** – services are accessible to children, young people, their families and carers according to their needs and capacity, provided in ways that reduce the stigma of mental illness and are responsive to individual circumstances.

3.5 Client Eligibility

For FMHSS, eligible participants are children and young people up to the age of 18 who are showing early signs of, or are at risk of developing, mental illness, and their families and carers.

Services cannot work with a child or young person without the involvement of their families or carers. It is expected that the providers will have their own systems in place to ensure they obtain written consent from parents or guardians to work individually with the children or young people.

A formal diagnosis of mental illness is not required to access services. Funded service providers may encourage children, young people and families to seek assistance through clinical mental health services if appropriate, but cannot exclude participants who decide not to engage with clinical services.

Screening processes

Screening is designed to determine if the person is eligible for services under FMHSS, and if this is the most appropriate service for the particular child, young person and his/her family. Screening occurs as soon as someone walks in off the street, rings up the service or turns up as the result of a referral.

The provider may use intake procedures already in place in its organisation. There is a screening template at Attachment B, but the provider may choose to design its own version based on this template to link in with its other documentation.

3.5.1 Priority target groups

FMHSS are required to prioritise support to children and young people facing additional disadvantage and risk factors for poor mental health outcomes.

These groups 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, disability, history of trauma.

3.5.2 Ineligible persons

Persons not eligible for FMHSS include those:

- not able to access services in the community because of their residential setting (residential care) or legal conditions imposed on their activities (detention)
- not able or willing to engage an adult family member or legal guardian (non-state ward) in at least the Assessment of need and development of a Family Action Plan
- under the care of (as distinct from 'in contact with') the child protection system, and
- living outside the boundaries of the designated Coverage Area¹.

Children in Contact with the Child Protection System

State governments have the responsibility for, 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.

Many children, young people and families who do not require formal statutory intervention, in terms of parental responsibility being delegated to the state, may qualify for FMHSS.

In instances where a provider is working with a child who subsequently comes under the care of the child protection system, it is anticipated that the service would work closely with the child protection agency to determine which supports and services would be best for the child or young person and his/her family, and gradually withdraw assistance in a planned way.

3.6 Complaints

The provider must have an 'internal complaints procedure' in place and it must be prominently displayed for participants. The 'internal complaints procedure' can include the complaint being handled by the organisation running the service.

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 providers and DSS to review and improve processes and the quality of services provided.

The procedures should allow confidentiality of participants in order for participants to express concerns without any fear of their complaints impacting on the support or assistance they receive.

¹ Up to 10 per cent of a provider's caseload can come from outside a site's Coverage Area, without the need for specific DSS approval. These clients are referred to as 'out-of-area' clients. Servicing someone from outside the site's Coverage Area should be considered on a case-by-case basis. A service provider must seek the approval of its DSS Grant Agreement Manager to service more than 10 per cent of its caseload outside its defined Coverage Area.

Service participants can refer their complaints to DSS if the complainants are dissatisfied with the providers' internal handling of the complaints. Participants will also be provided the opportunity to give feedback on services received as part of the evaluation process. Grant Agreement Managers will investigate complaints in circumstances deemed necessary by DSS.

The Commonwealth Ombudsman can also investigate complaints about the actions and decisions of Australian Government agencies to see if they are wrong, unjust, unlawful, discriminatory or just plain unfair.

For information on the complaints process for Applicants and grant recipients, please refer to the Programme Guidelines. Refer also to Section 14 of these Operational Guidelines.

4. Personnel, Subcontractors and Professional Membership

4.1 Disclosure of Personnel and Personnel Changes

Organisations must provide details of personnel providing FMHSS if requested by DSS. Organisations must notify DSS in writing if there are changes to staffing structures that may negatively impact service delivery.

4.2 Subcontracting

The service provider must not subcontract services under FMHSS, in accordance with the Grant Agreement.

4.3 Professional Membership

There are no minimum requirements for qualifications of staff employed to deliver FMHSS. However, the provider is expected to employ staff 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.

Where staff are employed in a professional capacity, the provider must ensure that staff possess current membership to a recognised professional association.

5. Facilities and Service Promotion

5.1 Premises

Services must be accessible to all potential participants. Disability access must be provided, including having information in a range of accessible formats such as for the vision or hearing impaired, and with respect to people with literacy issues or people with other language barriers.

There may be a need for the provider to develop specific policies and procedures if the service is co-located with other services to ensure safety for participants, appropriate client record storage, etc.

5.2 Hours of operation

Providers will establish their own hours of operation whilst keeping in mind they are not crisis services. Providers will also consider how their operating hours promote or hinder flexibility in service delivery. If necessary, providers will establish variable working hours to meet local needs.

5.3 Service Promotion

It is important to communicate and promote FMHSS and the importance of mental health and wellbeing for children, young people and their families.

Providers may name or brand their particular services in such a way that they are relevant and welcoming for children, young people and families in the local areas.

Providers may adopt local service names appropriate to the populations, the communities, and the intent of FMHSS. However, there is a requirement to acknowledge the funding is provided by the Australian Government Department of Social Services.

For example:

“(Name of the organisation) is launching a new service called (own brand name). This service is funded by the Australian Government Department of Social Services.”

Any promotional materials produced by service providers must be submitted to DSS Grant Agreement Managers for approval. All promotional materials must comply with the Australian Government Branding Design Guidelines, which can be found at dmhc.gov.au/guidelines.

5.4 Collaboration

FMHSS is designed to provide holistic and flexible support and therefore providers are required to develop and maintain close links with other services. Providers should:

- 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
- establish strong partnerships with services that deliver support to vulnerable and disadvantaged people in the local community, including those from Indigenous and culturally and linguistically diverse (CALD) backgrounds
- use their knowledge of local services and their partnerships to promote improved integration of local services across the Coverage Area
- Develop and maintain close links with other services including, but not limited to: family support services; clinical services; ‘First-to-know’ agencies such as childcare centres, schools and general practitioners; child protection agencies; Department of Human Services (Centrelink); housing agencies; and, youth services.

6. Guidelines on Client Service Delivery

6.1 Involvement of children and/or vulnerable persons

Providers will be delivering services to children, young people and individuals/families from vulnerable groups impacted by, or at risk of, mental illness. They are expected to operate within the set of practice principles outlined in this document. They must comply with relevant legislation regarding police checks for staff working with children.

6.2 Participant Diversity

Services must be flexible, culturally competent and culturally sensitive, and must ensure accessibility for all potential participants. Providers must document evidence of strategies to achieve this. They must offer services equitably, without bias or prejudice.

6.3 Fees Policy

FMHSS are free of charge for participants.

6.4 Refusal of Service

Service providers may refuse to provide services where there are safety concerns, or there is evidence to suggest that participants are not eligible for FMHSS.

6.5 Referrals

Providers are required to have networks of referral pathways and to refer people to other support services as appropriate. When issues arise that cannot be addressed by the funded service, people will be referred to appropriate specialised services such as drug and alcohol services or clinical mental health services.

When considering referrals, Commonwealth initiatives which could be useful for children, young people and their families include:

- [Family Support Program](#) which is a suite of Commonwealth-funded services to support families, and improve child wellbeing and development, safety and family functioning through the provision of integrated support
- [Communities for Children](#) services which provide prevention and early intervention to families with children up to 12 years, who are disadvantaged or at risk of disadvantage
- [headspace](#) which helps young people aged 12 to 25 with a broad range of issues around mental health and substance abuse
- [kidsmatter](#) which is a mental health and wellbeing framework for primary schools and early childhood education and care services
- [Children Of Parents with Mental Illness](#) (COPMI) which promotes better mental health outcomes for children of parents with a mental illness
- [Reconnect](#) which uses community-based early intervention services to assist young people aged 12 to 18 years who are homeless, or at risk of homelessness, and their families

- [Building Australia's Future Workforce](#) (BAFW) and Local Connections to work ([Local Connections](#)) which improve social and economic participation for all vulnerable Australians, including children and young people
- [Young Carers Respite and Information Services](#) which assist young carers up to the age of 25 years, who need support because of the demands of their caring roles, to complete their secondary education or vocational equivalent
- [Mental Health Respite: Carer Support](#) (MHR:CS) which provides a range of flexible respite and carer support options for carers and families of people with severe mental illness or psychiatric disability, and carers of people with an intellectual disability
- [Financial counselling services](#) which provide practical and essential support to help people build longer-term capability to manage their money better and increase financial resilience.

6.6 Distance or outreach services

Each FMHSS is allocated a site with a defined service Coverage Area based on the [Australian Statistical Geography Standard \(ASGS\)](#). The service Coverage Area is specified in the Grant Agreement. As a principle, DSS expects services to provide access to children, young people and families living within their defined site Coverage Areas through whatever means the provider deems suitable.

6.6.1 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 without seeking DSS approval. 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 service or because the family moves 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 his/her family in the long term?
- Is there another 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; will that individual actually receive the quality of service expected; would they be better serviced by another provider)?

There is no need to seek approval from a DSS Grant Agreement Manager to service one-off participants from outside the site's defined Coverage Area.

Service providers must seek approval from DSS Grant Agreement Managers to service more than 10 per cent of their caseloads from outside the defined site Coverage Area.

6.6.2 Servicing areas allocated to another service under this Sub-Activity

There may be circumstances where it is easier for another provider to service a particular area rather than the provider allocated to the area. Service providers can negotiate with one another to support participants residing in areas not allocated to them within the rules outlined in section 6.6.1.

Providers should present a business case to their Grant Agreement Manager, requesting a permanent change to the Coverage Areas. DSS will consider the requested change and, if agreed, will vary the Grant Agreements accordingly. This will ensure accurate information is available on service coverage for participant referrals.

7. Safety Policies, Procedures and Critical Incidents

7.1 Policies and Procedures for staff on safety

Providers must ensure that FMHSS meets health and safety requirements and all licence, certification and/or registration requirements in the area in which they are providing services. Clear and comprehensive health and policy guidelines for staff must be in place.

7.2 Critical Incidents

Critical incidents can include such things as:

- Death, injury or abuse of FMHSS participants while in the care of the provider
- Death, injury or abuse of FMHSS staff or volunteers
- Inappropriate conduct between FMHSS participants and employees
- Significant damage to, or destruction of, property impacting service delivery
- Adverse community reaction to FMHSS activities, and
- Misuse of FMHSS funding.

Incidents should be reported to DSS Grant Agreement Managers within 24 hours of occurrence or discovery.

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

Incident reporting instructions are at **Attachment D**.

8. Service delivery in scope

Eligible activities for FMHSS are offered in terms of three levels of support:

1. Intensive, long-term, early intervention support for children, young people and their families which may include: Assessment and identification of needs; practical assistance and home-based support; linking with other relevant services; and, targeted therapeutic groups.
2. Short-term immediate assistance for families which may include: Assessment of needs; information or referrals; and, limited or one-off support.
3. Community outreach, mental health education and community development activities which may include: organisation of and participation in community events; and, general group work in the community.

9. Service delivery out of scope

FMHSS cannot provide:

- clinical services or specialist medical services, although providers may assist participants to access appropriate services
- crisis services
- purchase of goods and services for participants and their families, with limited exceptions²
- personal care and domestic help for participants and their families
- purchase of land
- funding to cover retrospective costs
- costs incurred in the preparation of a funding application or related documentation
- major construction/capital works
- overseas travel, or
- activities for which other Commonwealth, State, Territory or Local Government bodies have primary responsibility.

10. Service delivery

10.1 Service settings

Services may be delivered in the setting most suited to the nature of the service and the participants involved, but should always be a safe and welcoming environment.

10.2 Service delivery design

Services delivery design should take into consideration the full range of local stakeholders. The provider will outline its proposed service delivery model in the Establishment Plan.

Early intervention – The provider must 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.

² Service providers may dedicate a small part of their budgets (up to 10 per cent) to support program participants and families to access practical and material assistance if all other options have been exhausted and the assistance is required to meet the goals of the Family Action Plans. Providers may not purchase services from other providers.

The provider must support its staff to remain skilled in and committed to an early intervention approach to service delivery.

The provider must 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.

Child and Young Person-Centred Approach – Providers must design service delivery around addressing the needs of the children and young people using the services.

Where intensive assistance is provided, the provider must develop and agree Family Action Plans (FAP) with the children and young people and/or their families (**Attachment E**).

The voices of children and young people must be sought and heard in the development of Family Action Plans, which are living documents and remain the property of the children and young people.

Providers must take an approach consistent with a Common Approach to Assessment, Referral and Support ([CAARS](#))³ (refer to **Attachment F**). This approach ensures service delivery remains child-centred, family-focused, strengths-based and holistic.

Providers must establish and maintain close links with other child and family services and agencies, and take advantage of relevant resources such as '[KidsMatter](#)' to encourage an ongoing focus on children.

Providers must 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.

Family Focus – Providers must work to ensure families feel comfortable in accessing the service, set up their premises to be welcoming and employ staff able to work cooperatively with the different types of families in the area.

Service Promotion – Provider must ensure any promotion of services clearly articulate support of children or young people in a family context.

Cultural Appropriateness – Providers must be aware of, and respond to, any specific cultural or religious practices or sensitivities of families in the local area. Providers must promote tolerance and respect for different cultural needs and circumstances.

Flexibility – Providers should actively seek to tailor services to the individual including their cultural needs and circumstances.

Providers should operate outreach as a way to make contact with hard-to-engage children, young people and families.

Providers must consider how their operating hours impact their ability to meet local needs and, if necessary, establish vary working hours appropriately.

Providers should actively consider how the use of technology and social media may increase their flexibility, especially in terms of working with young people.

Providers must link with local services to give greater flexibility to the options offered to children, young people and their families.

³ As part of the work involved with the National Framework for Protecting Australia's Children, CAARS has been developed by the Australian Research Alliance for Children & Youth ([ARACY](#)) to support universal service providers to identify children who may need help and to help connect them to the support they need. It encourages all professionals who work with children to think holistically about the strengths and needs of children and their families and help them access the support they need. It is not a formal risk assessment or screening tool.

Accessibility and Responsiveness - Services will comply with all accessibility requirements of their clients (refer also to Section 6.2), including varying information formats.

Providers must be mindful of the range of cultural and lifestyle contexts represented in the local community and design and promote the service accordingly. Staff should be employed with skills and/or trained to ensure the service is responsive to the range of lifestyle and cultural experiences of participants.

Providers should also design and deliver services in such a way as to reduce the stigma of mental illness in the community and prominently display and make available mental health crisis information for participants and the general public.

Providers must be aware that there are a range of issues which can create barriers to accessing services for priority target groups when developing individually tailored support for participants.

Barriers include:

- complex administration processes and procedures
- costs – perceived or actual out-of-pocket expenses may deter people
- shame and stigma (fear of being judged)
- prior negative experiences (e.g. with particular organisations or institutions)
- inflexible approaches (e.g. set hours of attendance at set locations)
- communication/cultural or linguistic barriers
- fear of authorities (negative experiences with authority figures or fear possible consequences of seeking help such as children being taken away or losing income support payments from Centrelink)
- lack of knowledge of entitlements, and
- social isolation.

Providers must have an open-door approach, using outreach (not just drop-in or appointment services), and using bottom-up approaches to planning and service delivery.

10.3 Service delivery model

10.3.1 Service delivery model

There are three elements to the service model, all of which must be delivered by the FMHSS:

1. Intensive, long-term, early intervention support for children, young people and their families or carers which may include:
 - assessment of child, young person and family risk factors, protective factors and needs, and identification of goals from which a Family Action Plan can be developed. Family Action Plans are reviewed and revised at least once every three months (a Family Action Plan template is provided in **Attachment E**).
 - practical assistance and home-based support for children and young people and their families (e.g. developing family activities and routines)
 - supportive counselling and family interventions (e.g. conflict resolution and communication skills)
 - referrals to alternative services as appropriate for individual family members or the family as a whole
 - collaboration and coordination with relevant services and agencies (e.g. schools) to ensure a holistic and integrated response to needs and goals identified in the Family Action Plan

- advocacy, and
- targeted, therapeutic groups for children, young people or their families.

Long-term intensive support is expected to require weekly contact initially. The same or less frequent support may continue for a period of 6–12 months, with the requirement that the Family Action Plan must be reviewed at least once every three months. There is no requirement to formally exit participants after the 6–12 months as a small number of participants may require longer-term support. Should participants require ongoing intensive support, the providers should investigate and refer to alternative support services available and appropriate to their needs.

2. Short-term immediate assistance for families which may include:

- assessment of needs
- information and referrals
- limited or one-off practical assistance and support.

Short-term assistance may be offered to families for up to six sessions and does not require a Family Action Plan.

3. Community outreach, mental health education and community development activities which may include:

- organisation of, and participation in, community events
- community development activities to promote mental health and wellbeing for children and young people, and
- facilitation of general group work with children, young people and their families.

10.3.2 Planning

Orientation – DSS may facilitate up to two orientation workshops for new services, to develop a common understanding of the intent of FMHSS, and facilitate the networking and sharing of good practice among services. Providers should make provision for attendance in their first-year budgets.

Staff roles, skills and qualities – although there are no defined team roles the composition of staff skills, experience and personal attributes should guarantee that the service is capable of delivering the three elements of the service delivery model.

Staff should have a range of personal and professional qualities, ensuring high-quality support to vulnerable children, young people, their families and carers. It is expected services will generally make provision for teams of around three full-time-equivalent workers.

10.3.3 Service Delivery Activities

Assessment process – Assessment of participant needs and the supports to be delivered to achieve goals are central to the achievement of outcomes under FMHSS.

Once the initial screening process indicates that the child/young person meets the eligibility for entry into these services the Assessment process should commence.

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 process and template are provided at **Attachment E**). Providers should consider a range of risk and protective factors or issues relevant to mental health outcomes (see **Attachment A**), recognising that not all will be relevant.

During the Assessment process the provider is encouraged to use the CAARS tools (refer to **Attachment F**). The tools can be used to support a conversation with a child or young person or family, to identify needs and strengths across the range of six life domains listed in the CAARS wheel.

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 the Family Action Plan.

There are three possible outcomes from the Assessment process.

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)

Accepted for short-term support – Families require only a few sessions (up to six), and there is no need for a Family Action Plan (data collected relates to the family overall). For example, a family may need only a couple of sessions to find ways to assist a child to manage anxious feelings, and resume school attendance.

Accepted for intensive long-term support – The provider must work with children, young people and families to develop a Family Action Plan, to ensure intervention is based on the agreed goals of the individuals involved.

Consent to provide data to DSS

A DSS-provided consent form which allows the transfer of participant information from service providers to DSS must be completed. This must be done before the Assessment information is collected or recorded. Participants are to be reassured the information provided is de-identified (i.e. data may be about them but DSS cannot identify who they are – DSS does not see the participant's name or address).

The '*Consent to collection, use and disclosure of personal information*' form and a plain English information sheet are available from Grant Agreement Managers.

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

Providers are required to develop their own consent forms for cases where they want to make a referral to another service and require the participant's consent to share information.

Exiting participants – When a child, young person or family exits, the service provider must update participant information accordingly in the data collection system. Providers must ensure participants exiting the service have adequate alternative supports in place, should they require them.

10.3.4 Funding

FMHSS funding may be used for:

- staff salaries and on-costs which can be directly attributed to service provision in the identified service area or areas as per the Grant Agreement
- employee training for paid and unpaid staff including Committee and Board members, that is relevant to service outcomes, as appropriate
- operating and administration expenses directly related to the delivery services, such as:
 - telephones
 - rent and outgoings
 - computer/IT/website/software
 - insurance
 - utilities
 - postage
 - stationery and printing
 - accounting and auditing
 - travel/accommodation costs
 - assets as defined in the Grant Agreement General Conditions, including motor vehicle purchase or lease.
- Practical Assistance – The service provider is able to use funds flexibly to provide practical assistance tailored to the needs and situation of each child, young person and family. The provider may dedicate up to 10 per cent of the service budget to support participants to access practical assistance and material goods if all other options have been exhausted. It is not the intent that the service becomes an emergency relief measure.
- As a part of the Community Mental Health Activity, organisations may choose to use up to 10 per cent of their funding for innovative projects. This will be negotiated as part of the Grant Agreement.

The Activity will be managed to ensure the efficient and effective use of public monies. This will be consistent the Commonwealth Grant Guidelines and the DSS Grant Agreement, and will aim to maintain viable services and act to prevent fraud upon the Commonwealth.

Funding must only be used for the purposes for which it was provided and the provider must meet the annual targets specified in the Grant Agreement.

10.3.5 Capacity Building

Community outreach, mental health promotion/education and community development activities are required 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.

10.3.6 Governance

A good governance framework is essential to achievement of outcomes under FMHSS and should include:

- explicit information on roles, responsibilities, rights, and remuneration
- procedures for quality assurance, risk management and issues management, and
- procedures for supervision, performance management and information management.

Participants', families' and carers' views should be considered as part of service planning, implementation and delivery.

10.3.7 Collaboration

Collaborative working relationships with other organisations must be established to ensure there is a 'joined up' service system to meet the wide range of needs identified for children, young people and families.

10.4 Interpreter services

Interpreting services may be required in order to assist participants undertake Assessment or attend services activities.

For this reason, DSS will accept the cost of interpreting services provided by the Translating and Interpreting Service (TIS National) that are required by each funded organisation to assist participants.

Grant Agreement Managers will arrange for providers to be allocated specific TIS National client codes for each site, as requested. It is important that the correct code/s be used for interpreting directly related to the funding. It will be each organisation's responsibility to demonstrate this, if requested. DSS will be directly billed by TIS National for these interpreting services.

TIS National provides both telephone and on-site (must be booked three months in advance) interpreting. Before booking an interpreter, the provider should consider the time and cost advantage of using a telephone service rather than an on-site service.

For more information about TIS National interpreting services contact the Client Liaison and Promotions Team:

Telephone: 131450

Email: tispromo@immi.gov.au.

11. Reporting

Full details of reporting requirements will be listed in the Grant Agreement for each funded provider.

Reports and data are to be submitted electronically. Providers should therefore ensure they have internet access and compatible IT (Windows 2000 or later and Adobe Reader 7.0.5 or later).

Providers are required to submit:

- Establishment Plans to their Grant Agreement Managers within six weeks of signing their grant agreements (a template is provided at **Attachment C**)
- client-level and aggregate data into an online system that must be updated at least every three months
- annual audited financial reports, and
- other reports as required by DSS.

12. Administrative Requirements

To access FOFMS and the online data collection system, providers must have a computer that, as a minimum, has:

- a secure operating system (for example Windows 2000 or Windows XP)
- internet browser software - Netscape 7.02 or Internet Explorer 5.01* (*5.5 if using Microsoft Windows ME operating system)
- Adobe Flash Player 7 or above to view DSS training materials
- a high-speed network connection (for example, ISDN, ADSL). A suggested minimum of 56kbps network bandwidth per active work-station is recommended
- an internet service provider
- an internet email account
- audio capability on your machine (optional)
- minimum of 128MB of RAM
- Intel® Pentium® II 450MHz or faster processor (or equivalent), and
- screen resolution of 1024x768dpi.

Providers will receive telephone and email support on IT matters and on data collection activities to assist them in complying with DSS reporting requirements. DSS Grant Agreement Managers should be the first point of contact for support. Providers may also email the DSS Program Helpdesk at program.help@dss.gov.au.

Funding will include the cost of information technology and communication devices limited to those directly related to the Activity.

13. Operational requirements

13.1 Primary contact person

The provider must notify DSS within five days if the primary contact person named in the cover letter accompanying the Grant Agreement changes, or the primary contact's details change.

13.2 Changes to your organisation

Organisations undergoing significant change (such as a change of name, change of legal entity type, or change of ABN) must provide **30 days written notice** to DSS.

13.3 Effective governance

Organisations must demonstrate good governance, ensuring policies and decision-making are accountable, transparent, lawful, responsive to community need, equitable and inclusive, effective and efficient, and participatory (reflect the views of all stakeholders).

13.4 Compliance

In entering into a grant agreement with DSS, the grant recipient must comply with all requirements outlined in the suite of documents that comprise the Agreement including the Programme Guidelines, these Operational Guidelines and the Grant Agreement.

Grant recipients are responsible for ensuring:

- the terms and conditions of the grant agreement are met
- service provision is effective, efficient, and appropriately targeted
- highest standards of duty of care are applied
- services are operated in line with, and comply with the requirements as set out within all state and territory and Commonwealth legislation and regulations
- ensuring Indigenous Australians have equal and equitable access to services
- working collaboratively to deliver the service, and
- contributing to the overall development and improvement of the service such as sharing best practice.

13.5 Operational Legislation and Policies

The provider is to ensure that services are delivered in accordance with all relevant Commonwealth and state and territory legislation.

These include, but are not limited to:

- State and territory mental health acts
- State and territory child protection acts and the *Family Law Amendment Act 2008*
- *Privacy Act 2012* and the National Privacy Principles (NPPs)
- *Racial Discrimination Amendment Act 1980*
- *Social Security and Other Legislation Amendment (Income Support Bonus) Act 2013*
- *Sex Discrimination Act 1984*
- *Sex Discrimination Amendment Act 2013*
- *Disability Discrimination Amendment Act 2005*
- *National Disability Insurance Scheme Act 2013*
- National Standards for Disability Services 2013
- National Standards for Mental Health Services 2013
- Work Health and Safety Act 2011
- Any applicable state or territory law relating to discrimination, and
- Any state or territory laws regarding young people who are under 18 years of age

Service providers should also be aware of any case-based law that may apply to, or affect, their service delivery. They must also ensure that the services meet health and safety requirements and all licence, certification and/or registration requirements in the area in which they are providing services.

13.6 DSS Audit and Compliance Strategy

DSS's Audit and Compliance Strategy allows DSS to manage fraud and compliance risks as well as facilitate continuous quality improvements. As part of DSS's Audit and Compliance Strategy there are certain documents the provider must keep (for five years) for DSS's auditing purposes. These are:

- a copy of the signed Client Consent Form and a subsequent copy for each claim that is submitted
- custody papers (if applicable)
- copies of the invoice for services rendered for which the provider has submitted

- Claim to DSS
- copies of any eligibility documents and the Letter of Introduction, and
- proof of residential address (if a change of address has occurred) – a utilities bill or tenancy agreement is acceptable.

DSS may conduct random audits to verify information submitted by providers and may exercise the right of entry and inspection under the Grant Agreement General Conditions.

For further information about financial reporting, please refer to section 2.11 of the Community Mental Health Programme Guidelines.

13.7 Security of Information

The *Archive Act 1983* requires that providers store records in a secure place and dispose of these records in an appropriate manner. The provider must also ensure that records containing personal information are retained for five years following the expiration or termination of the fee-for-service Funding Agreement.

All electronic records created by providers in FOFMS are stored in accordance with DSS's electronic record keeping policies and procedures. The Commonwealth owns the records produced in FOFMS. They are not owned by providers.

The Freedom of Information Act 1982 (the FOI Act) gives the public the right to access information in the possession of DSS with certain limited exceptions. Information collected or held by DSS may be made available on request, unless exempted under the relevant provision of the Act or under specific legislation that provides for the confidentiality of that information.

DSS has a statutory obligation to observe the FOI Act and must help all Applicants make a valid application under the Act. DSS will observe strict timeframes when acknowledging and responding to requests made for access to documents under the FOI Act. Any application for access to documents under the FOI Act must be made by letter or statement, or (where available) by completing a form.

13.8 Privacy Issues

All clients' personal details must be treated as personal information under *The Privacy Act 1988* (Privacy Act). Information about the National Privacy Principles (NPPs) can be found in the Grant Agreement General Conditions.

14. Complaints

14.1 Complaints made about a service provider

In the first instance where a client has a complaint about a service provider, DSS encourages the provider to attempt to resolve the complaint amicably in accordance with their complaints resolution process and policies.

Providers must have their own Complaints Management System in place, which are:

- consistent with Australian Standards on Complaint Handling
- flexible enough to encourage consumers to raise concerns
- supported with sufficient resourcing (financial, physical and human) to ensure that it is managed effectively, and
- supported by written policies and procedures, including who is responsible for the management of complaints and the complaints process.

Participants must be made aware of the avenues available to them to make a complaint and this must include multiple options – e.g. in person, in writing, over the phone, via email etc. Complaints are to be treated professionally and responded to in a timely manner. A complaint made by a parent or carer should not adversely affect the treatment of the child within the service.

If a parent or carer is unhappy with the provider's response, they must be directed to DSS's Complaints Management System.

Providers must report all critical incidents to their Grant Agreement Managers in the first instance, and formally advise DSS through the DSS Feedback Coordination Team at dssfeedback@dss.gov.au.

14.2 Complaints made to DSS

DSS has a formal complaints service – the DSS Feedback Coordination Team, which aims to provide:

- DSS clients with an accessible process that handles complaints in a timely, professional and consistent manner, and
- Information to assist DSS to improve its customer service and administrative processes.

Any member of the public who is dissatisfied with DSS's service(s) or the service of a DSS funded provider can make a complaint. The DSS Feedback Coordination Team handles complaints about: unreasonable delay; inadequate service, explanation or reasons; legal error; factual error in decision making process; human error; procedural deficiency; unprofessional behaviour by an officer; breach of duty/misconduct by an officer; discriminatory action or decision; flawed administrative process; and/ or inadequate knowledge/training of staff.

As the purpose of the system is to assist in improving DSS's processes as a department, the DSS Feedback Coordination Team does **not** handle complaints about: Government policy; legislation; reviews over eligibility for a benefit or entitlement; ministerial correspondence; Freedom of Information requests; or complaints made to providers as these will be covered by their own complaints mechanisms.

Complaints can be lodged with DSS by:

Phone: 1800 634 035

Fax: (02) 6133 8442

Email: dssfeedback@dss.gov.au

Post: DSS Feedback, PO Box 7576, Canberra Business Centre, 2610

If parents, carers or providers are dissatisfied at any time with DSS's handling of their complaints, they can also contact the Commonwealth Ombudsman at ombudsman.gov.au or by telephone on 1300 632 072.

Glossary

Applicant – an organisation submitting an application for funding for a service site.

Assessment – an initial conversation, after screening has occurred, to determine the reason a child or young person has come to the service. It will provide a preliminary understanding of the life circumstances (risk factors and protective factors) of a child or young person and his/her family, and a level of insight into the needs and strengths of the child or young person and his/her family. This will aid development of a Family Action Plan.

Children, Young People and Families Experiencing Significant Risk Factors – there are significant mental health risk factors for children who experience homelessness, unemployment, drug and alcohol abuse, domestic violence, disability and/or history of trauma. They have a higher risk of poor mental health outcomes later in life. Such children and young people are regarded as vulnerable and disadvantaged and are regarded as special needs groups for the purposes of these services.

Coverage Area – refers to the geographically defined area in which a particular service is delivered and in which participants must reside in order to qualify for services from that service provider.

Cultural competency / sensitivity – Cultural competence is much more than awareness of cultural differences. It is the ability to understand, communicate with, and effectively interact with people across cultures. Cultural competence encompasses:

- being aware of one's own world view
- developing positive attitudes towards cultural differences
- gaining knowledge of different cultural practices and world views
- developing skills for communication and interaction across cultures.⁴

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 consistent with a person's needs and values.

Culturally and Linguistically Diverse (CALD) – 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"⁵.

Humanitarian entrants - people who hold or have held a [humanitarian visa](#).

Establishment Plan – a plan that providers are required to submit within six weeks of signing their funding agreements to demonstrate how they intend to implement service delivery over the first 12 months of funding.

Family - the definition of 'family' in these Operational Guidelines 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.*' Carers are included as family members for the purposes of these guidelines.

⁴ Belonging, Being & Becoming - The Early Years Learning Framework for Australia <<http://docs.education.gov.au/node/2632>>

⁵ Victorian Multicultural Strategy Unit (2002) in Australian Psychological Society Ltd 2008

Family Action Plan – the Family Action Plan is negotiated between child, young person and family, and the practitioner to record the goals, needs and strengths of the referred child or young person, and each significant person in his/her family who will also be working with the provider. These are reviewed every three months.

'First to know' agencies – These are agencies that are often the first to have concerns that a child or young person may be experiencing difficulties. They include schools, child care centres, general practitioners, and hospitals.

Grant Agreement General Conditions – Schedule 1 of the Grant Agreement between the Department and organisations lists the terms and conditions.

Indigenous – 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”.

Programme Guidelines – These are the guidelines applicable to this Sub-Activity and include the Community Mental Health Guidelines, the Disability, Mental Health and Carers Programme Guidelines and the FMHSS Operational Guidelines.

Screening – the initial process by which a service determines if the service is appropriate for the child or young person and his/her 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.

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 15 years of age 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 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 these services 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.

Attachment A: Risk and Protective Factors for Mental Illness

A document adapted from the Australian Government National Mental Health Strategy (2000), *Promotion, Prevention and Early Intervention for Mental Health – A Monograph* (Monograph), which provides factors generally accepted by practitioners and research as important contributors to the development of mental health problems and illness. The risk and protective factors identified 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	Supportive caring parents	Sense of belonging	Involvement with significant other person (partner/mentor)	Sense of connectedness
Adequate nutrition	Family Harmony	Positive school climate	Availability of opportunities at critical turning points or major life transitions	Attachment to and networks within the community
Attachment to the family	Secure and stable family	Pro-social peer group	Economic Security	Participation in church or other community group
Above average intelligence	Small family size	Required responsibility and helpfulness	Good physical health	Strong cultural identity and ethnic pride
School achievement	More than two years between siblings	Opportunities for some success and recognition of achievement		Access to support services
Problem solving skills	Responsibility within the family (for child or adult)	School norms against violence		Community/Cultural norms against violence
Internal locus of control	Supportive relationship with other adult (for a child or adult)			
Social competence	Strong family norms and morality			
Social skills				
Good coping skills				
Optimism				
Moral Beliefs				
Values				
Positive self-related cognitions				

Table 2: Risk Factors

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

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? <ul style="list-style-type: none"> • 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	
Question	Response	Comment/s
10. What is the expressed request of the child or young person and their family? <ul style="list-style-type: none"> • 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 family are accepted into the service do	Yes/No	

<p>they consent to their information collected by this provider being disclosed in a de-identified form to DSS for the purposes data collection? (See Attachment E)</p>		
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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 the service provider 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: Establishment Plan template

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

Name of service provider:

State:

Site name:

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)
<p>Service operational:</p> <ul style="list-style-type: none">• When will you accept your first clients:<ul style="list-style-type: none">○ groups○ short-term assistance○ intensive • When do you expect your service to be fully operational, i.e. fully staffed and with all procedures and processes in place?	
<p>Service at capacity:</p> <ul style="list-style-type: none">• When do you anticipate being at capacity i.e. having a full caseload?	

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

Elements	Plan
<p>Service at capacity</p> <ul style="list-style-type: none"> • How are you planning to stage your implementation to reach full capacity by your target date? 	
<p>Targets:</p> <ul style="list-style-type: none"> • What are your targets for the number of clients you will have assisted by: <ul style="list-style-type: none"> ○ End of first 6 months of operating ○ End of the first 12 months of operating 	<ul style="list-style-type: none"> • Intensive ongoing assistance • Short-term assistance • Community engagement/group work
<p>Staffing</p> <ul style="list-style-type: none"> • How will you structure your team? <ul style="list-style-type: none"> - roles of each staff member 	
<p>Service model:</p> <ul style="list-style-type: none"> • Please confirm what your service model will be. (Note any changes from your application for funding and ensure you include enough detail to enable DSS to use this document when discussing service delivery with you) 	
<p>Coverage</p> <ul style="list-style-type: none"> • Details of where you will be delivering services from. Please include any outreach locations. 	
<p>Target groups</p>	

<ul style="list-style-type: none"> • Which particular vulnerable groups will you be targeting within your area? 	
<ul style="list-style-type: none"> • Which age cohort/s will you prioritise in your service? 	
<p>Promotion</p> <ul style="list-style-type: none"> • Key strategies to promote your service to ensure you are able to reach children, young people and families who may be eligible? 	
<p>Working with other agencies/services</p> <ul style="list-style-type: none"> • Key strategies to establish strong and effective partnerships with local service providers? 	
<p>Evaluation and continuous improvement</p> <ul style="list-style-type: none"> • 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 D: Incident Reporting

GUIDELINES FOR REPORTING INCIDENTS

Incidents should be reported to your DSS Grant 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 funded 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 funded activities
- Misuse of funding under this Sub-Activity.

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

The Incident Form should be completed by the Site Manager and forwarded to your DSS Grant Agreement Manager.

INCIDENT REPORT FORM

Organisation: _____

Service activity name: _____

Site: _____

DETAILS OF INCIDENT

DATE OF INCIDENT: ____/____/____ **TIME OF INCIDENT:** ____:____ AM/PM

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: _____

Attachment E: Family Action Plan

What is a Family Action Plan?

The 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 working with the provider. The goals or issues to be worked on are recorded against the six CAARS life domains used in the online system, as outlined below.

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).

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 for identifying progress and change are based on the outcomes star (Outcomes Star Australia).

1. I really don't know where to start/I've not made any progress
2. I've made a start/some progress but still need lots of help
3. I'm making progress and would still like regular support
4. I've progressed really well and only need to touch base occasionally
5. I'm where I wanted to be and no longer need help
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 are working with the provider to support the child or young person.

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

- Date the FAP was first developed
- Date of review/s
- 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 domains gives a snapshot of where participants were on each outcome area when they joined the service and at each (three monthly) review – the difference between starting point and review shows the progress made in that time.

The Department is also able to access data to compare the progress made by different sub-groups of participants. For example, it would be useful to know that 60% of children who wanted to work on their school attendance had improved their attendance rate over the first three months of service.

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

Family Action Plan Principles

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

- 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 support 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 service provider. 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 support worker and the participants. It is not something prepared without the participants.

Developing a Family Action Plan

An FAP template is provided. 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.

DSS asks the provider to base their modified FAP on the template contained in this document. There are some key elements that should be contained in any FAP. 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).

DSS does not expect the provider to work on all the issues identified by a child or young person or family member, rather 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.

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.

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)
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. I really don't know where to start/I've not made any progress
2. I've made a start/ some progress but still need lots of help
3. I'm making progress and would still like regular support
4. I've progressed really well and only need to touch base occasionally
5. I'm where I wanted to be and no longer need help
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)
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. I really don't know where to start/I've not made any progress
2. I've made a start/ some progress but still need lots of help
3. I'm making progress and would still like regular support
4. I've progressed really well and only need to touch base occasionally
5. I'm where I wanted to be and no longer need help
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? (e.g. 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? (e.g. 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)
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. I really don't know where to start/I've not made any progress
2. I've made a start/ some progress but still need lots of help
3. I'm making progress and would still like regular support
4. I've progressed really well and only need to touch base occasionally
5. I'm where I wanted to be and no longer need help
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? (e.g. 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? (e.g. 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 F: A Common Approach to Assessment, Referral and Support (CAARS)

The provider is encouraged to use the [CAARS approach](#) in service design which accurately reflects the intent and focus of the service and forms the basis of reporting to DSS on progress and outcomes. CAARS was developed by the Australian Research Alliance for Children and Youth, with support from the Australian Government. While not mandatory, using the CAARS tools is encouraged, as they can facilitate holistic and creative practice, provide a common language, and assist with online reporting requirements. If providers choose not to use the CAARS approach, they must use an alternative that is consistent and covers at least the six life domains adopted by CAARS.

The primary CAARS tool for providers is the 'wheel'. 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. The CAARS approach and the 'wheel' can be implemented across agencies to encourage consistent language across different programmes.

The CAARS wheel is designed to assist practitioners to 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.

CAARS Wheel

A COMMON APPROACH TO ASSESSMENT, REFERRAL AND SUPPORT



The 'Wheel'

The Wheel reminds us of the important things children and young people need to thrive. Use it to celebrate your strengths and recognise the areas where you might need some extra help.

