



Australian Government

Department of Social Services

National Disability Insurance Scheme Programme

National Disability Insurance Scheme Transition

**Mental Health Respite: Carer Support
Operational Guidelines
2015–16**

July 2015

Preface

The Australian Government Department of Social Services (DSS) has a suite of Programme Guidelines which provide information about each Programme that provides grants funding, and the Activities that contribute to that Programme. They provide the key starting point for parties considering whether to participate in a Programme and form the basis for the business relationship between DSS and the grant recipient.

These Operational Guidelines are to assist organisations delivering services in 2015–16 under the Mental Health Respite: Carer Support, within the National Disability Insurance Scheme Transition component of the National Disability Insurance Scheme Programme. They should be read in conjunction with the National Disability Insurance Scheme Programme – National Disability Insurance Scheme Transition Guidelines.

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

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1 Programme overview - National Disability Insurance Scheme (NDIS)

The Department of Social Services (DSS) works to provide improved independence, participation and lifetime wellbeing for people with disability, people with a mental illness and their carers.

The NDIS intends to ensure people with disability are supported to participate in and contribute to social and economic life to the extent of their abilities. People with disability and their carers will have certainty that they will receive the individualised care and support they need over their lifetime.

The NDIS aims to improve the wellbeing and social and economic participation of people with disability, and their families and carers, by building a National Disability Insurance Scheme that delivers individualised support through an insurance approach. This Programme also includes existing supports that are transitioning in to the NDIS in a phased approach as well as services to support the market, sector and workforce to adjust to the NDIS environment.

2 Programme component overview – National Disability Insurance Scheme Transition

The NDIS is the new way of providing individualised support for eligible people with permanent and significant disability, their families and carers. The changes that are required to existing disability support systems are significant. Arrangements are being made to ensure the NDIS can be introduced gradually, ensuring a smooth transition for people with disability and support providers.

The NDIS Transition component supports the market, sector and workforce transitioning to the NDIS environment by funding eligible organisations that provide:

- early intervention service, information and support to eligible children with a disability, and their family and carers
- short-term or immediate respite to carers of people with severe or profound disability and respite services to young carers at risk of not completing secondary education
- outside school hours care for teenagers with disability
- Australian Disability Enterprises assisting supported employees, and
- support services for people whose lives are affected by mental illness (**including Mental Health Respite: Carer Support services**).

The NDIS Transition component aims to manage the transition of existing activities identified to ensure:

- existing clients are sensitively transitioned into the NDIS in line with the full rollout of the Scheme
- services and service providers are transitioned gradually to the NDIS in line with the full rollout of the Scheme
- continuity of service throughout trial sites for clients that cannot access individualised packages under the NDIS, and

- an effective framework for transitioning the information, linkages and capacity building elements of transitioning programmes to provide systemic-level support.

The NDIS will support choice and control by providing needs-based, individualised funding to be used in a market-based environment. This will be a large shift for providers and clients currently delivering and receiving services under transitioning programmes. In particular, over time, there will be a move away from grant and block-funded one-size-fits-all services towards a purchaser/provider model individually funded by the choice of consumers. While there will be some provision for information, linkages and capacity building as well as individually funded services, wherever possible disability services will be provided in line with this new approach.

All grant recipients funded under the NDIS Transition will, therefore, be required to work closely with DSS and the NDIS to make the shift to this new model.

3. Mental Health Respite: Carer Support (MHR:CS)

3.1 MHR:CS overview

MHR:CS includes support for carers of people with mental illness whose health and wellbeing or other impediments are negatively impacting their ability to provide care.

MHR:CS provides a range of flexible support options for carers of people with mental illness that help them maintain their own health and continue to provide care.

Services focus on improving access to a broader range of carer support options and the need for carer support services that respond to changing circumstances.

NB. Funding for MHR:CS is gradually transitioning to the National Disability Insurance Scheme. MHR:CS providers located in NDIS sites have requirements in addition to those outside NDIS sites. These are detailed in **Attachments A and B**.

3.2 MHR:CS aims and objectives

MHR:CS provides a range of flexible support options for carers and families of people with mental illness, whose health and wellbeing is impacted by the caring role. The aim of services is to provide a range of supports to assist carers to continue providing care, and/or improve their health and wellbeing, through social and economic participation in the community.

The key objective of MHR:CS is to support carers to sustain their caring roles and improve care for people with mental illness. This includes maintenance or improvement of carers' physical and mental health and wellbeing and reduction of stigma and discrimination.

DSS is seeking the following outcomes from MHR:CS:

- carers are better able to sustain their caring roles
- carers have increased confidence, capacity and choices
- improved wellbeing for carers of people with mental illness and the person to whom they provide care, and
- improved social and economic participation for carers.

3.3 Clients / target groups

3.3.1 Client eligibility

To be eligible to receive services, a carer must be providing care to a person because of his/her mental illness (unless seeking support from a MHR:CS initially funded prior to 2011–12, whose client base may include up to 25 per cent carers of people with intellectual disability).

Carers must have poor physical or mental health, or other impediments, impacting their caring capacity. Highest priority will be given to carers assessed as most in need of support and without access to similar respite or carer support through other government-funded services (e.g. state disability services or the National Respite Carer Program).

Carers will undergo an eligibility assessment and a needs assessment to determine eligibility and access priority. Where a carer needs alternative care for the care recipient as a form of respite from the caring role, the care recipient's needs will also be assessed to determine the most appropriate service and the specifics of care needed.

Assessment criteria and processes ensure that the carer's total circumstances are taken into account and ensure that consumer rights, including privacy, are recognised and protected. Processes include review and re-assessment of the care situation, development of carer support plans and referrals, where appropriate.

3.3.2 Ineligible persons

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

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

3.3.3 Target groups

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

- Indigenous carers, including members of the Stolen Generations and Indigenous kinship carers
- carers with culturally and linguistically diverse backgrounds, including humanitarian entrants and recently arrived migrants and refugees
- older parent carers
- young carers
- carers needing urgent assistance or support, including those at risk of homelessness
- carers in rural and remote communities
- Forgotten Australians, and
- lesbian, gay, bisexual, transgender and intersex carers.

Services are required to prioritise and actively target these special needs groups, or others identified locally, for which there are significant populations in their coverage area, or who are inadequately supported.

MHR:CS service providers should be aware of the full range of needs within their region and ensure that their client base reflects the region's demographics.

3.3.4 How to access MHR:CS services

MHR:CS service providers are required to maintain open referral and access pathways into the service. Potential clients are able to access MHR:CS through a broad range of entry pathways including self-referral, referral by friends and family or other community services.

3.3.5 Fees

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

3.3.6 What clients can expect

Carers and their families can expect support to be provided according to the MHR:CS practice principles listed in paragraph 2.6.1.

In addition:

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

3.3.7 Client rights and responsibilities

Rights: [Standard 6 of the National standards for mental health services](#) lists rights applying to consumers of mental health services. They include that consumers must be *treated with respect, have their privacy protected, and receive services appropriate to their needs in a safe and healthy environment.*

Responsibilities: Carers have a responsibility to provide accurate information about their needs and circumstances in order to be provided with quality services. They are required to comply with the rules and regulations for engaging with services and behave in a manner that does not compromise the health and safety or privacy of others.

3.3.8 Exiting MHR:CS

As this service is voluntary, clients may exit the service at any time by declining any further participation. Service providers must ensure that carers exiting MHR:CS have adequate alternative supports in place should they require them. This may include access to relevant mainstream services, family support, and strategies in place to deal with crises, should they occur. Carers should be given assurances they can seek to return to MHR:CS at a later time, if appropriate.

3.4 Service delivery and eligible and ineligible MHR:CS activities

3.4.1 Service delivery

Services provided by MHR:CS include:

- Relief from the caring role to help maintain or improve the carers health and wellbeing
- Carer support that helps the carer provide better care, and/or
- Education, information and access to build the capacity of carers and their communities to respond appropriately to mental health issues.

Service providers must:

- manage entry to MHR:CS through assessment of carer eligibility
- develop carer support plans with carers, to ensure the services provided meet their needs and the needs of their families, including care recipients where necessary (plans should include strategies to help carers and families deal with crises and emergencies, and a broad range of supports to assist carers and families maintain their caring roles and their own wellbeing)
- coordinate carer support services and help carers navigate the mental health and community sectors
- promote MHR:CS services in the community
- liaise and work with other stakeholders to make and receive appropriate referrals for carers of people with mental illness, and
- develop, support and supervise staff, including peer support workers and volunteer workers.

3.4.2 Eligible activities

MHR:CS funding may be used for:

- staff salaries and on-costs, which can be directly attributed to the provision of MHR:CS in the identified service area as per the Grant Agreement
- employee training for paid and unpaid staff, Committee and Board members, that is relevant, appropriate and in line with the delivery of MHR:CS
- brokerage, or purchasing services on behalf of participating carers
- materials and equipment directly relating to service delivery
- marketing of services
- costs of service evaluation
- operating and administration expenses directly related to the delivery of MHR:CS, such as:
 - telephones
 - rent and outgoings
 - computer/IT/website/software
 - insurance
 - utilities
 - postage
 - stationery and printing
 - accounting and auditing

- travel/accommodation costs (Including accommodation costs incurred where MHR:CS workers are required to travel to distant or remote locations to service carers, or costs for staff travelling to attend training or personal development activities), and
- assets as defined in Grant Agreement Terms and Conditions, including motor vehicle purchase or lease.

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

3.4.3 Ineligible activities

MHR:CS funding may not be used for:

- costs not directly related to MHR:CS service delivery
- overseas travel
- profits, dividends, etc. to directors or other stakeholders.

3.4.4 Funding for MHR:CS

Funding for MHR:CS services varies according to demand for services within the coverage area, and the types of services delivered.

Funding for MHR:CS is provided through block funding to providers. A portion of block funding for MHR:CS in NDIS sites is notionally allocated to the National Disability Insurance Agency, further detailed at **Attachments A and B**.

3.5 Links and working with other agencies and services

3.5.1 Relationships with other services

To achieve the best outcomes for carers and their families, and to ensure a wide range of flexible support options are offered to carers, service providers must develop relationships and have referral processes in place with a wide range of mental health, family support, community and other support services. This should include other services funded by the Department such as Personal Helpers and Mentors (PHaMs), which provides support for people with severe mental illness and Family Mental Health Support Services (FMHSS) which provides early intervention for children and young people.

Funded organisations are required to maintain and foster relationships with the full range of community, welfare and mental health sector organisations necessary to comprehensively address the needs of carers, the care recipient and their families.

In keeping with the Australian Government's emphasis on improving social and economic participation for vulnerable Australians, providers are also encouraged to develop and maintain close links with Centrelink, housing, employment and other family support services that can assist family carers to achieve greater social inclusion, safety and stability.

MHR:CS services should also work closely with local clinical and mental health specialist services, where appropriate.

Commonwealth Respite and Carelink Centres in each Home and Community Care (HACC) region provide an information service that maintains a database of local disability services and supports. Centres can be contacted on Freecall 1800 052 222 during business hours.

Commonwealth and Commonwealth-supported initiatives relevant to caring for people impacted by mental illness and their families include:

- [Personal Helpers and Mentors](#)
- [Family Mental Health Support Services](#)
- [Family Support Program](#)
- [National Respite for Carers Program](#)
- [National Carer Counselling Program](#)
- [Young Carers Respite and Information Services Program](#)
- [Commonwealth Respite and Carelink Centres](#)
- [Mental health services in Australia](#)
- [headspace](#)
- [beyondblue](#)
- [Support for Day to Day Living in the Community Program](#)
- [Partners in Recovery Program](#)
- [National Disability Insurance Scheme](#)
- [Mental Health Professionals Network](#)
- [Reconnect Program](#)
- [Money Management services](#)

More information on Mental Health Services can be found on the [Department of Social Services](#) and [Department of Health](#) websites.

3.5.2 Interpreting services

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

For this reason, DSS will pay the cost of interpreting services provided by the Translating and Interpreting Service (TIS National) that are required by each funded MHR:CS service to assist clients. Grant Agreement Managers can advise on cost recovery for alternative translating or interpreter services (e.g. Indigenous language interpreter services or interpreter services for hearing impairment). Service providers should discuss their requirements with their Grant Agreement Managers prior to engaging the services.

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, as DSS will be directly billed by TIS National for these interpreting services. DSS may require organisations to demonstrate that correct codes have been used and that use of TIS was warranted.

TIS National provides both telephone and on-site (one week notice using the Interpreter booking form located on the [Interpreter booking form](http://www.tisnational.gov.au/Agencies/Forms-for-agencies/New-Job-booking-form) webpage <http://www.tisnational.gov.au/Agencies/Forms-for-agencies/New-Job-booking-form>) 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: 1300 655 082

Email: tispromo@border.gov.au.

3.6 Special requirements for MHR:CS

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

3.6.1 MHR:CS practice principles

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

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

3.6.2 National Standards for Mental Health Services

MHR:CS must be delivered in accordance with the National standards for mental health services, applying to all mental health services, including government, non-government and private sectors across Australia. The National Standards were endorsed by the Commonwealth and state and territory Health Ministers in 1996. They have since been revised with a particular focus on their implementation in the community mental health sector. The national standards focus on recovery and are based on values related to human rights and dignity. They promote the empowerment of consumers of mental health services, their carers and families. They emphasise practices which support continuous improvement in service quality.

3.6.3 Incident reporting

Service providers must notify DSS of any incidents such as accidents, injuries, damage to property, errors, acts of aggression, etc. that may adversely impact the delivery of services to carers, or on the Department.

The MHR:CS Incident Report Form at **Attachment C** should be completed by the service manager and forwarded to their DSS Grant Agreement Manager for the activity involved. 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.

3.6.4 Compliance with relevant legislation

MHR:CS providers must ensure that services are delivered in accordance with the [Carer Recognition Act 2010](#) and all other 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 Act 1975*
- *Privacy Act 2012* and the National Privacy Principles (NPPs)
- *Racial Discrimination Act 1975*
- *Social Security and Other Legislation Amendment (Welfare Reform and Reinstatement of Racial Discrimination Act) Act 2010*
- *Sex Discrimination Act 1984*
- *Sex Discrimination Amendment Act 2013*
- *Disability Discrimination Act 1992*
- *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.

In delivering MHR:CS, providers must:

- comply with all relevant laws
- comply with DSS policies, and
- ensure that workers (paid and voluntary) undertake training appropriate to the service they deliver.

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

Australia's Multicultural Access and Equity Policy: Respecting diversity. Improving responsiveness obliges Australian government agencies to ensure that cultural and linguistic diversity is not a barrier for people engaging with government and accessing services to which they are entitled, for example, by providing access to language services where appropriate. Organisations should consider whether services, projects, activities or events may require the use of professional translating or interpreting services in order to communicate with non-English speakers.

3.6.5 Service agreements for brokering / subcontracting MHR:CS services

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

Providers are strongly advised to seek their own legal advice before subcontracting services. This is to ensure that subcontracted services have appropriate 'duty of care' arrangements in place. The obligations of a subcontractor must be consistent with the obligations of the DSS service providers under their Grant Agreements. This includes any provisions relating to confidentiality, permitted disclosure, insurance requirements and privacy information.

3.6.6 Peer support and peer support workers

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

It is mandatory that service providers engage at least one peer support worker (can be paid or volunteer) with lived experience of caring for a person with mental illness. The role of the peer support worker within the service can vary and be tailored to the particular service. Peer support workers both paid and unpaid, must receive appropriate training, support and supervision.

This requirement supports Action 26 in the *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014* : an increase in consumer and carer employment in clinical and community support settings.

3.6.7 Carer representation in governance arrangements

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

3.6.8 Volunteer workers

The [National Volunteering Strategy](#) was released in 2011. It sets out the vision for volunteering, including supporting those who are currently volunteers and encouraging more Australians to participate in their communities through volunteering. The Strategy will set the direction for volunteering in Australia for the next ten years and will support organisations to adapt to changes in the ways that Australians want to volunteer.

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

- the work of volunteers is documented and regularly reviewed
- the work of volunteers is controlled and supported by agreed processes and procedures

- information is gathered about work satisfaction
- appropriate support is available, including access to professional debriefing
- effective channels of communication with volunteers are established, and
- appropriate processes are established to monitor, identify and address all health, safety and work satisfaction issues.

3.7 Activity performance and financial reporting

3.7.1 Activity performance reporting

The focus of activity performance reporting is to obtain meaningful information about service delivery outcomes.

The following Performance Indicators apply to MHR:CS services:

- Number of clients assisted
- Number of events / service instances delivered
- Percentage of clients with improved knowledge, skills, behaviours and engagement with services, and
- Percentage of clients from priority target groups/communities.

Reporting includes:

- on-line reporting through the DSS Data Exchange
- an annual financial report (as prescribed in Grant Agreements)
- other reports requested by the Department.

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

The Department has implemented improved programme performance reporting processes in Grant Agreements. These arrangements are supported by a new and simple to use IT system, known as the DSS Data Exchange (DEX). DEX:

- is a web based portal;
- allows submission of data through external approved third party applications, and
- supports submission of data through other approved methods.

Performance information required to be collected may include (but is not limited to):

- Client consent (where required)
- Client identity characteristics
- Client demographic characteristics
- Service delivery information
- Client outcomes.

[Information on DSS Data Exchange](https://www.dss.gov.au/grants/programme-reporting/dss-data-exchange-web-based-portal) can be found at the following link:
<https://www.dss.gov.au/grants/programme-reporting/dss-data-exchange-web-based-portal>

Services will receive support on IT matters and data collection activities to assist them in complying with DSS reporting requirements. The DSS Data Exchange Helpdesk can be emailed at dssdataexchange.helpdesk@dss.gov.au.

3.7.1 Financial reporting

The Activity must be managed to ensure the efficient and effective use of public monies. This must be consistent with best value in social services principles, the DSS Grant Agreement, and will aim to maintain viable services and act to prevent fraud upon the Commonwealth.

Financial documents must be provided to DSS as outlined in the DSS Grant Agreement.

3.8 Risk management strategy

All DSS Grant Agreements are managed according to their level of risk. A periodic monitoring process is undertaken during the term of an agreement which monitors service delivery and is used to provide evidence for ongoing risk assessments.

3.9 Complaints

MHR:CS providers must have a transparent and accessible complaints handling policy. This policy should acknowledge the complainant's right to complain directly to the provider, outline the process for dealing with the complaint, and provide options for escalation both within your organisation and to the Department if necessary. Providers should include information about the complaints handling policy and processes in all correspondence to ensure it is readily available to the public.

Providers and clients can lodge complaints through the following channels:

Telephone: 1800 634 035
Fax: (02) 6204 4587
Mail: DSS Complaints
PO Box 7576
Canberra Business Centre ACT 2610
Email: complaints@dss.gov.au

If a provider or client is dissatisfied with the Department's handling of a complaint, they can [contact the Commonwealth Ombudsman](http://www.ombudsman.gov.au) at www.ombudsman.gov.au/or 1300 362 072.

4 Contact information

For enquires regarding current Grant Agreements, service providers should contact their Grant Agreement Manager. For general programme enquiries contact Program.help@dss.gov.au or phone 1800 020 283.

[Department of Social Services website](http://www.dss.gov.au): www.dss.gov.au

Glossary

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

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

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

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

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

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

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

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

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

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

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

The network of 55 Commonwealth Respite and Carelink Centres has around 65 'walk-in' shopfronts throughout Australia. Many shopfronts are located near, or within, shopping centres.

Community capacity building – community development activities to improve community wellbeing through collaborative projects with community groups such as promoting mental

health awareness and first aid, or stigma reduction. This can also include establishing relationships and trust in communities to allow services to be delivered most effectively.

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

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

Culturally and Linguistically Diverse (CALD) – people who identify “...as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home, or because of their parents’ identification on a similar basis” (from *Victorian Multicultural Strategy Unit (2002) in Australian Psychological Society Ltd 2008*).

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

Duty of Care – The responsibility or the legal obligation of a person or organisation to avoid acts or omissions (which can be reasonably foreseen) to be likely to cause harm to others. For the purposes of MHR:CS this includes following –up if nobody answers the door when a provider attends to deliver a pre-arranged service.

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

Forgotten Australians – people raised in institutional or other out-of-home care in Australia in the 20th century.

Humanitarian entrants – 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. (*Dept of Immigration and Border Protection*)

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

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

Mental illness – a diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The brochure ‘[What is mental illness?](#)’ on the Department of Health and Ageing website provides more information.

NDIS site – service outlet located in an area that is a prescribed area for the purposes of a person meeting the residency requirements under section 23 of the National Disability Insurance Scheme Act 2013 (an NDIS prescribed area).

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

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

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

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

Terms and Conditions – means the [terms and conditions of the standard Grant Agreement](https://www.dss.gov.au/grants/information-for-grant-recipients/dss-grant-agreements-grant-conditions) between the Department and successful Applicants. For further details see: <https://www.dss.gov.au/grants/information-for-grant-recipients/dss-grant-agreements-grant-conditions>.

Attachment A: Mental Health Respite: Carer Support services operating in NDIS sites

The National Disability Insurance Scheme

Funding for Mental Health Respite: Carer Support (MHR:CS) is transitioning to the National Disability Insurance Scheme (NDIS). To facilitate the transition of MHR:CS to the NDIS these Guidelines take into consideration the different transition arrangements across the country.

Each site is transitioning to the NDIS with different timeframes and for different cohorts. It is the responsibility of each MHR:CS service to understand when the NDIS is being phased in for their clients or those they care for. Information about transition to the [National Disability Insurance Scheme](http://www.ndis.gov.au) is available at www.ndis.gov.au

Registration

Services operating in an area where the NDIS is available are required to register with the National Disability Insurance Agency. The [registration form and other important information](http://www.ndis.gov.au) is available at www.ndis.gov.au.

Services must register to enable the use of in-kind funds for NDIS eligible participants.

Funding

Some MHR:CS services in NDIS sites operate on an 'in-kind' arrangement. This means MHR:CS services will continue to receive block funding with a portion notionally committed to the NDIA by the Commonwealth, to fund supports provided to NDIS participants. In-kind service provision is when an organisation provides a support to an NDIS participant and lodges a claim (also known as 'drawing down') against its notional in-kind allocation. The in-kind allocation has been calculated based on the number of clients in the service area who are expected to be eligible for supports through the NDIS. In-kind allocations, do not impact on existing levels of funding for providers.

Claiming in-kind on the NDIS portal does not generate a payment from the NDIS however it draws down against the allocated in-kind amount.

Claims are made against the NDIA catalogue of supports. Providers can only claim for supports they have registered to provide.

In-kind services can be provided either to existing programme clients who have become NDIS participants, or new clients with supports in an individually funded support package through the NDIS who become MHR:CS participants.

DSS will advise providers of the amount of their in-kind allocations. The figures are also available on the NDIS Provider Portal.

Providers must make their best efforts to draw down their in-kind allocations.

The Department will monitor draw-down and will work with providers to address any issues or concerns.

Once providers have exhausted their in-kind allocation they can claim fee for service through the NDIA.

Please note that providers must not claim fee for service through the NDIA and use MHR:CS block funding for the same support provided to the same participant. Any supports provided through an NDIS individually funded plan must be either funded by drawing down against the in-kind allocation or claimed as fee for service from the NDIA.

National Disability Insurance Agency (NDIA)

MHR:CS service providers are expected to work closely with the NDIA in their localities in order to:

- support existing clients, or the people they care for, to test eligibility for NDIS support
- refer applicants for MHR:CS services to the NDIA if they are potentially eligible for NDIS support, i.e. the applicant meets geographic and/ or age cohort requirements
- establish and/or promote referral pathways to the NDIA (where relevant) so that people who are potentially eligible for NDIS support are referred to the NDIA
- participate in local planning and coordination activities as relevant.

Reporting

Providers in NDIS sites will be required to complete a table that identifies the number of carers who are caring for participants accessing the NDIS. This must be completed quarterly to enable the Department to monitor the transition of MHR:CS to the NDIS and to understand the experiences of people with psychosocial disability, their carers and providers to inform the full roll out of the NDIS.

Attachment B: MHR:CS services operating in an NDIS My Way Site

The Western Australia (WA) NDIS My Way Model

From 1 July 2014, Western Australia started participating in a two-year trial of the National Disability Insurance Scheme (NDIS).

The NDIS trial in WA includes the implementation of two different models in different locations over a two-year period: the Commonwealth's [National Disability Insurance Agency \(NDIA\) NDIS model](#), and the State Government's [WA NDIS My Way model](#).

The WA trial provides an opportunity to compare and contrast the two different models. Both will be independently evaluated over the two-year trial period and the outcome will inform how disability services are provided into the future in WA and nationally.

The WA NDIS My Way model is being implemented by the WA Disability Service Commission (DSC). In WA, each site is transitioning to the NDIS or NDIS My Way trial with different timeframes and for different cohorts. It is the responsibility of each MHR:CS service to understand the phasing for their clients or those they care for.

Registration

Organisations wanting to provide supports and services as part of the WA NDIS My Way trial need to [apply to be on the Disability Services Commission's Panel Contract for Individually Funded Services](#)

Funding

MHR:CS services in NDIS My Way sites operate on an 'in-kind' arrangement. This means MHR:CS services will continue to receive block funding with a portion notionally committed to the WA Disability Services Commission by the Commonwealth, to fund supports provided to NDIS My Way participants.

WA Disability Services Commission (DSC)

MHR:CS service providers are expected to work closely with the DSC in their localities in order to:

- support existing clients, or the people they care for, to test their eligibility for support
- refer applicants for MHR:CS services to the DSC if they are potentially eligible for support, i.e. the applicant meets geographic and/ or age cohort requirements
- establish and/or promote referral pathways to the DSC (where relevant) so that people who are potentially eligible for support are referred to the DSC in advance of MHR:CS services
- participate in local planning and coordination activities as relevant.

Reporting

Providers in NDIS My Way trial will be required to complete a table that identifies the number of carers who are caring for participants accessing NDIS My Way. This must be completed quarterly to enable the Department to monitor the transition of MHR:CS and to understand the experiences of people with psychosocial disability, their carers and providers.

Attachment C: Incident Report Form

Incident Report Form Mental Health Respite: Carer Support

ORGANISATION: _____

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

Providers should report incidents to their DSS Grant Agreement Manager within 24 hours of occurrence/discovery. Reportable incidents include:

- death, injury or abuse of a client while in a provider's care
- death, injury or abuse of staff or volunteers undertaking delivery of MHR:CS 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 the MHR:CS activities
- misuse of the MHR:CS funding.