Australian Government

Department of Families,
Housing, Community Services
and Indigenous Affairs

Resource Kit
Personal Helpers and Mentors Activity
under the Targeted Community Care (Mental Health) Program
November 2012

Preface

The Resource Kit provides additional information for parties considering whether to participate in the Personal Helpers and Mentors (PHaMs) Activity under the Targeted Community Care (Mental Health) Program. It also provides information to assist with the development and operation of PHaMs services.

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

This additional information expands on and complements the information provided in the Part C1 of Program Guidelines Suite – Application Information for the Personal Helpers and Mentors Activity.

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1. PHaMs Framework and Service Principles

1.1 Introduction

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

The three Activities funded under the TCC Program are:

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

Consultation with the community and key stakeholders guided the design and development of the PHaMs Activity.

Key themes that emerged from consultations that have been built into PHaMs include:

- Help people regardless of the mental illness label they are given – the severity of mental illness should be measured by the impact it has on a person's life and ability to function in the community. It should not be just a clinical definition.
- Be participant-focussed and centred around a person's wishes and goals.
- Use flexible approaches that support the episodic nature of mental illness (for example having a capacity to suspend services if a person has to go to hospital and allowing them to get straight back in when they come out).
- Be part of planning and discharge processes to create a more seamless transition from acute care to the community.
- Engender wellness thinking (focussing on strengths not deficits).
- Maintain support for people as long as they need it (not exiting them as soon as they show signs of recovery).
- Be flexible enough to acknowledge different levels of recovery (some people want to achieve small things, others may have long term goals).
- Focus on daily activities and the importance of connectivity to the community for long-term benefits.
- Engage consumers to become PHaMs peer support workers to re-enforce the principle that recovery and meaningful outcomes are possible.
- Ensure caseloads are not too high and focus on strong, long-term relationships that engender trust and respect and that can motivate and empower.

These key considerations have guided the operation and success of the program.

PHaMs services have assisted more than 21,000 participants since the Activity commenced in 2007.

As at December 2012, there are 175 PHaMs services operating in geographically defined sites across Australia:

- 95 in metropolitan sites
- 69 in non-metropolitan sites, and
- 11 in remote sites.

The 2011–12 Budget allocated an additional $154 million over the five years from 2011–12 to 2015–16 for new and/or expanded PHaMs services to assist an additional 3,400 people with severe mental illness, through the engagement of 425 new personal helpers and mentors.

Of this funding, $50 million is allocated to assist up to 1,200 people with a mental illness who receive the Disability Support Pension or other Government income support payments and are participating in, or willing to engage with employment services. PHaMs support will help these people address personal, non-vocational barriers to their participation in work or training.

Some PHaMs services are funded to provide specialist support to particularly vulnerable groups, either through funding for a targeted service or funding to deliver additional targeted services as part of an existing general service. These include PHaMs Employment Services, Remote Services and services targeted to particular groups such as homeless and Culturally and Linguistically Diverse people.

1.1 Practice Principles

Anthony (1993) described eight principles as important in understanding a recovery-based approach to serious mental health problems. These principles must be used in designing and delivering PHaMs services. These principles include recognising that:

- Each person's recovery is different.
- Recovery requires other people to believe in and stand by the person.
- Recovery does not mean cure. It does not mean the complete disappearance of difficulties.
- Recovery can sometimes occur without professional help.
- People hold the key to their own recovery.
- Recovery is an ongoing process. During the recovery journey there will be growth and setbacks, times of change and times where little changes.
- Recovery from the consequences of mental distress (stigma, unemployment, poor housing, loss of rights etc.) can sometimes be as difficult, or more difficult than recovery from the mental health issue or illness itself.
- People who have or are recovering from mental health issues or illness have valuable knowledge about recovery and can help others who are recovering (peer support).
- A recovery vision does not require a particular view of mental health problems.

All PHaMs services must operate with a strengths-based recovery focussed orientation and subscribe to a set of practice principles that underpin delivery of assistance to PHaMs participants.

The following principles expand on the principles set out in Part C1 of Program Guidelines Suit – Application Information for the Personal Helpers and Mentors Activity. The principles should guide the development and operation of PHaMs services.

Principle 1: Respect, Trust and Understanding – *each participant will be made to feel welcome and valued by their PHaMs worker and treated with respect, dignity and understanding as a unique person.*

- Service providers have knowledge and understanding of mental illness and the impacts it has on people's behaviours and lives.
- The lived experience of mental illness and the consumer perspective of the recovery process are valued and respected by service providers and incorporated into service delivery. Service providers build meaningful relationships with participants based on openness and trust.
- Service providers take all practical and appropriate steps to prevent abuse and neglect of participants and to uphold participant legal and human rights.

Principle 2: Empowerment – *participants are empowered to gain the knowledge, skills and attitude needed to cope with the changing circumstances in which they live, regain control of their lives, and undertake valued and meaningful activities in the community.*

- Participants have the opportunity to participate as fully as possible in making decisions about the events and activities of their daily lives in relation to the service they receive.
- Service providers develop Individual Recovery Plans with participants guided by the participant's choices, goals and aspirations.
- Service providers foster a sense of hope for the future and help participants to improve self-image and overcome stigma.
- Service providers assist participants to access appropriate services and supports so that participants can develop the skills they need to achieve their personal goals.
- Service providers work with participants, their family and carers to understand the needs and choices of participants in their recovery journey.
- The service provider promotes the belief and ability of participants to fulfil valued roles in the community.
- Service providers build relationships and collaborate with other community and clinical services to provide participants with the support they need to achieve their goals and lead meaningful and rewarding lives in the community.
- Service providers support participants by developing or finding meaningful activities or opportunities for participants to improve their quality of life, participation and involvement in the community.

Principle 3: Privacy and Confidentiality – *each participant's right to privacy, dignity and confidentiality in all aspects of life is recognised and respected.*

- The service provider complies with the *Privacy Act 1988* in order to protect and respect the rights of individual service recipients.
- The service provider only collects necessary information and uses it for the purpose for which it was collected. Information is only released to others with the written consent of the participant.
- The service provider promotes tolerance and respect for each participant's personal needs and circumstances.
- The service provider ensures the protection of information and data from unauthorised access or revision, to ensure that the information or data is not compromised through corruption or falsification.
- The service provider stores information and records in a secure place and disposes of them in an appropriate manner.

Principle 4: Accessibility – *services are delivered in a way that ensures all potential participants in the PHaMs target group are able to access them. This includes delivery through outreach and in participants' homes.*

- The service provider actively seeks out, maintains broad referral and entry pathways for participants.
- The service provider has effective strategies for promoting the service to people who are traditionally more difficult to engage, such as those who are homeless or transient, or who do not wish to access traditional mental health services.
- The service provider enables people without a formal diagnosis of mental illness to access the service by applying the Eligibility Screening Tool.
- The service provider is non-discriminatory in respect of age, gender, race, culture, religion or disability, consistent with the PHaMs funding agreement with the service provider and the purpose of the service.
- The service provider's entry and exit procedures are fair and equitable and consistently applied.
- The service provider promotes the PHaMs service, engages with other community and clinical services to open up referral pathways and service options for participants.
- The service provider promotes awareness of mental illness, community acceptance and the reduction of stigma for people with mental illness.

Principle 5: Flexibility, Choice and Appropriateness – *services are designed to meet the individual needs and personal recovery goals of participants.*

- Recovery goals are established objectively to reflect the participant's individual needs and aspirations.
- Each participant's recovery goals are recorded in an Individual Recovery Plan and used as the basis for service provision, with the service provider undertaking a process of planning, implementation, review and adjustment to facilitate the achievement of these goals.

- Service providers ensure that participants only undertake activities of their choice and participate in the service voluntarily.
- The service provider uses strengths-based recovery approaches in delivering services.
- The service provider delivers outreach support to PHaMs participants in an environment that is safe and comfortable for both participants and PHaMs team members.
- The service provider works collaboratively with other programs, services and agencies and helps participants to navigate the complex range of services and support available.
- The service provider manages caseloads effectively to ensure the best support and outcomes for participants and in accordance with the funding agreement.
- The service provider actively tailors services to meet the needs of special needs groups.
- The service provider (as appropriate) engages with and supports the family and carers of participants to achieve the best possible outcomes for participants.

Principle 6: Cultural Competency – *services are culturally appropriate.*

- Cultural competence is embedded in the philosophy, mission statement, policies and key objectives of the service provider.
- The service provider has a strong understanding of the cultural profile of their site and where possible, culturally and linguistically appropriate team members are employed.
- Cultural competence resources are readily available to team members in the workplace.
- Team members are encouraged to be flexible in their approach and seek information on specific cultural behaviours or understandings.
- Team members receive appropriate training for cultural competence.

Principle 7: Appropriate Staff – *PHaMs workers have appropriate attitudes, backgrounds, experiences and qualifications to meet the needs of participants in their site and receive appropriate training, support and supervision. This includes engagement of paid peer support workers by PHaMs services***.**

- Service providers provide team members with appropriate training, support and supervision to perform their role well.
- The service provider ensures that team members have appropriate attitudes and the relevant skills and competencies to undertake their role.
- Each PHaMs site has at least one paid Peer Support Worker (see 7.4 for an explanation of the Peer Support Worker role).
- The service provider ensures the provision of appropriate and relevant training and skills development for each team member.
- The service provider ensures that team members have the resources and equipment to do their jobs effectively, efficiently, lawfully and in a fair and reasonable way.

Principle 8: Service Development and Improvement – *the service provider's service delivery practices are regularly reviewed and revised to meet the needs of participants.*

- PHaMs participants and their carers/family are aware of the service provider's procedures for complaints handling.
- PHaMs participants and their carers/family are encouraged to raise, and have resolved without fear of retribution, any issues, dissatisfaction, complaints or disputes they may have about the service provider or the service they receive.
- Complaints and feedback are taken seriously by the provider, and are investigated, addressed and used to improve ongoing services.
- The service provider has quality management and financial systems in place to ensure standards of service are met and optimal outcomes for participants.
- The service provider fosters a flexible and learning culture to ensure improved outcomes for participants.
- The service provider understands the community and environment that they service.
- The service provider identifies and addresses any issues and risks that might impact on service delivery.
- The service provider has mechanisms in place to plan future service delivery and set objectives or goals to improve service delivery.
- The service provider has strong and effective leadership to provide strategic direction and uphold and exemplify the PHaMs values and standards.
- The service provider performs effectively against goals and standards, and annual service plans.
- The service provider is accountable for their decisions and actions and complies with legislation, policies, guidelines, instructions and standards.
- The service provider ensures their activities are being delivered effectively, efficiently, lawfully and in a fair and reasonable way.

2. Cultural Competence and Special Needs Groups

2.1 Cultural competence

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

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

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

2.1.1 Culturally Competent Services

In delivering culturally competent services, service providers should:

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

2.1.2 Organisational cultural competence

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

- Is the organisation's governing body educated about cultural competence?
- Are community members represented on the governing body and advisory committees?
- Does the organisation have both formal and informal alliances and links with local community representative groups?

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

2.2 Special Needs Groups

In PHaMs we identify groups of people that face additional disadvantages in the recovery journey as special needs groups.

Special needs groups include but are not limited to:

- Indigenous Australians (including Stolen Generation);
- People from culturally and linguistically diverse backgrounds, including Humanitarian Entrants and recently arrived refugees and migrants;
- Young people aged 16 to 24 years;
- People who are homeless or at risk of homelessness;
- People who have previously been institutionalised (including Forgotten Australians/Care leavers and child immigrants);
- Young people leaving out-of-home care;
- People who have been previously incarcerated, and
- People with drug or alcohol co-morbidity.

2.2.1 Indigenous Australians

An Indigenous person is defined as someone 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.

2.2.2 People from Culturally and Linguistically Diverse Backgrounds (CALD) including Humanitarian Entrants and recently arrived refugees and migrants

People from Culturally and Linguistically Diverse 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"[1]

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

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

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

2.2.3 Young people aged 16 to 24 years

Vulnerability to mental illness is heightened at times of major life change, in particular the critical developmental period of adolescence and young adulthood. Seventy five per cent of mental health problems among adults commence before age 25 years. Approximately 27 per cent of 18 to 25 year olds experience mental health problems each year. Co-morbidity is common, affecting about one in six of these young people.

2.2.4 People who are homeless or at risk of homelessness

Homelessness does not simply mean that people are without shelter. It can also mean that people are without stable or permanent accommodation. A stable home provides safety and security as well as connections to friends, family and a community.

There are three kinds of homelessness:

- Primary homelessness, such as sleeping rough or living in an improvised dwelling.
- Secondary homelessness including staying with friends or relatives and with no other usual address, and people staying in specialist homelessness services.
- Tertiary homelessness including people living in boarding houses or caravan parks with no secure lease and no private facilities, both short and long-term.

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

2.2.5 People who have previously been institutionalised (including Forgotten Australians/Care leavers and child immigrants)

The term 'institutionalisation' generally refers to the committing of an individual to a particular institution. However, it is also used to describe both the treatment of, and damage caused to vulnerable people, when a person becomes accustomed to life in an institution so that it is difficult to resume normal life after leaving.

Forgotten Australians are people who were raised in institutional care (out of home care, including entrants from the child migration program and Indigenous children) last century, predominately between 1930 and 1970.

2.2.6 Young people leaving out of home care

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

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

Out-of-home care refers to foster care, kinship care and therapeutic residential care. It focuses on those children and young people with Children's Court ordered care arrangements, where the 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.

2.2.7 People who have been previously incarcerated

Incarceration is where a person is detained in a prison, remand centre or other corrective institution for being suspected of, or having committed a criminal offence.

2.2.8 People with drug or alcohol co-morbidity

Co-morbidity means the co-occurrence of one or more diseases or disorders in an individual. Co-morbidity of mental disorders and substance use disorders is widespread and often associated with poor treatment outcomes, severe illness and high service use.

2.3 Service access for Special Needs Groups

2.3.1 Access Issues for Special Needs Groups

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

- Complex administration processes and procedures;

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

2.3.2 Overcoming access issues

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

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

3. Eligibility Screening Tool (EST) and Participant Data

3.1 What is the EST

PHaMs does not require a formal diagnosis of mental illness by a clinician before a person can enter the service. This is to ensure that the service is accessible.

FaHCSIA worked closely with the Australian Institute of Health and Welfare to develop an assessment tool for PHaMs eligibility that became known as the EST. The EST is a functional assessment tool that determines a person's level of functioning in managing daily activities, and living independently in the community. The EST provides a way to ensure that PHaMs support is accessible and the right people are being targeted – people who are severely impacted by mental illness.

The EST is designed to collect the minimum amount of information required to work out eligibility and meet PHaMs reporting requirements.

An EST assessment must be completed for each participant and entered on the FaHCSIA portal.

3.2 Nine Life Areas

The EST is based on gauging a person's level of functioning across nine life areas.

The nine life areas are:

Personal Capacity Activities

Interpersonal interactions and relationships	actions and behaviours of an individual to make and keep friends and relationships, behaving within accepted limits, coping with feelings and emotions
Learning, applying knowledge and general tasks and demands	understanding new ideas, remembering, solving problems, making decisions, paying attention, undertaking single or multiple tasks, carrying out daily routine
Communication	being understood, in own native language or preferred method of communication if applicable, and understanding others

Community Participation Activities

Working	actions, behaviours and tasks to obtain and retain paid employment
Education	the actions, behaviours and tasks an individual performs at school, college or any educational setting
Community (civic) and economic life	recreation and leisure, religion and spirituality, human rights, political life and citizenship, economic life such as handling money

Independent Living Activities

Domestic life	organising meals, cleaning, disposing of garbage, housekeeping, shopping, cooking home maintenance
Mobility	moving around the home and/or moving around away from home (including using public transport or driving a motor vehicle), getting in or out of bed or a chair
Self-care	washing oneself, dressing, eating, toileting

3.4 How to use the EST?

It is important that PHaMs workers understand how to use the EST appropriately. The EST is designed to be simple and easy to use and to not take too much time to complete (although it may some time to collect the information).

- The EST is accessed and completed on the FaHCSIA PHaMs Portal. To gain access to the Portal complete the USER Registration Form and fax it to the Mental Health Data Team.
- The information required for the EST can be collected manually (on paper) and then entered in the FaHCSIA PHaMs portal at a later time. Blank paper copies of the EST can be printed from the FaHCSIA portal.
- The EST is not designed to be an interview tool. Information should be collected from participants appropriately and sensitively using techniques normally used with participants.
- Participants should not be asked to complete the EST themselves or handed a computer and asked to answer the questions. It the responsibility of the PHaMs staff member to gather the required information and complete the EST.

- The EST questions should be answered after an appropriate discussion with the potential participant or others (such as carers or GPs – with the person's permission).
- Information from a variety of sources can be considered to answer the questions.
- The EST is not designed to be completed all at once in one session on the same day that the information is collected. It is expected that it might take up to 4 weeks to collect the necessary information (due to the sensitive and complex nature of some of the information required).
- The questions do not have to be asked exactly as they are written in the EST. It is the responsibility of the PHaMs worker to approach the issues with sensitivity and compassion.
- The participant can be given a copy of their EST assessment. Participants may want to use it to assist with other assessment processes for other community or clinical services.
- The EST is currently a point-in-time assessment to determine eligibility. In the future it may also be used to access participants' progress.

A comprehensive EST data guide that explains each of the EST questions and the scoring process is available on the FaHCSIA PHaMs portal or from FaHCSIA.

3.5 Informed consent

Informed consent means that the person is provided with enough information on the service to freely make a decision on whether to participate in the service. Service providers must ensure that the person understands:

- the voluntary nature of PHaMs;
- the potential benefits and limitations of what PHaMs can provide;
- their rights and limitations of privacy and confidentiality;
- what information or data will be collected about them and how it will be used or shared and in what circumstances; and
- how they will be assessed;

If there are concerns that the explanations are not sufficient for a participant or their level of understanding, service providers will need to think about whether there is a third party, legal guardian or person with power of attorney, carer or loved one who can take on this responsibility. Written assurance of the person's understanding of the points above is required. A copy of this written consent is to be provided to the participant and a copy kept on their file. Designated remote service providers may need to arrange to have the consent form developed in appropriate language(s) for use in their site.

3.6 Consent to provide data to FaHCSIA

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

This consent form is a legal requirement and cannot be used for any other purpose and cannot be altered by service providers. The wording on the form has specific legal meaning and can't be changed. A copy of the signed consent form must be kept on the participant's file. Service providers will need to develop their own consent forms for use where they want to make a referral to another service and require the participant's consent to share information.

4. Individual Recovery Plans (IRP)

The IRP is central to PHaMs effectiveness and success, as it is the basis around which all activities take place. It is how a participant's aspirations, goals, planned activities and services, achievements and progress are recorded.

Every participant in PHaMs must have an IRP tailored to meet their needs.

Service providers operating in designated remote service sites or who are providing services to CALD participants may need to arrange to have the IRP developed in the participant's first language or develop other suitable arrangements to ensure participants are aware of and kept informed about changes to the content of their IRPs.

4.1 IRP Principles

The IRP is central to the PHaMs principle of participant empowerment. The following principles must be followed when working with participants to develop recovery plans.

- The participant is central to all planning processes.
- Discussions between the participant and their PHaMs worker should be based on the participant's life goals, not just their mental illness.
- The IRP should be focus on the participant's goals aspirations and preferences and affirm the strengths, talents and capacities of the person.
- Other people involved in the IRP development need to be personally invited by the participant.
- The IRP is a living document and can and should be regularly reviewed to reflect the person's recovery journey. It should be updated six monthly as a minimum. At this time, PHaMs workers are encouraged to seek feedback from the participant on their experiences of the service and any recommendations they may offer.
- The IRP is owned by the person and not the PHaMs service. It is considered as 'Mary's IRP' rather than 'the IRP for Mary'. The participant should always be able to have a copy of their plan and know exactly what is in it. Nothing should be in the IRP that the participant did not agree to.
- The IRP should use the participant's language or way of expressing their needs and goals and not service or clinical language.
- The process of planning and developing an IRP is a shared responsibility between a PHaMs worker and the participant. It is not something prepared without the participant.
- The plan should be entirely directed by the participant. The participant should have all the options presented and explained to them and be allowed to make choices that are always be respected.

4.2 Developing an IRP

A sample IRP is provided at **Attachment A** and it is also on the PHaMs portal.

Service providers adapt the sample template or develop a new plan template. However, there are some key elements that should be contained in any IRP that is used for PHaMs.

4.3 Key elements of a IRP

The key elements that must be contained in a PHaMs IRP are:

- identifying a participant's strengths, goals and aspirations;
- identifying areas where support is needed by the participant (this can be done through using the EST based on conversations with the participant);
- detailing any planned activities that the participant wishes to undertake (including when and how these are to occur and who is responsible for arranging them);
- recording any referrals that you make to other services; and
- a crisis/care plan which documents what is to happen in the event that the participant becomes unwell or a crisis occurs.

5. Involving the parents and families of participants

It is important that participants are the primary focus and centre of PHaMs. In many cases, participants will have lost family or carer support and the role of the PHaMs worker will be to help rebuild those connections. However, where the participant has carer or family support, they need to be involved appropriately and sensitively.

5.1 Supporting families and carers

Because of the significant role of family members and carers in supporting people with a mental illness, PHaMs services should also support families and carers through:

- engaging them as early as possible in the IRP (provided the participant has consented);
- making available information about mental health services;
- providing advice and support in managing mental illness, including recognising symptoms such as behavioural change;
- providing support when the person with the mental illness is acutely unwell; and
- sharing information.

Members of the PHaMs team must have the appropriate skills to work with families and carers and if required, staff should be trained in working sensitively with families and carers.

5.2 Family sensitive services

It is often difficult to balance the rights of the participants with the expectations of families and carers. However, families and carers often make the point that the information they need does not have to breach confidentiality. For example, carers require information about services that are available for the person they care for and strategies to help them cope with difficult situations.

Carers also make the point that sometimes they do not need to be told anything, and what they most want is to be listened to and contribute to the recovery of participants. The input of families and carers can be invaluable because they know the participant better than anyone else does. Families and carers will often be the first to see changes in the participant or behaviours that are out of the ordinary.

6. Service Coverage Areas

6.1 Defined service coverage areas

Each PHaMs service is allocated a site with a defined service coverage area. The service coverage area is specified in the funding agreement. The service coverage area for PHaMs services established before 2012 are defined by postcodes. PHaMs services established from 2012 will be defined by Local Government Areas. As a principle, FaHCSIA expects services to provide access to people living within their defined site coverage areas.

6.2 Servicing participants outside of the site's coverage area

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

There may be times when a decision is required on whether to provide services to an out-of-area participant. This decision may be required when a participant applies to be part of PHaMs or because they move out of the site's range. 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 participant in the long term?
- Is there another PHaMs provider that could service the participant?
- What is the site's capacity to service this individual and what, if any, impact could this have on servicing participants from within the designated site's coverage area?
- How difficult will it be to service that individual (e.g. if there are long distances for workers to travel to service that individual, then will that individual actually receive the quality of service expected – would they be better serviced by another provider)?

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

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

6.3 Servicing areas that are allocated to another PHaMs site

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

FaHCSIA should be notified of any agreement between service providers on servicing areas outside of allocated site coverage area. A PHaMs provider should not begin servicing participants (other than one off or those within the 10 per cent allocation) in areas allocated to other providers without agreement from the other PHaMs provider.

Service providers should request a permanent change to their coverage area when they want to cease servicing an area or increase coverage to another area. FaHCSIA will consider the

requested change and, if agreed, will vary the Funding Agreement accordingly. This will ensure accurate information is available on PHaMs service coverage for participant referrals.

7. Participant Transfers, Turning Away Referrals and Exiting Participants

7.1 Participant transfers

The procedures for facilitating an internal transfer of a participant between PHaMs service providers will differ depending on circumstances.

Scenario 1: *Participant advises service provider they are moving to an area not serviced by the provider.*

A PHaMs service provider in NSW has assessed an applicant with the Eligibility Screening Tool. The participant is eligible and receiving support from the NSW service provider. The participant moves interstate to Victoria to an area covered by another PHaMs service provider. The participant advises their current PHaMs worker they will be doing this. The participant asks for continued assistance in Victoria with a new PHaMs service provider and gives permission for their details to be sent to the new provider.

Procedure for original service provider

The original service provider (NSW) is expected to make contact with the new service provider (Victoria) and ensure the new service provider has capacity to take on new participants.

If they do have capacity, then the original service provider (NSW) should facilitate transfer of the participant by filling in the internal transfer form with the participant to ensure participant's consents to transfer their information.

They original service provider should then provide the new service provider with:

- the participant's contact details;
- a copy of the participant's Eligibility Screening Tool (EST) assessment results;
- a copy of the participant's Individual Recovery Plan (IRP); and
- copies of other relevant information (agreed to by the participant) such as timing of the move (if known), progress and any ongoing requirements.

Procedure for the receiving service provider

The receiving service provider should:

- File a copy of the internal transfer form and ensure all contact details are recorded;
- Establish first appointment with transferring participant;
- Enter participant's EST assessment results onto the Portal; and
- Work with participant as outlined in the IRP.

If the participant has been active in PHaMs and receiving support, a new Eligibility Screening Tool assessment does not need to be undertaken by the receiving service provider.

Note: When a participant moves from one area to another and a referral is made from the current PHaMs provider to the new PHaMs provider, the new provider should proceed in a proper, fair and equitable manner and follow due process.

Priority should be given to a current transferring participant over a new referral. The exception would be if the receiving service did not have the appropriate mechanisms in place to support the requirements of the participant being referred. For example, the participant may have special needs and the receiving organisation may not have the experience or skills to take on the referral.

PHaMs providers must not reject any client based on hearsay or previous history.

Scenario 2: *A Participant moves to an area where there is no PHaMs service provider or the existing service provider is operating at capacity and cannot take new PHaMs participants.*

A PHaMs service provider in NSW has assessed an applicant with the EST. The participant is eligible and receiving support from the NSW service provider. The participant moves interstate to Victoria to an area not covered by another PHaMs service provider. The participant advises their current PHaMs worker they will be doing this.

Procedure for the service provider

An out-of-area referral to another provider can be considered if appropriate.

If an out-of-area referral is not appropriate or cannot be brokered, the service provider is expected to assist the client in their transition into local services in the area the participant is moving to.

Participant records are to be stored according to organisational procedure.

The participant is exited from PHaMs.

Scenario 3: Participant moves to an area where there is another PHaMs service provider but neither service provider is made aware prior to the move.

A PHaMs service provider in NSW has assessed an applicant with the Eligibility Screening Tool. The participant is eligible and receiving support from the NSW service provider. The participant moves interstate to Victoria to an area which is covered by another PHaMs service provider. The participant does not advise their current PHaMs worker that they will be doing this. The participant seeks support at the new service provider in Victoria and gives permission for their details to be sent to the new provider.

Procedure for the receiving service provider

The receiving service provider (Victoria) is expected to make contact with the original service provider (NSW) and do the following:

- Fill in the internal transfer form with the participant to ensure participant's consent to transfer participant's information.
- Send a copy of the transfer form to the original service provider.

- Discuss the participant's progress and requirements with the original service provider.
- Request the following information from the original service provider (NSW) to facilitate the transfer of the participant:
    - the participant's contact details;
    - a copy of the participant's EST assessment results;
    - a copy of the participant's IRP; and
    - copies of other relevant information.
- File a copy of the internal transfer form and ensure all contact details are recorded.
- Enter participant's EST assessment results onto the system.
- Work with participant as outlined in the IRP.

Procedure for the original service provider

Original service provider (NSW) is expected to do the following:

- File internal transfer form; and
- Send requested information to the new provider (Victoria).

7.2 Turning away referrals

In the event that demand for services exceeds caseload recommendations, service providers will need to turn away new referrals. FaHCSIA expects service providers to provide the potential participant with information about alternative services which could assist them in the community.

FaHCSIA requires service providers to collect turn away number totals and reasons as a part of routine reporting. FaHCSIA does not require service providers to keep a list detailing people who have been turned away (although service providers may wish to for purposes of filling vacancies as they occur).

7.3 Exiting participants

When a participant exits a PHaMs service, the service provider must complete the exit form which is located on the FaHCSIA portal. This form captures information about the reason for exit, general participant demographics, and any referrals or supports established for the participant. This information forms part of the regular reporting obligations to FaHCSIA.

As outlined at *2.3.8 of Part C1: Application Information for the Personal Helpers and Mentors Activity*, PHaMs service providers will ensure that participants exiting PHaMs have adequate alternative supports in place should they require them.

8. The PHaMs Team and Roles

8.1 Personal qualities

Service providers are expected to employ Personal Helpers and Mentors with a range of backgrounds, qualifications, skills and knowledge, relevant to working with people who have a mental illness.

All Personal Helpers and Mentors team members should have the following attributes, personal skills and knowledge:

- compassion, patience and ability to empathise;
- genuine commitment to helping people who have a mental illness in their recovery, a capacity to relate to them with dignity and respect, and as a unique person;
- ability to think and act calmly and deal sensitively with distress and unpredictable behaviour;
- knowledge of mental illness and skills in working with people experiencing mental illness;
- ability to promote the rights, responsibilities, and recovery of participants;
- effective listening and communication;
- non-judgmental;
- knowledge of when to seek help or supervision and how to work in a team environment;
- understand and promote mental health issues and consumer rights and responsibilities;
- creative in their approach to problem solving;
- promotes ethical behaviour and anti-discriminatory practice that treats consumers, family and staff with dignity and respect, and balances the right to privacy and confidentiality with duty of care;
- cultural competence;
- ability to work safely; and
- knowledge of local community resources.

8.2 Roles

Each PHaMs worker is expected to have a caseload of participants. There are also additional roles that a PHaMs worker may undertake, including specialist roles such as a Peer Support Worker, Cultural Broker or Specialist Employment Worker. A PHaMs worker may have more than one specialist role within the team and more than team member can undertake the same specialist role.

Each role within the PHaMs team has been carefully considered and developed to form an integral part of the overall PHaMs team and is crucial to the success of the team. No one role is more or less significant than any other – they each play their own part in ensuring a balanced team.

8.3 Team Leader role

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

8.4 Peer Support Worker role

The Peer Support Worker is a specialist role within the PHaMs team. Peer support workers are individuals with a personal experience of mental health issues. In PHaMs, the Peer Support Worker engages with participants at a personal level, assisting or supporting them through their recovery journey using their own experience of mental illness and recovery.

Peer Support Workers know what it is to have a mental illness, the difficulties and the challenges to be faced. They can engage and encourage participants in a way that no-one else can because they have lived or shared a different but similar experience and learned how to get through it and regain control of their life. Peer Support Workers can share their own recovery journey (the ups and the downs) and show that recovery is possible. They can encourage participants to share their own stories and experiences, help them to reflect on their progress and provide them with hope and optimism for the future. They may also be able to provide practical ways to cope or manage difficulties based on their personal experiences.

The Peer Support Workers role has been designed to focus on:

- Promoting a team culture where the views and preference of participants, family and carers for recovery are recognised, understood, valued and respected.
- Educating the PHaMs team about the personal experience of living with a mental illness rather than clinical or text book knowledge of mental illness.
- Representing the perspective of the participant to the PHaMs team to ensure they understand how mental illness affects the participant, their family, their life and how they want PHaMs to help them on their recovery journey. The Peer Support Worker may provide support to participants where they are unable to clearly explain their thoughts or experiences to another team member.
- Providing support to participants that comes from the perspective of someone who has already lived or experienced the recovery journey and can understand, support and encourage them.
- The Peer Support Worker may also take an active role establishing and participating in participant support groups.

A Certificate 4 in Mental Health Peer work has now been established. FaHCSIA encourages on-going training for all Peer Support Workers.

8.5 Case Worker role

The Personal Helpers and Mentors Case Worker role is focused on developing a relationship with a participant, understanding the participant's personal needs, goals and aspirations. They then provide opportunities, support and services to develop or redevelop the participant's skills, build their confidence and help them to reconnect with the community.

The PHaMs Case Worker also ensures that services accessed by PHaMs participants are appropriate, coordinated and integrated. They provide direct and personalised assistance through outreach services and link the participant with other appropriate services that support their needs. This is not just a paper referral process rather a personal support that could and often does involve going with a participant to ensure they feel safe and secure and supporting them until they are comfortable doing it on their own.

PHaMs case workers are directly involved with PHaMs participants – from assessing eligibility and needs (using the EST and other methods) through to developing and monitoring IRP's that reflect the participant's goals and aspirations and linking them with other clinical and community support services and case managers. The role could involve some advocacy, mediation, conflict resolution with family and others, and supporting the development of skills for daily life and independent living. It is a complex and very varied role but is always focussed on developing a trusting, respectful relationship.

8.6 Cultural Broker role

The Cultural Broker helps to bridge the gap between the PHaMs service and the local community. The Cultural Broker builds team awareness and understanding of the cultural factors of the community and of the ways in which these factors influence the community. Cultural Brokers are an important specialist role for sites in remote Indigenous remote communities. Cultural Brokers can be also considered for targeted PHaMs services or in a site with a high number of CALD community members.

Cultural Brokers should have a history and experience with the local community, which means that they have:

- the trust and respect of the community;
- knowledge of the values, beliefs, and health practices of the community;
- knowledge of different groups within the community and how they identify;
- an understanding of traditional and Indigenous wellness and healing networks within the community; and
- experience and knowledge of the PHaMs service and health and community support services in the community.

The Cultural Broker can have many roles:

- Liaison and advocacy – help to ensure more effective communication and liaison between participants (family, carers and community members) and the PHaMs team. Advocate for participants to ensure that the services they receive are most effective and meet their needs.

- Cultural competency – can help the PHaMs team to incorporate culturally and linguistically competent principles, values, and practices. They can ensure the PHaMs team environment is safe, non-threatening and non-judgemental for participants and community members. They can advise about non-traditional ways to deliver services that could be more effective in the local community context. They can help to develop educational and promotional materials that will help participants and the community to learn more about the PHaMs service and mental health more generally.
- Mediation – Cultural Brokers can help to ease the historical and inherent distrust that may exist between the community and the PHaMs team (as outsiders to the community). To do this, the Cultural Broker must be able to establish and maintain trust and have the capacity to devote sufficient time to build meaningful relationships between the PHaMs team and participants. The use of the Cultural Broker in this role should improve access to PHaMs services in the community.
- Models and mentors – They model and mentor behavioural change, which can break down bias, prejudice, and other institutional barriers that exist. They work toward changing attitudes and relationships, so that the PHaMs team can build capacity from within to adapt to the changing needs of the community.

Cultural Brokers have a range of skills that enable them to:

- communicate in a cross-cultural context;
- communicate in two or more languages (at least one should be English and the other language from the community);
- interpret and/or translate information from one language to another;
- advocate with and on behalf of participants and community members;
- negotiate health care and other service delivery systems; and
- mediate and manage conflict.

The benefits of using a Cultural Broker include:

- more positive experiences for participants and an increased likelihood of access to services;
- service delivery that is more effective and better received because it respects and incorporates community cultural perspectives;
- community members are more likely to seek support (and sooner) if they know that the PHaMs team understands and respects their cultural values and health beliefs and practices; and
- participants will be better able to communicate their needs more effectively and better understand their support and recovery options.

8.7 Family Broker role

Family Brokers may play an important role in the PHaMs remote service model (particularly where services visiting services are provided). These paid positions can be full or part-time

depending on the level of support required and will be offered to a strong family member of the participant on a short term basis (up to 6 months) to provide additional ongoing daily support to the participant.

The Family Broker will:

- Receive information, support and training from the PHaMs team about mental illness and how to manage the behaviours of their family member arising from the symptoms of the illness.
- Help their family members to identify their strengths and needs.
- Support and encourage the family member to set and achieve their goals and establish regular routines.
- Support and celebrate their family member's achievements with them and help to raise their confidence and self-image.
- Listen to and acknowledge their family member's feelings and experiences.
- Provide practical help to learn new tasks and manage their day-to day activities.
- Recognise changes in behaviour that might indicate something is not right (ie stop talking to family and friends, become afraid or suspicious for no reason, sleep poorly or often be awake all night, develop strange ideas, hear voices no one else can hear, say things that don't make sense).
- Recognise and help the family member to see positive changes in their life that they have made.
- Help other family members to understand what their family member is experiencing.
- Be a strong role model for the family member.

8.8 Specialist Employment Worker

The role of the PHaMs Employment worker will include providing intensive support to 10 to 12 participants, for a maximum of 6-12 months. This will include:

- Working directly with the participants and providing practical support to address issues in their lives that have been identified as barriers to employment, for example securing stable housing and improving relationships with family.
- Supporting the participant's family and support networks as needed to ensure they understand and support the participant's transition to work.
- Communicating with clinical and primary care providers to ensure they are aware and supportive of participant's employment goals and tailor treatments accordingly.
- Assisting participants to navigate employment services and Centrelink systems, including referring participants to appropriate employment services and accompanying participants and advocating for them at appointments, and assessments.
- Providing less intensive ongoing support to 10 to 12 participants, for 1-2 years, including 'checking in' with participants on a regular basis about their progress.

- Being available to both the participant and employer to assist if circumstances change and/or a participant's job is in jeopardy (for example, the person has an episode of their mental illness).

The PHaMs Employment worker will be required to work closely with employment consultants, including:

- Coordinating supports for participants, to ensure roles are complementary, not duplicatatory.
- Preparing participant profiles which can be given to employment consultant to assist their understanding of a participant's background, current circumstances, skills and employment goals.
- Providing on-the-job support as necessary, to assist the participant to maintain a job – particularly beyond the 13 and 26 week points, when the capacity of Employment Consultants to provide ongoing support reduces.
- Facilitating employment peer support networks and activities.

The PHaMs Employment worker will have an important role of building the capacity of general PHaMs services to better assist participants to achieve employment goals, through such things as assisting services to navigate the employment services system and training of PHaMs workers. This capacity building role will also include:

- Providing an education service for both employment services and employers to build their capacity and willingness to work with participants and employees with mental health issues.
- Publicising and marketing the availability of PHaMs employment support to employment services and other referring agencies.
- promoting the benefits of employment for people with mental illness.

9. Privacy and Complaints Handling

9.1 Confidentiality and privacy

PHaMs workers develop relationships with vulnerable people and as part of these relationships, a PHaMs worker will have access to very personal and sensitive information. Personal information should be only shared with participant consent and it should be kept safe and secure from access by others.

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

9.2 Handling complaints

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

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

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

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

- afford privacy, dignity and confidentiality;
- provide information about alternative avenues for any complaint that cannot be resolved internally (including referral to FaHCSIA);
- be provided free of charge; and
- where the participant/carer does not receive satisfactory resolution of their concerns, the complaint should be referred to the FaHCSIA Contact Person as named in the Funding Agreement.

10. Communication and Promotion

An important part of PHaMs is to communicate and promote the Personal Helpers and Mentors service and the importance of mental health and wellbeing. However, these activities should avoid creating unrealistic expectations in the community about the resources allocated to PHaMs.

10.1 PHaMs Promotional Products

Service providers will be provided with promotional material consisting of brochures both in hard copy and in pdf format and posters in hardcopy. FaHCSIA expects service providers to distribute the posters to local services that could be entry and referral points for PHaMs.

The brochures should be distributed to potential participants that visit the service or request information. Distributing the PHaMs brochures in bulk may create unrealistic expectations regarding the ability of the service to meet community demand within allocated resources. Service providers should include their site contact information on the brochure and poster.

In addition, service providers may use other forms of promotion, including references in local newsletters, email newsletters and local media.

Service providers working in designated remote service sites may want to work with local community members or artists to design more appropriate service imagery to be used to promote PHaMs in their site. Final imagery should be approved by FaHCSIA before it is used.

10.2 PHaMs Logo and Branding Instructions

The logo has been issued for the purposes of the promotion of the Personal Helpers and Mentors only.

The PHaMs logo should be used according to the following guidelines.

- The logo should appear in its entirety.
- The logo should appear in colour (see CMYK and Pantone values below) or black and white ONLY. No other variation is permitted.
- The CMYK values for the colour logo are 73.100.0.0. The Pantone value is 527C.
- The logo should be no smaller than 40mm wide to ensure the text remains legible, and no other font should be substituted.
- If the logo is resized, the proportions must be maintained.
- The logo must contrast strongly with the background: it should not be placed on colours similar to the blue and purple used in the design.
- For ease of use, the preference is for the logo to be used against a white background.
- The black and white version of the logo should be used when the document will be printed in black and white.
- The logo and its component parts should NOT be distorted or modified in any way.

- The ‘Personal Helpers & Mentors’ text font is Helvetica Neue.

10.3 PHaMs - Using the Logo

- The logo should always include the "An Australian Government Initiative" text
- The logo must be either greyscale logo (with shades of grey and black) OR colour
- Do NOT distort the logo
- The logo should NOT appear on merchandise or stationery
- The logo has been issued for the purposes of the promotion of the Personal Helpers and Mentors service only and has been given to PHaMs service providers on this basis. If you have any queries, please contact your PHaMs Funding Agreement Manager.

Further information on using the logo is at Attachment B.

11. Contacting FaHCSIA

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

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

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

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

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

Locations and contact details of service providers can be viewed at:

http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/personal-helpers-and-mentors/locating-a-personal-helpers-and-mentors-service

12. Further Reading and References

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Attachment A Individual Recovery Plan SAMPLE

Case Example:

Fred is a 24 year old man who has experienced several occasions where he hears voices commenting on and directing his behaviour. Fred's first experience of this was during his teenage years when he was living with his family in a rural area, and it was apparent it interfered with his schoolwork. Fred and his family gained assistance through their GP and local mental health service. With therapy and the support of family and community, the voices disappeared and Fred was able to complete his schooling and gained entry to a tertiary institution in the city.

In the city, Fred slipped into a demanding study, social and part-time work schedule. At the end of his first-year exams, he heard voices again but found that alcohol and sleeping later helped to manage them. During his break, he focused on employment to save for the year ahead, and the voices went away.

Over the next two years Fred found that the voices would return with more frequency and he needed to drink and sleep more to prevent them interfering. Unfortunately, during this time he stopped studying, lost his employment as a result of his drinking and eventually lost his accommodation.

Fred goes to a homeless centre for food, company and to gain any other help he needs. He has been living on the streets and in homeless shelters. Last week, he went to the centre and said he does not want to keep living this way and wants to regain his life but does not know where to start. The worker in the homeless centre discussed the Personal Helpers and Mentors Program with Fred, who agreed to give the Program a try.

Fred met a Personal Helper and Mentor, proceeded with assessment and was found to be eligible. The Eligibility Screening Tool highlighted a number of areas Fred might focus on for his recovery journey. Fred has discussed these with his Personal Helper and Mentor and prioritised his goals and considered his next steps. Fred, in discussion with the Personal Helper and Mentor has identified the following plan which he would like to follow for the next three months.

Personal Helpers and Mentors Program
Individual Recovery Plan – SAMPLE

Participant Name Fred

Areas of need identified in assessment

Nowhere to live
Sometimes can't control voices and this distresses me and stops me from doing things
No money, usually benefit goes on alcohol
Difficulty changing lifestyle because can't access help
Loss of contact with supportive people who can help recovery

My strengths

Good sense of humour
A relaxed attitude towards self and others, used to be a good mate to others
Previously had a strong relationship with family
A good mind and academic ability - commenced environmental studies
Able to survive when homeless
Know when becoming unwell
A good and willing worker when well and holds employment skills – able to work on farms, in hospitality, and in research and related to environment
Previously played sport: soccer, tennis, cricket

My goals and aspirations

Find somewhere to live
Stay well for longer
Gain work

Planned activities – Refer to planning worksheet at the end of this document

What I can do to stay well

Get some help when I notice I am becoming unwell.
Limit alcohol.
Slowly become more involved with activities and people that I enjoy which will support recovery.

People who can support me

Who	Phone number	What I need them to do
Toby – Personal Helper and Mentor	55501555	Reassure me that I can manage this; remind me of the steps to take. Help me get the assistance I need; including food and payments.
Jenny – Homeless Centre Worker	55015555	Listen to me and help with getting assistance if Toby is not available
Nathan – Friend	55555501	Tell me if I am losing it; help me phone Toby and Joe; make sure my bills are paid and I stay in touch with people.
Joe – GP	55550155	Listen to what I am experiencing and help me with medication and getting the level right.

I do not want the following people involved in any way in my care (list names and (optionally) why you do not want them involved)
Joanne – ex-girlfriend. Do not want her involved because she convinces me to drink more.

Signs that I may be beginning to feel worse: anxiety, excessive worry, overeating, sleep disturbances
When I don't get enough sleep, when others are pressuring me for money or to drink, and when I notice I am beginning to worry, my mind goes over and over things, I can't make a decision, and I begin to hear voices.

What I can do if I am starting to feel worse: mark those that you must do--the others are choices
*Tell Toby and Nathan what is happening.
*Follow the directions of Toby and Nathan.

What I want from my supporters when I am well
Listen to me and respect that I know what I am doing and what I need to do.
Help with moving towards my goals.

What I don't want from my supporters when I am unwell
To make decisions about me and what I should do.
To talk to others about me without my agreement.

How I want disagreements between my supporters settled
I will decide what will happen for me.
If I am unwell I trust Jenny to settle the disagreement because she has known me a long time.

Things I can do for myself
I can speak to others on my own behalf, although at times I may need someone to provide supportive references.
I can judge when I am becoming unwell.

Record of referrals

Name of Agency referred to	Date referred	Date accepted	Ongoing assistance/support required	Contact
SAAP/Community Housing			Priority access for housing	
GP			Treatment review, Application for DSP	
Centrelink			Application for DSP	
Budget advisor			Discuss options for managing money and gaining bond money	
Community cricket			Return to sporting activities	

This plan was completed on / /

_____

_____ _____

Participant name **Signature**
Original to Participant Copy on file

Planning Worksheet (SAMPLE)

Task or Responsibility	Step	When you would like to take this step
Get to know Toby	Meet Toby twice a week for two weeks at the Homeless Community Centre for coffee and a talk. Decide in 2 weeks if the Personal Helpers and Mentors Program is right for me.	Immediately
Apply for assistance to gain accommodation	Appointment with Housing to apply for private housing assistance. Toby will come with me.	Next week
Money for rental bond	Appointment with budget counsellor to help with letter of support. Appointment afterwards with Centrelink for rental assistance. Toby will come with me.	Next week
Get better control of voices	Appointment with GP Joe and Tony to discuss voices and how best to manage these.	This week
Get better control of alcohol	Appointment with Alcohol counsellor to talk about strategies.	Two weeks
Reconnect with others that will help maintain health	Return to cricket through the local community cricket game.	Starts next month

Attachment B Using the Personal Helpers and Mentors logo

The logo should always include the 'An Australian Government Initiative' text	
The logo must be either: **greyscale logo** (with shades of grey and black) OR **colour**	
Do NOT distort the logo	
The logo should NOT appear on merchandise or stationery	
PLEASE NOTE **QUERIES**	The logo can only be used with the permission of the Australian Government Department of Families, Community Services and Indigenous Affairs. If you have any queries please contact your PHaMs Funding Agreement Manager.