Australian Government

Department of Families, Housing, Community Services and Indigenous Affairs

Mental Health Respite Program

National Respite Development Fund Guidelines

Version No. 6
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Foreword

The Mental Health Respite Program (the Program) demonstrates the Australian Government's recognition and support for carers who provide a valuable role and make a considerable contribution to families and communities across Australia.

The Program provides much needed respite support for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.

In July 2006, the Council of Australian Governments adopted the National Action Plan on Mental Health 2006-2011 (the Plan). The Plan is directed at achieving outcomes in four areas:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention, and
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including an increase in stable accommodation.

The Mental Health Respite Program is one of nineteen Australian Government measures funded in 2006 through this process. This Program represents a large investment by the Australian Government, recognising that severe mental illness/psychiatric disability and intellectual disability are significant issues in our community that touch the lives of all Australians, whether they are consumers, carers, friends, family or service providers.

The Mental Health Respite Program contributes to the FaHCSIA outcome of:

> An adequate standard of living, improved capacity to participate economically and socially, and manage life-transitions for people with disability and/or mental illness and carers through payments, concessions, support and care services.

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1 Preface

These Program Guidelines (the Guidelines) provide the framework for the implementation and administration of the National Respite Development Fund (NRDF) component of the Mental Health Respite Program (MHRP or the Program). The Guidelines also provide the basis for the business relationship between the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA or the Department) and the service providers. They should be read in conjunction with the Funding Agreement.

The Guidelines set out the roles, responsibilities and accountabilities for FaHCSIA and the service provider. These roles and responsibilities are focused on delivering appropriate, effective services, which will improve the quality of carers' lives and that of their dependants.

The program guidelines include:

- the purpose of the MHRP, in particular the NRDF component;
- FaHCSIA's expectations of service providers including performance expectations, guiding principles and values;
- monitoring and contract management arrangements including accountabilities and program governance arrangements for FaHCSIA and the service provider; and
- other information relevant to the successful delivery of the NRDF component of the MHRP.

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

Comments or clarifications on the MHRP Guidelines should be referred to FaHCSIA at mentalhealth@fahcsia.gov.au.

2 Program Overview

2.1 History/Context of the Mental Health Respite Program

Mental illness describes a range of conditions that result in a significant impairment of a person's thinking, emotions and behaviour which may require long-term treatment and support. Examples of types of mental illness include psychotic and non-psychotic disorders, such as depression, anxiety, bi-polar disorder, affective disorders, mood disorders, personality disorders, schizophrenia and eating disorders. These conditions may be short or long term.

The prevalence of mental illness is high in all western countries including Australia. About one in five adults in Australia will experience symptoms of mental illness in a 12 month period. This means that 2.4 million Australians had at least one condition during the last year. The most prevalent mental health problems are anxiety-related and depressive disorders. Approximately 10 per cent of the population are affected by an anxiety-related disorder in any one year, and six per cent of the population experience depressive disorders in a year.[1] Psychotic illnesses such as schizophrenia and severe mood disorders are less common, but are usually very disabling.

Mental health conditions typically appear in people in early adulthood and may occur as a single episode or may recur throughout their lives.

Many factors can trigger the onset of a mental illness including stress, bereavement, relationship breakdown, child abuse, unemployment, social isolation, accidents and life-threatening illnesses.

The Australian Institute for Health and Welfare reported mental disorders to be the third leading cause of overall disease burden, accounting for 13 per cent of total burden and 27 per cent of total years lost to disability. Mental disorders rank third after heart disease and cancer as the largest causes of illness related burden in Australia. However, they represent the largest cause of disability, accounting for nearly 30 per cent of the burden of non-fatal disease. Depression and anxiety account for nearly half of this burden. Depression is the leading single cause of disability[2].

Intellectual disability is associated with impairment of intellectual functions, limitations in a range of daily activities and/or restrictions in participation in various life areas. People with an intellectual disability may require support throughout life. The level of support may be consistent over a period of time but can change in association to life circumstances.

[1] Australian Bureau of Statistics, Mental Health and Wellbeing: Profile of Adults, 1997.
[2] The burden of disease and injury in Australia, AIHW, 1999.

The ABS Disability, Ageing and Carers Survey found the prevalence of intellectual disability was reported by 436,200 people aged under 65 (2.5 per cent of this age group) of whom 432,000 (2.5 per cent had activity limitations or participation restrictions, and 215,100 (1.2 per cent) had a profound or severe activity limitation.

There is some relationship between the nature and the extent of disability, to the frequency of need for assistance with core activities. “People with intellectual disability are the most likely to need assistance six or more times a day.”[3] The effect of caring for a person with intellectual disability on the carers’ physical and mental health is well documented.

Adults with an intellectual disability and mental illness (dual diagnosis) often have complex and high support needs[4] and are in need of improved access to a broad range of government and non-government services.

Two per cent of the Australian population have an intellectual disability and the prevalence of mental illness in this population is 30-50 per cent, the equivalent of at least 100,000 people. Their needs are often ignored because they fall between the gaps. Often the two disorders are treated separately or people are only referred to a specialist service when a holistic approach to a person’s recovery is taken[5].

The largest services gap in respite care for carers of people in the two groups are for those with complex needs who exhibit challenging behaviours.

2.1.1 Council of Australian Governments National Action Plan on Mental Health 2006-2011

Of the 19 new initiatives announced as part of the National Action Plan on Mental Health 2006-2011 (the Plan), FaHCSIA is responsible for the development and implementation of the following three initiatives:

- **Personal Helpers and Mentors Program** $284.8 million to provide 900 personal helpers and mentors to assist people with a severe functional limitation resulting from a mental illness to manage their daily activities. This includes access to a range of appropriate and integrated community and social supports, accommodation, health, welfare and employment services. The Program targets people aged 16 years and over whose ability to live independently in the community is severely impacted because of a mental illness. It creates opportunities for recovery through helping overcome social isolation and increases connections to their community.
- **Mental Health Respite Program**, $224.7 million to establish and provide flexible respite care options for carers and families caring for people with a severe mental illness/psychiatric disability and for people with an intellectual disability. Under this program, priority is given to elderly parents 65 years of age and over (for Indigenous carers 50 years of age and over) who live with and care for children (including adult children) with a severe mental illness/psychiatric disability and intellectual disability.

[3] Australia’s Welfare 2005
[4] People with a Dual Diagnosis of Intellectual Disability and Mental Illness, Queensland Government.
[5] Human Rights and Equal Opportunity Commission website, October 2006.

- **Community Based Program** $45.2 million to fund a diverse range of practical projects to support families, children and young people with a particular focus on Indigenous families and those from a culturally and linguistically diverse background.

2.1.2 Consultations on Mental Health Respite Program Design

During 2006, FaHCSIA consulted widely on the design and development of all three initiatives. The consultation process was undertaken in the early design stages in August/September 2006 and included some early stakeholder focus groups followed by national consultation workshops in all capital cities and two regional areas. Over 1,000 participants representing government, non-government, peak bodies, consumers, families and carers attended.

Key findings from the consultations have significantly influenced the design of the programs. Key issues raised relating to the MHRP included:

- provide flexibility and choice for carers;
- tailor respite options to the needs of carers and the care recipient;
- provide respite options that are appropriate to the specific needs of the care recipient;
- support services to build relationships of trust with carers and the care recipient;
- promote and enable early access to respite to minimise emergency or crisis situations; and
- under supply of respite services in many regions across Australia prevent many support services providing assistance to carers.

The MHRP was designed to respond to these issues, providing flexibility for carers and the care recipient through the brokerage service delivery model, as well as increasing the supply of respite options through direct service funding.

More recently, the Department responded to issues raised at post implementation workshops conducted in 2008 by implementing a ‘no wrong-door’ approach for carers to enter the program.

2.1.3 COAG Working Groups

To support the effectiveness of the Plan, COAG agreed that the Premier or Chief Minister’s departments in each state and territory would establish and convene a COAG Mental Health Working Group. These groups involve Australian Government and state and territory representatives and engage with non-government organisations, the private sector, consumers and carer representatives.

These groups provide a forum for oversight and collaboration on how the different initiatives from the Australian Government, and state and territory governments will be coordinated and delivered. The groups represent a commitment to collaborate on improving the responsiveness of the mental health system for the benefit of individuals, families, carers and the wider community.

Since July 2006, FaHCSIA has been working closely with the COAG Mental Health Working Groups in each state and territory. In relation to the MHRP these groups have undertaken mapping of mental health and intellectual disability respite services available in each state and territory. This information was used to guide FaHCSIA in the direct funding of respite services through this Program.

2.2 Mental Health Respite Program Description

The MHRP provides a range of flexible respite options for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.

There are two components to the Program:

- Part A - a brokerage service model provided across Australia in all Home and Community Care (HACC) regions using the existing network of Commonwealth Respite and Carelink Centres (Centres). The brokerage component (MHRP-BC) of the Program was implemented in April 2007 using a brokerage model enabling carers, the care recipient and their families to have the maximum choice and flexibility tailored to their specific respite needs; and
- Part B - a direct funding model using the NRDF as a component of the MHRP to increase the supply of appropriate respite services where limited service supply needs were identified. A level of service delivery money for the newly established services has been incorporated into this component of the MHRP to support the 'no-wrong door' approach for carers entering the program.

2.2.1 Aim of the MHRP

The overall aim of the MHRP is to provide support to carers by increasing access to flexible respite services to meet the individual needs of carers and the care recipient. Respite enables carers to sustain their on-going care responsibilities and take a short term break from their caring role, supporting them with time and space to focus on other commitments or personal needs and aspirations.

2.2.2 *Aim* of the Brokerage Component (MHRP-BC)

The aim of the MHRP – BC is to provide flexibility to meet the individual needs of carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.

2.2.3 Aim of the National Respite Development Fund (NRDF)

The aim of the NRDF component of the Program is to identify, fund and deliver a range of new flexible and innovative respite options for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability that respond to the particular needs of the different regions across Australia.

2.3 Planned Outcomes of the MHRP

The purpose of the MHRP is to provide alternative or supplementary care arrangements and family support with the primary purpose of giving the carer a short-term break from their caring role and responsibilities. This includes planned and unplanned respite.

Respite is perceived as:

- an outcome for carers (carers experience a short term break from their caring role);
- a service for carers (carers receive a service appropriate to their needs); and
- a service for the people for whom they provide care (a care recipient receives a service appropriate to their needs).

Specific outcomes for the Program include:

1. ***Carers have greater access to respite and carer support services***

The **primary** outcome is respite for carers of people with a severe mental illness/psychiatric disability and carers of people with an intellectual disability. However, the need to carefully balance the two interests of carer and care recipient in an appropriate way is critical to the effective support for carers and therefore the achievement of the outcome for carers. Therefore, the MHRP also needs to provide suitable and positive opportunities for the care recipient.

Post implementation consultations identified that carers of people with a mental illness want respite and support in their care co-ordination role. Service providers need to ensure that any form of respite or carer support is flexibly focused on the needs of the carer and family with the aim of improving family and community connection.

2. ***Increased supply of mental health respite and carer support options***

To achieve the primary Program outcome of providing respite and carer support for carers of people with a severe mental illness/psychiatric disability and carers of people with an intellectual disability, the Program's second outcome must increase the supply of respite and carer support options. Carers cannot receive respite services unless they are available within the service sector. It is expected that availability of appropriate respite will be increased by providing:

- funding in the community through Centres, stimulating the development of new and or expanded respite options; and
- NRDF funding to create new options where the service sector is not able to respond adequately to meet community need, including a level of service delivery funding.

2.3.1 Program Logic

A program logic model is a picture of what the Program aims to achieve and how it should operate. It describes the outcomes, outputs, processes and

inputs and how these elements relate to each other. The diagram at **Appendix A** represents how FaHCSIA sees the program logic for the MHRP.

2.4 Program Principles, Quality and Standards

Service providers funded under the MHRP are required to provide high quality services and to comply with all relevant legislation and standards.

2.4.1 MHRP Principles

Both components of the MHRP will operate within a set of core principles, which should be applied by all parties involved in the Brokerage, and development and delivery of respite services. These include:

- **partnerships** - between the carer, the care recipient and the service provider in planning and delivering services;
- **flexibility and choice for carers** – in design and delivery and will be tailored to the individual requirements of the carers, the care recipient, and their family;
- **appropriateness of services** – targeted at the level of care identified to meet the needs of the carer and the care recipient with the focus on providing meaningful activities for the care recipient, and including cultural sensitivity and culturally appropriate models where possible;
- **accessibility and equity** – ensuring that people within the target groups have information that enable them to access the Program regardless of where they live or their level of income. Services should be delivered on the basis of fair treatment to clients who are eligible to receive them; and
- **quality of service** – respite services will be required to meet specific standards in quality, including legislative requirements.

Services will therefore reflect the following characteristics:

- carers and care recipient's rights and dignities will be protected and promoted;
- service providers will ensure access for carers of people with high dependency needs, complex care needs and challenging behaviours;
- services will be coordinated, planned and promote positive coping strategies to maintain the carer's physical and mental wellbeing;
- service providers will take a personalised approach to care that maintains the lifestyle, activities and interests of both the carer and care recipient while in respite;
- service providers will recognise the broader needs and inter-relationships of the family as a whole;
- services will be planned, but flexible enough to respond to emergency situations;
- services will be appropriate for the type of care required; and
- service providers will provide information about the range of services, eligibility criteria and access requirements in formats that are appropriate to the needs of the carer and the care recipient.

2.5 Links with other Programs

The provision of services for carers and care recipients are spread across the Australian, state and territory governments, and community organisations. Respite care is funded by both the Australian and state and territory governments and some respite initiatives are jointly funded by both levels of government.

It is expected that both Centres and service providers funded under the MHRP will develop close working links in providing appropriate respite options for carers of the two target groups.

2.5.1 Links to the other Australian Government Respite Programs

A range of Australian Government respite programs are available to carers of the frail aged and people with disabilities, including people with psychiatric and intellectual disability. The MHRP seeks to complement these existing Australian Government programs. However, the MHRP aims to meet the specific needs of carers of people with a severe mental illness/psychiatric disability, and carers of people with an intellectual disability by increasing the number of eligible carers who have access to respite and carer support.

Examples of Australian Government programs that are available to carers include:

i. Commonwealth State Territory Disability Agreement (CSTDA);

ii. Home and Community Care (HACC) Program;

iii. National Respite for Carers Program (NRCP);

iv. Veterans' Home Care (VHC) Program;

v. Young Carers Respite and Information Services;

vi. Respite Support for Carers of Young People with a Severe or Profound Disability; and

vii. Other specifically targeted programs.

2.5.2 Links to State and Territory Disability Programs

To support the aim of increasing the number of carers who have access to respite services, it is intended that the MHRP will provide respite to carers who are unable to access respite through a range of state and territory programs. Examples of these programs designed to assist people with disability, their carers and families, include:

- home assistance with bathing, shopping and meals;
- out of home activities (recreational activities, day placement & holiday support);
- respite in and out of home;

- special equipment or aids;
- volunteer and other carer reimbursement expenses;
- transport assistance; and
- clinical support.

2.5.3 Links to Community Programs

Carers, people with disability and their families may also be able to access different types of support from community organisations such as Australian Red Cross, Salvation Army and other voluntary organisations.

3 Program Management and Service Delivery details

3.1 Service Provider Eligibility

To be eligible for funding under the NRDF component of the MHRP service providers must be non-government organisations (NGOs), must be a legal entity and able to confirm their legal status.

FaHCSIA will only enter into Funding Agreements with legal entities such as:

- Incorporated Associations (incorporated under State/Territory legislation);
- Incorporated Cooperatives (also incorporated under State/Territory legislation, commonly have 'cooperatives' in their legal name);
- Not for profit companies (Incorporated under the Corporations Act 2001);
- Aboriginal corporations (incorporated under the Aboriginal Councils and Associations Act 1976 administered by the Registrar of Aboriginal corporations);
- Organisations established through a specific piece of Commonwealth or State/Territory legislation (may be public benevolent institutions, churches universities etc);
- Partnerships;
- Trustees on behalf of a Trust; and
- Aboriginal and Torres Straight Islander Community Councils.

FaHCSIA will only contract with an individual service provider. Service providers may determine that efficient or effective service delivery is best achieved through the use of a network of providers through a sub-contracting arrangement. Successful service providers who utilise an authorised sub-contracting arrangement will be held liable for all obligations contained in the terms and conditions of the Funding Agreement. This includes monitoring, management, financial performance, service outcomes, and specifically insurance coverage.

Service providers funded by the NRDF must accept the legal responsibilities associated with administering the service. Service providers must be incorporated under relevant State or Territory legislation and comply with all Australian Government, State/Territory and local government statutes, by-

laws and other prescribed requirements. This includes the requirement for the service to meet all their obligations in respect of taxes, duties and government charges and appropriate insurance/s, and to comply with legislation, standards and codes in relation to Risk Management and Occupational Health and Safety (OH&S).

Who is not eligible?

The following list identifies service providers who are not eligible:

- Individuals;
- State and Territory government agencies are not eligible to apply for funding under the MHRP. However, local government may act as a partnering organisation, in an authorised sub-contracting arrangement;
- Third parties seeking funds on behalf of others; and
- Bodies that are not legal entities.

3.1.2 Selection Process for Service Providers

The NRDF is provided to eligible service providers across Australia.

The round 1 funding was conducted in 2007-2008 through an open competitive funding process followed by a direct approach. The 2nd funding round is a restricted competitive process targeted at eligible service providers delivering services to carers of people with a mental illness.

3.2 Funding

Under the MHRP 2006–2011, the Australian Government notionally allocated funding for:

NRDF - 60 per cent of total Program funds were notionally allocated to the NRDF component of the Program for direct funding of new respite services in areas of need. This included a level of service delivery funding to service providers for 2008/09 and 2009/10.

	2006-07 $M	2007-08 $M	2008-09 $M	2009-10 $M	2010-11 $M	Total $M
Total	$0	$29.447	$36.598	$30.062	$29.891	$125.998

MHRP-BC- 40 per cent of funds were notionally allocated to the Brokerage Component of the Program to Centres at HACC regional levels, based on ABS primary carer population data[6] , as follows:

	2006-07 $M	2007-08 $M	2008-09 $M	2009-10 $M	2010-11 $M	Total $M

[6] Primary carer numbers for the Northern Territory were not published by ABS as they were considered too unreliable for general use. Funding for the Northern Territory is based on total population statistics.

Total	$5.069	$17.413	$24.898	$20.041	$19.928	$87.349

* Current Funding Agreements with Centres are from 2006-07 to 2009-10

3.3 NRDF Conditions of Funding

Funding will be provided to service providers, subject to:

- Upon signing, compliance with all Terms and Conditions of the Funding Agreement; and
- the provision of funds through the annual appropriation of funds by Parliament.

3.4 Fees

Under the NRDF component funded service providers can develop their own policy on carer financial contribution. No carer must be refused service or be disadvantaged as a result of being unable to contribute to the cost of the service whether they are referred by a Centre or enter the program directly through a service provider.

3.5 Payments

Service providers will be provided with milestone-based payments to allow flexibility in their local service delivery.

Payments are attached to signing of the Funding Agreement and the provision of Regular Reports in relation to the Program outcomes outlined in the Program Logic at Appendix A.

3.6 Service Delivery Model

NRDF funding is provided to non-government organisations to develop and establish new respite and support services and/or expand existing services. Following post implementation workshops held nationally in May 2008, a level of service delivery funding has been incorporated in the funding model to improve access pathways for carers.

As a result of the post implementation workshops a ‘no wrong door’ approach was implemented. While a level of service delivery funding has been allocated to NRDF providers to support this approach, it is expected that Centres and NRDF providers will continue to work together to build strong and productive relationships.

The ‘no wrong door approach’ means carers will continue to enter the program through referrals from Centres or they may gain access to the program directly through NRDF service providers.

Carers referred by Centres

It is expected that all service delivery costs incurred by NRDF service providers for carers referred by Centres will be recovered from the Centres.

Centres will continue to conduct a ‘carer need assessment’ for all services they broker from NRDF service providers.

Carers entering the program directly through a service provider
All carers must undertake a 'care need assessment' (see section 3.8). Service providers can choose to conduct the assessments or request Centres to do so on their behalf for a fee.

Additional service delivery funding or re-phased establishment funding is used for delivering the services. Service providers must ensure that all service delivery costs for respite services are included in their fee for service.

3.7 Program Eligibility and Access

3.7.1 Who is Eligible for the MHRP?

Carers eligible to receive respite services under the NRDF will include both carers of people with a severe[7] mental illness/psychiatric disability; and carers of people with intellectual disability[8]

Intellectual disability is included as a target group in recognition of the gaps in service provision in some current programs for intellectual disability, especially for complex cases with dual diagnosis or severe behavioural problems.

Autism spectrum disorders are classified as intellectual disability for the purposes of the MHRP[9]

3.7.2 Who is not eligible for the MHRP?

Carers of people with a condition other than mental illness/psychiatric disability or intellectual disability are not eligible for respite under the MHRP. Non-qualifying 'conditions' include Acquired Brain Injury, neurological conditions and physical disability.

If the care recipient has a dual diagnosis which includes mental illness/psychiatric disability or intellectual disability (not Acquired Brain Injury) this may qualify the carer for the MHRP.

Carers who are already receiving respite services under existing programs for carers of people with a mental illness or people with an intellectual disability are not eligible for respite under the MHRP.

3.7.3 Access Priorities

Specific age related priority includes:

- **elderly parent carers 65 years**[10] of age and over (Indigenous carers over 50 years of age and over) **who live with and care for children**

[7] 'Severe' refers to the level of core activity limitation cause by the mental illness/psychiatric disability.
[8] Please note Round 2 service providers are funded to provide services to carers of people with a mental illness only
[9] Autism disorders are categorised as an intellectual disability by the National Community Services Data Dictionary.
[10] *This Program aligns with existing respite and other government Programs targeted to the elderly. 'Elderly' is defined as 65 years and over (over 50 years for Indigenous carers). It also provides flexibility to service carers just below the 65 years.*

(including adult children) with a severe mental illness/psychiatric disability or intellectual disability;

- **other non residential elderly parent carers 65 years** of age and over (Indigenous 50 years and over) who are the **primary carer** of children (including adult children) with a severe mental illness/psychiatric disability or intellectual disability;
- carers of any age who care for people with a severe mental illness/psychiatric disability or intellectual disability who require **emergency respite care** (unplanned respite); and
- carers aged 55 to 65 (Indigenous 40-49) who live with and care for children (including adult children) with a severe mental illness/psychiatric disability or intellectual disability.

These priorities do not exclude other carers of people with mental illness or carers of people with intellectual disability accessing the Program. Other eligible carers may access the Program, subject to funding, if the needs of the priority groups have been addressed.

Particular attention should be paid to ensuring that the needs of people with severe and profound conditions or challenging behaviours are identified and appropriate respite options provided for this group.

It should be noted that carers who are eligible to receive respite services under existing programs for carers of people a mental illness or with intellectual disability are **not eligible** for respite under the MHRP.

The Program does not set levels of funding for each of the different target or priority groups, as access is to be based on carer need, but may include them in later versions of the Guidelines should it become necessary.

3.8 Assessment of Carer and Care Recipient Need

Priority of access is based on an assessment of **relative carer need**

3.8.1 Carer Need Assessment

All carers entering the MHRP program must be assessed for relative carer need.

Centres who broker services from NRDF providers must undertake a carer need assessment to ensure the service is appropriate for the care recipient. Consistent with this approach, where a carer directly approaches a NRDF service provider, the provider must undertake this assessment. NRDF service providers may request Centres to undertake the assessment on their behalf for an agreed fee.

Centres and NRDF service providers are encouraged to share tools and expertise across HACC regions when conducting a carer need assessment. These practices will encourage consistency in the assessment process.

Factors influencing carer need include:

- the availability of other informal support to the carer, such as family members, friends or volunteer groups;
- the availability and use of other services to support the carer and/or care recipient, for example: home help, disability support services or mental health services;
- the carer's own physical and mental health status;
- the carer's study and work load demands;
- other demands on the carer, such as other family responsibilities;
- the number of people cared for; and
- the presence or extent of the care recipient's challenging behaviours.

In all situations, carers and care recipients should be closely involved in the decisions about which services are provided, and wherever possible, the carer and care recipient should be included in the selection of the suitable respite options.

A carer assessment framework for NRDF service providers is at 10.2 Appendix B

3.8.2 Establishing the Needs of the Care Recipient

The needs and interests of care recipients will vary between individuals as well as between the two distinct target groups of the MHRP. Service providers must ensure that care recipient needs are assessed to enable respite services provided to a care recipient are appropriate to the individual's needs.

Service providers are encouraged to create innovative and flexible options for care recipients. For example, respite provided for carers of people with a mental illness/psychiatric disability can also support and contribute to the recovery goals[11] of the care recipient through rehabilitation while in respite care.

3.8.3 Respite Care Planning

The intent of the MHRP is to promote and develop a planned approach to respite. This involves both the carer and care recipient in discussions about their needs, interests and care requirements.

These discussions should lead to developing both a carer and care recipient plan. They may be separate care plans or incorporated into one plan. These plans should be confirmed in writing and reviewed at least every 12 months.

[11] Recovery in the context of people, who experience mental illness, is a process of growth and development. Recovery refers to a way of living a satisfying and hopeful life, despite the limitations caused by mental illness and associated stigma. Recovery doesn't necessarily mean cure – the symptoms of mental illness may remain. It reflects a process of the person regaining control of their life by learning to manage the illness and its associated impacts, rather than being managed by them (Vicserv).

3.9 Working with Commonwealth Respite and Carelink Centres

Service providers funded under the NRDF component of the MHRP will be expected to establish and maintain effective working relationships with their regional Centre reflecting the Program principles and ensuring program outcomes are achieved.

The Centres are required to work with carers and the care recipient within a supportive and holistic approach. To meet these requirements Centres will:

- promote planned respite as early intervention and prevention support for carers;
- work in partnership with carers, carer recipients and family members to plan appropriate options;
- refer and broker appropriate options according to agreed plans or as required;
- refer and broker appropriate emergency respite options; and
- share tools and expertise in carer assessment needs.

3.10 What will be funded

Service providers are funded to develop and deliver new innovative and flexible respite services and/or expand on existing respite services targeted at meeting the needs of the MHRP target groups. Some examples of possible respite models may consist of, but are not limited to:

- **Centre-based** Multiple care recipients with similar care needs are engaged in supervised activities in a building leased/owned by the service;
- **In-home** Respite care is provided in the carer/care recipient's house;
- **Host Family** Care recipient or group of care recipients are cared for in the home of a (paid or unpaid) respite worker;
- **Flexible Respite** Services that offer any combination of own home and host family/peer support respite;
- **Cottage day/or Overnight** Several care recipients with similar care needs are cared for in a building leased/owned by the service that simulates a home-like environment;
- **Recreational** Services focussing on the care recipient being involved in community activities including one-on-one respite;
- **Peer Support (Recipient)** Peer run mental health and/or intellectual disability initiatives providing respite services for people with mental illness and/or intellectual disability;
- **Peer Support (Carer)** Peer run mental health and/or intellectual disability initiatives providing support to carers;

- **Troopie Van** Responsive respite service that provides respite without sending the care recipient out of their family. A vehicle & camping equipment is loaned to remote communities to enable them to provide bush respite for care recipients;

- **Care Recipients camps** Holiday Care which runs for two or more days and provides care recipients with a positive experience in a supportive environment; and

- **Education / Training** Specific projects funded to provide education/training to carers of people with a mental illness and/or intellectual disability to help them to maintain their caring role.

3.10.1 Allowable NRDF funding uses

The NRDF is intended to assist service providers to establish new or expand existing respite services as well as building the capacity and viability of the services. It is expected that funded service providers will work towards long-term viability and organisational capacity.

However, smaller and new providers will need time and funding to establish themselves and develop and maintain viability. They will achieve this by developing strong community partnerships and links and increasing awareness of respite services. There is also a need to improve workforce capacity through training and education programs to ensure long term viability in the sector.

Funding under the NRDF is made available for the following:

- staff expenses (including training and salaries for staff employed to establish the service, manage the project and deliver the service);
- carer and care recipient activities, including 'Carer Needs Assessments';
- premises for the service (rent, contribution to mortgage payments, insurance cleaning, maintenance and repairs of buildings and grounds, other property expenses);
- materials and equipment related to the implementation and delivery of the service;
- operating expenses of the service such as office materials, utilities, office equipment, stationery, telephones, bookkeeping, FaHCSIA reporting requirement, vehicle leases[12] (including internal vehicle arrangements[13]);
- travel within Australia for staff development purposes;

[12] Prior to entering into a vehicle lease arrangement of greater than $5,000, service providers must submit an application and obtain written approval from the NRDF Program Manager. The application must include details of the proposed arrangement, including registration, insurance and licensing requirements (Appendix C – Vehicle Leasing Approval).

[13] Internal Vehicle Arrangements are when an organisation purchases a vehicle from other funding sources and attributes costs for its use to a particular program, such as NRDF through an internal cost attribution process. Prior to entering into an internal vehicle arrangement of greater than $5,000 service providers must submit an application and obtain written approval from the NRDF Program Manager confirming that NRDF program funding has not been used to purchase the vehicle (See Appendix D for Internal Cost Attribution Approval Form).

- marketing of respite places (developing strong links with Centres, community and clinical services);
- expenses involved in conducting formal and informal evaluation of the service; and
- support workers training (building workforce capabilities).

3.10.2 Unacceptable Funding Uses

Funding is not provided for the following categories of costs:

- capital costs (buildings);
- as a substitute or supplement for funding already provided by the Australian, state and territory governments or the agencies for the service;
- overseas travel; and
- retrospective costs, including costs incurred in the preparation of the application.

3.11 Service Requirements – Delivering the NRDF Component

3.11.1 Management and Administration

Service providers need to ensure that the NRDF component is delivered according to the Guidelines and specifications of the Funding Agreement.

Service providers are required to undertake all activities relating to the management, administration and delivery of the NRDF. This includes ensuring that:

- appropriate governance structures, policies and processes are in place to support the NRDF component of the Program delivery;
- key management and staffing roles are functional and appropriate to service requirements;
- performance monitoring and reporting meets NRDF requirement; and
- legal responsibilities, risk management policy and quality standards are met.

3.11.2 Key Roles

Service providers are required to undertake a service development and delivery role by increasing and expanding respite services for carers of people with a severe mental illness/psychiatric disability and carers of people with an intellectual disability.

A FaHCSIA requirement in relation to service development and delivery is that it is consistent with the purpose and objectives of the NRDF Guidelines. However, the focus is specific to the target groups of the NRDF.

Service providers are strongly encouraged, wherever possible, to recruit staff with skills and experience in the mental health area where these are not already available in the organisation.

3.11.3 Carer and Care Recipient Involvement

All services provided to carers under the NRDF must be the result of collaboration with carers and the care recipients to reflect a supportive and holistic approach.

Support carers and provide access to information

- recognise the importance of readily accessible and comprehensive information which facilitates a carer's ability to make informed choices about their caring role;
- help carers gain access to support and assistance, particularly respite care, that is appropriate to their needs and the needs of the care recipient;
- ensure practical advice and support for family carers is an integral part of respite services; and
- promote and publicise the service to ensure hidden carers are aware of the service.

Support service coordination and quality

- provide a clear and dedicated focus on the target groups of the Program in service providers operations and staffing;
- effectively coordinate with other organisations delivering respite services for carers and care recipients;
- ensure a continuous improvement strategy is part of ongoing internal assessments of service performance;
- ensure the respite service is adequately staffed by appropriately trained and skilled care workers;
- ensure services are delivered in a suitable and safe physical environment for the carers and care recipients, including meeting all state, territory and local government regulations such as building and fire safety;
- account for the effective and proper use of public funds; and
- ensure the service represents value for money.

3.12 Volunteer Support

The vast majority of respite for carers is provided informally by other family members or friends. For some carers lower level support or assistance could be provided by an appropriate volunteer carer support program.

If volunteers assist in the provision of services to carers and care recipients, they must also provide that service at the same high quality expected of paid staff. To facilitate this, volunteers need a clear description of their tasks (preferably in writing), appropriate training opportunities, insurance coverage, and access to allowances to cover basic expenses such as travel costs. It is also acceptable to pay the travel costs of family members to provide alternate care while the carer takes a break. However, family members and volunteers are not paid for providing care. Volunteers should have access to staff for support, supervision and skill development.

Peer support programs in the mental health field may also be considered where appropriate to levels of care required.

3.13 Information technology

Funded service providers are expected to ensure they have information technology systems in place that allow them to meet their data collection and reporting obligations.

4 Responsibilities and accountabilities under the Program (Clause 3)

The following is a summary of the responsibilities and obligations of FaHCSIA and service providers in respect to the MHRP.

4.1 FAHCSIA Responsibility

FaHCSIA National Office is responsible and accountable for activities relating to the development, implementation and the management of the MHRP including:

- developing and establishing the Program;
- promoting the Program at the national level;
- approval of funding and offer/agreement of funding;
- Program risk, Program profile and Program logic development;
- negotiation and population of Funding Agreement schedules and work plan;
- on-going management of Funding Agreement, including the monitoring of service provision;
- payment of funds and monitoring of expenditure including acquittals;
- risk assessment and management;
- Program review and evaluations;
- national stakeholder, relationship and issues management; and
- reporting to the Australian Government on provider performance and Program performance.

FaHCSIA state and territory offices will support implementation by providing:

- input to the development and establishment of the Program when required;
- feedback to National Office on perceived implementation issues; and
- state-based stakeholder, relationship and issues management.

4.2 Service Provider Responsibility

Funded service providers under the NRDF are responsible and accountable for:

- providing and delivering quality services which are effective, efficient, and appropriately targeted;
- reporting in the appropriate format outlined in the Funding Agreement;
- working collaboratively with relevant Centres, service providers and stakeholders;
- contributing to the overall development and improvement of the Program;
- complying with all relevant Australian Government, State/Territory and Local Government legislation, including any relevant Program specific legislation;
- adhering to the terms and conditions of the Funding Agreement;
- meeting the obligations and accountabilities stated in the Funding Agreement;
- meeting privacy and confidentiality obligations including record keeping;
- providing a complaints handling mechanism;
- conducting the service consistent with any Code of Conduct duty of care policies relevant service quality standards that may apply to the Program; and
- informing FaHCSIA promptly of issues or events that may significantly impact on delivery of the Program or the reputation of the Program.

5 Performance Management and Evaluation

5.1 Process Outcomes

Process outcomes inform how well the Program is operating. These are measured at the service provision level and include, for example:

- improved access to respite for cares of people with a mental illness/psychiatric disability and intellectual disability, and
- increased responsiveness of respite service providers to the needs of carers with a mental illness/psychiatric disability and intellectual disability

5.2 Reports

Service providers are required to submit reports containing financial and appraisal information. Reports are due on the dates specified in the Schedule to the Funding Agreement.

Report	**Content**
Establishment Plan and Annual Budget	As per FaHCSIA template
Annual Budget	As per FaHCSIA template
Progress Report	As per FaHCSIA template

Annual Audited Financial Acquittal Report	As set out in clause 7.4(a) (i) of the Funding Agreement Terms and Conditions;
Final Audited Financial Acquittal Report	As set out in clause 7.5 of the Funding Agreement Terms and Conditions

5.2.1 Financial Reports

Service Providers should operate efficiently and in accordance with sound financial and managerial principles and practices in the approved level of funds.

Annual Acquittal of Funds

Service providers must provide an audited Financial Acquittal Report, in accordance with Item E2 of the Schedule to the NRDF Funding Agreement, which contains:

- a statement of compliance signed by an authorised officer which sets out whether the funds have been used for the purpose for which it was provided and the conditions of the Funding Agreement have been met; and

- a combined audited Statement of Income and Expenditure and a combined audited Balance Sheet, in respect of the funds from this Program. These audited statements must be prepared in accordance with Australian Accounting Standards and Statements of Accounting.

5.2.2 Performance Reports

Performance will be monitored by FaHCSIA through a range of information detailed in *Item E - Reports* of the Schedule to the Funding Agreement, including Annual budgets and Progress Reports,

5.3 Performance Indicators

FaHCSIA is refining Performance Indicators and will provide them to service providers as soon as they are approved.

5.4 Program Evaluation

An evaluation of the NRDF will be undertaken by FAHCSIA and service providers may be required to provide information for and input into the evaluation.

An evaluation framework will be developed to assess the achievement of outcomes sought by the NRDF. FaHCSIA will advise service providers of details when they become available.

6 Funding Agreement

The Funding Agreement articulates the formal agreement between FaHCSIA and the service provider over the life of the NRDF. The Funding Agreement is a standard FaHCSIA Funding Agreement and the service providers are expected to comply with all the requirements of the Funding Agreement.

The duration of the Funding Agreements for service providers is up to three years.

6.1 Legal status

FaHCSIA staff confirms a service provider is a legal entity before an offer of funding is made. Having a Registered Business number (State legislation) or an Australian Business Number (ABN) for tax purposes is not an indication of a legal entity.

6.2 Mandatory Reporting

Each state and territory has legislation on mandatory reporting of sexual, physical and emotional abuse and neglect. The service provider must comply with the relevant legislation in their State or Territory.

6.3 Administration of Funding Agreement

FaHCSIA National Office manages all MHRP funding agreements.

6.4 Storage of Funding Agreements

One hard copy of the signed funding agreement and terms and conditions must be kept stored in a secure place by the Department and by the successful service provider.

6.5 Assets

Assets may be purchased in accordance with Clause 10 and Item I of the funding agreement.

6.6 Insurance Requirements

The Funding Agreement (Clause 17) requires that the service provider has adequate insurance in place and wherever requested, the service provider is required to provide FaHCSIA with a copy of the policies and a certificate of currency.

6.7 Acknowledgement and Publications

The Funding Agreement requires service providers to acknowledge any financial and other support received from the Australian Government in all publications, promotional materials and activities relating to their work under the Funding Agreement. An acceptable format for publications such as booklets, pamphlets or posters is:

> '"An Australian Government initiative".

7 Privacy and Confidentiality

7.1 Privacy and Confidentiality

All NRDF team members, including paid and volunteer members and subcontractors, are required to sign a deed of confidentiality on commencement with the program (see Attachment C for the confidentiality deed). Service providers are to keep all signed confidentiality deeds in a secure location and these are to be made available to FaHCSIA upon request.

Confidentiality Deeds cover all records and information service providers collect for the funded project that contain the personal details, medical histories and any other personal information of the participants in the project.

Detailed information is provided in the Funding Agreement Terms and Conditions

7.2 Freedom of Information

The Freedom of Information Act 1982 (the FOI Act) gives the public the right to access information in the possession of the Department with certain limited exceptions. Information collected or held by the Department must be made available on request, unless exempted under the relevant provision of the Act or under specific legislation that provides for the confidentiality of that information. The Department has a statutory obligation to observe the FOI Act and must help all applicants make a valid application under the Act.

The Department will observe strict time frames when acknowledging and responding to requests made for access to documents under the FOI Act. Any application for access to documents under the FOI Act must be made by letter or statement, or (where available) by completing a form.

7.3 Security of Information

Service providers are required to store records in a secure place and dispose of them in an appropriate manner. Service providers should retain a copy of all reports; records or account books in original form for at least 5 years following the expiry or termination of the Funding Agreement.

8 Complaints

8.1 Service provider

Complaints will be dealt with under the FaHCSIA Complaints Management System. The Complaints Management System ensures that any problems with FaHCSIA's services, decisions or policies, and those of FaHCSIA funded service providers, are taken seriously and dealt with promptly.

For the NRDF the initial contact person is:

Section Manager
Program Management Section
Mental Health Branch, TOP CE2
PO Box 7576
Canberra Mail Centre ACT 2610

If you still feel this has not been successful, and your issue or complaint has not been resolved satisfactorily then you will need to contact a FaHCSIA Complaints Officer on 1800 634 035. They will work with you to satisfactorily resolve the complaint or suggest further action if appropriate.

For more information please see:
http://www.fahcsia.gov.au/internet/facsinternet.nsf/aboutfacs/complaints_management.htm

If the Service Provider is dissatisfied at any time with the Department's handling of their complaint, they can also contact the Commonwealth Ombudsman at www.ombudsman.gov.au.

8.2 Complaints – clients/customers

FaHCSIA requires service providers to have effective complaints handling mechanisms in place and to ensure carers are aware of them. Services should ensure that all carers receive and are assisted to understand written and other appropriate information about the role and responsibilities of the manager and other staff (including volunteer staff), their rights as carers and the complaints or problem solving mechanisms available to them. The service provider should handle any complaints fairly, promptly and confidentially and without retribution. Records of complaints received and the process used to resolve them should be kept and appropriate details forwarded to FaHCSIA as part of routine reporting requirements.

The service provider's complaints policy should include information on:

- how service providers deal with complaints;
- what standards and written policies providers have in place; and
- what practices providers have in place including privacy measures, monitoring and reporting.

The System should record all complaints verbal, written and electronic, for example:

- complaint accepted and received recorded;
- who took the complaint;
- nature of the complaint;
- name and details of complainant (if supplied);
- how the complaint was/will be handled, by whom and when;
- generate acknowledgment of complaint within two days of receipt;
- refer complaint to appropriate National Office Branch or STO or agency where necessary; and
- follow up flag if complaint not resolved within specified time frame.

9 Contact Information

For further information please contact:

Jean Krystyn

Section Manager

Program Management Section

Mental Health Branch

Department of Families, Housing, Community Services and Indigenous Affairs

Box 7576

CANBERRA MAIL CENTRE ACT 2610

Natalee Gersbach

Assistant Section Manager

Program Management Section

Mental Health Branch

Department of Families, Housing, Community Services and Indigenous Affairs

Box 7576

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Wendy Walsh

Acting Assistant Section Manager

Program Management Section

Mental Health Branch

Department of Families, Housing Community Services and Indigenous Affairs

Box 7576

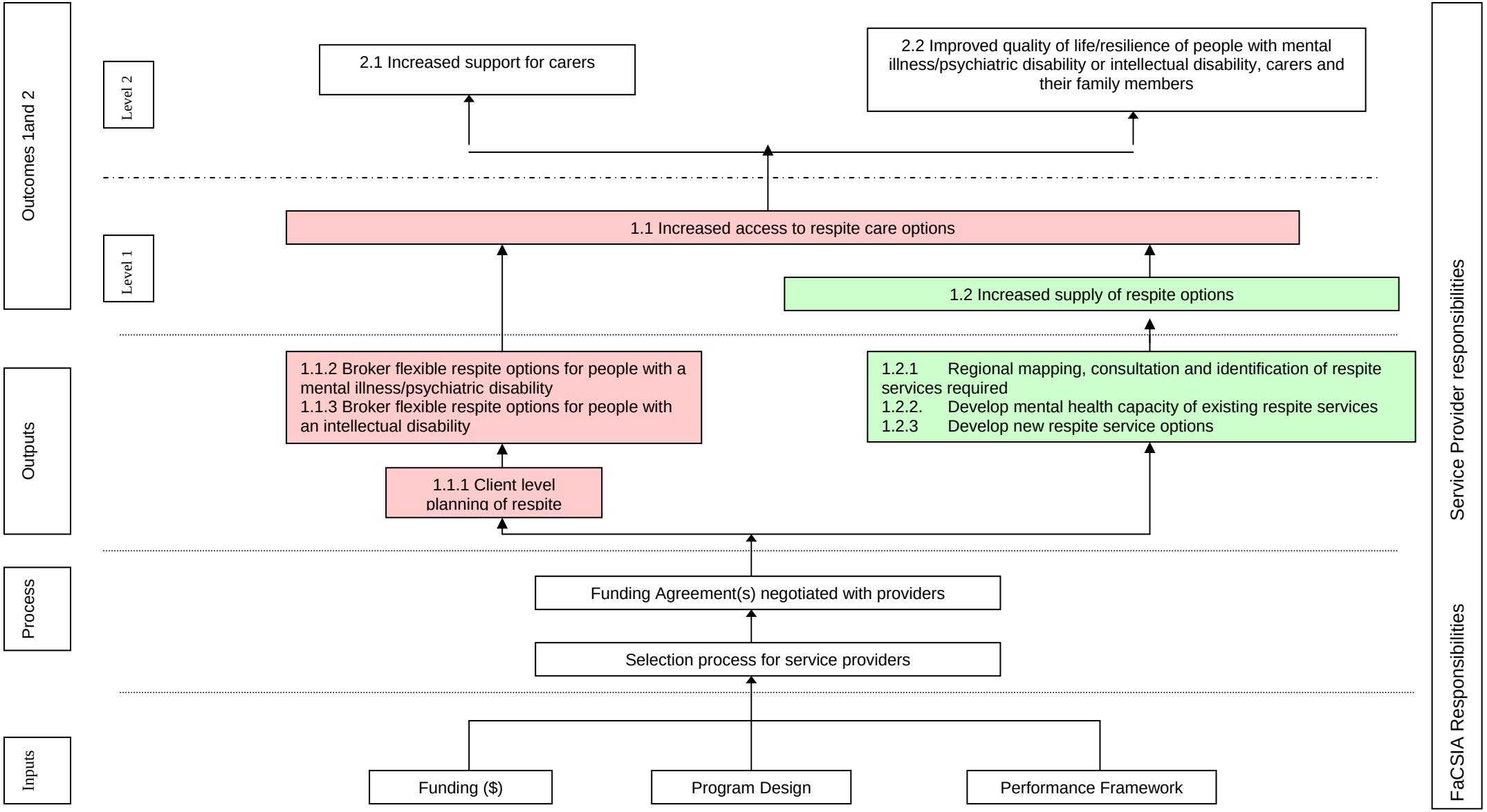
CANBERRA MAIL CENTRE ACT 2610

Ph: 1800 688 249
Fax: 02 6244 8457
Website: www.fahcsia.gov.au
Email: mentalhealth@fahcsia.gov.au

10 Appendices

10.1 Appendix A – Mental Health Respite Program Logic

Mental Health Respite Program Logic



10.2 Appendix B – CARER ASSESSMENT FRAMEWORK FOR NRDF SERVICE PROVIDERS

Carers are the principal focus of the MHRP. Appropriate carer needs assessments must be conducted to determine the level of assistance and support required by the carer.

The MHRP has specific eligibility criteria and access priorities for carers wishing to access the program. Before conducting a carer or a care recipient need assessment, the eligibility and priority requirements to access the program must be established. The prerequisites to access the Program are in Section 3.7 of the Program Guidelines.

Service providers must undertake an assessment of the carer and care recipient's needs for all carers not referred by Centres. Carers and care recipients should be involved in decisions and be included in the selection of suitable respite options.

Service providers may choose to undertake the formal assessments or they may rely on other appropriately skilled agencies including Centres to conduct assessments on a fee for service basis.

Assessment criteria and processes must ensure that the carer's and care recipient's total circumstances are taken into account, that consumer rights, including privacy, are recognised and protected, that duplication of assessment is avoided and that effective review processes are in place.

MHRP Core Principles
The following core principles must be considered when conducting assessments:

- **partnerships** between the carer, the care recipient and the service provider in the planning and delivering services;
- **flexibility and choice** for carers in the design and delivery and tailored to the individual requirements of the carer, the care recipient and their family;
- **appropriateness of services** – targeted at the level of care identified to meet the needs of the carer and the care recipient with the focus on providing meaningful activities for the care recipient including culturally appropriate models where possible;
- **accessibility and equity** ensuring that people in the target groups have information to enable them to access the Program regardless of where they live or their level of income. Services should be delivered on the basis of fair treatment to clients who are eligible to receive them;
- **quality of service** – respite services must meet specific standards in quality, including legislative requirements;
- **safety** – the activities and environment of the service are safe for consumers, carers, families, staff and the community;
- **privacy and confidentiality** – the service ensures the privacy and confidentiality of carers and care recipients.

Assessment Framework
The following information provides a framework for the assessment of relative need for services and should take into account the needs and circumstances of the carer and the caring relationship:

- the carer's own physical and mental health status;
- the availability of other informal support to the carer, such as family members, friends or volunteer groups;
- the availability and use of other services to support the carer and/or care recipient, for example home help, mental health services or disability support services;
- the carer's study and work load demands;
- other demands on the carer, such as other family responsibilities;
- the number of people cared for; and
- the presence or extent of the care recipient's challenging behaviours.

Care Plans
The intent of the MHRP is to promote and develop a planned approach to respite. This involves both the carer and care recipient in discussions about their needs, interests and care requirements.

These discussions should lead to developing both a carer and care recipient plan. They may be separate care plans or incorporated into one plan. These plans should be confirmed in writing and reviewed at least every 12 months.

Service providers are encouraged to take innovative approaches to service provision. Whenever set backs or problems are encountered, service providers should review, re-plan and continue to provide appropriate services.

Reviews
Service providers must review care plans at least every 12 months to meet the changing needs of carers and care recipients. The review process may require service providers to refer carers to other services which may be more appropriate to the changing needs of the carer or care recipient.

Referral to other support services
Respite is one of a range of services provided by a network of providers designed to support carers in maintaining their caring role of people with a mental illness or intellectual disability. Carers should be referred to other service types where appropriate. In particular, a close collaboration between services funded under the NRDF and the network of regional Centres is required. This is especially so in respect of emergency or unplanned short-term respite access and other carer supports in the community.

Carer Fees
Carers or care recipients may be asked to contribute to the cost of the service based on their ability to pay. However, no carer is to be refused the service or

disadvantaged because of their inability to contribute. Neither should they be caused financial hardship as a result of the charge.

10.3 - Appendix C – External Vehicle Leasing Approval Form

National Respite Development Fund
Vehicle Leasing Approval Form

Organisation:
HACC Region and State:
Organisation Contact Name and Phone Number:

Lease Company	
Number of Vehicles	
Make and Model of Vehicles	
Lease Period	
Lease Amount	
Insurance Policy Details	

Organisation Delegate Approval:

_____

Date: _____

_____

FaHCSIA Delegate Approval:

_____

Date: _____

10.4 Appendix D – Internal Vehicle Leasing Form Approval Form

Mental Health Respite Program – National Respite Development Fund
Internal Cost Attribution Approval Form

Organisation:

HACC:

Organisation Contact Name and Phone Number:

I confirm that MHRP program funding has not been used to purchase a vehicle for the purposes of internal cost attribution arrangements.

***Note: The table below only needs to be completed if the cost attribution value is greater than $5,000**

Number of Vehicles	
Make and Model of Vehicles	
Cost Attribution Period	
Cost Attribution Amount	
Insurance Policy Details	

_____ _____

Service Provider's signature **Date**

FaHCSIA Delegate Approval:

_____

Date: _____

Glossary

Accessibility refers to the Australian Government policy that is aimed at ensuring that government services:

- are available to everyone who is entitled to them;
- are free of discrimination and irrespective of a person's country of birth, language, gender, disability, culture, race or religion; and
- take in to consideration the needs and differences of program participants.

Annual Budget refers to the budget which service providers will provide to the Department on an annual basis.

Annual Plan refers to the document which the service providers will outline their proposed approaches for each year of funding.

Asset means any item of personal, real or intangible property, with a price or value of $5,000 or more, inclusive of GST, and which has been created, acquired or leased wholly or in part with the Funding, except Intellectual Property Rights (IPR) and licences provided for in Clause 13 of funding agreement.

Audit is an examination and verification of the accounts, records, procedures etc. of a service provider, conducted by a registered independent auditor, accountant, or official.

Auditor means a person who is either:

- a registered company auditor under the Corporations Act 2001;
- a Certified Practicing Accountant;
- a member of the National Institute of Accountants; or
- a member of the Institute of Chartered Accountants.

but who is not a principal, member, shareholder, officer or employee of You, or of a Related Body Corporate of You within the meaning of that term as given in the *Corporations Act 2001.*

Brokerage is when a Commonwealth Respite and Carelink Centre pays for the services or goods of another organisation to assist a program participant with particular needs.

CALD means the individuals or groups from culturally and linguistically diverse backgrounds.

Capacity refers to the ability to perform a task.

Care Recipient refers to the person with a severe mental illness/psychiatric disability and intellectual disability who relies on the daily support of a carer to live in the community.

Carer is defined as a person such as a family member, friend or neighbour, who provides regular or sustained care and assistance to another person without payment for their caring role other than a pension or benefit. The focus of the Mental Health Respite

Program is on supporting the primary carer, defined as the person who provides the most informal assistance to the care recipient.

The assistance given/needed has to be ongoing, or likely to be ongoing for at least six months and be provided for 'everyday types of activities' including a care-coordination role, to a person from one or more of the Mental Health Respite Program target groups.

FaHCSIA's position is that a carer who qualifies for Carer Payment and/or Carer Allowance qualifies for carer respite on a needs basis, as they have been assessed as providing substantial levels of care with basic activities of daily living, every day, to a person who requires care for six months or more.

The definition of carer excludes formal care services such as care or assistance provided by paid workers or volunteers arranged by formal services.

Carer Support includes activities such as carer peer support initiatives providing support to carers and education and training projects providing education and training specifically tailored for the target group

Centre refers to the Commonweatlh Respite and Carelink Centres which is a component of the National Respite Program and is being implemented as a brokerage model enabling carers, the care recipient and their families to have the maximum choice and flexibility to their special needs.

Child/Children is defined for the purpose of this program as a male or female aged between 0 to 15 years.

Challenging Behaviours means the type of behaviour exhibited is aggressive, disruptive, agitated or offensive (including inappropriate sexual behaviour).

COAG is the Council of Australian Governments

Coping Skills/Strategies is the methods a person uses to deal with stressful situations. These may help a person face a situation, take action, and be flexible and persistent in solving problems.

Core Activity Limitation - four levels of core activity limitation are determined based on whether a person needs help, has difficulty, or uses aids or equipment with any core activities. Core activities are communication, mobility and self care. A person's overall level of core activity limitation is determined by their level of limitation in these activities.

Core activity limitation may be mild, moderate, severe or profound:

Mild:	having no difficulty performing a core activity but using aids or equipment because of disability;
Moderate:	not needing assistance, but having difficulty performing a core activity;
Severe:	sometimes needing assistance to perform a core activity; and
Profound:	unable to perform a core activity or always needing assistance.

Incidence of severe and profound core activity limitation is considered to be the most accurate indicator of need for formal and informal support services.

Cultural Diversity is accepting and encouraging a diversity of cultures and adapting services appropriately.

Department means the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

Direct respite services provide the carer with quality **alternative or supplementary** care for the person for whom they are the primary carer. Alternative care may be provided in the home, suitable temporary accommodation or an appropriate community setting.

DoHA means the Australian Government Department of Health and Ageing

Duty of Care is the obligation owed to anyone whom it is reasonably foreseeable would be injured or negatively affected by the lack of care for that person. For a duty of care to arise, there must exist a relationship of proximity between the person or body owing the duty and the person or body to whom the duty is owed. The duty of care may be owed by and to auspice bodies, service providers and program participants.

Early Intervention means timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental illness. Early intervention also encompasses the early identification of people suffering from a mental illness.

Effectiveness (Evaluation) is the extent to which program outcomes achieve the stated Program objectives or the extent to which actual outcomes match planned outcomes.

Efficiency (Evaluations) is the extent to which the processes (activities/strategies/operations) used to produce the outputs of the Program represents value-for-money.

Eligible Service Provider refers to the organisation eligible to apply for funding under the National Respite Development Fund an applicant MUST be a non-government organisation (NGO). Applicants must also be a legal entity and able to confirm their legal status.

FaHCSIA will only contract with individual providers. Applicants may determine that efficient or effective service delivery is best achieved through the use of a network of providers through a sub-contracting arrangement. A successful provider who utilises an authorised sub-contracting arrangement will be held liable for all obligations contained in the terms and conditions of the Funding Agreement. This includes monitoring, management, financial performance, service outcomes, and specifically insurance coverage.

Emergency Respite Care means unplanned respite care.

Evaluation is a systematic objective assessment of the appropriateness, effectiveness or efficiency of a program and/or part of a program.

FaHCSIA means the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

Flexible refers to the design and service delivery which will be tailored to the individual requirements of the carers, the care recipient, and their family.

Funding Agreement is the legal contract between FaHCSIA and the service provider that outlines service delivery, accountability and reporting requirements.

Funding Period is the period of time between the commencement date and the completion date of a project/service.

Holistic Approach is an approach to providing services that encompasses and accounts for interrelationships among whole systems, or the 'whole person' rather than focussing on parts of those systems. A holistic approach considers all the properties of a given system e.g. biological, physical, social, economic, and psychological.

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

Indirect Respite Services provide the carer with assistance and support, which provides a *respite effect,* such as carer retreats, carer education, counselling, gym membership or a couple of nights in a motel to catch up on sleep etc, or services which relieve the carer of tasks other than the caring role, e.g. provision of a shopping or cleaning service, maintenance etc.

Innovative refers to new and original ways of delivering respite services.

Intellectual Disability is associated with impairment of intellectual functions in a range of daily activities with limitations in a range of daily activities and restrictions in participation in various life areas. Support may be needed throughout life, the levels of support tending to be consistent over a period of time but may change in association with changes in life circumstances (AIHW).

Mental Health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life.

Mental Illness/Psychiatric Disability is associated with clinically recognisable symptoms and behaviour patterns, frequently associated with distress that may impair personal functioning in normal social activity. Impairments of global or specific mental functions may be experienced, with associated activity limitation and participation restrictions in various areas. The support needed by the care recipient may vary in

range and intensity during the course of the condition. Changes in the level of support tend to be related to changes in the extent of the impairment or in the environment.

Non-qualifying 'conditions' for the purposes of the MHRP are conditions which are not regarded as mental illness/psychiatric disability or intellectual disability. If the care recipient has a dual diagnosis which includes mental illness/psychiatric disability or intellectual disability (not Acquired Brain Injury) they may qualify their carer for the MHRP. Non-qualifying 'conditions' include:

- **Acquired Brain Injury** arising from damage to the brain acquired after birth. It results in deterioration in cognitive, physical, emotional or independent functioning which is the result of an accident, stroke, brain tumour, infection, poisoning (including substance abuse), lack of oxygen, degenerative neurological disease etc;
- **Neurological** conditions which apply to impairments of the nervous system occurring after birth, including epilepsy and organic dementias (e.g. Alzheimer's disease) as well as such conditions as multiple sclerosis and Parkinson's; and
- **Physical Disability**.

Not for profit means an organisation where any profits generated are returned to further the work of the organisation, and not paid out to individuals or shareholders.

NRDF means the National Respite Development Fund

Peer Support is about having intentional relationships with others in ways that promote growth, recovery, and wellness. They are relationships built on trust and respect, because each person understands where the other is coming from.

Performance Indicators are a set of measurements designed to measure outputs and outcomes. Performance indicators can be made up of price, quantity, quality and, depending on delivery, funding criteria.

Planned Respite refers to providing planned opportunities for the carer to take a break and the care recipient to participate in activities with a positive benefit. Planned respite requires an approach that builds relationships with carers to identify respite and other support needs and to work with the carer and the care recipient to identify and plan suitable respite options that are beneficial to the carer and the person for whom they care.

Prevention is interventions that occur before the initial onset of a disorder.

Primary Carer is defined as the person who provides the most informal assistance to the care recipient.

Program Logic is an analytical tool which illustrates the way in which the Program operates by describing the relationship between inputs, processes, outputs and outcomes of the Program. A program logic model maps the cause and effect relationships between program activities (or processes) and the outcomes they should produce.

Relative Carer Need refers to assessments of relative carer need which will be done by Commonwealth Respite and Carelink Centres (Centres) and / or NRDF service providers to determine priority of access.

Respite Care is defined as an alternative or supplementary care arrangement with the primary purpose of giving the carer a short-term break from their usual caring role and/or assistance with the performance of their caring role on a short term basis.

Service Delivery is the activities undertaken by a service provider.

Service Provider means a person or organisation that provides respite care services for carers of persons with disabilities at a professional level.

Severe and Profound should be interpreted in line with *the Disability, Ageing and Carers Survey 2003 (Australian Bureau of Statistics).* The Disability, Ageing and Carers Survey reports on the level of assistance required by people in relation to three core activities which are considered to underlie all aspects of everyday life: self care, mobility; and communication.

A person with a severe limitation in core activities sometimes requires assistance to perform a core activity, while a person with a profound restriction is unable to perform a core activity or always requires assistance to perform a core activity.

Incidence of severe and profound core activity limitation is considered to be the most accurate indicator of need for formal and informal support services.

Unplanned Respite refers to the need for emergency care by an alternate carer for a care recipient because the usual carer cannot provide that care due to illness, misadventure, death or other unforeseen circumstances

Young People is defined for the purpose of this program as a male or female aged between 16 to 24 years.

Viability refers to the feasibility of the project.