

|  |
| --- |
| Practice guidelines  National Disability Insurance Scheme and mainstream services interface |
|  |

|  |
| --- |
|  |
| To receive this publication in an accessible format [email Edwina Mason](mailto:Edwina.mason@dhhs.vic.gov.au) <Edwina.mason@dhhs.vic.gov.au>  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.  © State of Victoria, Department of Health and Human Services June 2018.  Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.  ISBN 978-1-76069-435-7 (pdf/online/MS word)  Available at [Practice guidelines – NDIS and mainstream services](http://providers.dhhs.vic.gov.au/practice-guidelines-ndis-and-mainstream-services) <http://providers.dhhs.vic.gov.au/practice-guidelines-ndis-and-mainstream-services> |
|  |

Contents

[Context 4](#_Toc516837306)

[Principles for the interaction between the NDIS and mainstream services 4](#_Toc516837307)

[Applied principles and tables of support 4](#_Toc516837308)

[NDIS online resources 5](#_Toc516837309)

[Health and aged care 6](#_Toc516837310)

[Circumstance 1–Supporting NDIS access pathway 6](#_Toc516837311)

[Circumstance 2–Supporting NDIS planning for a new participant 8](#_Toc516837312)

[Circumstance 3–Coordinating health care and disability supports (existing NDIS participant) 10](#_Toc516837313)

[Circumstance 4–Changes in circumstances and/or functioning (existing NDIS participant) 12](#_Toc516837314)

[Circumstance 5–Hospital discharge planning (potential NDIS participant) 13](#_Toc516837315)

[Circumstance 6–Hospital discharge planning (existing NDIS participant) 15](#_Toc516837316)

[Circumstance 7–Urgent - time critical - responses (existing NDIS participant) 16](#_Toc516837317)

[Children youth and families 18](#_Toc516837318)

[Circumstance 1–Risk of carer breakdown (child is a potential NDIS participant) 18](#_Toc516837319)

[Circumstance 2–Risk of carer breakdown (child is an existing NDIS participant) 20](#_Toc516837320)

[Circumstance 3–Immediate response to parent/carer breakdown (child is a potential NDIS participant) 22](#_Toc516837321)

[Circumstance 4–Immediate response to parent/carer breakdown (child is an existing NDIS participant) 23](#_Toc516837322)

[Circumstance 5–Reunification (child is an existing NDIS participant) 25](#_Toc516837323)

[Circumstance 6–Leaving care (child is an existing NDIS participant) 27](#_Toc516837324)

[Circumstance 7–Family violence crisis situation (child is an existing NDIS participant) 29](#_Toc516837325)

[Specialist clinical mental health services 31](#_Toc516837326)

[Circumstance 1–Supporting NDIS access 31](#_Toc516837327)

[Circumstance 2–Supporting development of consumer’s first NDIS plan 34](#_Toc516837328)

[Circumstance 3–Supporting NDIS plan implementation 36](#_Toc516837329)

[Circumstance 4–Discharge planning (potential NDIS participant) 38](#_Toc516837330)

[Circumstance 5–Discharge planning (existing NDIS participant) 40](#_Toc516837331)

[Circumstance 6–Change in circumstances and/or functioning (existing NDIS participant) 42](#_Toc516837332)

# Context

All governments have agreed that our vision is for an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens. To achieve this vision, all Australian governments, non-government organisations, business and the wider community have a role to play.

The interactions of the National Disability Insurance Scheme (NDIS) with other service systems will reinforce the obligations of other service delivery systems to improve the lives of people with disability, in line with the National Disability Strategy.

## Principles for the interaction between the NDIS and mainstream services

* People with disability have the same right of access to services as all Australians, consistent with the goals of the National Disability Strategy, which aims to maximise the potential and participation of people with disability.
* The NDIS will fund personalised supports related to people’s disability support needs, unless those supports are part of another service system’s universal service obligation (for example, meeting the health, education, housing, or safety needs of all Australians) or covered by reasonable adjustment (as required under the *Commonwealth Disability Discrimination Act 1992* or similar legislation in jurisdictions).
* Clear funding and delivery responsibilities should provide for the transparency and integrity of government appropriations consistent with their agreed policy goals.
* There should be a nationally consistent approach to the supports funded by the NDIS and the basis on which the NDIS engages with other systems, noting that because there will be variation in non-NDIS supports funded within jurisdictions there will need to be flexibility and innovation in the way the NDIS funds and/or delivers these activities.
* In determining the approach to the supports funded by the NDIS and other service systems governments will have regard to efficiency, the existing statutory responsibilities and policy objectives of other service systems and operational implications.
* The interactions of people with disability with the NDIS and other service systems should be as seamless as possible, where integrated planning and coordinated supports, referrals and transitions are promoted, supported by a no wrong door approach.

## Applied principles and tables of support

In addition to the six general principles, applied principles have been developed in a range of other service systems to assist governments to further define the funding responsibilities during the launch of the NDIS. See [Principles to determine the responsibilities of the NDIS and other service systems](https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-11-december-2015) <https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-11-december-2015> attached to Council of Australian Governments Meeting Communiqué, 11 December 2015.

The purpose of the Applied Principles and Tables of Support is to define the activities funded by the NDIS and other systems and it does not intend to place additional obligations on other systems. Applied principles and more detailed tables of funding responsibilities have been developed for:

* health and aged care
* children youth and families
* mental health.

## NDIS online resources

This information does not replace existing practice instructions and is designed to be read in conjunction with:

* [NDIS Supports for Participant’s Plans Rule 2013](https://www.legislation.gov.au/Details/F2013L01063)  
  <https://www.legislation.gov.au/Details/F2013L01063>
* [NDIS Operational Guideline – Access](https://www.ndis.gov.au/operational-guideline/access)   
  <https://www.ndis.gov.au/operational-guideline/access>
* [NDIS Operational Guideline – Planning](https://www.ndis.gov.au/operational-guideline/planning.html)  
  <https://www.ndis.gov.au/operational-guideline/planning.html>
* [NDIS Operational Guideline – Registered Providers](https://www.ndis.gov.au/operational-guideline/registered-providers-sitemap.html)  
  <https://www.ndis.gov.au/operational-guideline/registered-providers-sitemap.html>
* [NDIS Operational Guideline – Review of Decision](https://www.ndis.gov.au/operational-guideline/review-of-decisions-sitemap.html)  
  <https://www.ndis.gov.au/operational-guideline/review-of-decisions-sitemap.html>
* [support for your child](file:///\\N028\group\COSP\NDIS\2.%20Policy%20Coordination%20Unit\2.4%20Mainstream%20System%20Interface\Practice%20Guidelines\PRACTICE%20GUIDELINES%20WEB%20VERSION\Practice%20guidelines%20NDIS%20and%20mainstream%20services%20intrerface.docx)  
  <https://www.ndis.gov.au/ecei.html>

# Health and aged care

This guidance assists health and aged care services to work with the National Disability Insurance Agency (NDIA) and improve outcomes for Victorians with a disability. This information clarifies the roles of the NDIA, local area coordinators (LAC), Early Childhood Early Intervention access (ECEI) partners, support coordinators and Victoria’s health and aged care services and outlines practices that support good outcomes for shared clients.

The groups most likely to have shared involvement with health services, NDIS service providers and the NDIA include, but are not limited to:

1. People who have a newly acquired disability who are likely to meet the NDIS access requirements (disability or early intervention), are nearing completion of the hospital/ rehabilitation phase and, need timely access to the NDIS to gain the supports, services and equipment they need for a safe discharge.
2. People aged under 65 years who have complex disability and health needs living in a range of settings including, but not limited to, residential aged care and shared supported accommodation who need disability supports, for example therapy, community-based nursing, support to access the community, and potentially Specialist Disability Accommodation.
3. Existing NDIS participants who require hospitalisation.
4. People receiving health services who are not likely to meet the NDIS access requirements but will require support from a local area coordinator to link them into mainstream and community services.
5. People accessing allied health, Home and Community Care (HACC) or nursing services in the community and are an NDIS participant or potential NDIS participant.
6. Children who are born with complex disability/health needs who are likely to meet the early childhood intervention requirements and need referral to Early Childhood Early Intervention partners.

## Circumstance 1–Supporting NDIS access pathway

### Definition

Individuals who are not currently in receipt of existing state-funded disability supports, may ask a health service to provide evidence of their disability and functional impairment to support their NDIS access request. The participant provides this supporting documentation along with their NDIS Access Request Form to the National Access Team.

Visit [Accessing the NDIS](https://www.ndis.gov.au/people-disability/access-requirements.html) <https://www.ndis.gov.au/people-disability/access-requirements.html> for more information about the NDIS access process>.

### Context

The NDIS access process involves completing an Access Request Form. Among other things the individual needs to provide:

* their personal details (name, age, residential address etc.)
* medical evidence of the diagnosis of their disability
* information about the impact of their disability on everyday functioning and social and economic participation
* consent for the NDIA to collect and share personal information.

The NDIA has a list of diagnoses that result in permanent impairment and substantially reduced functional capacity. If the person has a condition on this list, written evidence of the diagnosis from a doctor or specialist is sufficient and no further information to support eligibility is required. A list of these conditions is available on the [Providing evidence of your disability page of the NDIS website](https://www.ndis.gov.au/people-with-disability/access-requirements/completing-your-access-request-form/evidence-of-disability) <https://www.ndis.gov.au/people-with-disability/access-requirements/completing-your-access-request-form/evidence-of-disability>.

If the person’s diagnosis is not on this list, evidence of the impact of the condition on the person’s everyday life, including any impact on mobility, communication, social interaction, learning, self-care and self-management will be required.

The NDIA may also request additional information such as existing letters or reports by health professionals. Using the information provided, the NDIA will make a determination within 21 days as to whether or not the individual meets the access requirements.

### Best practice

* Responses to access requests should be timely and recognise the need for prompt access to the NDIS.
* A willingness to be flexible, collaborative and well informed.
* High quality information is provided that aids NDIS decision-making about an individual’s access request.
* Evidence about the impact of the individuals’ impairment should be described in terms of impact on their:
  + - mobility/ motor skills (such as use of transport)
    - communication (such as expressing themselves including their needs and preferences and ability to understand verbal or written information)
    - social interaction (such as controlling emotions, developing and maintaining relationships)
    - learning (such as paying attention and mastering new skills)
    - self-care (such as bathing, eating, caring for health)
    - self-management (such as doing daily jobs, making decisions, handling problems and money).

### Roles and responsibilities

#### Health services

* Identify potential participants early and inform them about the NDIS and the access process. This includes directing them to the access checker on the NDIS website and the national access team (1800 800 110 between 8am–8pm Mon-Fri), and/or the local area coordinator or Early Childhood Early Intervention partner. This [Victoria rollout: Participant information pack](https://www.ndis.gov.au/html/sites/default/files/documents/our-sites/NDIS-Victoria-roll-out-Participant-pack.pdf) <https://www.ndis.gov.au/html/sites/default/files/documents/our-sites/NDIS-Victoria-roll-out-Participant-pack.pdf> may assist.
* Provide timely evidence reports that outline the potential participant’s diagnosis and the functional impact on the person’s everyday life and social and economic participation. Ensure these reports are written in language that a non-clinical person can understand.
* If possible, provide the NDIA with a health service contact to whom they can direct any health-related queries.

#### Early Childhood Early Intervention partner or local area coordinator

* Inform potential participants about the NDIS access process, including the Access Request Form, supporting documentation (if relevant) and details about the national access team (including their contact details and timeframes).
* If required, help the individual and/or their nominee to complete the access checker and the Access Request Form.
* Inform the person of local services and if relevant refer them to relevant mainstream services (on a case-by-case basis).
* Work with health services in their area to support access request process and identify potential participants.

#### National Disability Insurance Agency

* Manage enquiries from potential participants in a timely manner.
  + Enquire if the person is in hospital and discuss where any correspondence should be sent.

Upon receiving a completed Access Request Form, the NDIA:

* Reviews the Access Request Form and any supporting documentation to ascertain if the individual has provided the necessary information. If they have insufficient information the NDIA will contact the individual and request further information. The individual will have at least 28 days to provide the information.
* Determines if the individual meets the NDIS access criteria. The NDIS Act (2013) states this decision should be completed within 21 working days of receiving the necessary information.
* If required, provide updates to the person or their nominated contact about the progress of their access request.
* Notifies the individual within 14 working days if they meet NDIS access criteria.
  + Provides the individual and health service (subject to consent by the individual) with an NDIA contact to whom they can direct any access queries.

## Circumstance 2–Supporting NDIS planning for a new participant

### Definition

An individualised plan is developed for each participant by the NDIA or a local area coordinator/early childhood intervention partner. This plan should clearly state the participant’s goals and the reasonable and necessary supports the NDIA will fund.

### Context

The NDIS planning process consists of a planning conversation between the NDIA planner or local area coordinator/ early childhood intervention partner and the participant. This may involve other parties.

During the planning process, the participant and the NDIA planner or local area coordinator/ early childhood intervention partner discuss:

* the participant’s goals and aspirations – these become the *Participant’s Statement of Goals and Aspirations*
* the supports that are provided by other systems (such as health care, housing, education)
* their informal supports, including family, friends, and community
* the reasonable and necessary supports they need funded by the NDIS to achieve their goals
  + how the participant’s plan will be managed (options include the participant or their nominee managing the funds, the NDIA managing the funds, using a plan manager or a combination of these).

The planning process can occur over more than one meeting.

The plan may be developed by the NDIA, or a local area coordinator. If the participant is a child aged under six, then an Early Childhood Early Intervention partner will complete their plan with their family/guardian.

### What is in a participant’s plan?

The NDIS funds reasonable and necessary supports for participants in accordance with the *NDIS Act 2013.* For a support to be considered reasonable and necessary it must be related to the person’s disability and their goals, be evidence-based and offer value for money. The NDIA also take into account any:

* informal supports already available to the individual (informal arrangements that are part of family life or natural connections with friends and community services)
  + universal obligations and responsibilities of other service sectors such as health, employment, housing and education.

Reasonable and necessary supports will help participants to:

* pursue their goals, objectives and aspirations
* increase their independence
* increase social and economic participation
  + develop their capacity to actively take part in the community.

More information about reasonable and necessary supports can be found on [the NDIS What are reasonable and necessary supports? page](https://www.ndis.gov.au/participants/reasonable-and-necessary-supports) <https://www.ndis.gov.au/participants/reasonable-and-necessary-supports>.

### Best practice

* The planning process upholds the participant’s autonomy and choice and control.
* The participant can invite others to either support them during planning or provide input into their plan.
* The plan can be developed face to face or via telephone – depending on the participant’s preferences.
* Participants are well-informed about the types of supports and services the NDIS funds and what is available via mainstream services.
* Planners/ local area coordinators/Early Childhood Early Intervention partners receive all the information they need to complete a high quality plan.
  + The plan is based on the participant’s goals, needs and preferences and outlines the reasonable and necessary supports they need to live an ordinary life and achieve their goals.

### Roles and responsibilities

#### Health services

* Health services provide tailored pre-planning information and support to the participant. This may include, helping them to understand the process, understanding their goals and outlining the types of supports they are likely to need and whether these are an NDIS or health responsibility. It may also include completing assessments, equipment prescriptions or reports for the participant to provide as part of their planning conversation.
* If the participant chooses to have the health service involved in their plan, the relevant health practitioners participate in the planning conversation.
* Collaborate with the participant, NDIA and local area coordinators/Early Childhood Early Intervention partners to ensure plans are high quality and developed in a timely manner.
* Provide any health/disability related advice and articulate the services that health services will provide.
* Work with the NDIA and its partners to identify the supports and services needed both to address the participant’s immediate needs and their medium to longer term needs.
  + Maintain communication (subject to the participant’s consent) with the NDIA and its partners during the planning process.

#### Early Childhood Early Intervention partner or local area coordinator

* Contact participants to outline the planning process and make arrangements to develop their plan and discuss who they would like (if anyone) involved in their planning process.
* Ensure people have any supports they need (such as advocacy, communication devices) to participate fully in the planning process.
* Ensure the person completing the plan is well informed about the types of supports and equipment that participants with particular conditions may need.
* Seek additional information if needed from health professionals or other agencies.
* Develop the plan in accordance with the NDIA’s operational guidelines and ensure it reflects the information provided by the participant or others in the planning meeting.
  + Submit the plan for approval by the NDIA.

#### National Disability Insurance Agency

* If the plan is being developed by a NDIA planner - contact participants to outline the planning process and make arrangements to develop their plan and discuss who they would like (if anyone) involved in the planning process.
* Develop the plan in accordance with the NDIA’s operational guidelines.
* Approve the participant’s plan.

## Circumstance 3–Coordinating health care and disability supports (existing NDIS participant)

### Definition

An NDIS participant with complex health and disability needs requires well-coordinated services from the disability and health system. They may also have involvement from other agencies (such as education or justice).

### Best practice

* Be flexible and committed to an integrated, seamless and coordinated care and support approach.
* Ensure there is a clear understanding of each party’s roles and responsibilities in regard to this participant.
* Ensure timely and appropriate support and care is provided by the NDIS, health and aged care service systems.
* Ensure sound collaboration between the participant and their local area coordinator /Early Childhood Early Intervention partner, NDIS providers (including NDIS funded support coordination where applicable), health providers and any other agencies.
* Hold regular meetings (subject to the participant’s consent) with the participant and the parties involved.
* Develop a mutually agreed plan for how the parties will respond if there is a deterioration in the participant’s functioning or if a crisis or emergency occurs.
* Communicate effectively and in a timely manner.
* Uphold the participant’s choice and control over their supports and services.

### Roles and responsibilities

#### Health services

* Provide the agreed health related treatments and services.
* Collaborate and share relevant information with other parties (subject to the participant’s consent and operating within relevant privacy laws).
  + Inform the NDIA if the participant’s functioning significantly deteriorates or their circumstances change.

#### Early Childhood Early Intervention partner or local area coordinator

* Maintain contact with the participant and review their progress.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the environment.
* If the situation is complex and the participant doesn’t already have support coordination funding, request the NDIA to conduct an emergency plan review and recommend that this participant requires support coordination.
  + Refer the participant to their local health service if any concerns for the participant’s health status or wellbeing arise.

#### Support coordinator (if this service is funded in the participant’s plan)

* Assist the participant to establish, coordinate and maintain the services and supports they need -this may include establishing service agreements with NDIS providers and linking the participant to mainstream and community services.
* Maintain contact with the participant and review their progress.
* Coordinate meetings with the participant and relevant parties (including health providers) to discuss progress and any issues that may emerge in relation to their functioning, circumstances or supports and services.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
  + Refer the participant to their local health service if any concerns for the participant’s health status or wellbeing arise.

#### National Disability Insurance Agency

* Ensure the plans of people with complex disability and health needs or multiagency involvement include sufficient funding for support coordination.
* Ensure the participant’s plan is managed in accordance with their preferences and funds are available to pay providers in a timely manner.
* Ensure the market is diverse and well-developed to promote participant’s choice over who provides their supports.
* Ensure NDIS providers meet any required registration and quality and safety standards, especially for vulnerable participants.
* Undertake regular scheduled plan reviews in a timely manner.
* Respond in a timely manner to any requests for an emergency or unplanned plan review due to a deterioration in functioning, a change in the participant’s circumstances or in an emergency.
  + Respond to any complaints and appeals.

## Circumstance 4–Changes in circumstances and/or functioning (existing NDIS participant)

### Definition

An NDIS participant has had a change in circumstances or their functional status has deteriorated and their NDIS plan no longer meets their needs and they require greater supports and services.

### Best practice

* Participants are supported to complete the request for a NDIS plan review.
* Health services provide evidence to the NDIS and describe the changes in regard to the participant’s functioning in regard to their:
  + - mobility/ motor skills (such as ability to get around, use transport, physical skills)
    - communication (such as expressing needs, comprehension)
    - social interaction (such as developing and maintaining relationships)
    - learning (such as paying attention and mastering new skills)
    - self-care (such as bathing, eating, caring for health)
      * self-management (such as doing daily jobs, making decisions, handling problems and money).
* Review the participant’s health care plan and make any necessary changes.

### Roles and responsibilities

#### Health services

* Identify any significant changes in functioning or changes in the participants circumstances.
* Support the participant to inform their NDIA planner/ support coordinator/ local area coordinators/Early Childhood Intervention partner of this change.
* Work in partnership with the participant, NDIA planner/ local area coordinator/ Early Childhood Early Intervention partner to ensure they have necessary information for completing a plan review.
* Participate in, or provide input into the plan review process (subject to the participant’s consent).
* Provide any health/disability related advice, if requested by the NDIA or their partners, and articulate the services that health services will provide.
  + Conduct any assessments, equipment prescriptions and, if relevant, provide quotes that will assist the NDIS plan review process.

#### Early Childhood Early Intervention partner or local area coordinator

* Maintain contact with the participant and identify any significant changes in functioning or changes in the participants circumstances.
* Explore opportunities to flexibly use the participant’s NDIS funding to address the changes in their circumstances and functioning.
* If the situation is complex and the participant doesn’t already have support coordination funding, request the NDIA to conduct an emergency plan review and recommend that this participant requires support coordination.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
  + Refer the participant to their local health services if there are concerns about their health status or wellbeing.

#### Support coordinator (if the participant has this service funded in their NDIS plan)

* Maintain regular contact with the participant and identify any significant changes in functioning or changes in the participant’s circumstances.
* Explore opportunities to flexibly use the participant’s NDIS funding to address the changes in their circumstances and functioning.
* Identify if additional supports are required.
* If additional supports are required, support the participant to request an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
  + Refer the participant to their local health services if there are concerns about their health status or wellbeing.

#### National Disability Insurance Agency

* Undertake a plan review in a timely manner.
* Ensure the NDIA has the capacity and processes to undertake emergency plan reviews when the situation is complex or urgent.
  + Undertake regular scheduled reviews.

## Circumstance 5–Hospital discharge planning (potential NDIS participant)

### Definition

A person with complex health and disability needs who is preparing for hospital discharge requires coordinated planning for all community based supports and services they need on discharge.

### Best practice

* People are in hospital for the clinically appropriate time to meet their health needs.
* Good discharge planning results in better outcomes and ensures each individual has the supports, services and equipment they need on discharge.
* Discharge planning should be timely and coordinated and involve the relevant parties and agencies involved in the person’s care and support.
* Where a person is unable to return home, all options for appropriate accommodation and care should be explored and the person accommodated in an age-appropriate setting.
* This requires the NDIA, local area coordinators and the health and aged care service system (including Aged Care Assessment Services) to:
  + - Coordinate access to the NDIS and any other supports and care the individual requires in a timely manner.
    - Provide reliable and timely information to the individual and their family.
    - Reach a shared understanding about how each system operates, including the practice drivers and any service limitations.
    - Communicate early with inpatients to coordinate discharge planning – including determining a person’s NDIS eligibility and their post discharge support and care needs.
    - Collaborate with other parties and recognise that at times, inputs may be required from two or more systems at the same time or, there is a need to ensure a smooth transition from one to another.
      * Ensure the individual is referred to the NDIS before a referral to Aged Care Assessment Service is made.

### Roles and responsibilities

#### Health services

* Oversee and manage the discharge planning process, taking into account the individuals and carers preferences.
* Facilitate and organise case conferencing and family meetings.
* Ensure medical, nursing and allied health assessment and interventions assess the individuals’ needs and consider appropriate discharge options, including mainstream supports in the community.
* Make timely referrals to appropriate services (including, local government services, general practice and community programs).
* Work to identify potential participants early and assist them to access the NDIS.
* Prepare and provide timely information to the NDIA and participate in the planning process (subject to the consent of the participant). See Circumstance 2: Supporting NDIS planning for a new participant.
* Implement an agreed discharge plan, including securing supports required to deliver a sustainable and safe discharge outcome.

#### Aged Care Assessment Services

If relevant, the Aged Care Assessment Services will:

* Ensure age appropriate accommodation options have been explored as part of discharge planning.
* Inform the individual about any residential aged care options and the access processes and if this is required on discharge from hospital:
  + - undertake a timely assessment
    - participate in case planning.

#### Early Childhood Early Intervention partner or local area coordinator

* Work with the participant and health service to maximise the participant’s timely and coordinated discharge.
* Seek relevant health information to promote effective NDIS planning.
  + Ensure the disability supports the participant needs are included in the participant’s NDIS plan and are in place prior to discharge (if no support coordination is included in the participant’s plan) along with any mainstream services.

#### Support coordination (if included in the participant’s NDIS plan)

* Ensure the NDIS disability supports in the participant’s approved NDIS plan and any mainstream services are in place prior to discharge.
* Assist the participant to establish, coordinate and maintain the services and supports they need. This may include establishing service agreements with NDIS providers and linking them to mainstream and community services.
* Maintain contact with the participant and review their progress.
* With the consent of the participant, coordinate meetings with the participant and relevant parties (including health providers) prior to discharge to finalise the arrangements and ensure there is clarity in the respective roles and responsibilities.
  + Maintain contact with the participant and other parties (including health services) post discharge to review the participant’s progress.

#### National Disability Insurance Agency

* Ensure access requests are managed efficiently.
* Ensure participant is notified within 14 days of the decision of their access request.
* Ensure NDIS plan development is of a high standard and wherever possible includes input from health practitioners for this cohort of participants.
  + Ensure plan approvals occur in a timely manner.

## Circumstance 6–Hospital discharge planning (existing NDIS participant)

### Definition

An NDIS participant with complex health care and disability supports requires access to well-coordinated NDIS funded supports to enable hospital discharge.

### Best practice

* Good discharge planning results in the participant having a well-coordinated and timely discharge from hospital with the necessary supports, services and equipment in place.
* Where a person is unable to return home, all options for appropriate accommodation and care should be explored and the person accommodated in an age appropriate setting.
* This requires the NDIA, LAC, the health and aged care service system (including Aged Care and Assessment Services) and the participant’s NDIS providers to:
  + - Coordinate the participant’s care and supports in a timely manner and ensure a smooth transition from hospital.
    - Provide reliable and timely information to the participant and their carers, and others involved in their care and support.
    - Reach a shared understanding about how each system operates, including the practice drivers and service limitations and the supports and service each system will be provided to the participant.
    - Actively engage with the participant, carers and other parties prior to hospital discharge, recognising that at times, inputs may be required from both systems at the same time, or there is a need to ensure a smooth transition from one to another.
      * Refer to the NDIS before a referral to the Aged Care Assessment Service is made.

### Roles and responsibilities

#### Health services

Health services including acute (hospital) or subacute (rehabilitation) will:

* Facilitate discharge planning and information sharing with the NDIA.
* Facilitate and organise case conferencing and family meetings.
* Discuss discharge options with the person and family members/support network and oversee and manage the discharge planning process.
* Ensure medical, nursing and allied health assessment and interventions achieve a satisfactory person-directed outcome, including early notification to NDIA to determine a person’s status as a NDIS participant.
* Assess the participant’s care needs and consider appropriate discharge options, including services and supports available within the community.
* If the participant’s circumstances have changed, then prepare and provide documents to support the participant’s request for a plan review.
* Make timely referrals to appropriate services (including NDIA, local government, general practice, community programs).
  + Implement an agreed discharge plan, including securing supports required to deliver a sustainable and safe discharge outcome.

#### Aged Care Assessment Services

If the discharge involves access to residential aged care facility, the Aged Care Assessment Service will:

* Ensure that age appropriate options have been explored as part of discharge planning.
* Determine eligibility and provide information to access a residential aged care facility where required on discharge from hospital.
* Undertake a timely assessment and provide information regarding access to residential care services.
  + Participate in case planning.

#### Early Childhood Early Intervention partner or local area coordinator

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address any changes in the person’s functioning or circumstances.
* Escalate to the NDIA requests for an emergency review with the aim of increasing the amount of support the participant receives or adding new supports.
  + Make a referral to the health services if there are concerns for the persons wellbeing.

#### Support coordinator (if this is funded via the participant’s NDIS plan)

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address any changes in functioning or personal circumstances.
* Identify any additional supports that may be required.
* If additional supports are required, support the participant to request an urgent plan review
* Ensure the supports are in place to assist the participant’s discharge.
  + Post discharge, refer the participant to their local health services if there are concerns for their health and wellbeing.

#### National Disability Insurance Agency

* Undertake an emergency review and inform the participant of the outcome in a timely manner.
  + Undertake regular scheduled reviews.

## Circumstance 7–Urgent - time critical - responses (existing NDIS participant)

### Description

Participant is at risk of inappropriate admission to residential aged care or hospital due to a sudden change in their support needs or circumstances.

### Best practice

Timely and effective responses to urgent circumstances will attempt to avert, or slow the rate of deterioration of a person’s functioning and reduce their long-term support and care needs. This requires the health and aged care service system (including Aged Care Assessment Services) and participant’s NDIS providers, including support coordinators, to:

* Identify quickly any deterioration in the participant’s functioning, support needs or circumstances.
* Notify and communicate in a timely manner about these changes with the other parties.
* Work quickly and collaboratively to stop an avoidable admission.
  + Empower the individual to exercise choice and control and to be as independent as possible in the community.

### Roles and responsibilities

#### Health services

* Support the participant to contact the NDIA (or contact the NDIA on their behalf) to inform them of the sudden change the participant’s circumstances or risk of hospitalisation.
  + Work together to plan and coordinate streamlined care for participants requiring both health and disability services and recognising that both inputs may be required at the same time, or that there is a need to ensure a smooth transition from one to the other participate in case planning.

#### Early Childhood Early Intervention partner or local area coordinator

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the environment.
* If there is an increase in the amount of supports the participant receives or they need additional supports, escalate to the NDIA an urgent review.
  + Make a referral to the health services if there are concerns for the persons wellbeing.

#### Support coordinator (if this is funded via the participant’s NDIS plan)

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Identify additional supports that may be required.
* If additional supports are required, support the participant to request an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
  + Refer the participant to their local health services if there are concerns for their health and wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review in a timely manner and notify the participant, local area coordinator/ Early Childhood Early Intervention partner of the outcome in a timely manner.

# Children youth and families

This information is to support Aboriginal community-controlled organisations (ACCOs), community service organisations (CSOs), Child FIRST, Integrated Family Services, family violence services, out-of-home care (OOHC) and child protection workforces to support children, young people and vulnerable families access supports through the National Disability Insurance Scheme (NDIS) or the NDIA’s Early childhood intervention approach for children aged 0–6 and how these services will work with the NDIA and early childhood partners to support these people. The information will also assist the Support and Safety Hubs (Hubs) once established in Victoria.

The guidelines are to be read in conjunction with the following:

* *Children, Youth and Families Act 2005*
* *Family Violence Protection Act 2008*
* *The Charter of Human Rights and Responsibilities 2006 and Practice* Guidelines
* Aboriginal Child Placement Principles
* Child protection Manual
* *Best Interest Case Practice Model Summary Guide*
* *Best Interests Action Plan 2015*
* *Looking After Children Framework*
* A Strategic Framework for Family Services
* *Code of Practice for Specialist Family Violence Services*
* *Common Risk Assessment Framework*
* *Child protection Interim NDIS Guidelines*
* Change to the DFVCRI Information Sheet
* Program requirements for Family and Early Parenting Services in Victoria
* *Care and Transition Planning for Leaving Care in Victoria – A framework and guide*
* The Professionals Reporting Guide on the [Child Protection Manual](http://www.cpmanual.vic.gov.au/) <http://www.cpmanual.vic.gov.au/>.

## Circumstance 1–Risk of carer breakdown (child is a potential NDIS participant)

### Definition

A child or young person that is not an NDIS participant that, either due to unmet disability support needs or changes in the family circumstances, is at increased risk of their care arrangement breaking down resulting in risk of entering out-of-home care.

### Roles and responsibilities

#### Child FIRST/Integrated Family Services

* Early identification of a disability and NDIS eligibility is important.
* Support the family to urgently make an access request to the NDIA.
* Establish relationships with NDIS Partners in the Community delivering Early Childhood Early Intervention (ECEI) services and/or Local Area Coordination (LAC) services, to build a partnership approach to supporting vulnerable families eligible for NDIS participation.

#### Child protection

* At the point of intake identify and record information about the child’s disability or developmental delay and seek information on their current NDIS participant status.
* If it is identified that the child requires early Intervention or disability support and is not currently receiving them through state funded services, refer the family to the NDIA to test eligibility for children 7 years and old or to their local early childhood partner (for children aged 0-6 years).
* If there are no concerns for the child’s safety and protection, provide the reporter with the contact details of the NDIA to enable the family to self-refer.
* If concerns are evident for the child’s wellbeing or for the family’s capacity to access the NDIS, refer the family to Child FIRST.
* If an urgent placement is required and the child is not assessed to be in need of protective intervention, child protection may:
  + - * consider a referral to Child FIRST to support the family to identify possible respite options and to support engagement with the NDIA
      * secure a placement through a voluntary child care agreement and refer to Child FIRST / Integrated Family Services.
* If there are concerns for the child’s safety and protection, work with the NDIA locally to support timely access to reasonable and necessary supports through the NDIS or for access to the Early Childhood Early Intervention approach for children aged 0-6 years.
  + If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC provider – voluntary child care agreement with a foster care provider

Foster care providers will only have contact with families at risk of carer breakdown when providing voluntary respite.

* Provide family, other professionals and members of the community with online and telephone contact details for the NDIA and local EC Partners for children aged 0-6 years.
* Support parents to self-refer to access the NDIS.
* Refer the family to Child FIRST if there are concerns for the child’s wellbeing or for the family’s capacity to access the NDIS.
* Where Child FIRST or Integrated Family Services are involved, work together to support NDIS planning and plan implementation.
* Ensure the care team is aware of the NDIS plan and supports available.
* NDIA partners in the community delivering Early Childhood Early Intervention (ECEI) services and/or local area coordination (LAC) services Prepare the child and carer for getting ready for NDIS access and planning.
* For children aged 0-6 years, provide information about the Early Childhood Early Intervention pathway to the carer and person responsible for the child (casework, parent etc.) to support the meeting with the early childhood partner.
* Help the child and carer to work out goals and identify supports to avoid carer breakdown.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

Upon receiving an access request, the NDIA responsibilities include:

* Notifying the person within 21 working days if they meet NDIS access criteria.
* Providing updates on the NDIS access process to the person or their nominated contact.
* Requesting further information (where required) to assess an access request. In this case, the person will have at least 28 days to provide the information.
* Upon receiving the final piece of information, notifying the person within 14 working days if they meet NDIS access criteria.

## Circumstance 2–Risk of carer breakdown (child is an existing NDIS participant)

### Definition

A child or young person that is an NDIS participant that, either due to unmet disability support needs or changes in the family circumstances, is at increased risk of their care arrangement breaking down resulting in risk of entering out-of-home care.

### Roles and responsibilities

#### Child FIRST/Integrated Family Services

* Establish collaborative working relationships with NDIS local area coordinators (LACs), NDIA regions, support coordinators and Early Childhood Early Intervention partners to build a partnership approach to supporting vulnerable families with disability.
* Identify unmet disability supports that may prevent carer breakdown such as regular short-term living assistance.
* In the first instance, convene a care meeting and liaise with the LAC, support coordinator and/or Early Childhood Early Intervention partner to identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the family environment to prevent carer breakdown.
* If additional supports are required, liaise with the LAC, support coordinator and/or early childhood partner to facilitate an urgent plan review with an aim of assessing the possible need to increase, add or vary support services required to address the changes in the family environment to prevent carer breakdown.
* Participate and advocate for the family at the NDIS plan review.
* Undertake a risk assessment of the carer in terms of mental, physical and financial health and facilitate appropriate referrals to services and supports; identifying family needs separate to disability support needs.
* As part of the family case plan, prepare for expected life stage transitions (such as adolescence) that may require changes in the type of disability supports provided in the NDIS plan, in collaboration with the NDIA, LAC, Early Childhood Early Intervention or support coordinator.
  + Build the capacity of families to manage life stage transitions (such as adolescence in children with challenging behaviours) in collaboration with the NDIA, LAC, Early Childhood Early Intervention or support coordinator.

#### Child protection

* Undertake a risk assessment of the child's safety and protection.
* At the point of Intake discuss with the reporter the child’s disability needs and seek information on their current NDIS participant status.
* As required, contact the NDIA or the funded service provider to inform the risk assessment.
* If there are no concerns for the child’s safety, provide the LAC, Early Childhood Early Intervention, support coordinator or NDIS service provider with information, where required, to promote a child’s best interests, consistent with legislative requirements regarding information sharing, for example by advising of a disability support need that is potentially not being met.
* If concerns for the child’s safety and protection are identified proceed to investigation.
* Ensure the LAC, Early Childhood Early Intervention or support coordinator is included in the ongoing planning throughout child protection involvement.
  + If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC provider - voluntary child care agreement with a foster care provider

Foster care providers will only have contact with families at risk of carer breakdown when providing voluntary respite.

* Support the carer in accessing the supports available for the child or young person through the NDIS plan.
* Refer the family to Child FIRST if there are concerns for the child’s wellbeing or for the family’s capacity to access the NDIS.
* Where Child FIRST or Integrated Family Services are involved, work together to support the family’s access to the NDIS or Early Childhood Early Intervention services and with NDIS planning.
* Work with the NDIA, LAC, Early Childhood Early Intervention services and/or support coordinator to ensure the necessary disability supports are in place for the child’s return home.
* Ensure the care team is aware of the NDIS plan and supports available.

#### NDIA partners in the community delivering Early Childhood Early Intervention services and/or local area coordination services

* Liaise with key stakeholders such as Child FIRST, child protection, OOHC provider as necessary.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the family environment to prevent carer breakdown.
* Escalate to the NDIA for an emergency review for support coordination services if risk of carer breakdown is complex and participant doesn’t already have support coordination funding.
  + Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Liaise with key stakeholders such as Child FIRST, child protection, OOHC provider as necessary.
* Develop and implement contingency plan to address risk of carer breakdown.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the family environment to prevent carer breakdown.
* Identify additional supports that may be required to prevent carer breakdown.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the changes in the family environment to prevent carer breakdown.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

* Urgently undertake a review for support coordination services if risk of carer breakdown is complex and the participant doesn’t already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Consider appropriate contingencies within NDIS participant plans.

## Circumstance 3–Immediate response to parent/carer breakdown (child is a potential NDIS participant)

### Definition

A family that is unable to continue the day-to-day care for a child or young person, who is not yet an NDIS participant, due to the child or young person’s disability needs.

### Roles and responsibilities

#### Child FIRST/Integrated Family Services

* Conduct a risk assessment.
* Where the carer breakdown is due to the child or young person’s disability support needs, support the family to access respite care with a relevant agency.
* Facilitate the establishment of a voluntary child care agreement and participate in OOHC planning.
* Support the family to urgently make an access request to the NDIS or Early Childhood Early Intervention services pathway for children 0-6 years old.

#### Child protection

* Undertake a risk assessment regarding the child’s safety and protection.
* At the point of intake discuss with the reporter the child’s disability needs and seek information on their current NDIS participant status.
* Support the reporter to encourage the family to make a NDIS access request (child protection intake will not have direct contact with the family unless the family is the reporter).
* If an urgent placement is required and the child is not assessed to be in need of protective intervention, child protection may:
  + - consider a referral to Child FIRST to support the family identify possible respite options and to support engagement with the NDIA
      * secure a placement through a voluntary child care agreement and refer to Child FIRST / Integrated Family Services.
* Support the reporter to encourage the family to urgently make an access request to the NDIA (child protection intake, will not have direct contact with the family unless the family is the reporter).
* If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC providers–voluntary child care agreement with a foster care provider

* Identify potential disabilities and disability support needs as early as possible.
* Ensure family, other professionals and members of the community have NDIA contact details and support parents to self-refer to the NDIA.
* Refer the family to Child FIRST if there are concerns for the child’s wellbeing or for the family’s capacity to access the NDIS.
* Where Child FIRST or Integrated Family Services are involved, work together to support NDIS planning and plan implementation.
  + Ensure the care team are aware of the NDIS plan and supports available.

#### OOHC providers–statutory arrangement

* Seek information from child protection through the referral and 72 hour meeting about the child or young person’s disability including details of whether a NDIS plan in place.
* Work with the care team to gather evidence of the child or young person’s disability.

#### NDIA partners in the community delivering Early Childhood Early Intervention services and/or local area coordination services.

* Prepare the child and carer for getting ready for NDIS access and planning.
* Help the child and carer to work out goals and identify supports to respond to carer breakdown.
* Monitor risks of carer breakdown.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

Upon receiving an access request, the NDIA is responsible for:

* Notifying the person within 21 working days if they meet NDIS access criteria.
* Providing updates on the NDIS access process to the person or their nominated contact.
* Requesting further information (where required) to assess an access request. In this case, the person will have at least 28 days to provide the information.
  + Upon receiving the final piece of information, notifying the person within 14 working days if they meet NDIS access criteria.

## Circumstance 4–Immediate response to parent/carer breakdown (child is an existing NDIS participant)

### Definition

A family that is unable to continue the day-to-day care for a child or young person who is an NDIS participant due to the child or young person’s disability needs.

### Roles and responsibilities

#### Child FIRST/Integrated Family Services

* Conduct a risk assessment.
* In the first instance, liaise with the local area coordinators (LACs), support coordinators and partners delivering Early Childhood Early Intervention services to identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the caring environment (such as short-term living assistance).
* If additional supports are required, liaise with LAC, partner delivering Early Childhood Early Intervention services, or support coordinator to facilitate an urgent plan review with an aim of increasing or adding support services to assist with carer breakdown.
* Ensure family plan reflects OOHC arrangement and voluntary agreement/ child protection order.
* Continue to work with family to strengthen parenting capacity and family functioning to support family reunification.

#### Child protection

* Undertake a risk assessment of the child's safety and protection.
* At the point of intake discuss with the reporter the child’s disability needs and seek information on their current NDIS participant status.
* Where the carer breakdown is imminent and the child is not assessed to be in need of protective intervention, child protection may:
  + - consider a referral to Child FIRST to support the family with possible respite options and service coordination with the LAC, partner delivering Early Childhood Early Intervention services, or support coordinator
    - secure a placement through a voluntary child care agreement and refer to Child FIRST/Integrated Family Services.
* If concerns for the child’s safety and protection are identified proceed to investigation.
* Ensure the partners delivering Early Childhood Early Intervention services or support coordinator is included in the ongoing planning throughout child protection involvement. Additionally involve NDIS service provider if one is involved.
* In the first instance, liaise with the partner or support coordinator to identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the caring environment (such as short-term living assistance).
* If additional supports are required, liaise with partner or support coordinator to facilitate an urgent plan review with an aim of increasing or adding support services to assist with family reunification.
* If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC providers–voluntary child care agreement with a foster care provider

* Support the carer in accessing the supports available for the child or young person through their NDIS plan.
* Refer the family to Child FIRST if there are concerns for the child’s wellbeing or for the family’s capacity to access the NDIS.
* Where Child FIRST or Integrated Family Services are involved, work together to support the family’s access to the NDIA plan.
* Work with the care team to ensure that any goals developed by the NDIA for the child are included in the child’s Looking After Children documentation (such as the care and placement plan) and any other relevant documents to ensure a holistic approach.
* Ensure the care team are aware of the NDIS plan and supports available.
* Work with the NDIA, partners delivering Early Childhood Early Intervention services and/or LAC services and/or support coordinator to ensure the necessary disability supports are in place for the child’s return home.

#### OOHC providers–statutory arrangement

* On receipt of referral seek information from child protection through the referral and 72 hour meeting about the child or young person’s disability including details of whether an NDIS plan is in place.
* In cases where the child is subject to a statutory order and case management remains with child protection, work with child protection, or an authorised Aboriginal agency, to support the engagement with the NDIS providers.
* Support the carer in accessing the supports available for the child or young person through the NDIS plan.
* Work with the care team to ensure that any goals developed by the NDIS for the child are included in the child’s case plan, Looking After Children documentation (such as the care and placement plan) and any other relevant documents to ensure a holistic approach.
* Work with the care team to ensure the partners delivering Early Childhood Early Intervention and/or LAC services and/or support coordinator are informed when there is a change in disability related support needs and review of a child’s NDIS plan is required (as necessary).
* Ensure the partners delivering LAC and/or Early Childhood Early Intervention services, and/or support coordinator, and other NDIS providers are part of the child’s care team and/or leaving care plan.

#### NDIA partners in the community delivering Early Childhood Early Intervention services and/or local area coordination services

* Monitor accommodation and family risks and liaise with key stakeholders such as Child FIRST, child protection, and the OOHC provider as necessary.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address immediate support needs.
* Escalate to the NDIA for a review if risk of carer breakdown is complex and participant requires funding for support coordination.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Monitor risk of carer breakdown and liaise with key stakeholders such as Child FIRST, child protection, OOHC provider as necessary.
* Be aware of and assist in implementing any contingency plan to address carer breakdown.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address carer breakdown.
* Identify additional supports that may be required to address carer breakdown.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address immediate support needs and carer breakdown.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review for support coordination services if carer breakdown is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Undertake regular scheduled reviews.

## Circumstance 5–Reunification (child is an existing NDIS participant)

### Definition

Planning for the return of a child or young person to their family with NDIS supports may primarily occur:

* + 1. Immediately after parent carer breakdown takes place care and the child has been placed on a voluntary child care agreement.
    2. When a child has been living in OOHC medium/long term and an NDIS package can address previously unmet disability support needs, enabling the child to return home to the care of their family.

### Roles and responsibilities

#### Child FIRST/Integrated Family Services

* Ensure family plan reflects OOHC arrangement.
* Continue to work with family to strengthen parenting capacity and family functioning to support family reunification.
* Work with family to identify any unmet disability supports that may be required to support family reunification.
* Child protection or contracted OOHC provider case manager (child protection or contracted or authorised Aboriginal agency) to lead case work which prepares children and their families for sustainable reunification.
* Commence early planning with the NDIA, partners delivering LAC and/or Early Childhood Early Intervention services, or support coordinators to ensure the disability supports are in place to enable the family to care for the child.
* Support the family’s engagement with NDIS providers.
* Ensure all members of the care team, including the NDIS providers, are aware of the reunification and their role in supporting the family.
* Ensure the LAC or support coordinator is involved in regular care team meetings for the life of the case plan.
* If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC provider

* In cases where the child is subject to a statutory order and case management is contracted to the OOHC provider, the provider is to follow steps outlined above (child protection or contracted OOHC provider case manager tasks).
* In cases where the child is subject to a statutory order and case management remains with child protection, work with child protection, or the relevant Aboriginal agency where an authorisation under section 18 has been made, to commence early planning with the NDIA or LAC to ensure the disability supports are in place to support the family to care for the child.
* In cases where the child is subject to a voluntary child care agreement, work directly with parents to commence early planning with the NDIA or LAC to ensure the disability supports are in place to support the child return home. If the OOHC provider identifies that risk of harm issues are preventing reunification from taking place, the OOHC provider should consider a report to child protection.
* In cases where the child is subject to a voluntary child care agreement, if concerns are evident for the child’s wellbeing or for the family’s capacity to access the NDIS, refer the family to Child FIRST.
* In all cases coordinate the care team, ensuring the NDIS providers are aware of the reunification plan and the NDIS provider’s role in supporting the family.
* In all cases ensure the LAC is involved in regular care team meetings for the life of the case plan.

#### Local area coordinator

* Actively participate in the child or young person’s care team.
* Ensure the NDIS plan reflects the current and expected disability support needs of the child or young person.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the child return and remain home.
* Escalate to the NDIA for an urgent review for support coordination services if reunification is complex and participant doesn’t already have support coordination funding.
* Assist the child or carer to access and implement disability supports required to support the child to return and remain home.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Actively participate in the child or young person’s care team.
* Where appropriate, assist in implementing any contingency plan for reunification.
* Ensure the NDIS plan reflects the current and expected disability support needs of the child or young person.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the child return and remain home.
* Identify additional supports that may be required to support the child return and remain home.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to support the child return and remain home.
* Assist the child or carer to access and implement disability supports required to support the child to return and remain home.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review for support coordination services if risk of carer breakdown is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Undertake regular scheduled reviews.

## Circumstance 6–Leaving care (child is an existing NDIS participant)

### Definition

A young person that is a NDIS participant and leaving out-of-home care into independent living or adult accommodation.

### Roles and responsibilities

#### Family services

* If the young person leaving care is a parent, or is about to become a parent, work with the young person to build parenting capability and capacity.
* If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### Child protection or contracted OOHC provider case manager

* Commence early planning with the NDIA to determine the best future housing and support arrangements for the young person as they transition to adult accommodation arrangements including eligibility for Specialist Disability Accommodation (SDA).
* Support the LAC and/or support coordinator to secure appropriate accommodation including exploration of SDA options by liaising with the DHHS divisional vacancy coordination, who assist to facilitate a process in Victoria for prospective tenants to apply for SDA.
* If the care arrangement will be managed by a non-disability mainstream provider (such as public housing or private rental), work with the LAC or support coordinator in identifying appropriate disability supports for the young person’s transition to adult accommodation.
* Ensure all members of the care team, including LAC, support coordinator and NDIS providers are involved in the development of the 15-plus Care and Transition plans and understand their role in supporting the young person.
* Follow the steps outlined in the memorandum of understanding between DHHS and the Public Advocate when leaving care planning for a young person with a cognitive disability who, upon reaching adulthood, may require an adult guardian to assist with decision making.
* Ensure the LAC or support coordinator is involved in regular care team meetings for the life of the case plan.
  + If there are concerns regarding the presence of family violence, seek secondary consultation from a specialist family violence service.

#### OOHC provider

* In cases where the child is subject to a statutory order and case management remains with child protection, work with child protection, or the relevant Aboriginal agency where an authorisation under section 18 has been made, to commence early planning with the NDIA or LAC to ensure leaving care arrangements are in place.
* In cases where the child is subject to a voluntary child care agreement work directly with parents to commence early planning with the NDIA or LAC to ensure the disability supports are in place to support the family to care for the child.
* In all cases, commence early planning as part of the 15plus care and transition plan, commence early planning to determine the best future housing arrangements for the young person.
* In all cases work directly with parents to commence early planning with the NDIA or LAC to ensure the disability supports are in place including securing SDA where the person is eligible.
* In all cases ensure all members of the care team, including the LAC, support coordinator and/or NDIS providers are aware of the leaving care plans and their role in supporting the young person.
* In all cases ensure the LAC and/or support coordinator is involved in regular care team meetings for the life of the case plan.

#### Local area coordinator

* Actively participate in the child or young person’s care team.
* Ensure the NDIS plan reflects the current and expected disability support needs of the child or young person.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the young person transition to adult accommodation.
* Assist the young person to access and implement disability supports required to support the young person to return and remain home.
* Escalate to the NDIA for an emergency review for support coordination services if leaving care is complex and participant doesn’t already have support coordination funding.

#### Support coordinator (where funded within the NDIS participant plan)

* Actively participant in the child or young person’s care team.
* Develop and implement contingency plan for leaving care.
* Ensure the NDIS plan reflects the current and expected disability support needs of the child or young person.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the young person to transition to adult accommodation.
* Assist the young person to access and implement disability supports required to support the child to return and remain home.
* Identify additional supports that may be required to support the young person to transition to independent living or adult accommodation.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to support the young person to transition to independent living or adult accommodation.
* Make a referral to Child FIRST if there are concerns for the child or young person’s wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review for support coordination services if transition to adults accommodation is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Undertake regular scheduled reviews.

## Circumstance 7–Family violence crisis situation (child is an existing NDIS participant)

### Definition

Where a family violence risk escalates and it is no longer safe for a woman and her child/children to remain safely in their home.

### Context

#### Disability Family Violence Crisis Response Initiative (DFVCRI)

DFVCRI will continue until the end of Victoria’s transition to the NDIS. During the transition there will be different pathways to access immediate supports for women and children with a disability.

Women and children with a disability who are not participants of the NDIS can access immediate disability supports through the DFVCRI. Individuals should be referred at the earliest opportunity.

Women who reside in areas that have transitioned to NDIS, but who are not yet themselves participants, or their child with a disability is not yet a participant can access immediate disability support through the DFVCRI. They should be referred at the earliest opportunity.

In the interest of ensuring women or children have access to immediate disability support, when it is unclear whether a woman or child is a participant, or is eligible to be a participant of the NDIS, the DFVCRI will provide assistance for immediate disability supports until full roll out of the NDIS in June 2019.

The DFVCRI liaison officer will continue to provide secondary consultative advice and guidance regarding the best pathways for critical supports for all women and children with disabilities during this time.

If a family violence worker is unsure who to contact to arrange immediate disability supports for an NDIS participant they can contact the DFVCRI coordinator during business hours. Outside of business hours, Safe Steps Family Violence Response Centre should be contacted as per the DFVCRI guidelines.

### Role and responsibilities

#### Family violence

* Ask questions about disability needs during all initial risk assessments to determine if disability support is required.
* Enquire at intake whether an individual with a disability is a NDIS participant and has a NDIS plan.
* Engage with support coordinator, LAC or other NDIS service providers to assist with linking to NDIS funded supports.
* In the first instance, liaise with LAC or support coordinator to identify opportunities to flexibly use NDIS funding within current funding plan resources for immediate disability supports during the family violence crisis.
* If additional supports are required, liaise with LAC or support coordinator to facilitate an urgent plan review with an aim of increasing or adding disability support required during the family violence crisis and over the longer term.

#### Local area coordinator

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the women or child/children during family violence crisis.
* Escalate to the NDIA for an emergency review for support coordination services if family violence crisis is complex and participant doesn’t already have support coordination funding.
* Update all NDIS service providers regarding the change in circumstances. This includes updating information regarding confidentiality. This is critical if the perpetrator has previously been involved in the plan with access to information.

#### Support coordinator (where funded within the NDIS participant plan)

* Develop and implement contingency plan for family violence crisis.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to support the women or child/children during family violence crisis.
* Identify additional supports that may be required to support the women or child/children during family violence crisis.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to support to support the women or child/ children during family violence crisis and over the longer term.
* Update all NDIS service providers regarding the change in circumstances. This includes updating information regarding confidentiality. This is critical if the perpetrator has previously been involved in the plan with access to information.

#### National Disability Insurance Agency

* Undertake an urgent review for support coordination services if transition to independent living is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Undertake regular scheduled reviews.

# Specialist clinical mental health services

The purpose of this information is to support how health services that deliver specialist clinical mental health services work with the National Disability Insurance Agency (NDIA), partners in the community delivering local area coordination (LAC) services and the NDIS market including support coordinators to support good outcomes for consumers and patients with a severe mental illness and associated psychosocial disability.

The groups most likely to have shared involvement with specialist clinical mental health services, NDIS partners and the NDIA include (but are not limited to) consumers under 65 years:

* Who are likely to meet the NDIS eligibility requirements (disability or early intervention) who are preparing for discharge from a bed based mental health treatment service and may benefit from timely access to the NDIS funded disability supports.
* Who are likely to meet the NDIS eligibility requirements (disability or early intervention) live in a range of settings in the community and may benefit from timely access to the NDIS funded disability supports.
* Who are an NDIS participant who requires hospitalisation and a coordinated discharge response.
* Who is an NDIS participant experiencing a rapid increase in their psychosocial support needs necessitating changes to their NDIS supports and how they are implemented.
* Who is an NDIS participant for whom joint service/support coordination and planning is needed to optimise their mental health and wellbeing.
* Who are not likely to meet the NDIS eligibility requirements but will require short term LAC support to link them into mainstream and community services.

## Circumstance 1–Supporting NDIS access

### Description

#### Consumers of a Mental Health Community Support Service (MHCSS) defined program

The NDIA will endeavour to contact the consumer by phone up to six months before MHCSS defined programs begin transitioning to the NDIS to confirm they wish to be a participant and complete the access process. As clients of a MHCSS defined program meet the NDIS disability requirement, health services do not need to provide evidence of disability for this consumer group.

#### Consumers on MHCSS needs register (wait list)

The MHCSS intake service will assist people on the wait list to collect the evidence they need to make an NDIS access request. With the person’s consent, the MHCSS intake will ask the consumer’s psychiatrist and treating team to: confirm they have a psychiatric condition and associated psychiatric disability that is likely to be permanent; confirm the assessment undertaken by the MHCSS intake service of the consumers functional capacity across the NDIS functional domains; and provide relevant reports. MHCSS intake will provide the NDIA with the consumers contact details (with their consent). The consumer may nominate MHCSS intake or their clinician to be their preferred contact though the access process.

All other consumers, their family and carer/s will need support from their case manager/clinician to understand and prepare for the NDIS access process and collect the evidence they need to make an NDIS access request.

### Context

To access the NDIS, an applicant must first make an access request to the NDIA. To complete the access process, the applicant will need to provide evidence they meet the NDIS age, residence (including citizenship or visa status) and disability requirements. Without this evidence the person cannot complete the NDIA access process.

As part of this process the NDIA will ask the person to provide consent to collect and share personal information so the NDIA can make a decision about whether the person is eligible for the NDIS. If this consent is given, the NDIA may contact the person’s specialist clinical mental health service (if a consumer) to gather clinical information to determine if the person meets the disability requirements.

Specialist clinical mental health services will play a key role in assisting their consumers to check their eligibility for the NDIS by:

* identifying those consumers who would likely be eligible for the NDIS
* explaining to consumers and their carer and family the benefits of being a NDIS participant
* explaining the access criteria to the consumer and their carer and family and/or referring them to the NDIS access checklist
* explaining the NDIA access process and supporting the consumer and their carers and family throughout this process
  + providing past (if discharged from the health service in the last 12 months) and current consumers with the evidence they need to demonstrate to the NDIA that they meet the NDIS disability requirements (as part of the NDIS access request process).

In this regard, the consumer may ask their case manager/clinician to:

* Provide copies of reports, such as results of Health of the Nation Outcome Scales (HoNOS) and Life Skills Profile 16 (LSP-16), recent assessment of their psychiatric disability (and other co-existing disability if relevant) and the impact it has on their day to day mobility, communication, social interaction, learning, self-care and or ability to self-manage.
* Organise for their psychiatrist to provide a letter to attach to the Access Request Form, confirming they have a mental health condition that is likely to be life-long in nature and causes significant functional impairment.

#### Assessment of functional capacity

An assessment of a consumer’s functional capacity can be completed by an allied health worker with appropriate mental health credentials and training (i.e. psychologist, social worker, occupational therapist, registered psychiatric nurse). The assessment should cover the following six domains:

1. mobility/motor skills

2. communication

3. social interaction

4. learning

5. self-care

6. self-management.

Substantially reduced functional capacity to undertake any one of these activities is considered by the NDIA to affect a person’s capacity to participate fully in the social and economic life of the community.

### Best practice

* Assist with an access request for a consumer only with their consent.
* The processes related to assessment of functional capacity, related conversations and the language and concepts used in the provision of evidence to support an NDIS access request are meaningful to the consumers and are based on recovery-orientated practice principles to maintain and protect consumer outcomes, particularly hope, empowerment and self-identity.
* It is general good practice for assessments of consumers functional capacity to be conducted when the person has been receiving treatment for a minimum period of three months. Determination of an individuals’ functional capacity should not be conducted when a person is in crisis, acutely unwell or starting to become acutely unwell.
* Clear procedures for communication with the consumer and their family/carer regarding the findings of the assessment of their functional capacity, including the consumer’s right to seek an alternative opinion, are established.
* Information provided to the NDIA is limited to evidence required by the NDIA to determine if the consumer meets the disability access requirements of the NDIS.

### Key points

* A determination of eligibility by the NDIA is a based on the impact of the condition on the person’s psychosocial functioning. A consumer’s level of functional impairment may be episodic or debilitating and long lasting. Consumers whose level of impairment varies over their lifetime may still be eligible for the NDIS.
* Having a substance misuse problem does not disqualify a person with a psychosocial disability from becoming a NDIS participant.
* The NDIS access request process can happen while the person is in a bed based mental health service so that their plan is ready to start when they are discharged.
* A consumer in a bed based mental health service may be eligible for some NDIS supports while they live in this service setting, such as mobility and/or communication aids and equipment.

### Roles and responsibilities

#### Specialist clinical mental health services

* Check eligibility using NDIS access checklist, print as a prompt.
* If likely to be eligible, provide the consumer and their carer with information on the benefits of the NDIS, the access criteria and the access request process.
* Discuss communication preferences and ask if they would prefer their clinician to be their initial contact. With the consumer’s consent, call 1800 800 110 for an Access Request Form to be sent to the address provided by consumer.
* Provide the consumer and their carer with:
  + - A letter from their psychiatrist: The letter should confirm they have psychiatric condition and other secondary diagnosis (if relevant) and that their psychiatric condition is chronic and ongoing.
    - Provide a statement of clinical rationale if a commonly known treatment for the condition has not been explored (if relevant).
    - Clinician reports (by allied health professionals): provide any recent assessment of the consumer’s psychosocial functioning and confirm their psychosocial impairment is likely to be life-long or permanent OR complete Part F of an Access Request Form.
    - Any other relevant reports: such as Health of the Nation Outcome Scales, The Life Skills Profile - 16 (or other Life Skills Profile instruments if used) and disability support pension (DSP) applications undertaken within the last 6 months.
* Discuss the assessments of the consumer’s functional capacity and other supporting evidence with the consumer and their carers and provide an opportunity for the consumer to include personal views about assessment conclusions.
* Support the consumer and their carer/family to send the completed Access Request Form to the NDIA (if required).
* Provide further information or clarification on the supporting evidence if requested by the NDIA in a timely manner.
* Ask the consumer to advise their case manager/clinician of the NDIA’s decision regarding their eligibility for the NDIS.
* If the NDIA has decided the consumer is not eligible for the NDIS follow up and request clarification from the NDIA (with the consent of the consumer or their correspondence nominee).
* If it is felt that the consumer should be eligible for the NDIS support the consumer to request a review of the NDIA access decision, if required.
* Support the consumer to get ready for their planning discussion with the NDIA.

#### National Disability Insurance Agency

Upon receiving an access request, the NDIA is responsible for:

* Notifying the person within 21 working days if they meet NDIS access criteria.
* Providing updates on the NDIS access process to the person or their nominated contact.
* Requesting further information (where required) to assess an access request. In this case, the person will have at least 28 days to provide the information.
* Upon receiving the final piece of information, notifying the person within 14 working days if they meet NDIS access criteria.

## Circumstance 2–Supporting development of consumer’s first NDIS plan

### Description

Consumers of a specialist clinical mental health service who the NDIA have determined are eligible for an NDIS individualised funding package and need support to prepare for and engage in their first NDIS plan discussion.

### Context

A consumer’s clinical case manager and other support staff within the health service will play an important role in helping a consumer and their carer/family members to understand and prepare for their NDIS first plan discussion.

Providing this support will be particularly important for consumers who, for example, struggle with communication, have trouble concentrating, have little or no informal support network, have complex needs, are hard to engage or have reservations about engaging with unfamiliar people or formal service systems.

Talking and making decisions about goals, aspirations, and choices may be very challenging for some consumers. For this reason, it is important that specialist clinical mental health services consider ways they can help consumers and their carers to prepare for their plan discussion. Key areas of support include:

* Explaining the types of supports available through the NDIS. Some consumers may need practical supports with daily living that they have previously not been able to access, such as help to clean their house, assistance with self-care, support get to appointments or manage public transport or help to get and keep employment, as well as supports that have been a core part of the Mental Health Community Support Services program, such as supports to manage/improve behaviour and social interactions, support to develop life skills and engage in community activities and care coordination.
* Explaining what will happen through the NDIS planning process.
* Explaining what the NDIA planner/LAC will ask in the first plan discussion and why.
* Explaining to the consumer they can choose a Plan Nominee to help them with the plan discussion.
* Explaining to the consumer that they can invite whoever they wish to the plan discussion, including family, friends, carers or others. The consumer can also ask their clinician/case manager and/or a peer support worker (if available) to support them in this conversation and provide clinical input.
* Supporting the consumer (with their carers) to think about and write down what they would like to achieve in respect to, for example, their health and wellbeing, social interactions, community engagement, independence, education and employment and identify what is working well and what needs to change.
* Talking about what type and level of support is needed when the consumer is unwell and what supports can help them maintain wellbeing and better manage the impacts of their mental illness.
* Explaining to the carer that they can make a written Carer Statement or request a separate meeting with the NDIA planner or LAC.

### Best practice

* Develop a prompt/ script with the consumer and their carer to assist them with the plan discussion.
* Actively support consumers (with their consent) who need assistance to exercise choice, express their needs and goals and make decisions.
  + The consumer’s carer is supported to provide the NDIA with a written carer statement.

### Key points

* A consumer or their Plan Nominee can ask for a face to face meeting with the NDIA at a place that suits them - this may be particularly important for consumers who experience difficulties interpreting communication, following instructions, conversations or directions, reading nuances of verbal and non-verbal cues, and have difficulty communicating their needs/wants.
* The consumer can ask anyone to attend the NDIA planning discussions, including their clinical case manager and/or peer support worker (if available).
* Some consumers will need help to coordinate the supports in their NDIS first plan and connect to mainstream services. In these circumstances, the consumer should ask for support coordination to be part of their plan.
  + The consumer or their plan nominee can ask for a review of their NDIS first plan if they feel the plan does not provide them with necessary supports.

### Roles and responsibilities

#### Specialist clinical mental health services

* Link consumers and carers to NDIA participant information sessions, the NDIS website and NDIS resources such as the reimagine.today workbook which helps prepare consumers for the NDIS and explore, set goals and make decisions for the future.
* Offer to help the consumer and their carer prepare for their planning discussion with the NDIA planner or LAC by discussing how their mental health condition impacts on their mobility, communication, social interaction and relationships, learning, capacity for self-care and self-management.
* Support the consumer and their carer to think about what and how much psychosocial support they need when they are unwell and what supports they need to maintain or improve their psychosocial functioning and capacity to self-manage their mental illness.
* Provide the consumer with recent Health of the Nation Outcome Scales (HoNOS) and Life Skills Profile 16 (LSP-16) assessments as evidence of their level of psychosocial functioning – ensure you give these reports to the consumer and their carer or plan nominee prior to the meeting.
* If invited by the consumer to the planning discussion, be prepared to provide clinical input on how the consumer’s mental health condition impacts on their psychosocial functioning and the supports needed in response to these impacts. Discuss what you will say at the meeting with the consumer and their carer before the NDIA planning discussion.
  + Support the consumer to request a review of their NDIS plan if it is felt by the consumer, their carer/family and their clinical team that key supports have not been included in the plan and/or the amount of supports in the plan are not adequate.

#### National Disability Insurance Agency or local area coordinator

* Provide information for potential participants and carers to help them understand what supports are available under the NDIS and prepare for the planning discussion.
* Prepare a participant’s plan once the NDIA has confirmed that a person meets access criteria.
* Coordinate the planning conversation with the person and their family, friends, carer(s) or other people who are important to the person, including their clinical case manager.
* Support the participant to work out goals and identify supports.
* Support the participant to develop and exercise meaningful choice throughout the planning process.
* Request information, assessments or reports about the participant’s support needs (e.g. medical reports, assessments) and collect information about the participant from various sources
* Consider what supports are reasonable to expect from carers and families and take into account carer’s statements.
* Communicate with the participant, their family, friends, carer(s) and involved service providers the agreed outcomes from the planning discussion.
  + Provide the participant with a written copy of their NDIS plan. Specify a review date for a participant’s plan.

## Circumstance 3–Supporting NDIS plan implementation

### Description

NDIS participant receiving treatment from a specialist clinical mental health service and joint service/support coordination and planning is needed to optimise the health and wellbeing of the individual.

### Context

Some NDIS participants will have complex needs associated with their psychiatric condition and associated psychiatric disability and will need support to connect to and coordinate mainstream and NDIS funded supports. They may also need support to resolve points of crisis and service delivery issues. In these circumstances, the NDIA may fund support coordination as part of the participant’s NDIS plan. A key focus of support coordination is helping the participant build capacity to make decisions about their support and to coordinate their NDIS and mainstream (non NDIS) supports.

The coordination of service/supports between the person’s specialist clinical mental health service and any NDIA funded support coordination - with the active involvement of the participant and carers - will ensure a more integrated, planned response to the participant’s psychosocial support and mental health treatment needs.

Specialist clinical mental health services can support this outcome by:

* Requesting the NDIA consider support coordination be part of the participant’s NDIS plan if in their judgement, they feel this is a necessary support.
* Facilitating and/or participating in joint planning meetings with the consumer/participant and their NDIS funded support coordination provider (where available) or LAC to ensure the participant’s NDIS plan and mental health treatment plan complement each other and the participant’s NDIS plan considers the consumer’s current and changing psychosocial support needs.
  + During transition raising concerns with the Mental Health Branch, Department of Health and Human Services if they have evidence that a registered NDIS provider is delivering supports in a manner that is unsafe or is impacting negatively on the physical and emotional wellbeing of a consumer.

Achieving a coordinated approach to the implementation of the consumer/participant treatment and NDIS plan, will require the LAC, NDIS funded support coordinator and other NDIS support provider/s and specialist clinical mental health services to work together in a way that:

* Supports the participant/consumer to feel empowered to exercise choice and control in the implementation of their NDIS plan and its review.
* Ensures clinical treatment and psychosocial disability supports are delivered in a coordinated manner, with the active involvement of the consumer/participant or at their direction.
* Facilitates timely communication between the parties, particularly when a consumer/participant experiences a rapid or significant change in their psychosocial functioning.
  + Facilitates smooth, timely discharge from bed-based clinical mental health services.

It should be noted that admission to a mental health inpatient or clinical bed based rehabilitation service will not result in the consumer ceasing to become a NDIS participant, although their supports will likely change or cease for this period.

### Best practice

* The consumer’s preferences regarding how and when their NDIS psychosocial supports are engaged are known and respected.
* The consumer’s psychosocial support needs and preferences are documented alongside their (mental health) Advance Statement, at the direction of the consumer.
  + Clear processes and guidelines for communication with the consumer’s support coordinator or LAC are established and maintained.

### Roles and responsibilities

#### Specialist clinical mental health services

* Confirm with the consumer what support is in their plan and who will assist implementing, such as LAC or support coordinator.
* With the consumer’s consent, contact their NDIS funded support coordinator or LAC.
* With the consumer and their support coordinator/LAC agree to a process that will ensure treatment and NDIS supports are well coordinated, including how the participant’s NDIS providers will respond when the consumer experiences a rapid increase in their psychosocial support needs or crises related to their psychosocial disability.
* With the consumer’s consent, notify their support coordinator or LAC when they:
  + - experience an urgent/rapid increase in their psychosocial support needs
    - experience a sustained increase or significant change in their psychosocial support needs
    - are admitted to a bed-based mental health treatment service
    - no longer receive their treatment from the specialist clinical mental health service system.
  + Contact the department or the Mental Health Complaints Commissioner if it is felt the consumer is receiving unsafe or poor quality NDIS funded supports.

#### Local area coordinator

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in the circumstances.
* Escalate to the NDIA an urgent review for a support coordination service where the circumstance is complex and the participant does not already have support coordination funding.
* Make a referral to the Area Mental Health Services if there are concerns for the consumers wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Identify additional supports that may be required.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
* Make a referral to the Area Mental Health Services if there are concerns for the consumer’s wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review where the circumstance is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgency reviews for additional supports.
* Undertake regular scheduled reviews.

## Circumstance 4–Discharge planning (potential NDIS participant)

### Definition

Where a person is a patient in an acute mental health, sub-acute, secure extended care or community care unit and needs to undergo NDIS access to determine eligibility, develop a NDIS first plan (subject to meeting the eligibility criteria) and obtain NDIS supports to facilitate timely discharge.

### Context

Coordinated discharge planning between the NDIA, LAC and specialist clinical mental health service will ensure consumers with a severe mental illness and associated psychosocial disability have their psychosocial support needs appropriately identified and NDIS supports in place at the time of discharge from a bed-based mental health service. It will also contribute to reducing length of stay in bed-based mental health services and prevent avoidable hospital re-admissions attributable to inadequate supports in the community.

To achieve coordinated discharge planning for consumers who are prospective NDIS participants, the NDIA, LAC and the specialist clinical mental health service system will need to:

* Work together to accelerate the access request and planning processes to respond to time critical discharge circumstances, particularly for patients in acute inpatient and high dependency beds, and sub-acute Prevention and Recovery Care (PARC) services.
* Proactively support the consumer and their carer to make decisions regarding their psychosocial support needs, throughout the NDIA access and planning process.
* Undertake the access and planning processes in situ to ensure NDIS supports are in place when the consumer is discharged.

### Best practice

* An NDIS access request for a consumer is only facilitated with the consumer’s or their nominated person’s consent.
* Consumers and their carer and family are actively engaged throughout the discharge planning process.
* The access and planning process will be commenced at the earliest possible time to ensure NDIS funded supports are in place on discharge – for secure extended care units and community are units this process will commence a minimum of three months prior to planned discharge.
  + All parties (NDIA national access team, NDIA planners, LAC, support coordinator and clinical treatment team) agree on their roles and responsibilities to support timely discharge.

### Key points

* The NDIS access and planning process can occur while the consumer is in the bed-based service.
* If the consumer receives a plan while in the bed-based service that includes support coordination, this aspect of the plan can be activated to help the consumer and their carer select a support provider/s prior to discharge.
  + A consumer in a bed-based mental health facility may be eligible to receive aids or equipment related to a co-occurring disability, such as deafness, being blind or if they have a mobility issue.

### Roles and responsibilities

#### Specialist clinical mental health services

* Confirm with the consumer they are not a NDIS participant on admission or shortly after.
* Monitor changes in the consumer’s psychosocial function and social support needs throughout their stay in a mental health facility and ensure these are considered in discharge planning.
* Discuss the benefit of the NDIS with the consumer and their family/carer, as part of discharge planning.
* Prepare and collate relevant evidence to support the consumer to make an NDIA access request.
* With the consumer’s consent, participate in NDIS plan discussion, to provide clinical input regarding how the consumer’s mental health condition impacts on their psychosocial functioning and the supports needed in response to these impacts on discharge.
* Work with the NDIA/LAC to fast track the NDIS access request and planning processes.
* Develop an agreed discharge plan throughout the consumers stay, in collaboration with the consumer, their carer and family, the NDIS funded support coordinator or LAC and other relevant mainstream supports.
* Keep the NDIA, support coordinator or LAC up to date regarding the consumer’s planned discharge date.
* Work with the consumer’s support coordinator or LAC to prepare the consumer for discharge.
* Oversee and manage the discharge planning process, as it relates to the coordination of the consumer’s clinical treatment needs.
* If the NDIS access, plan development or plan implementation process is not completed before the consumer is discharged from the bed-based service, ensure the consumer’s clinical case manager is briefed on the status of the process so they can help the consumer and carer complete the process in the community.

#### Local area coordinator

* Prepare the consumer and/or carer for getting ready for NDIS access and planning.
* Help the consumer and/or carer to work out goals and identify supports.
* Discuss concerns regarding the consumer’s wellbeing with clinical staff.

#### National Disability Insurance Agency

* Undertake NDIS access and planning processes where possible in a manner that supports time critical discharge circumstances.
* Provide updates on NDIS access and planning status to the individual, family, hospital and relevant mental health or other practitioners involved in the person’s treatment and care.
* Undertaking joint discharge planning with the person’s mental health service provider to ensure their NDIS plan and treatment plan are coordinated.
* Working with the participant and their carers/family to identify a support coordinator prior to discharge.

## Circumstance 5–Discharge planning (existing NDIS participant)

### Definition

Where a consumer is an existing NDIS participant and requires coordinated planning to support their timely discharge from an acute mental health inpatient, sub-acute, secure extended care or community care unit and:

* NDIS funded supports need to be re-engaged and/or
* more intensive, additional and/or specific NDIS supports may be required to support the consumer’s safe and timely discharge and the participant is at risk of a longer than necessary stay in the absence of an appropriate level of NDIS support and/or
* the participant has multiple service responses that require coordination to ensure timely discharge and appropriate discharge destination/outcome.

### Context

On discharge from hospital (acute inpatient) or bed-based clinical mental health settings, a consumer who is an existing NDIS participant may have changed or newly acquired psychosocial support needs which need to be in place prior to discharge or shortly after. In some circumstances, the consumer may need specific supports that are not in their NDIS plan (such as behaviour supports). A significant change in consumers/participants psychosocial functioning may necessitate an urgent review of their plan, particularly if pressing psychosocial issues are contributing to risk of suicide, self-harm or attempted suicide.

In some instances, additional supports may need to be provided with minimal notice at the time of discharge or within hours of discharge, particularly when a person is discharged from an acute mental health inpatient or sub-acute Prevention and Recovery Care service, given the short length of stay in these service settings. This will require urgent engagement with the consumer’s support coordinator (if they have one) or the LAC to ensure supports are in place on discharge.

To facilitate a smooth discharge process, mental health or other relevant staff should ask the consumer if they are a NDIS participant when they are admitted to the acute inpatient service or the Prevention and Recovery Care service. Please note the NDIA is unable to provide this information to protect the privacy of participants.

Providers of secure extended care units and community care units, should also identify consumers who are NDIS participants and (with the consumer’s consent) commence working with the LAC or the consumer’s support coordinator (if they have one) to review their plan and coordinate the supports the person will need on discharge. This process should commence at least three months before it is anticipated the consumer will be discharged.

### Best practice

* An NDIS change of circumstance process is only facilitated with the consumer’s or their nominated person’s consent.
* Consumer’s and their carer and family are actively engaged throughout the discharge planning process.
* The change of circumstance process (if required) will be commenced at the earliest possible time to ensure NDIS Plan is changed and supports are in place prior to or on discharge.
* All parties (NDIA planner or LAC, NDIS support coordinator and clinical treatment team) agree on their roles and responsibilities to support timely discharge.

### Key points

* + Regardless of how long a consumer stays in a bed-based mental health facility, they will remain a NDIS participant even if they are not using any supports in their plan.

### Roles and responsibilities

#### Specialist clinical mental health services

* Confirm with the consumer they are a NDIS participant and ask for permission to contact their support coordinator or LAC.
* Provide timely advice to the consumer’s support coordinator or LAC that they have been admitted to a bed-based mental health service.
* Prepare and collect relevant document/evidence to support the NDIA change in circumstances process, if there has been a substantial change in the consumer’s psychosocial functioning and/or circumstances (such as significant reduction in, or loss of, informal supports).
* Facilitate discussion and information sharing between the consumer, their carer, the consumer’s mental health team and the support coordinator or LAC to finalise the change in circumstance process (if required).
* Keep the LAC or support coordinator up to date regarding the consumer’s planned discharge date.
* Work with the consumer’s NDIS funded support coordinator or LAC to prepare the consumer for discharge and agree on the discharge related responsibilities of all parties.
* Oversee and manage the discharge planning process, as it relates to the coordination of the consumer’s clinical treatment needs.
  + If the NDIS change in circumstance process is not complete before the consumer is discharged, ensure the consumer’s clinical case manager is briefed on the status of the process so they can help the consumer and carer complete the process in the community.

#### Local area coordinator

* Consider clinical input form the consumer’s mental health team regarding any change to the consumer’s support needs, including the need for additional supports or a specific support not in the participant’s plan.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Escalate to the NDIA an emergency review for a support coordination service where the circumstance is complex and the participant doesn’t already have support coordination funding.
  + Make a referral to the Area Mental Health Services if there are concerns for the consumer’s wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Consider clinical input from the consumer’s mental health team regarding any change to the consumer support needs, including the possible need for additional supports or a specific support not in the participant’s plan.
* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Identify additional supports that may be required.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
* Make a referral to the Area Mental Health Services if there are concerns for the consumer’s wellbeing.

#### National Disability Insurance Agency

* Consider clinical input from the consumer’s mental health team regarding any change to the consumer support needs, including the possible need for additional supports or a specific support not in the participant’s plan.
* Provide updates on NDIS planning status to the individual, family, hospital and relevant mental health or other practitioners involved in the person’s treatment and care.
* Undertake an urgent review where the circumstance is complex and participant does not already have support coordination funding.
* Respond to requests for urgent reviews for additional supports.
* Undertake regular scheduled reviews.

## Circumstance 6–Change in circumstances and/or functioning (existing NDIS participant)

### Definition

* When a consumer of a specialist clinical mental health services is an NDIS participant and is experiencing:
  + - a significant and/or rapid change in their psychiatric condition, resulting in a significant reduction in their psychosocial functioning and the need for a rapid escalation in their psychosocial disability supports
      * a demonstrable reduction in their psychosocial functioning over time because of repeated psychiatric episodes and/or significant change in their life circumstances, and/or side effects of treatment (such as significant sedation, tardive dyskinesia, etc.).
* When a consumer/participant has been, or is at risk, of hospital admission and increased or additional psychosocial supports are required to address the pressing psychosocial issues that are contributing to the risk of hospital admission.
  + A consumer/participant is unable to be discharged from an acute inpatient, sub-acute and extended care mental health service without additional NDIS supports.

### Context

People with a severe mental illness and associated psychiatric disability often experience frequent or periodic relapse in their mental health condition. This in turn can result in a significant reduction in their psychosocial functioning and the need for a rapid escalation in their psychosocial support. A need for increased psychosocial supports can also happen if the person’s circumstances change, such as becoming homelessness or experiencing re-occurring homelessness, a recent trauma (such as witnessing or being a victim of a crime), or the informal supports available to them are no longer available.

In these situations, if the consumer does not receive timely access to the right type and level of psychosocial support, they may be at heightened risk of experiencing a relapse in their mental health condition. Over time, frequent relapses will increase the severity of their psychiatric disability.

For these reasons, it is important that changes in a consumer’s/participant’s psychosocial support needs are monitored, identified as early as possible and responded to in an appropriate and timely manner. Specialist clinical mental health services are skilled in recognising when a consumer is, or is predicted to, need an increased level of psychosocial support.

Further, in the early stages of receiving NDIS support many participants may struggle to identify goals. On this basis, it is likely that some consumers will require iterative goal planning in plan reviews.

### Key points

* The NDIA will schedule a review prior to the end date of the plan.
* A review can be requested by a consumer or their plan nominee at any time if their circumstances have changed but evidence of a significant change may need to be provided.
* An NDIS support provider may be able to increase the amount of support when a participant’s support needs increase (within the limits of the quantum of support available in their plan in each 12-month period).
* If a consumer acquires another disability (such as an acquired brain injury) a plan review may be required.

### Roles and responsibilities

#### Specialist clinical mental health services

* Monitor consumer/participant for any significant change in their psychosocial functioning and/or other circumstances (such as significant decrease in, or loss of, informal supports).
* Use outcome measurement tools such as Health of the Nation Outcome Scales (HoNOS) and Life Skills Profile 16 (LSP-16) to monitor this change over time.
* Notify the consumer’s support coordinator or LAC (if they do not have a support coordinator) when the consumer’s psychosocial support needs significantly increase, with the consumer’s consent.
* Support the consumer and their carer or plan nominee to request a plan review (using the plan review request form) by providing evidence of change in their psychosocial functioning and risks if pressing psychosocial disability needs are not addressed.
* If requested by the consumer, participate in the NDIS plan review process.

#### Local area coordinator (where the participant does not have support coordination in their NDIS plan)

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Escalate to the NDIA an urgent review for a support coordination service where the circumstance is complex and the participant does not already have support coordination funding.
* Make a referral to the Area Mental Health Services if there are concerns for the consumer’s wellbeing.

#### Support coordinator (where funded within the NDIS participant plan)

* Identify opportunities to flexibly use NDIS funding within current funding plan resources to address the changes in circumstances.
* Identify additional supports that may be required.
* If additional supports are required, escalate to the NDIA for an urgent plan review with an aim of increasing or adding support services required to address the complex circumstances.
* Make a referral to the Area Mental Health Services if there are concerns for the consumer’s wellbeing.

#### National Disability Insurance Agency

* Undertake an urgent review where the circumstance is complex and participant doesn’t already have support coordination funding.
* Respond to requests for urgency reviews for additional supports.
* Undertake regular scheduled reviews.