SGP Knowledge Article Template

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Guide – Psychosocial disability Appendix A – Discharge planning

This article provides guidance for **planner delegate**, **internal review delegate**, **national reassessment delegate**, **local area coordinator**, **early childhood partner**, **technical advisors**, **liaison officers (HLO/JLO)**, or **complex support needs (CSN) planner** to understand:

- discharge planning with participants living with a psychosocial disability.

Recent updates

October 2023

Current guidance.

Before you start

You have read and understood:

- Our Guideline – Reasonable and necessary supports (external)
- article Guide – Complex Support Needs (CSN) Pathway.

Appendix A – Discharge planning

This overview is of hospital/secure mental health facility discharge processes. It includes considerations for planning if a forensic order is in place and when a discharge date has been set.

The NDIS and the mental health system work together to plan and coordinate streamlined care for individuals requiring both health and disability services. Planners, recovery coaches, support coordinators and local area coordinators (LACs) consult with their State or Territory's relevant specialist mental health discharge planning guidelines. The guidelines are used to engage the responsibilities of specialist mental health services during a participant's transition from rehabilitation or hospital settings.

Keep lines of communication open and provide clear information to the participant and all parties involved in planning for discharge. For advice on reasonable and necessary transitional supports during the discharge processes from either mental health or justice facilities, Technical Advisory Branch (TAB) advice can be sought.

Note: Advice may be mandatory in some circumstances. Refer to the technical advice case in PACE and article Understanding when to request for plan advice to understand if you need to request mandatory TAB advice.

Health Liaison Officers

Health Liaison Officers are represented in all states and territories and work within the Complex Support Needs (CSN) Pathway Branch of the NDIA. They provide a single point of contact for health staff to facilitate support for participants (prospective and current) in hospital settings.

For more information refer to the Health Liaison Officer factsheet.

Transition supports

The NDIS is responsible for working with the mental health system during discharge planning to support participants with psychosocial disability who require disability-related functional supports following discharge.

NDIS involvement in transition planning should commence when a participant has stabilised and there is a need for ongoing disability-related supports to maintain or manage functional capacity once the participant returns to living in the community.

The health system is responsible for general discharge planning to support participants through the discharge process and during transition to post-discharge care provided in the community. For example, referral to community mental health team and housing supports.

NDIS plans for participants in hospital or mental health facilities should be developed when a discharge date is available and this date is within 6-12 weeks' time. However, prior to this time, a community connections plan may be developed.

If the participant has a current NDIS plan, the funding remains active and is available to support the participant to reintegrate into the community and day-to-day living activities following discharge.

Note: The participant or representative may request a plan variation or reassessment or the Agency may commence a plan reassessment when there is a change in the participant's situation that requires a change in their ongoing support needs.

Effective joint discharge planning ensures:

- the participant's psychosocial support needs are appropriately identified
- NDIS supports are in place at the time of discharge
- smooth service delivery during transition.

A planning meeting involving the recovery coach, specialist support coordinator or LAC, the participant and clinical mental health service should be held before discharge. As part of this meeting, the treating mental health representative should be asked to provide information about what treatments will be put in place post discharge.

Service providers/recovery coaches/support coordinators/LACs should provide supports so the participant is supported through the change, as well as supports that assist participants to develop self-care and self-management capacities.

Article topics and case names – internal use only

Topics

This article relates to the following topics:

- **Add:** t_complaintsandcriticalincidents
- **Add:** t_complexsupportneeds
- **Add:** t_implementation
- **Add:** t_planchanges
- **Add:** t_planmanagement
- **Add:** t_psychosocialdisability
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- **Add:** t_reviewingdecisions
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Case names

You can use this guidance for the:

- **Add:** dc_case_checkin
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0.1	JJP788	Draft. Content from article Guide – Psychosocial disability v0.2	DRAFT	2022-11-18
1.0	CS0074	Class 1 approval	APPROVED	2022-11-18
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Guide – Psychosocial disability

This article provides guidance for a **planner delegate**, **internal review delegate**, **national reassessment delegate**, **local area coordinator**, **early childhood partner**, **technical advisors**, **liaison officers (HLO/JLO)** or **complex support needs (CSN) planner** to understand:

- what is psychosocial disability?
- how to recognise psychosocial disability
- the social model of health
- diversity and social inclusion
- the recovery approach
- trauma informed support
- recovery based language
- what is a psychosocial recovery coach?
- things for planners to consider
- forensic patients
- the functional impact of mental health conditions.

You can also refer to the following articles:

- Guide – Psychosocial disability – Case examples
- Guide – Psychosocial disability – Appendix A – Discharge planning
- Guide – Psychosocial disability – Appendix B – Definitions
- Guide – Psychosocial disability - Appendix C – Guide for decision makers.

Recent updates

October 2023

Current guidance.

Before you start

You have read and understood:

- Our guideline - Reasonable and necessary support (external)
- article Guide – Complex Support Needs (CSN) Pathway.

What is psychosocial disability?

Psychosocial disability is the term used to describe the experience of people with impairments and participation restrictions related to mental health conditions. The NDIS considers mental health conditions to be a broad term that describes many different disorders, illnesses, and syndromes. While not everyone with a mental health condition will experience psychosocial disability, those that do can experience severe psychological effects and social disadvantage (National Mental Health Consumer and Carers Forum, 2011).

This Guide focuses on best practice models of psychosocial support, including promoting individual recovery for the participant and person-centred practice to work towards bridging the gap between medical and social models of recovery.

Gaining a better understanding of mental health recovery, recovery language and what recovery oriented means, allows you to:

- promote a culture and language of hope and optimism
- develop your capabilities to support people with psychosocial disability
- encourage participants to recognise and take responsibility for their own recovery and wellbeing to enable them to define their goals, wishes and aspirations.

How to recognise psychosocial disability

Psychosocial disability differs from other disability types in that it is episodic and fluctuating in nature. It may be difficult to identify and understand compared to other disability types because:

- it cannot always be seen or observed
- there is a strong relationship between mental ill-health and psychosocial disability in which each impacts on or can cause the other. Mental illness describes a broad range of conditions with different symptoms, treatments and recovery journeys
- the experience and impact is different for every individual.

Social Model of Health

The social model of health examines all the factors that contribute to health, such as social, cultural, economic and environmental factors. It differs from the medical model of health that

only considers whether a disease or condition is present or not. Psychosocial disability crosses both social and medical recovery models and affects the participant's ability to participate fully in life (Report: Psychosocial Capability in the NDIA). People with psychosocial disability are more likely than the general population to experience:

- poor physical health and suicide
- lower levels of employment and education
- limited positive and supportive relationships
- trauma and discrimination that further reduces access to health care, housing and other mainstream services.

The NDIS supports participants to identify what support they need across all areas of their life and maximise their opportunities for social and economic participation.

Diversity and social inclusion

A socially inclusive society is one where all people feel valued, their differences are respected, and their basic needs are met so that they can contribute in a meaningful way.

Understanding diversity, social inclusion and the social model of health will enable you to:

- identify and address the particular socioeconomic barriers faced by the participant with psychosocial disability, and how some of these differ from other disability types
- recognise and address attitudinal barriers including stigma and discrimination
- identify the reasonable and necessary supports that will support the participant to achieve their goals including employment, education, housing and social supports
- support better access to and outcomes from mainstream services for the participant.

Aboriginal and Torres Strait Islander people often perceive their health in the context of the social, emotional and cultural wellbeing of the whole community rather than in terms of their own physical and mental health. They may not accept the language of mental illness and disability. The impact of wellbeing is influenced by their connection to land, culture, spirituality, family and community. Refer to the Guide – Aboriginal and Torres Strait Islander Planning Support to develop strategies and consider how you can support Aboriginal and Torres Strait Islander peoples to achieve the best possible outcomes.

The recovery approach

What is recovery?

The term ‘recovery’ is used widely throughout the mental health sector and has different meanings for different people. People who experience psychosocial disability may describe themselves as being on a ‘recovery journey’. In the NDIS, recovery is achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental health condition.

Clinical recovery and personal recovery are quite different:

- Clinical recovery is based on the medical model of health and is the treatment of impairments and the minimisation of symptoms of mental health conditions.
- Personal recovery is based on the social model of health and is living a meaningful life and being able to contribute to a community within the limitations caused by a mental health condition.

When people talk about their mental health recovery, they are actively seeking to have a sense of purpose and meaning in their life, despite the symptoms, impairments and disability their condition may bring.

An understanding of the recovery approach allows you to communicate in an appropriate, strengths-based manner and use recovery based language throughout the participant’s experience with the NDIS.

Recovery is an individual and unique process. It is defined by the person and driven by their needs and choices. Recovery involves:

- having hope
- being motivated
- feeling optimistic about the future
- having the skills and strategies to manage the challenges the participant may experience.

Trauma informed support

When engaging with the participant it is important:

- to be aware they may have experienced trauma
- to understand how trauma can impact on their capacity and willingness to participate in planning meetings, particularly discussing their goals and thinking about their progress.

Trauma may not be immediately obvious and can be hidden under the surface and triggered by seemingly normal situations. It is important to remember that many participants with a psychosocial disability have had an experience with trauma. You will need to tailor your communication accordingly.

The impact of trauma is different for every individual. It can be experienced as:

- a high state of alert emotion
- a sense of numbness and avoidance
- headaches and fatigue
- anxiety and depression
- nightmares
- sleeping and eating issues
- misuse of alcohol or drugs.

It is important to listen to the participant's experiences and respond to each situation accordingly to recognise where specific discussions or experiences may trigger a trauma response.

Recovery based language

It is important to use language that conveys hope and optimism to the participant and to support and promote a culture that fosters recovery. For example, use the term 'person with a mental health condition' rather than 'mentally ill person'.

The following resources will help you to understand and use recovery language:

- Recovery orientated language guide (external) produced by the Mental Health Coordinating Council (MHCC)
- Reimagine website (external).

Over 90% of our communication is non-verbal, comprising body language, non-verbal cues such as nods and smiles and tone of voice. When communicating with the participant you should focus on:

- your non-verbal communication as well as the language you use
- the participant's age, hearing, cognitive or language needs
- being authentic, transparent and sincere.

Note: Suicidal or self-harm related thoughts or statements must be taken seriously and are considered to be a participant critical incident. You should use the Participant Critical Incident

Framework to determine the necessary and appropriate actions to undertake if you become aware that the participant is threatening or attempting self-harm.

What is a psychosocial recovery coach?

A psychosocial recovery coach (recovery coach) is a qualified mental health worker and through their own experiences and training, understands mental health and its impacts. They can support the participant to build confidence and motivation, foster hope and build capacity to achieve their goals and use their supports to live a full and contributing life.

A recovery coach will also support the participant to understand how the NDIS operates within a broader ecosystem of supports including mainstream and community supports.

With support from a recovery coach, it is anticipated that over time, the participant will be able to build their capacity in areas of their life which will then mean they require less support overall to achieve their goals. This could see a decrease in other reasonable and necessary supports in their plan.

Recovery coach types

There are two types of recovery coaches. The participant can decide which type of recovery coach they feel will be the best fit for them. Both types of recovery coach have qualifications, training and experience working in the field of mental health. You should understand and discuss with the participant which type of recovery coach might best suit their individual needs.

This may depend on a number of factors:

- the participant's stage in their recovery journey
- whether they feel more comfortable with a recovery coach who has lived experience of psychosocial disability
- other personal preferences that may influence their decision.

The two types of recovery coach are:

1. Lived Experience Recovery Coach – with lived experience competencies.
2. Psychosocial Recovery Coach – with learnt experience competencies.

A lived experience recovery coach, in addition to their formal qualifications has lived through their own experiences with mental health and recovery. They will draw on their personal understanding of mental illness and its impacts when working with the participant.

They are able to disclose their lived experience in a purposeful manner to build rapport and a trusting relationship with the participant. This allows them to better understand how the

participant may be feeling and they can use that understanding to support the participant on their own recovery journey.

How a recovery coach will work with the participant

The participant may not have had this type of support before. They may ask you about the type of support a recovery coach will provide and what benefits they may get from this additional support. It is important that you understand and discuss the role with the participant so they understand how a recovery coach will support them to pursue their goals and live a full and contributing life.

Discuss the below points with the participant and explain how the recovery coach will support them in their recovery, engagement with the NDIS and other supports.

A recovery coach will support the participant to build their capacity and positive relationships in the community, which in turn will reduce the intensity of supports required in the future. A recovery coach will work with the participant to:

- develop a recovery-enabling relationship with them, their families and carers. This relationship will be built on trust and a shared understanding of the participant's goals and needs so they can work through the ups and downs of a recovery journey together.
- develop and maintain an individual recovery plan. The Recovery Plan will support the participant and optimise available resources (including their NDIS funding and clinical mental health services).
- provide recovery coaching. A recovery coach will engage with the participant and support them to take more control of their lives. Supporting the participant to better manage the complex challenges of day to day living and articulate and own what a contributing life means for them and their families, and carers.
- coordinate services and support them to access a range of different resources and services in a way that helps them work towards their goals identified in their Recovery Plan.
- complete progress reports to demonstrate that supports are meeting participant expectations and needs. The recovery coach will provide progress reports to the participant and NDIS at agreed times. Progress reports will outline how NDIS funds and other resources are being effectively utilised to progress goals identified in the participant's Recovery Plan.

- engage with the NDIS by developing their knowledge and skills in navigating the NDIS, self-advocacy and fund management so they become an active participant.

Things for planners to consider

Planning for episodic conditions

The symptoms of psychosocial disability may be episodic and vary in intensity and need for support. To allow the participant to manage these needs, you should:

- ensure Core support categories are flexible so supports can be increased or decreased as necessary
- explain plan flexibility to the participant and their informal supports so they understand how to use their plan funding flexibly
- explain that if they are hospitalised, some of their NDIS funded supports (for example Core supports) may not be available to them while they are an inpatient. The supports can start as soon as they are out of hospital.

Supports to consider

Funded supports should be considered in the context of:

- A focus on capacity building and individual skill development. Many people with a psychosocial disability have had little or no access to skill-based assessments and supports that build their individual capacity.
- Identifying support needs based on the whole of person. The participant may experience social isolation and may not have informal support networks to help them engage with mainstream, community or funded supports. The participant will likely need support to implement their plan.
- The impact both regular and irregular supports may have on maintaining the participant's wellness. Funded supports for domestic assistance, and/or assistance with self-care and community access, could all be integral to supporting the participant to maintain their overall wellness, even if they are only used episodically.

Capacity building supports

These may include:

- improved daily living skills. For example, assistance with decision making, daily planning and budgeting
- improved relationships. For example, individual social skills development
- increased social and community participation. For example, life transition planning including mentoring, peer support and individual skill development
- improved living arrangements. For example, assistance with applying for accommodation and tenancy obligations

Capacity building – Recovery coach

Support by a recovery coach who will work with the participant to:

- build capacity and resilience
- manage the complex behaviours involved with psychosocial disability issues
- improve social and economic participation
- identify, plan, design and coordinate supports
- plan and maintain engagement through periods of increased support needs

Capacity building – Support coordinator

Support by a support coordinator to

- connect with informal, mainstream and/or funded supports
- maintain support relationships
- resolve service delivery issues and points of crisis (LAC or support coordination depending on the participant's individual circumstances).

Note: some participants may already have a support coordinator and may choose to continue working with their support coordinator rather than changing to a recovery coach.

Core supports

Support to assist the participant to manage activities of daily living:

- personal care
- community access
- attending appointments
- shopping, household and health management.

For a breakdown of supports generally funded by the NDIS, and supports generally funded by other parties, refer to the article Guide to psychosocial disability - Appendix C.

Note: The NDIS does not fund supports for clinical treatment related to mental health conditions.

Forensic patients

In cases where the participant is in hospital or detained in a secure mental health facility there may be further planning considerations you need to take into account. Participants who are in a secure mental health facility may be forensic patients. Forensic patients are people who:

- have been found unfit to be tried for an offence (whether or not a special hearing has been held) and ordered to be detained in a correctional centre, mental health facility or other place
- have gone through a criminal trial or a special hearing and are 'not guilty on the grounds of mental illness' (Mental Health Coordinating Council).

Please refer to articles Guide to psychosocial disability – Appendix A for information related to participants involved with the criminal justice system. For example, incarcerated and pending release.

Functional impact of mental health conditions

Funded supports must address the impact of the participant's functional impairments. Supports associated with treating the symptoms of the mental health condition is considered clinical treatment and remains the responsibility of other mainstream service systems.

For example, if a participant experiences symptoms of panic or paranoia when using public transport and accesses Cognitive Behavioural Therapy to address this, the provision of this support would be the responsibility of the health system. The NDIS could fund capacity building supports (Increased Social and Community Participation support category) to support the participant to build capacity to use public transport with the aim of independent travel. This may include support with trip planning, understanding transport systems and developing strategies to manage when trips don't go to plan.

For further examples of symptoms and related functional support needs, please refer to pages 7-8 in NDIA's Completing the access process for the NDIS: Tips for Communicating about Psychosocial Disability (external) for individuals with psychosocial disability.

Next steps

1. For guidance on how to add psychosocial recovery coach funding to a participant's plan, refer to article Add psychosocial recovery coach funding.
2. For guidance on how to add support coordination funding to a participant's plan, refer to article Add support coordination funding.

Article topics and case names – internal use only

Topics

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Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	CS0074	Class 1 approval	APPROVED	2022-11-18
1.1	MGC723	Updated to make sure content is transferred from PG – Psychosocial Disability. Minor updates to change any NDIS Business System language to PACE language.	DRAFT	2023-08-23
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Guide – Psychosocial disability Case examples

This article provides guidance for a **planner delegate**, **internal review delegate**, **national reassessment delegate**, **local area coordinator**, **early childhood partner**, **technical advisors**, **liaison officers (HLO/JLO)**, or **complex support needs (CSN) planner** to understand:

- case examples of participants living with psychosocial disability.

Recent updates

October 2023

Current guidance.

Before you start

You have read and understood:

- Our Guideline – Reasonable and necessary support (external)
- article Guide – Psychosocial disability.

Case examples

Billy

Meet Billy

Billy has met access requirements, has been hospitalised for four months in a mental health facility and is on a forensic order. The forensic order is a community-based order, as opposed to a custodial order, and states that he must continue to access treatment and attend all appointments made in relation to his mental health condition as recommended by his treating psychiatrist.

Discussion

Funded supports should not be provided while Billy is residing in the facility. While Billy is an inpatient, the health system is responsible for meeting the day-to-day care and support needs, including those related to his disability. This includes any supports required to access the community as part of rehabilitation.

In this case, the mental health system retains responsibility for providing:

- clinical treatment related to the participant's mental health condition
- rehabilitation/recovery treatment
- residential care where the primary purpose of the care model is for time-limited support following inpatient treatment, for example, Step Up/Step Down programs.

Planning

Before developing Billy's plan, the plan developer requests information regarding discharge planning from the mental health facility and records the following information in PACE:

- planned timeframes for discharge
- confirmation that the participant's mental health condition has stabilised and the participant is well enough to live safely in the community
- details of where the participant will be living after discharge including what informal supports are available to them
- details of the mental health and health clinical supports that will be put in place to support the participant post discharge
- information about what other supports will be required post discharge to support the participant with daily activities
- any other information available.

When discharge is planned for within 12 weeks, a plan is developed following the normal planning process. Once the plan is approved, a warm handover is completed with the recovery coach or support coordinator. The recovery coach or support coordinator starts working with Billy and facility staff to progress transition planning.

If Billy requires a plan prior to 12 weeks before the scheduled discharge date, a community connections plan with the details of his mainstream and informal supports can be developed. The plan should be developed and plan meeting conducted before discharge, once the discharge date is known, to include funding in the plan for supports required when the participant leaves the mental health facility.

The partner or planner attaches a copy of the forensic order to the participant's record in PACE. The planner adds an alert related to the order.

Note: Refer to the technical advice case in PACE to understand if you need to request mandatory TAB advice. To learn more, go to article Understanding when to request for plan advice.

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Jane

Meet Jane

Jane is 41 years old and lives in public housing. Jane was studying to become a vet before her education was interrupted by the onset of mental illness. Jane experiences high levels of anxiety when she leaves her home. She has previously been hospitalised following a decline in her mental health.

Access to Informal, Community and mainstream supports

Jane receives support from a support worker funded through her NDIS plan. However, Jane reports having no friends and that she rarely sees her family.

Jane lives alone and has a number of bird cages and pet accessories. The public housing authority asked Jane to reduce the clutter in her house so that it can be cleaned, but she refused. Jane has been threatened with eviction.

Engagement with the NDIS

Jane has a plan reassessment meeting with her My NDIS Contact and they discuss recovery coach support available to participants with psychosocial disability. We include capacity building support for a recovery coach in Jane's NDIS plan as she is currently not linked to clinical supports and has little informal or community supports in place.

The recovery coach helps Jane to develop a recovery plan. They identify what's important to her, exploring her values and interests and link this to her NDIS goals of maintaining her current housing and getting a job.

Jane identified caring for animals as an interest. The recovery coach supported Jane to:

- identify the barriers to achieving her goals
- identify the skills she needed to help her take steps toward these goals
- to link with a psychologist to work with her to develop strategies for managing anxiety and building up emotional strength to spend time out of the house

Jane sought out reassurance and encouragement from her recovery coach to engage with her psychologist. She initially felt that her sessions with her psychologist were not a good use of the psychologist's time. She discussed her concerns with her recovery coach who reassured her that the psychologist was there to support her.

The recovery coach helped Jane to develop the confidence to begin volunteering at an animal shelter.

Jane, having practiced self-advocacy and negotiation skills with her recovery coach, is working with a housing support officer to reduce the clutter of pet accessories in her house. She has

successfully negotiated the sale of several items through Gumtree. Jane has managed to avoid eviction and her housing is stable.

What's happening for Jane now

It has been several months since Jane began receiving support from a recovery coach. She has increased her volunteering hours during this time, and she hopes to increase to two days a week in the future. Through her volunteering Jane has made several friends, has taken up swimming and joined a walking group which are helping her physical strength, energy and sense of wellbeing.

Jane has updated her goals in her recovery plan with her next goal being to learn computer and other digital skills so she can study an online certificate in animal care. Jane, with the help of an employment service hopes to apply for a job at the local animal shelter.

Article topics and case names – internal use only

Topics

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Add or update psychosocial recovery coach funding in a plan approval case

This article provides guidance for a **planner delegate** to:

- understand when to include recovery coach support
- understand factors to consider when determining level of funding
- add psychosocial recovery coach support funding
- update psychosocial recovery coach support funding.

Refer to article Guide – Psychosocial disability for information about planning with participants with a psychosocial disability.

Recent updates

October 2023

Current guidance

Before you start

You have:

- read and understood Our Guideline – Reasonable and necessary supports (external)
- made a decision to include psychosocial recovery coach funding in a participant's plan
- read and understood article Understand the product catalogue
- read and understood article Support Categories

When to include recovery coach support

The inclusion of recovery coach support in the participant's plan must be determined to be reasonable and necessary. A recovery coach will be available to participants across all streams – General, Supported, Intensive and Super Intensive.

Generally, if a participant's primary disability is psychosocial disability, you should consider including the support of a recovery coach. Recovery coach support should be included if, in your discussions with the participant, you identify they require support to:

- link to and maintain engagement with informal, community, mainstream and funded supports
- build capacity, including strengths and resilience.

The provision of recovery coaching should be prioritised for the first five years of the participant's involvement in the Scheme. The level of funding should consider both the period of engagement with the NDIS and the functional capacity of the participant.

Effective recovery coaching results in improved engagement in recovery, self-management and capacity building. The rate of improvement will vary based on the individual, their life circumstances and the patterns of their mental health condition. However, it is reasonable to expect progress over a five-year period.

If recovery coach support is included in the plan, submit the Request for Service during plan implementation. Refer to article Complete the request for service.

Support Coordination

Generally, the participant should not have funding for both recovery coach support and support coordination included in their plan.

If the participant's previous plan had funding for support coordination, talk about the supports a recovery coach can provide. Explain how a recovery coach can provide targeted support in relation to their psychosocial disability and can support them in their recovery journey.

If the participant is already connected with a support coordinator, they can choose:

- if they want to use their recovery coach funding to continue receiving support from their support coordinator
- or change to support provided by a recovery coach.

For more information, refer to article Add or update support coordination funding in a plan approval case.

Levels of recovery coach support

You should consider the participant's individual circumstances when you determine the level and number of hours to be included in their plan. Consider existing informal supports and any additional barriers when you determine the level and number of hours to include in their plan. Provision of recovery coach hours should be based on the needs and expressed preferences of the participant and feedback from their support network.

There are three indicative levels of funding for a psychosocial recovery coach:

- Level 1: 100 hours per year
- Level 2: 50 hours per year
- Level 3: 30 hours per year.

Use these levels as a guide for reasonable and necessary decision making. Participants generally require level 1 funding if:

- this is their first plan with recovery coach funding included
- it is during the first three years of engagement with the NDIS.

Funding may be adjusted to level 2 and 3 after this period. The level of funding can be reduced over time as the participant builds on their strengths and capacity.

Factors to consider when determining level of funding

Factors to consider when determining reasonable and necessary level of funding include:

- **Level of support required to connect and maintain engagement with informal, community, mainstream and funded supports**. Consider historical levels of engagement with supports and if recovery coaching supports are needed to maintain engagement and/or to support to reconnect after a period of disengagement. Consider the level of support required to ensure other funded supports are working in a recovery-oriented way.
- **Period of time in the Scheme**. The provision of recovery coaching should be prioritised in the first five years of a participants' involvement with the Scheme. Effective recovery coaching should build participant capacity in engagement, self-management and use of recovery plans and clinical supports.
- **Level of engagement with clinical supports**. For example, a participant engaged with an appropriate level of coordinated clinical supports will generally require a lower level of recovery coach supports.
- **Level of social isolation**. For example, a participant with low levels of social and economic participation will generally require increased levels of recovery coaching. These increased levels will address barriers, identify, and build strengths and increase motivation.

- **Fluctuating needs**. Many people with psychosocial disability experience fluctuating needs. Consider what level of recovery coaching support is needed for the duration of the plan period to address fluctuating needs. An increase in funding may be required for some participants who experience an acute episode of mental ill-health. This will address further decline in functional capacity.

For further guidance use the **Plan Conversation Support Tool**. Find the **Plan Conversation Support Tool** in the Tasmania Resource library (intranet).

Add psychosocial recovery coach funding

Add psychosocial recovery coach funding

To add psychosocial recovery coach funding in a draft budget, complete the following PACE steps:

1. In a **Plan Approval** case, select the **Draft Budget** tab.
2. Select **New Support Category**.
3. Enter **Support Coordination and Psychosocial Recovery Coaches** into the **Support Category** field.

   Note: The support budget will be locked to **Capacity Building**.
4. The **Budget Type** for this support will default to 'Stated'.
5. Select the **Instalment Type**.

   Note: The **Frequency** and **Plan Duration** fields will be locked. To change the plan duration, refer to article Change plan duration.
6. Enter the **Amount** of this support.

   Note: For instalment type 'regular', this amount is the monthly amount. PACE will calculate the frequency amount and the total plan amount. Use the **Plan Conversation Support Tool**. Find the **Plan Conversation Support Tool** in the Tasmania Resource library.
7. Record the **TSP Variance Reason** from the drop-down list.
8. Record **Additional Description** about why this support is needed.

   Note: These comments will not display on the participant's plan. Use these comments to discuss funded supports as part of a plan implementation meeting.
9. If the support meets all of the NDIS funding criteria under the **Justifications** heading, select the checkbox.

10. Record **Justification** in the free text field. For some supports, this might automatically populate. For more information about recording justifications, refer to article Add budget justifications.

    Note: This field has a character limit of 3000. Certain special characters in this field may cause an error. This is generally caused when copying justifications from SAP CRM into PACE. If you see the characters **|%,** you will need to remove these before you can select save.

11. If you're using evidence to support your justification, select the **Evidence Used** checkbox.
12. Select the **Evidence Type** from the drop-down list.
    - if the **Evidence Type** is **Document,** go to step 13
    - if the **Evidence Type** is **Other**, go to step 14.
13. Enter the **Evidence Link** name. You can view linked evidence on the **Evidence** tab of the **Plan Approval** case. To learn more about linking evidence, refer to article Add and link evidence to a case.
14. Enter the **Evidence Explanation** into the free text field
15. If you need to add more evidence to support your justification, select the checkbox **Add further evidence links** and repeat step 12.
16. Select **Save**.

Update psychosocial recovery coach funding

Update psychosocial recovery coach funding

To update psychosocial recovery coach funding in a draft budget, complete the following PACE steps:

1. In a **Plan Approval** case, select the **Draft Budget** tab.
2. Select **Support Coordination and Psychosocial Recovery Coaches** from the **Stated Budget** items.
3. The **Budget Type** for this support will default to 'Stated'.
4. Select the **Instalment Type**.

   Note: The **Frequency** and **Plan Duration** fields will be locked. To change the plan duration, refer to article Change plan duration.
5. Enter the **Amount** of this support.

6. **Note**: For instalment type 'regular', this amount is the monthly amount. PACE will calculate the frequency amount and the total plan amount. Use the **Plan Conversation Support Tool**. Find the **Plan Conversation Support Tool** in the Tasmania Resource library.
7. Record the **TSP Variance Reason** from the drop-down list.
8. Record **Additional Description** about why this support is needed.

   Note: These comments will not display on the participant's plan. Use these comments to discuss funded supports as part of a plan implementation meeting.
9. If the support meets all of the NDIS funding criteria under the **Justifications** heading, select the checkbox.
10. Record **Justification** in the free text field. For some supports, this might automatically populate. For more information about recording justifications, refer to article Add budget justifications.

    Note: This field has a character limit of 3000. Certain special characters in this field may cause an error. This is generally caused when copying justifications from SAP CRM into PACE. If you see the characters **|%,** you will need to remove these before you can select save.
11. If you're using evidence to support your justification, select the **Evidence Used** checkbox.
12. Select the **Evidence Type** from the drop-down list.
    - if the **Evidence Type** is **Document**, go to step 13
    - if the **Evidence Type** is **Other**, go to step 14.
13. Enter the **Evidence Link** name. You can view linked evidence on the **Evidence** tab of the **Plan Approval** case. To learn more about linking evidence, refer to article Add and link evidence to a case.
14. Enter the **Evidence Explanation** into the free text field.
15. If you need to add more evidence to support your justification, select the checkbox **Add further evidence links** and repeat step 12.
16. Select **Save**.

Remove psychosocial recovery coach funding

To remove psychosocial recovery coach funding in a draft budget, complete the following PACE steps:

1. In a **Plan Approval** case, select the **Draft Budget** tab.

2. Select **Support Coordination and Psychosocial Recovery Coaches** from the **Stated Budget** items.
3. If removing the support item, scroll to bottom and select **Remove Support from Budget**.
4. Select **Yes** to **Are you sure you want to remove?**.
5. Select **Save**.

Next steps

1. If you have added or updated psychosocial recovery coach funding, you will need to make a fund management decision. Refer to article Make fund management decision.
2. If you need to add further supports, refer to article Change the draft budget.
3. If you are ready for the plan meeting, refer to article Prepare for the plan meeting.

Article topics and case names – internal use only

Topics

This article relates to the following topics:

- **Add**: t_createaplan
- **Add**: t_planchanges
- **Add**: t_psychosocialdisability
- **Add**: t_reasonableandnecessary

Case names

You can use this guidance for the:

- **Add**: case_planapproval
- **Add**: case_planchange

Version control

SGP Knowledge Article Template

For Internal Use Only

Version	Amended by	Brief Description of Change	Status	Date
1.1	BTM847	KA transferred to correct template KA title updated Aligned to Pace system steps and language Included system steps for update and remove support Added before you start and next steps sections	DRAFT	2023-08-09
1.2	REB563	Peer review	DRAFT	2023-09-20
1.3	BTM847	Action peer review Sent for VT review VT results: Long sentences 8.25% Passive voice 10.31% Readability 45/100 Grade level 9.1	DRAFT	2023-09-20
1.4	JS0082	EL2 review to progress to BiLs	DRAFT	2023-09-21
1.5	BTM847	BIL feedback transferred Action BIL feedback BIL endorsement received	DRAFT	2023-09-28
2.0	JS0082	Class 1 Approval	APPROVED	2023-09-28

Schizophrenia Disability Snapshot

This Disability Snapshot provides general information about schizophrenia. It will assist you in communicating effectively and supporting the participant in developing their goals in a planning meeting. Each person is an individual and will have their own needs, preferences and experiences that will impact on the planning process. This information has been prepared for NDIA staff and partners and is not intended for external distribution.

Peak body consulted

In developing this resource we consulted with Mental Health Australia.

What is schizophrenia?

Schizophrenia is an established medical disorder that is common worldwide. Up to 1 in 100 people will experience schizophrenia.

Schizophrenia is characterised by symptoms that are grouped as positive, negative and cognitive:

- **positive symptoms** are intense episodes of psychosis, in which a person may experience auditory and/or sensory hallucinations and delusional beliefs, including paranoia. Psychosis can make it difficult for a person to distinguish between what is real and what isn't real
- **negative symptoms** are often characterised by reduced expression and/or reduced motivation and/or a reduced capacity to function in everyday life
- **cognitive symptoms** generally relate to attention, memory, verbal skills and may include longer periods of slowed or confused thinking.

Antipsychotic medicines are the main form of treatment for schizophrenia.

It is important to note that people experiencing schizophrenia do not have a split or multiple personalities and they are not inherently more prone to violence. In fact they are more likely to become a victim of violence.

How is schizophrenia diagnosed?

Schizophrenia may take time to diagnose. A person will only receive a confirmed diagnosis of schizophrenia after experiencing one month of psychotic symptoms and six months of reduced functioning.

A GP or other medical professional might make the initial assessment, and would then refer the person to a specialist, usually a psychiatrist for diagnosis. The specialist might then make a working diagnosis of schizophrenia, so that treatment can begin without delay.

There is no known biological marker for schizophrenia. Schizophrenia is primarily a clinical diagnosis, it is diagnosed by identifying signs and symptoms and monitoring how the symptoms develop over time.

Language and terminology

People living with mental illness don't like to be defined by their diagnosis, to be stigmatised or have assumptions made about them. Therefore phrases such as 'schizophrenia sufferer' or 'he's a psychotic' are inappropriate.

Instead say:

- she lives with schizophrenia
- she has had an experience of schizophrenia
- he has had an experience of psychosis
- person living with schizophrenia
- the person has schizophrenia.

Enabling social and economic participation

Support to participate in the community and in work can help prevent social isolation and promote recovery and wellness for people living with schizophrenia. It is important to explore how a person with schizophrenia can be supported to participate in activities, education and employment, taking into consideration their interests and aspirations as an individual.

NDIS supports can assist participants build life skills, capabilities and greater independence. This may include being supported through a vocational 'discovery' process to explore their strengths and interests in the context of work, particularly for young people transitioning from school into employment.

Early access to pre-vocational training and employment opportunities can improve long-term outcomes in both employment and education. Peer support from other people living with schizophrenia can also play a key role in improving participation in work and the community.

Volunteering can also be a first step in building confidence and exploring the person's interests and strengths.

How can I tailor a meeting to suit a participant with schizophrenia?

People experiencing schizophrenia are above all, individuals the same as you and me. No two people with schizophrenia are alike, they will experience schizophrenia in different ways and their needs will vary as much as anyone else. They enjoy family, friends, have a sense of humour, sporting interests and like to participate in all aspects of the community.

Many people living with schizophrenia are indistinguishable from people without the condition and they may not require any special considerations or treatment.

However, a person experiencing schizophrenia may be affected by slowed or confused thinking, or reduced expression, motivation and functioning. They may also experience distressing side-effects of their medication. This may mean the person might require more time than usual to understand what is being said and to compose or express their thoughts.

When meeting with a person with schizophrenia, provide a quiet, respectful and calm environment. Allow the person the time they need. Avoid the temptation to finish their sentences or rush them. Do not assume you know what they need or want.

A person experiencing active psychotic symptoms, delusional beliefs and/or sensory hallucinations may find it very difficult to concentrate and to trust the situation they are in. They may feel irritated, agitated or frightened. Remain calm, show respect and compassion and focus on how they feel, rather than the details of their delusions or hallucinations.

Helpful links

- Spotlight on Schizophrenia — SANE Australia website.

Version control

Version	Amended by	Brief Description of Change	Status	Date
2.0	NAN927	Class 1 Approved Annual review of resource, additional information added on enabling social and economic participation.	APPROVED	2020-03-25

Psychosocial Disability Snapshot

The content of this document is OFFICIAL. This Disability Snapshot provides general information about psychosocial disability to assist you in communicating effectively and supporting participants to develop their goals. Each person is an individual with their own needs, preferences and experiences. This information has been prepared for NDIA staff and partners and is not intended for external distribution

Peak body consulted

In developing this resource we consulted with Community Mental Health Australia (CMHA) and Mental Health Coordinating Council of NSW (MHCC).

What is psychosocial disability?

Psychosocial disability refers to the social and economic consequences related to mental health conditions. It is used to describe the challenges, or limitations, a person experiences in life that are related to mental health conditions. This may include challenges or limitations in their capacity to:

- have a good social network including friends and a family of their own
- participate fully in life
- experience full physical health
- manage the practical, social and emotional aspects of their lives
- engage in education, training, cultural activities and economic participation
- achieve their goals and aspirations.

The impact of psychosocial disability can vary over time because of the difficulties people experience with mental health conditions and many other factors in the individual's life. Not everyone living with mental health conditions will experience a significant psychosocial disability and individuals will experience psychosocial disability differently.

In Australia, people with a psychosocial disability make up a significant proportion of Australia's most disadvantaged population. People with a mental illness (21.7%) are the second largest group receiving the Disability Support Pension.

People with psychosocial disability may also have lived and living experience related to trauma, suicidal ideation, and substance use. The complexity of this means you should adopt a whole of person approach.

How is psychosocial disability identified?

A person may be diagnosed with a mental health condition, but psychosocial disability is not a diagnosis. Psychosocial disability is **identified** by the impacts of, or impairment resulting from, the person's mental health conditions.

A health professional such as a GP, psychiatrist or allied health professional may identify psychosocial disability through assessment or testing.

Impairment resulting from psychosocial disability can be episodic or fluctuating. To understand the functional impact and psychosocial disability for an individual, it can be helpful for an allied health professional (for example occupational therapist, psychologist, speech therapist, social worker) to provide an overall assessment of the person's functioning. It is important that the assessment considers the impacts in relation to:

- mobility
- communication
- social interaction
- learning
- self-care
- decision-making.

Psychosocial disabilities often include cognitive difficulties which may affect function in the areas of:

- memory
- communication
- organising and planning skills
- social interactions
- visual interpretation.

The symptoms of a mental health condition may be of an episodic nature and vary in intensity and need for support. How this impacts on psychosocial disability may mean that there will be times when a person may experience significant limitations; while at other times they may be able to go about their daily life without experiencing the same challenges.

Language and terminology

When talking with or about a person with a psychosocial disability, use 'person first' language. For example, saying 'person living with a psychosocial disability' rather than 'disabled person'. People with mental health conditions usually prefer not to be defined by them. Using strength-

based language, rather than focusing on a person's limitations, maximises a person's sense of self, and independence.

The term 'recovery' is used widely throughout the mental health service system and can have different meanings for different professionals/disciplines and people accessing the services. The NDIA defines recovery as achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental health condition.

Recovery is an individual and unique process. It is defined by the person and driven by their needs and preferences. Recovery involves:

- having hope
- being motivated
- feeling optimistic about the future
- having the skills and strategies to manage the challenges the participant may experience
- ensuring that services are delivered using a trauma-informed recovery-oriented practice approach.

It is important to use language that reflects the recovery-based approach. You can find more information on recovery-orientated language in the Helpful Links section and in the Practice Guide – Psychosocial Disability.

Enabling social and economic participation

Some of the consequences of psychosocial disability may include:

- poverty
- discrimination
- unemployment
- poor educational outcomes
- poor housing.

The relationship between these consequences and the underlying mental health condition can be interconnected and two-way. For example, loss of connection with family, friends and community can worsen a participant's mental health. It is important to focus on building and maintaining social connection and relationships.

The earlier a person connects with services and supports, the better. The episodic nature of a mental health condition may vary on a day-to-day basis or over the person's life span, and their plan needs to be flexible enough to respond effectively.

A self-directed, strengths-based, trauma-informed, recovery-oriented approach to a person's mental health and well-being is highly effective. This may mean working with the person to help them identify some safe activities to start such as building their social networks or getting back into work. Capacity building supports are important to this approach as well as core and assistive technology supports. Adopting a **strengths-based approach** in supporting the participant to identify their goals, objectives and aspirations is vital to build rapport and develop independence. In using a strengths-based recovery approach, you will focus on the participant's talents, positive attributes and potential and identify how that will help them to achieve their goals.

Capacity building supports:

- A **Recovery Coach** support can provide assistance in building capacity and resilience in people with psychosocial disability and support them to live a more fulfilling life. Recovery coaches work with participants, families, carers, and other services to get the best outcomes from NDIS supports.
- A **support coordinator** can be effective in maintaining continuity of supports and allows for supports to be increased quickly and/or accessed at short notice as needed. Support coordinators can also ensure appropriate support is available around transitions from hospital to community, and that an ongoing relationship is there to facilitate engagement in social, economic and community life.
- An **occupational therapist** with specialist knowledge in mental health can assess functional capacity and provide support in maintaining a job, volunteer role, study, and/or social networks.
- An **exercise physiologist** can provide an accessible and achievable exercise program to support a person's mental health and build community networks.

Core supports:

- A functional home environment can improve mental health. **Support workers** can assist with daily living activities in the home like meal preparation and cleaning.
- **Support workers** can also assist with and encourage participation in an exercise plan given by an exercise physiologist and promote self-care with regards to personal care and physical health.
- Access to **community groups** can help facilitate social inclusion and build relationships.

Assistive Technology (AT):

- **AT** can provide both functional and emotional support for example by assisting individuals to learn new information and build organisation, concentration and planning skills.

Families and carers

Family, friends, carers and kinship groups play an important role in a person's recovery. Mental health carers can include a parent caring for a child, an adult caring for a partner, friend, parent, or sibling, or a child caring for a parent. Due to the episodic nature of mental health conditions, people living with psychosocial disability may require regular on-call care. Family members often provide care for many years, often either in their own home or the home of the person living with psychosocial disability.

Other informal supporters are often unexpectedly called upon to play a role in mental health care. They may have found themselves in this carer role because they see it as part of their relationship with the person with psychosocial disability. Nevertheless, they may not think of themselves as a 'carer'.

It is important to consider whether the level of care provided by family members, carers or informal supports is sustainable. It may be reasonable and necessary to include core supports and respite to prevent carer burnout. To support carers and family members in this role, provide them with relevant resources and information.

Refer to the Helpful Links section for more information.

How can I tailor a meeting to suit a participant with psychosocial disability?

Many people who live with psychosocial disability may have experienced trauma in their life and can become distressed if they do not feel safe. To facilitate a sense of safety make sure you:

- Allow enough notice for the person to prepare for meetings (ideally four weeks) and be clear about what 'prepared' means.
- Consider the environment and ask the person what helps them feel safe in a room. Let them know the choices they have, such as having the meeting in a familiar place, having a support person with them, and whether the gender of the support person and the NDIA representative is important. A support person may need to be invited to attend as they can be particularly important to help convey a person's needs.

- Provide easy access to exits and offer breaks or follow-up meetings.
- Be honest and clear about what you can and can't do. Set boundaries and expectations early and allow the person to set their own boundaries if possible.
- Maintain confidentiality and be clear about what information will be kept and what it will be used for.
- Provide information about your recommendations and why they are relevant, even if it seems obvious.
- Ensure the participant understands what choice and control means in the conversation. People may feel very disempowered by those they see as 'authority figures' and may feel intimidated. Encourage the person to take part in the process, allow them space and time to speak up. An example question could be: "Is this the ideal outcome today from your point of view? How do you think we could achieve this?"
- Listen non-judgmentally and collaborate with the person to clarify their need. Ask the person what they find important and don't make assumptions. Use paraphrasing and clarifying questions to understand their wants and needs.
- Use the Reimagine Workbook (see the Helpful Links section) which has a tool to use in collaboration with the participant.

What people with psychosocial disability want you to remember

- People living with psychosocial disability have first-hand knowledge of what they experience.
- Involving a support person in a planning meeting can help the participant feel safer and more confident to ask for what they need and don't want.
- The road to recovery varies from person to person.
- People with psychosocial disability often experience stigma and discrimination which can be highly distressing.
- Psychosocial disability is not a visible disability, but the impact on a person's life is very real.
- Take the concerns of the person living with psychosocial disability seriously.
- Social inclusion and community connection are significant to recovery.

Helpful links

- Reimagine
- Reimagine my life Workbook
- Mental Health Carers Australia
- Recovery Oriented Language Guide
- Unravelling Psychosocial Disability Booklet
- Practice Guide – Psychosocial Disability
- Conversation style guide

Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	ZWECKM	Initial Version Class 3 Approved	APPROVED	2020-08-28

Advice Support Tool

Theme: Capacity Building

Sub-Theme(s): Exercise Physiology

References:

NDIS Act 2013 Section 34 1. (a) - (f) and 2.

NDIS Support for Participant Rules 2013

Note: All criteria need to be met for the supports to be funded through the NDIS.

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
34.1(a) Enabling the participant's goals and objectives (supports will assist the participant to pursue the goals and objectives in their plan)	☒ Yes → ☐ No →	With requests for Exercise Physiology, it is likely that this criterion will be met. If a Participant's goals are not related to any sort of physical function, then this criterion may not be met.
34.1(b) Assist the participant's social and economic participation (supports will assist the participant to undertake activities to facilitate their social and economic participation)	☒ Yes → ☐ No →	The intention of Exercise Physiology is typically for the management of disability related deficits in functional capacity (i.e., strength, mobility, balance). Maintaining these aspects of function are important for a Participant's ability to access the community for social and economic participation. This criterion is usually met.
34.1(c) Value for money (supports represents value for money, ie the costs of support are reasonable, both in terms of the benefits achieved and the cost of alternative support) Consider NDIS Support for Participant Rules 2013 Part 3.1 (a) – (f); Are there any expected changes to the participant's circumstances in the next 1-2 years that may make it inappropriate to fund the requested equipment or modifications? If yes, have comparative costs of purchasing or hiring the equipment or modifications been provided? Are there comparable support options which would achieve the same outcome at a	☒ Yes → ☐ No →	**There are 2 scenarios where an increase can be considered (should 34.1c be the only R&N criteria not met):** 1. The Participant is accessing therapies at the planned rate/amount, and they are not able to maintain function. 2. The Participant is accessing the therapy at an increased rate/amount than is accounted for in the plan and maintaining function. In both instances, the exercises being completed within the therapist-led sessions should be requested (i.e., are they doing things in therapy that are not addressing the Participants functional deficits?).

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
substantially lower cost? What alternative supports were considered? Is there evidence that the support will substantially improve the life stage outcomes and be of long-term benefit to the participant? Is there evidence that funding support is likely to increase independence and reduce funded support costs in the long-term? Is there evidence the support will increase the participant's independence and reduce the participant's need for other kinds of supports? Consider the primary purpose of support and if any additional or non-standard features have direct functional outcomes that will reduce funded support needs. Is there evidence the quoted support cost is comparable to expected cost of same kind of supports? Consider NDIA benchmark pricing guide and PANDA tool.		If it is clear they are completing appropriate exercises to address the Participant's needs AND lower cost options have been explored and are not suitable, then an increase can be considered. If it is evident that the Participant is making progress/maintaining function with an amount of support that is LESS than what is being requested, then it is fair to say that the current level is sufficient. **Evidence to consider whether 34.1c is met/not met:** - Is there a home program in place? If the Participant can exercise at home or in the community, this should be encouraged as much as possible. It is likely that better outcomes will be achieved from implementation of daily strategies to address strength, mobility, and balance compared to isolated therapy sessions. - Has the therapist and Participant trailed a home program? If yes, has the therapist provided reasons why it was inappropriate or insufficient to meet their needs. If no, why not? - Can support workers or informal supports be used to oversee a basic home program written by an EP? - Can the Participant access a community gym with a support worker using Core SCCP funding? - What else is the Participant funded for? Physio? OT? Are there overlaps in what the other therapists are doing? A lot of times Physiotherapists will be working towards more localized

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		aspects of a disability (i.e., respiratory function, range of motion, transfers) and an exercise physiologist will be focusing on more global aspects (strength, mobility, and balance). It should be noted that Physiotherapists are qualified to and will prescribe generalized exercise programs to address strength, mobility and balance. - Is the amount being requested excessive? Especially considering CB supports are typically provided for maintenance of function (excluding early childhood). Anything more than 1 hour per week could be considered rehabilitative and not in-line with what is provided for maintenance of function or to improve the capacity of the Participant to independently manage their disability. Creating a reliance on therapists is not the aim of NDIS funded CB supports. - Is 1 hour per week likely to produce a different outcome to 1 hour per fortnight or 1 hour per month? Depending on the level of physical disability, the evidence provided by the therapist and whether the Participant's disability is acquired or congenital should impact decision making. If a home program has been found to be unsafe or ineffective, then increased therapist contact can be considered. - Generally, for physical disabilities which are acquired later in life, a higher frequency of therapy can be considered. For congenital disabilities which are stable, it is likely the Participant's function can be managed with a lesser level of

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		therapist support and a delegated model of care can be used to deliver the exercise program (Therapy Assistants, Support Workers, or Informal Supports) **Therapy Assistants** - Therapy Assistants have a Cert IV in Allied Health Assistant and are qualified to assist with the delivery of EP prescribed exercise programs. - In most instances, these are a suitable lower cost option for Participants requesting EP supports. - EP's will claim TA's don't have the knowledge, skills or qualifications to adjust prescription due to the Participants fluctuating presentation, which is true. - It is expected that the EP provide the TA with multiple programs that can be completed based on the Participants presentation (i.e., 3 programs - one for a "normal" day, "good" day and "bad "day) - TA's can be difficult to find and sometimes the EP's will use this as a justification for their increased involvement. Unfortunately, this is not something the NDIS considers when applying S34.1 criteria.
34.1(d) Support is effective or beneficial for the participant (supports will be, or are likely to be, effective for desired effect and beneficial for the participant, having regard to current good practice) Consider NDIS Support for Participant Rules 2013 Part 3.2 and 3.3	☒ Yes → ☐ No →	The EP must provide measurable outcomes to justify their recommendations to prove that the therapy is effective and beneficial for the Participant. Reports that uses words like "increased", "decreased" or "improved",

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
What are the expected benefits of the support provision? How will effectiveness of achieved outcome be measured? When will effectiveness of achieved outcome be achieved? Are there other supports required to achieve or maximise the reported support outcomes for participant?		is not measurable and should be flagged. Data such as strength assessments (measured in kg's), range of motion (measured in degrees), balance (timed) and mobility (distance covered, gait description) should all be captured every 3-6 months. Laypersons descriptions for completions of ADL's (i.e., couldn't make a cup of tea and can now make a cup of tea) can be sufficient but it can be difficult to determine whether these outcomes can be directly attributed to EP therapy. If the EP is unable to prove that the therapy, they are completing is effective in managing the Participants function, then 34.1d may not be met.
34.1(e) Support coordinates with but does not replace informal support (funding or provision of supports takes account of what it is reasonable to expect families, carers, informal networks and the community to provide) Consider NDIS Support for Participant Rules 2013 Part 3.4	☒ Yes → ☐ No →	As discussed above in 34.1c: - If the Participant can exercise at home with supervision from informal or formal supports, this should be encouraged. - If the Participant can access a community gym (alone or with a support worker) this should be encouraged. An EP may go to a gym or to the Participants home with the Participant and support worker present to determine which equipment and exercises are suitable for completion independently or with a support worker present.
34.1(f) Support is most appropriately funded by the NDIS (supports are not more appropriately funded or provided through other general service systems or universal service obligations Consider NDIS Support for Participant Rules 2013 Schedule 1.	☐ Yes → ☒ No →	Requesting EP for the following purposes USUALLY will not meet 34.1f: - Weight management - Cardiovascular health - Bone density (osteoporosis, osteopenia) - Mental health or mood management

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
Support will not cause harm (Supports will not be funded if it is likely to cause harm to the participant or pose a risk to others, or the support would be contrary to a law of a jurisdiction) Consider NDIS Support for Participant Rules 2013 Part 5.1 and 5.3	☒ Yes → ☐ No →	Criteria usually met
Support is directly related to the participant's disability (supports will not be funded under the NDIS if they do not relate to the participant's disability or are day-to-day expenses or income replacement) Consider NDIS Support for Participant Rules 2013 Part 5.1 and 5.2	☒ Yes → ☐ No →	Criteria usually met. Even in instances where a Participant has met access for a Psychosocial disability, EP support can be related to a Participant's disability in most instances.
Support does not duplicate other supports (supports do not duplicate other supports delivered under alternative funding through the NDIS such as Information, Linkages and Capacity Building (ILC) funding.) Consider NDIS Support for Participant Rules 2013 Part 5.1	☒ Yes → ☐ No →	As discussed, there can be some duplication risk with Physiotherapy in particular. It is important to understand what each therapist is completing with the Participant (the goals may be the same but the strategies should differ).
Are all of the above criteria met for all supports?	☒ Yes → ☐ No →	Criteria most often NOT met = 34.1c and 34.1e. Usually lower cost options are suitable and can produce comparable outcomes and usually some delegation of the exercise program is appropriate.

Version Control

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V1.0	Cleared	01/09/2023	JGM776	Production of initial V1.0
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Advice Support Tool

Theme: Continence

Sub-Theme(s):

References: [include any relevant referenced documents]

NDIS Act 2013 Section 34 1. (a) - (f) and 2.

NDIS Support for Participant Rules 2013

SOP_DisabilityRelatedHealthSupports.docx

Continence Supports | NDIS

Continence Assessment

Note: All criteria need to be met for the supports to be funded through the NDIS.

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
34.1(a) Enabling the participant's goals and objectives (supports will assist the participant to pursue the goals and objectives in their plan)	☒ Yes → ☐ No →	The participant may not have a specific goal regarding incontinence, however, consider how the management of urinary and faecal incontinence may underpin and assist the participant to pursue their stated goals. For example, goals around increased independence and community access may be achieved if provision of appropriate continence consumables and formal support are provided to ensure appropriate management and containment resulting in maintaining health, wellbeing and dignity.
34.1(b) Assist the participant's social and economic participation (supports will assist the participant to undertake activities to facilitate their social and economic participation)	☒ Yes → ☐ No →	Continence management will result in appropriate and socially acceptable strategies in place to ensure that the participant's urinary and fecal incontinence is appropriately managed, and their dignity preserved. This in turn increases the participant's opportunities to be included and to participate in social and economic opportunities. This may include the provision of continence consumables and formal supports if the participant is unable to independently manage their incontinence.
34.1(c) Value for money (supports represents value for money, ie the costs of support are reasonable, both in	☒ Yes →	Has there been a Continence Assessment by an independent or hospital-based Continence Specialist

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
terms of the benefits achieved and the cost of alternative support) Consider NDIS Support for Participant Rules 2013 Part 3.1 (a) – (f); Are there any expected changes to the participant's circumstances in the next 1-2 years that may make it inappropriate to fund the requested equipment or modifications? If yes, have comparative costs of purchasing or hiring the equipment or modifications been provided? Are there comparable support options which would achieve the same outcome at a substantially lower cost? What alternative supports were considered? Is there evidence that the support will substantially improve the life stage outcomes and be of long-term benefit to the participant? Is there evidence that funding support is likely to increase independence and reduce funded support costs in the long-term? Is there evidence the support will increase the participant's independence and reduce the participant's need for other kinds of supports? Consider the primary purpose of support and if any additional or non-standard features have direct functional outcomes that will reduce funded support needs. Is there evidence the quoted support cost is comparable to expected cost of same kind of supports? Consider NDIA benchmark pricing guide and PANDA tool.	☐ No →	nurse? NOTE a product recommendation from a nurse employed by the manufacturer of continence consumables is not a continence assessment. Has the participant been using the suggested continence consumables for some time and the request is to continue with these consumables? If yes, then typically we should consider that the consumables meet the needs of the participant. Has the assessor considered any likely changes i.e., are the individual needs stable? Participant's continence consumable needs may change over time and though many participants use the same consumables for many years it must not always be assumed that they remain the most effective and beneficial or best value for money. Have comparable continence consumables been explored and reasons outlined why they could not achieve the same outcome at a substantially lower cost? All consumables should be clinically indicated by the functional need this may include higher cost consumables such as hydrophilic catheters for Clean Intermittent Self-Catheterisation (CISC). Does the continence consumable reduce the reliance on formal and informal support? For example, this may influence the type of continence pad suggested or a request for waterproof linen which only requires a wipe over rather than full wash when contaminated. For newly suggested consumables – has a trial been completed? If so, what was the trial result? Or is the request to fund a trial? This is particularly important for higher cost consumables such as Transanal Irrigation (TAI) – typically the TIA may be effective but is not always tolerated by the participant, so a trial

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		is necessary before funding a full years' worth of consumables. Is the suggested consumable required due to the participants functional impact? E.g., is a more expensive catheter required due to the participant's anatomical requirements, or their reduced dexterity or are bariatric sized pads required due to obesity? Less standard consumables are typically more expensive but may be reasonable and necessary to fund due to participant individual need. In some circumstances lower cost consumable alternatives may achieve the same outcome. For assistance with considering if an item is value for money please refer to Continence Consumables NIB743 11.08.2023.docx – consider pricing of the same consumables from a different service provider. Consumables can be bought from different shops/providers. If the participant is unable to manage their incontinence independently, they may rely on informal/formal support. The level of Core DA support provided is typically included within the provision of personal care however, consideration must be given to providing support throughout the day/night, at home and in the community to ensure appropriate level of incontinence management, skin integrity maintenance and participant dignity.
34.1(d) Support is effective or beneficial for the participant (supports will be, or are likely to be, effective for desired effect and beneficial for the participant, having regard to current good practice) Consider NDIS Support for Participant Rules 2013 Part 3.2 and 3.3 What are the expected benefits of the support provision?	☒ Yes → ☐ No →	Has the participant been using the suggested consumables for some time? Or has a trial been completed? Or is the request to fund a trial of high-cost consumables? For example, Transanal Irrigation (TIA). This evidence will outline that the suggested consumables provide appropriate containment or management of urine and faecal matter without leaks and that a pad has the appropriate capacity.

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
How will effectiveness of achieved outcome be measured? When will effectiveness of achieved outcome be achieved? Are there other supports required to achieve or maximise the reported support outcomes for participant?		For skin integrity consumables – the aim is to clean the skin, protect the skin from damage and restore skin to its natural balance. Has the participant been using the suggested consumables for some time? Or has there been a trial completed? This will demonstrate that skin integrity has been maintained and the incidence/risk of Incontinence Associated Dermatitis (IAD) has been reduced. If skin integrity issues are present how are the requested consumables going to be effective and beneficial in lowering the risk? And how will this be measured i.e., is a wound assessment by a Wound Specialist nurse required to complement the continence consumables request? It is important to consider multiple requests for skin care consumables as they may provide a duplication of support. Typically, we only want one product each to clean, protect and restore. Are the continence consumables compatible with the environment where they will be used? E.g., it would be reasonable and necessary to include some hand sanitizing gel for a participant managing incontinence while accessing community as there may not be access to hand cleaning facilities. If the participant is unable to manage their incontinence independently, they may require informal/formal supports to assist with toileting, personal care including catheterization/complex bowel care and skin care to manage the risk of integrity issues.
34.1(e) Support coordinates with but does not replace informal support (funding or provision of supports takes account of what it is reasonable to expect families, carers, informal networks and the community to provide) Consider NDIS Support for Participant Rules 2013 Part 3.4	☒ Yes → ☐ No →	Typically, if a child requires support to manage their incontinence this would remain a parental responsibility. However, as the child gets older it may not be socially or culturally acceptable for the parent to be providing such support e.g., a single male parent providing continence support to a 12yo

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		daughter may feel that this is no longer appropriate.
34.1(f) Support is most appropriately funded by the NDIS (supports are not more appropriately funded or provided through other general service systems or universal service obligations Consider NDIS Support for Participant Rules 2013 Schedule 1.	☒ Yes → ☐ No →	If the participant is an inpatient (hospital) it is deemed the responsibility of the health system to provide continence products during the hospital stay. Discharge planning may request continence consumables be funded for use in the community. Evidence will be provided by the hospital nursing/Continence Specialist. If the incontinence is new, trials may have been undertaken during the hospital stay and training will have been provided. Incontinence must be directly linked to the disability otherwise the health system will provide continence consumables for use upon discharge into the community. Is the requested consumable a treatment which is not funded by NDIS? E.g., laxatives, enemas? These may be available on the PBS, or the participant may need to purchase them privately. As per Continence Supports | NDIS, typically if a child has incontinence issues NDIS may fund consumables after age 5yo however in rare situations NDIS may fund continence supports for children younger than 5yo for disability related medical conditions. Where the participant resides in an Aged Care Facility the Aged Care Quality of Care Principles (2014 legislation - Quality of Care Principles 2014 (legislation.gov.au)) Part 2 Care and services – to be provided for all care recipients who need them, 2.1 (b) includes the provision of managing incontinence. Free stoma appliances and products are provided by Stoma Appliance Scheme (health) Stoma Appliance Scheme | Australian Government Department of Health and Aged Care

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
Support will not cause harm (Supports will not be funded if it is likely to cause harm to the participant or pose a risk to others, or the support would be contrary to a law of a jurisdiction) Consider NDIS Support for Participant Rules 2013 Part 5.1 and 5.3	☒ Yes → ☐ No →	Has the Continence Assessment outlined any potential risks? Some continence consumables should only be used after prescription by a health practitioner and training should have been provided. Ongoing review may be appropriate. Once a trial has been undertaken any risks will have been identified and alternative supports suggested. With any invasive procedure there is a level of acceptable risk of harm such as a much higher risk of anatomical damage or infection with catheter insertion or skin integrity issues including IAD due to the exposure of skin to acid in urine and faeces – therefore the aim is to minimize the risk of harm as it will never be completely excluded.
Support is directly related to the participant's disability (supports will not be funded under the NDIS if they do not relate to the participant's disability or are day-to-day expenses or income replacement) Consider NDIS Support for Participant Rules 2013 Part 5.1 and 5.2	☒ Yes → ☐ No →	Have the continence consumables been recommended to address the functional impacts (incontinence) associated with disability for which the participant has gained access to the scheme? – check Disability tab in CRM. For example, 64yo participant meets access for anxiety and PTSD and they are diagnosed with stress and urge incontinence – this is not likely to satisfy this criterion. Incontinence is not a typical functional impact of psychosocial disabilities and stress/urge incontinence is common in the aging population. When considering a list of consumables requested each consumable must be required as a direct link to the disability i.e., domestic cleaning solutions/wipes may be considered an every day living expense which the participant would have had to purchase even if they didn't have a disability.
Support does not duplicate other supports	☒ Yes →	This section refers to the support being duplicated under other funded sources from NDIS – it is not

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
(supports do not duplicate other supports delivered under alternative funding through the NDIS such as Information, Linkages and Capacity Building (ILC) funding.) Consider NDIS Support for Participant Rules 2013 Part 5.1	☐ No →	referring to other mainstream services.
Are all of the above criteria met for all supports?	☒ Yes → ☐ No →	

Version Control

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