

# Information for mental health clinicians

## Supporting access to the NDIS for consumers, families and carers of area mental health services

The National Disability Insurance Scheme is a completely new way of getting psychosocial support. It creates some more work for clinicians to set it up but a lot more choice for consumers. If eligible, consumers will be able to choose the services they want. Consumers, families & carers will require help to apply, so it's important to understand the process. Once eligible, the NDIS will be available for life & has potential to make a huge change in the lives of consumers, families & carers. *Please note: This overview is a start but as NDIS is constantly evolving this advice will change and be updated as we learn more.*

### Introducing the NDIS



#### KEY POINTS

- ✓ Check if any other service providers have already begun supporting access to the NDIS. If yes, liaise.

**Language to support eligibility** - 'impairment which is likely to be permanent'.

#### How long will the process take?

From Access to Service Delivery can take 3 - 12 months.

#### What will the NDIS fund?

Reasonable and necessary supports.

- ✓ Support families & carers to understand and have input into the process.

Most of the NDIS Access & Planning process is conducted over the phone – discuss communication preferences & supports needed including written consent to share information with NDIA.

### Assisting access



#### KEY POINTS

**For registered MHCSS consumers** - NDIA will contact the consumer by phone about a month before transition in May 2017 (& in some instances earlier) to complete the access process. Liaise with MHCSS provider.

**For consumers on MHCSS waitlist** - MHCSS Intake will contact the consumer to offer assistance via phone and commence Access process. Consumer can nominate clinician to be their preferred contact. Liaise with local MHCSS Intake assessment Service.

#### All other consumers

Check eligibility using [NDIS Access Checklist](#), print as a prompt. Discuss preferred contact details & methods with consumer, family & carers. Consider a Plan or Correspondence Nominee. Access Request Forms can be collected from some Centrelink offices (check with you local office) or call 1800 800 110 for a form to be sent to address provided by consumer.

#### IMPORTANT LINKS

[My NDIS Pathway](#)  
[NDIS Access Checklist](#)  
[What are Correspondence & Plan Nominees?](#)  
[NDIA Decision making guide for adults with cognitive impairments or mental ill health \(plan nominees\)](#)

### Collecting evidence



#### KEY POINTS

The key items:

- **Letter from psychiatrist:** confirmation of diagnosis & likely to be permanent
- **Clinician report:** functional impact of disability - Part F of Access Request Form
- **Any other relevant reports** (incl. HoNOS, LSP-16 and DSP applications)

The NDIA is required to make a decision or request further information within 21 days of receiving an Access Request Form.

#### IMPORTANT LINKS

[Completing the access process](#)  
[Providing proof of age & residence](#)  
[Psychiatrist letter template](#)  
[Clinician report template](#)  
[Prompts for Clinician report](#)  
[Tip Sheet](#)  
[Sample allied health report](#)

### Supporting the planning process



#### KEY POINTS

**Most consumers' first plans will be completed over the phone,** through a planning conversation with an NDIA representative about the consumer's existing supports, needs and main goals. Consider a prompt/script to assist this phone conversation.

**If phone planning isn't suitable,** consumers will need to request a face-to-face meeting when NDIA calls them.

- ✓ **Assist consumer, family and carers to prepare** for the planning meeting. Be creative - together imagine how life could be better. Build on recovery plans & functional report.

- ✓ **Discuss option of support coordination** to implement plan.

Clinicians can attend meetings and assist with planning conversations with consumer consent.

#### IMPORTANT LINKS

[What does an NDIS plan look like? Example 1 and 2](#)  
[Preparing for the planning conversation](#)  
[What are Local Area Coordinators \(LACs\)?](#)  
[What is Support Coordination?](#)  
[Mental Health Carers Checklist](#)

### Sharing information



#### KEY POINTS

**Examples when interface may occur**

- Significant/rapid change of health needs
- Discharge/transition planning
- Unable to remain living in community without additional support
- NDIS access, planning or review of NDIS plan
- Recovery or health plan being developed or reviewed

#### IMPORTANT LINKS

[NDIS and area mental health service interface](#)  
[Definitions](#)  
[Troubleshooting](#)

#### IMPORTANT LINKS

[About the NDIS](#)  
[NDIS Information for Specialist Clinical Mental Health Services](#)  
[Psychosocial disability, recovery & the NDIS](#)  
[What will NDIS fund?](#)  
[Guide for mental health carers Supporting families & carers](#)

# NDIS & area mental health service interface



Adapted from *National Disability Insurance Scheme (NDIS) Information for Specialist Clinical Mental Health Services* DHHS, 2016

## 1. Supporting people to access the NDIS

To access the NDIS, a prospective participant must first make an access request to the NDIA. This process includes the need to provide consent for the NDIA to collect and share personal information to make a decision about whether the person can access the NDIS. To complete this process the person 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.

### Role of area mental health services

Area mental health services can play a key role in explaining to relevant consumers the benefits of being a NDIS participant and the NDIA access process. Current and past consumers (discharged from the service in the last 12 months) will need the help of area mental health services to provide evidence they meet the disability requirements of the NDIS.

In this regard, the person may ask their health professional to:

- Provide copies of reports, letters or recent assessment of their psychiatric disability (and other co-existing disability if relevant) and the impact it has on their mobility, communication, social interaction, learning, self-care and or ability to self-manage OR
- Complete a functional assessment.

## 2. Supporting participants in the NDIA planning conversation

Once a person has been assessed as meeting the NDIS access criteria the NDIA will contact them to develop a NDIS Plan. The person can invite people who are important in their life to help or support them during their NDIS planning conversation, including family, friends, carers or others. The purpose of this discussion is to develop a personal, goal orientated plan. More than one discussion will occur if required. Some NDIS participants, due to their high level psychiatric disability and severity/acuity of their mental illness, may require intensive or tailored support to make and express decisions related to their psychosocial support needs throughout the NDIA administration process (from access to plan development, implementation and review).

A NDIS participant may authorise a person (such as a carer/ family member/guardian/advocate) to make decisions on his/ her behalf regarding the Plan. In some circumstances this representative may need support to make decisions regarding the individual's psychosocial support needs. The need for additional support is particularly relevant for people who do not have a carer/family/guardian/advocate to support them.

### Role of area mental health services

Area mental health services may assist registered consumers by attending the NDIA planning meeting/s (with the consent of the individual) to assist them with the planning conversation. This may be particularly important for consumers with complex needs and/or those who do not have other formal or informal supports.

In some situations this planning discussion may need to take place in a bed based clinical mental health setting. Health service can provide the consumer with a record of their most recent Health of the Nation Outcome Scale (HoNOS) and Life Skills Profile 16 (LSP-16) assessment to assist them and the NDIA with the planning conversation.

## 3. Coordinated service planning

Some NDIS participants will have complex needs associated with their psychiatric disability and may experience barriers to accessing, developing and implementing their NDIS plan. In these circumstances the NDIA may fund support coordination as part of the participant's NDIS plan. Support coordination is not funded for all NDIS participants. For some participants support coordination may be provided by the Local Area Coordinator (LAC) Support coordination can include, for example, assisting a participant to: engage with area mental health services; make decisions related to their disability support; be actively engaged in case/care planning; and make and attend appointments. Few people diagnosed with psychiatric conditions have a static set of psychosocial support needs. As people explore or move towards one goal, another goal will emerge, or change. In the early stages of receiving NDIS support many participants may struggle to identify goals. On this basis it is likely that most people with psychosocial disability will require more frequent and iterative goal planning and review. Coordination of service/supports between a participant's NDIA service provider/s and health service, in collaboration with the individual, will ensure a more integrated response to the participant's psychosocial support and mental health treatment needs.

### Role of area mental health services

Area mental health services can support this outcome by:

- Participating in joint case planning with the NDIA, or funded NDIS providers/NDIS support coordination provider to ensure the participant's NDIS Plan and treatment plan complement each other.
- Request the NDIA consider support coordination be part of the participant's NDIS plan if in their judgement they feel this is a necessary support.

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## NDIS & area mental health service interface continued

- Initiating contact with the NDIA/Local Area Coordinator or the participant's NDIS provider when the participant is experiencing a significant change in their psychosocial functioning and request a review of their NDIS Plan.
- Notifying the participant's nominated NDIS service provider or funded NDIS support coordination provider when:
  - A participant is admitted to a bed-based area mental health service (acute inpatient, sub-acute and extended care services).
  - A participant ceases to be a consumer of the clinical specialist mental health service system.

### 4. Information sharing

Information on prospective and existing NDIS participants who are registered consumers of the area mental health service system will need to be shared between the service system and the NDIA to support participants to engage in, and complete, the NDIS access, assessment, planning, review and implementation processes.

The sharing of consumer/participant information can only occur with the informed consent of the individual.

Robust information sharing practices will: reduce the risk that consumers of the area mental health service system who are eligible for the NDIS miss out on required supports; ensure consumer/participant treatment and support plans are well coordinated and efficiently delivered; and the participant's NDIS plan is responsive to the participants changing psychosocial disability support needs.

#### Role of area mental health services

Information sharing practices between health services and the NDIA are to be applied in circumstances when a consumer of an area mental health service:

- Is in the process of providing evidence to establish NDIS access
- Is in the process of planning to develop a NDIS Plan or reviewing their NDIS Plan
- Is experiencing a significant or rapid change in their psychosocial support requirements which requires an immediate response
- Is admitted to a bed-based area mental health service
- Experiences a change in legal status, as this relates to the application or cessation of an involuntary treatment order or a compulsory treatment order
- When the clinical mental health services ceases to deliver treatment to a consumer who is a NDIS participant.

### 5. Discharge Planning

On discharge from hospital (acute inpatient) or bed-based clinical mental health settings, existing and prospective NDIS participants may have changed or newly acquired psychosocial disability support needs that need to be in place in order for the person to be discharged.

In some instances, support 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 setting.

This will require timely engagement with the NDIA, the Local Area Coordinator and/or the participant's NDIS provider (if they have one). Good joint discharge planning will ensure patient/consumer's psychosocial support needs are appropriately identified and NDIS supports are in place at the time of discharge.

#### Role of area mental health services

Joint discharge planning should be applied in circumstances where an individual - either an existing or prospective NDIS participant - requires planning to support their discharge from acute mental health inpatient, sub-acute, secure extended care and community care unit service settings. This includes circumstances where:

- Patients in a bed-based specialist mental health service require specific funded NDIS support to facilitate discharge, and need to undergo NDIS access and planning to determine eligibility and obtain this support.
- An existing NDIS participant's discharge from hospital, sub-acute or a secure extended care mental health service is conditional on the provisional of additional NDIS supports being available and the person is at risk of a longer than necessary stay in the absence of an appropriate level of NDIS support.
- A person has multiple service responses that require coordination by their NDIS provider to ensure a timely discharge and appropriate discharge destination/outcome.

Specialist mental health services delivering acute (hospital), bed-based subacute or rehabilitation services need to:

- Ensure early notification to NDIA to determine a person's status as a NDIS participant, with their consent or that of their carer/family/advocate/ nominated person.
- Provide timely advice to the NDIA that the consumer/participant has been admitted to a bed-based mental health services.
- Prepare and collect relevant document/evidence to support the NDIA access and planning process for prospective NDIS participants.
- Facilitate case planning and information sharing between the service, the patient/consumer and their carer/s and the NDIA while the person is in the bed-based service.
- Develop, review and implement an agreed discharge plan throughout the persons stay, in collaboration with the NDIA, the individual's carer/family/guardian/advocate (as relevant) and other relevant non NDIA support services the person may need.
- Oversee and manage the discharge planning process, as it relates to the coordination of the consumer's clinical treatment needs.
- Monitor changes in the patient's medical and functional status and social support needs throughout the persons' hospitalisation/sub-acute admission and ensure these are taken into account in discharge planning.

For more information regarding interface and role of the NDIA refer to [NDIS Practice Advice for Health Services – Mental Health Services](#) (NDIS Information for Specialist Clinical Mental Health Services)

# NDIS access checklist for consumers



[www.ndis.gov.au/ndis-access-checklist](http://www.ndis.gov.au/ndis-access-checklist)

The questions below will help you work out if you can access the NDIS.

They will also help prepare you for the initial discussion when you visit NDIS staff at Centrelink or call the NDIS to start the application process.

## 1. Do you have Australian residency?

To access the NDIS you must live in Australia and be: an Australian citizen OR a permanent resident OR hold a Protected Special Category Visa

## 2. Are you under the age of 65?

To access the NDIS you must be aged under 65 years.

## 3. Do you live in an area where the NDIS is available?

To access the NDIS right now, you must live in an area it is available.

## 4. Do you usually need support from a person or equipment to do everyday things for yourself because of an impairment or condition that is likely to be permanent?

To meet the NDIS disability rules you need to have an impairment or condition that is *likely* to be permanent (lifelong) and that stops you from doing everyday things by yourself.

The following questions may help you decide if your answer is 'yes'.

Do you usually need support from a person or assistive equipment so you can:

- understand and be understood by other people?
- make and keep friends and cope with feelings and emotions?
- understand, remember and learn new things?
- get out of bed and move around the home and outside the home?
- take a bath or shower, dress and eat?
- do daily jobs, handle money and make decisions?

NDIS will communicate with you via phone or mail.

This doesn't suit everyone, and you can nominate someone (family member, carer, friend, clinician) who NDIS can also contact if that is helpful.

You might like to make sure you've got their contact details (address, phone number etc.) written down as a reminder.

# What are Correspondence & Plan Nominees?



Given that the NDIS Access and Planning processes involves a considerable amount of information management via mail or telephone, it is worth discussing with your consumer the role of nominees and if they would find it useful for you to act as a nominee.

There are two types of nominees: a correspondence nominee or a plan nominee and one individual can perform both functions.

Nominees will be appointed where requested by the participant or where necessary. If a guardianship arrangement is in place the presumption is that the guardian will be appointed the nominee.

Nominees will have a duty to ascertain the wishes of the participant and make decisions that maximise the personal and social wellbeing of the participant.

The NDIS Rules set out further information on how the Agency will determine who should be appointed and how the nominee should act. [www.ndis.gov.au/families-carers/what-are-nominees-and-guardians](http://www.ndis.gov.au/families-carers/what-are-nominees-and-guardians)

There are two types of nominees: a correspondence nominee or a plan nominee and one individual can perform both functions

## Correspondence Nominee

A correspondence nominee can undertake all activities that a participant would undertake, except for:

- the preparation, review or replacement of the participant's plan; and/or
- management of the funding for supports in the participant's plan.

## Plan Nominee

A plan nominee can undertake all activities that a participant would undertake under the Scheme including:

- the preparation, review or replacement of the participant's plan; and/or
- management of the funding for supports in the participant's plan.

**However** the plan nominee may not undertake activities on behalf of the participant that may be outlined when the plan nominee is appointed.

## Guardianship Information

Those who are in a formal caring role and acting on behalf of a person with disability **are able to** contact the National Disability Insurance Agency on behalf of that person, if the person is unable to make contact themselves.

In appointing a nominee under section 86 or 87 of the NDIS Act 2013, the National Disability Insurance Agency must consider whether someone legally:

- has guardianship of the participant; or
- has been appointed by a court, board or panel who has power to make decisions for the participant and whose responsibilities are relevant to the duties of a nominee.

If another person or body has all or part guardianship responsibility for a participant, then the National Disability Insurance Agency will work with the guardian in decision making in the same way they would work with parents and carers of participants who are under 18.

Guardians and nominees are advised that, in the context of the planning process, planners will support participants to exercise choice and control over their supports and providers.

## More resources

### NDIA decision-making guide for adults with cognitive impairments or mental ill health 2015

[www.publicadvocate.vic.gov.au/our-services/publications-forms/219-ndia-decision-making-guide?path=](http://www.publicadvocate.vic.gov.au/our-services/publications-forms/219-ndia-decision-making-guide?path=)

Guide to assist the National Disability Insurance Agency (NDIA) to determine when decision-making support, advocacy, and substitute decision making is needed for current and potential adult NDIS participants who have significant cognitive impairments or mental ill health.

Developed by the Office of the Public Advocate (Vic) in consultation with the NDIA Victoria Launch Site.

# Providing proof of age and residence



The Access Request Form process requires applicants to provide proof of age and residence.

**Access Request Form**

Complete this form to request to become a participant in the National Disability Insurance Scheme (NDIS). You must provide proof of age and residence (including citizenship or visa status) with this Access Request Form. We cannot make a decision on your access request without this information.

If the consumer is receiving Centrelink benefits they have already provided proof of age and residence, as such they can provide their customer reference number (CRN) and consent for NDIA to collect the information held by Centrelink.

This will save them from having to collect this information and provide it to the NDIA.

**Part B: Your privacy and consent for NDIA to collect and share your information**

Any of your personal information held by the NDIA is protected under the *National Disability Insurance Scheme Act 2013* and the *Privacy Act 1988*. The NDIA collects your personal information to help us to make decisions about whether you can access the NDIS.

If you become a participant, we will use your information to help develop and implement your NDIS plan and do other things related to the NDIS (such as monitoring NDIS supports and spending of NDIS money). We collect this information from you, your existing service providers, health and medical practitioners, and other State / Territory and Commonwealth government agencies. We will collect this information with your consent or without your consent if authorised or required by law.

More information about the collection, use, disclosure and storage of your personal information by the NDIA can be accessed on our online Privacy Notice and Privacy Policy at [www.ndis.gov.au/privacy](http://www.ndis.gov.au/privacy) or by contacting the NDIA.

You can give us **consent to obtain information about your age, disability, and residence from Centrelink** (below) or you can provide us with certified copies of the required documents yourself.

**We cannot make a decision without this information.**

The Australian Government Department of Human Services (including Centrelink and Medicare)	<input type="checkbox"/> <b>Yes, I consent</b>	<input type="checkbox"/> <b>No, I do not consent.</b>
	My CRN is:	I will provide the information myself.

NDIA will not collect or disclose any information without consent. Consumers can ask to see the information NDIA holds about them at any time. If any of the information is incorrect they can ask to have this corrected.

# Prompts for Clinician Report/Part F of the NDIS Access Request Form

Connecting NDIS functional domains, symptoms, functional impact & support



## Functional Domains

### 1. Mobility/motor skills

#### Symptoms

*Paranoia*  
*Anxiety*  
*Sensory sensitivity*  
*Low confidence*  
*Side effects causing weight gain, lethargy, tremor*  
*Compulsions*

#### Examples of functional impact

- Difficulties using public transport, leaving the house, going to shopping centres, attending recreational/vocational activities.
- Mobility difficulties as a result of side effects of treatment (e.g. tremor, weight gain).
- Reluctant to travel alone to unfamiliar environments.
- Goes out alone infrequently.
- Will often refuse to travel alone to unfamiliar environments.
- Travels alone only in familiar areas (such as the local shops or other familiar venues).
- Unable to travel away from own residence without a support person.

#### Support considered

- Person to accompany when using public transport/provision of transport/Low stimulus options.
- Personal support to, build confidence & provide feedback.
- Aids/ equipment to overcome movement difficulties & to help cope with symptoms.

### 2. Communication

#### Symptoms

*Delusional thinking*  
*Hallucinations*  
*Range of affect*  
*Cognitive difficulties - social cognition*

#### Examples of functional impact

- Difficulties interpreting communication, following instructions, conversations or directions, seeking help/direction, reading nuances of verbal and non-verbal cues, awareness of others, communicating needs/wants.

#### Support considered

- Person to assist with interactions, especially with appointments.
- Personal support to develop skills, provide coaching & feedback/behavioural support
- Aids equipment to overcome communication difficulties.

## Functional Domains continued

### 3. Social Interaction

Symptoms	Examples of functional impact	Support considered
<p><i>Post-traumatic stress</i></p> <p><i>Anxiety</i></p> <p><i>Cognitive difficulties - social cognition (e.g. challenges with reading nuances of verbal and non-verbal cues)</i></p> <p><i>Disinhibition, aggression, irritability, mood lability, interfering behaviours</i></p> <p><i>Side effects of medication</i></p> <p><i>Rapport with others</i></p> <p><i>Disrupted social development.</i></p> <p><i>Response to stigma/discrimination</i></p> <p><i>Low confidence</i></p>	<ul style="list-style-type: none"> <li>• Difficulties initiating and responding to conversations, making and keeping friendships, talking to strangers or particular people, making and keeping friends, interacting with the community, sustaining relationships, coping with feelings &amp; emotions, interacting with other people.</li> <li>• Friction with or avoidance of, others in the household.</li> <li>• Impact on sense of purpose in life; connection with faith/spirituality/volunteering/community.</li> <li>• Not actively involved when attending social or recreational activities.</li> <li>• Not actively involved in social events.</li> <li>• Have interpersonal relationships that are strained with occasional tension or arguments.</li> <li>• Very limited social contacts and involvement unless these are organised for the person.</li> <li>• Extreme difficulty interacting with other people and is socially isolated.</li> <li>• Interaction affected by specific behaviours (e.g. overactive, aggressive, disruptive, offensive)</li> <li>• Minimal social contact (e.g. isolated and withdrawn).</li> <li>• Vulnerable to influence of others.</li> <li>• Occasional interpersonal conflicts at work, education or training that requires intervention by a supervisor, manager or teacher or changes in placement or groupings</li> <li>• Often has interpersonal conflicts at work, education or training that require intervention by supervisors, managers or teachers or changes placement or groupings</li> <li>• Unable to attend work, education or training/ on a regular basis/ other than for a short period</li> </ul>	<ul style="list-style-type: none"> <li>• Person to accompany when attending social activities at least for a period of time/ until trust and relationships established</li> <li>• Assistance or support from a companion to engage in social interactions.</li> <li>• Personal support to develop skills, provide coaching,</li> <li>• Personal support to provide motivation, accompany to build confidence, provide feedback.</li> <li>• Provide feedback/behavioural support</li> <li>• Equipment to assist person to cope with symptoms.</li> </ul>

### 4. Learning

Symptoms	Examples of functional impact	Support considered
<p><i>Cognitive difficulties – alertness, orientation, spatial awareness, concentration, learning, planning, problem solving, following instructions, generating ideas.</i></p> <p><i>Distracted/tangential thinking. Poverty of thought.</i></p> <p><i>Side effects -lethargy</i></p>	<ul style="list-style-type: none"> <li>• Difficulty organising task, planning, remembering, learning new information, concentrating, participating in group learning (classes, tutorials), focusing on complex tasks for more than 1 hour.</li> <li>• Some difficulties completing education or training.</li> <li>• Finds it very difficult to concentrate on longer tasks for more than 30 minutes (such as reading a chapter from a book).</li> <li>• Finds it difficult to follow complex instructions (such as from an operating manual, recipe or assembly instructions).</li> <li>• Has difficulty concentrating on any task or conversation for more than 10 minutes.</li> <li>• Has slowed movements or reaction time due to symptoms or treatment effects.</li> <li>• Extreme difficulty in concentrating on any productive task for more than a few minutes.</li> <li>• Extreme difficulty in completing tasks or following instructions.</li> </ul>	<ul style="list-style-type: none"> <li>• Equipment that assists with recording and organising.</li> <li>• Person to assist with learning and engaging in particular activities &amp; provide feedback/ behavioural support</li> <li>• Devices that can assist with cognitive problems.</li> </ul>



## Functional Domains continued

### 5. Self-care

Symptoms	Examples of functional impact	Support considered
<p><i>Cognitive difficulties</i>  <i>Issues related to self-awareness, safety, self-esteem, lifestyle choices, compulsions, understanding of illness.</i>  <i>Side effects - weight gain, increased appetite, lethargy</i>  <i>Amotivation</i></p>	<ul style="list-style-type: none"> <li>● Issues with personal care/grooming, coping strategies, maintaining physical health, non accidental self-injury, managing medication, sexual health and wellbeing</li> <li>● Lives independently but may sometimes neglect self-care, grooming or meals.</li> <li>● Needs some support (that is, an occasional visit by or assistance from a family member or support worker) to live independently and maintain adequate hygiene and nutrition.</li> <li>● Needs regular support to live independently, that is, needs visits or assistance at least twice a week from a family member, friend, health worker or support worker.</li> <li>● Needs continual support with daily activities and self care.</li> <li>● Unable to live on their own and lives with family or in a supported residential facility or similar Severely disturbed behaviour which may include self harm, suicide attempts, unprovoked aggression towards others or manic excitement.</li> <li>● Judgement, decision-making, planning and organisation functions are severely disturbed.</li> </ul>	<ul style="list-style-type: none"> <li>● Assistive equipment to enable self-care activities.</li> <li>● Access to healthy lifestyle/ health promoting activities including exercise. Personal support to provide prompts/ cues, supervise (e.g. for safety), assist (e.g. work alongside), encourage &amp; provide feedback.</li> <li>● Devices to assist with cognitive problems e.g. electronic reminders, monitors/feedback devices, visual cues &amp; prompts.</li> </ul>

### 6. Self-management

Symptoms	Examples of functional impact	Support considered
<p><i>Amotivation</i>  <i>Cognitive difficulties – impulsivity, decision making, planning, problem solving.</i>  <i>Side effects - weight gain, lethargy.</i>  <i>Issues related to self-awareness, self-esteem, safety, vulnerability, lifestyle choices, mood disturbances, thoughts of self harm/suicide</i></p>	<ul style="list-style-type: none"> <li>● Difficulty in attending to responsibilities due to lack of motivation, interest, concentration, organisation, or different priorities. Easily overwhelmed.</li> <li>● Difficulties/requires prompting/ assistance managing household responsibilities (e.g. laundry, paying bills, housecleaning), budgeting money, solving problems that arise, making decisions, taking responsibility, behaving responsibly/safely, maintaining adequate diet/nutrition, shopping/cooking. Keeping safe in home environment (food storage, use of stove etc.)</li> <li>● Unusual behaviours that may disturb other people or attract negative attention and may sometimes be more effusive, demanding or obsessive than is appropriate to the situation.</li> <li>● Slight difficulties in planning and organising more complex activities.</li> <li>● Difficulty coping with situations involving stress, pressure or performance demands.</li> <li>● Occasional behavioural or mood difficulties (such as temper outbursts, depression, withdrawal or poor judgement).</li> <li>● Activity levels are noticeably increased or reduced.</li> <li>● Behaviour, thoughts and conversation are significantly and frequently disturbed.</li> <li>● Guardian/administration order in place?</li> <li>● State Trustees?</li> <li>● Family support?</li> </ul>	<ul style="list-style-type: none"> <li>● Person to supervise, prompt, support with care of house, managing money, getting services, problem solving, develop new skills.</li> <li>● Personal support to provide feedback/behavioural support</li> <li>● Equipment/aids</li> <li>● Devices that can assist with cognitive problems</li> </ul>

# What are Local Area Coordinators?



Local Area Coordinators (LACs) are employed by the NDIA (National Disability Agency) to provide information to the participant and their supporters about how the funded supports in the plan can be implemented. This may include providing information about what agencies are registered to provide supports. It may also include assisting the participant to link in with registered providers able to provide the supports as funded in a plan. Local Area Coordinators are also able to provide linkage and referral to community and other agencies for supports not funded by the NDIS.

In the North Eastern Melbourne Area (NEMA) NDIS planning is a partnership with the Brotherhood of St Laurence (BSL) the Local Area Coordinator, Australian Healthcare Associates (AHA) the information gatherer and all plans ultimately approved by NDIA.

LACs work with participants to

- Provide assistance to connect to and build informal and natural supports
- Provide assistance with the planning process and effective implementation
- Work with non-participants as part of [Information, linkages and capacity building](#)
- Work with community, providers and mainstream to build inclusion and awareness of the needs of people with disability

Local Area Coordinators do not provide case management, act as an advocate for the person with disability, and they cannot approve an NDIS plan.

## How can you contact the BSL NDIS team?

Phone: 1300 BSLNDIS (1300 275 634)

Email: [ndis.info\(at\)bsl.org.au](mailto:ndis.info(at)bsl.org.au)

Office locations:

- Banyule and Nillumbik – 65 Main St, Greensborough
- Darebin – 293 High St, Preston
- Whittlesea – 1/1 Latitude Boulevard, Thomastown
- Yarra – 95 Brunswick St, Fitzroy

## How are support coordinators and planners different from Local Area Coordinators?

Support Coordinators are a funded line item in a Participant's Plan. Participants will have choice and control as to which provider they use for this budget. Support Coordinators will work with some Participants after they have a first plan. They will help manage NDIS funded supports and assist consumers to work with other systems like justice and child protection etc. Support Coordinators are expected to help consumers reduce some of the complexity in their life. Planners will work with some Participants after their first plan. These include people with complex needs or in complex circumstances. It is unlikely that consumers will have a funded Support Coordinator if they are working with a Local Area Coordinator.

**Support Coordination** refers to assistance funded via NDIS Plan to strengthen participants' abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.

# What is Support Coordination?



Taken from [www.aasw.asn.au/document/item/8572](http://www.aasw.asn.au/document/item/8572)

The National Disability Insurance Agency (NDIA) defines Support Coordination as primarily being;

*'Assistance to strengthen participants abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.'*

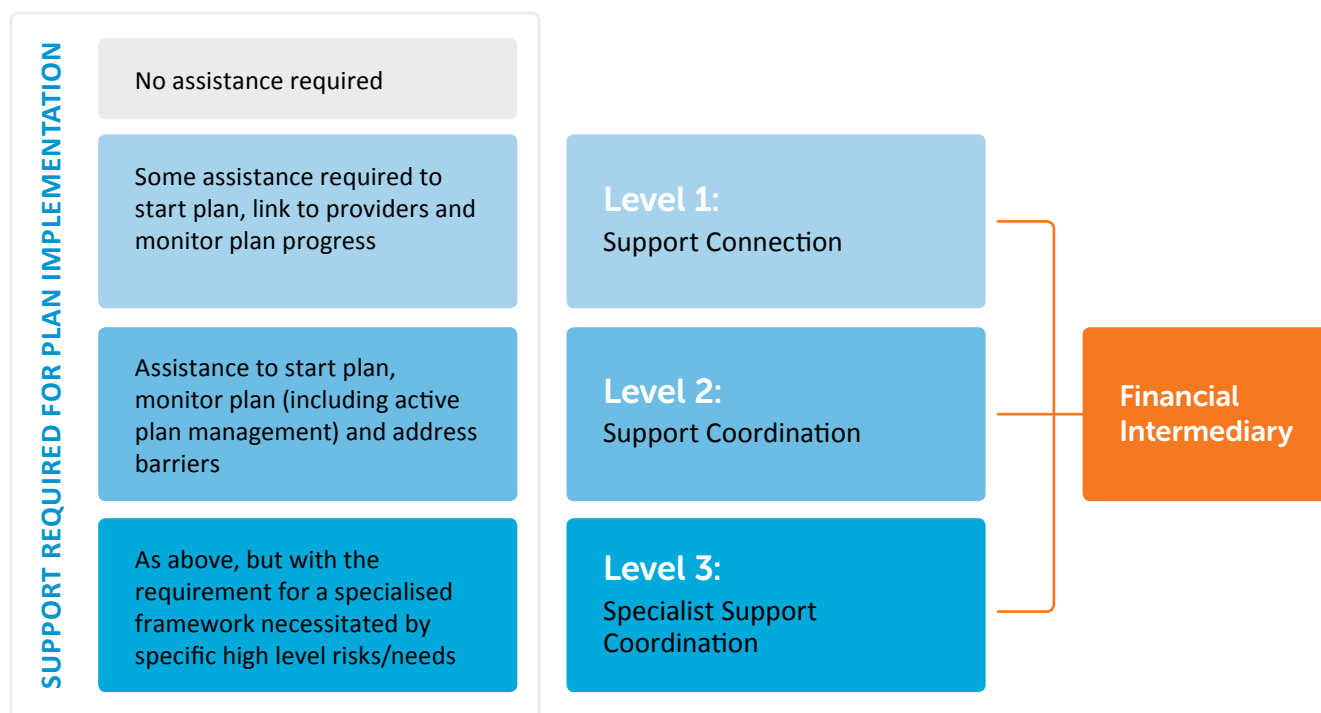
## Role of a funded coordinator of supports

In relation to the NDIA's definition of Support Coordination, the primary role of a Support Coordinator is to:

- Support implementation of all supports in the plan, including informal, mainstream and community, as well as funded supports
- Strengthen and enhance the participant's abilities to coordinate supports and participate in the community
- Ensure mainstream services meet their obligations (i.e. housing, education, justice, health)
- Build the capacity of the participant to achieve greater independence to self-direct services and supports in the longer term
- Provide the NDIA with reports on outcomes and success indicators within the agreed reporting frequency

## Three levels of coordination

A broad outline of a tiered approach for funded coordination of supports is illustrated in the following diagram:



## What is Support Coordination? continued

### Level 1: Support Connection

*Time limited assistance to strengthen participant's ability to connect with informal, mainstream and funded supports, and to increase capacity to maintain support relationships, resolve service delivery issues, and participate independently in NDIA processes.*

Support Connection is a non-ongoing service focussed on enabling the participant to connect to supports in the plan. The word "connection" is appropriate for a support that assists participants to establish arrangements with funded providers, and to build a network of informal and mainstream supports.

Support Connection's primary focus is helping the participant to start their plan implementation by assisting them to:

- Identify options (funded, mainstream and in informal networks)
- Investigate options
- Understand funding flexibility
- Reach decisions regarding services
- Reach agreement with providers
- Commence service and ensure new support arrangements thrive

**Through the provision of this support it is expected that participants will gain skills to participate in NDIA processes, and gain independence in creating and maintaining supports.**

In the first participant plan, Support Connection may be made available for the full duration of the plan

(up to 12 months) to support the participant to learn how to:

- Activate their plan (i.e. link to service providers)
- Monitor quality and spend of services
- Manage flexibility within the plan
- Prepare for review

There may also be some need to address barriers to participation, and resolve service delivery issues.

During subsequent (review) plans, Support Linkages should only be provided for a specific purpose, such as to support the participant to change service provider, or build capacity to achieve specific community participation goals, as opposed to the first year where it may be provided to orient the participant to implement their plan more generically.

### Level 2: Support Coordination

*Assistance to strengthen participant's abilities to connect to and coordinate informal, mainstream and funded supports in a complex service delivery environment. This includes resolving points of crisis, developing capacity and resilience in a participant's network and coordinating supports from a range of sources.*

Support Coordination has the features of Support Connection, with an increased focus on:

- Addressing barriers to participation, and
- Resolving service delivery issues.

The word "coordination" indicates a more intensive engagement than "connection". It avoids using either

"Complex" or "Higher Intensity", both of which may be viewed by participants as not being strengths based. In addition to the features of Support Connection, Support Coordination would focus on:

- Regular active management and ongoing adjustment of supports due to participant's changing needs.
- Management of multiple/complex supports from a range of providers which intersect with mainstream services.
- Crisis resolution and developing resilience.
- Regular monitoring and outcome reporting for the participant/NDIA

In the first participant plan, Support Coordination may be made available to enable the participant to activate their plan and learn about other aspects of the plan cycle, including preparing for review.

**There is an expectation that, where possible, Support Coordination will be replaced in subsequent (review) plans by Support Connection.**

If Support Coordination is required in a review plan, it should be provided for a specific purpose, such as to support the participant to change service provider, or to resolve specific points of crisis or barriers affecting support, as opposed to the first year where it may be provided to orient the participant to implement their plan more generically.

### Level 3: Specialist Support Coordination

*The provision of Support Coordination within a specialist framework necessitated by specific high level risks in the participant's situation. This support is time limited and focuses on addressing barriers and reducing complexity in the support environment, while assisting the participant to connect with supports and build capacity and resilience.*

Specialist Support Coordination includes all the activities outlined in "Support Coordination", but addresses situations where it is appropriate to have a specialist deliver Support Coordination-style activities, necessitated by specific high level risks in the participant's situation.

**Specialist Support Coordination is time limited and focuses on addressing barriers and reducing complexity in the support environment, while assisting the participant to connect with supports and build capacity and resilience.**

For Specialist Support Coordination to be included within a plan there must be clear benefits to the participant that result from this model of supports coordination. It is anticipated that this support will be very rarely required and only under exceptional circumstances. Specialist Support Coordination must include clear goals for the duration of the first plan that aim to decrease the need for this high intensity support to continue. It is expected that if coordination is required beyond the first plan, the NDIA will recommend Support Coordination, rather than Specialist Support Coordination.

## What is Support Coordination? continued

### Financial Intermediary

A Financial Intermediary assists participants to manage their plan by paying for and monitoring the funded supports on their behalf. A participant can decide to use a registered plan management provider to manage some or all of the funding of supports in their plan.

The activities of a Financial Intermediary include:

- Paying service providers and processing expense claims for participants
- Developing monthly statements for participants

### Claiming from the NDIA

The core goal for a Financial Intermediary is to manage the administrative elements of the funded supports in the participant plan, which in turn helps the participant to achieve their goals and live their life without the concern of claiming.

A financial intermediary is not responsible for negotiating or organising service providers to deliver supports, monitoring delivery or the quality of the supports received.

### Additional information

- It is a policy of the NDIA that coordination of supports is delivered by an NDIA registered provider.
- Where the Support Coordinator also delivers other funded supports in the participants plan, the provider must ensure that any perceived or real conflict of interest is managed in accordance with the NDIA's Terms of Business.

### Definitions

Carer	A person who provides unpaid care and support to a family member or friend who has a disability.
Capacity	In this context, refers to the participant's current ability to understand and follow the NDIA's processes, and to engage with other organisations. It is based on existing knowledge and skills, and the ability to develop new knowledge and skills as required.
Disability	An umbrella term used in relation to the disability requirements for access to NDIS. (NDIS Act 2013 s.24)
Financial Intermediary	A service provider engaged by the NDIA that holds funds, makes payments at the direction of the person with a disability or nominated person in accordance with their plan, keeps records of each person's funding and reports expenditure to the person and to the NDIA.
Informal Support	Naturally occurring support or assistance available within families, among friends, neighbours and members of a community.
Mainstream Support	Goods, services supports and assistance available for the general community which lie outside funding in the NDIS. These are the first option for service provision for all NDIS participants. Support required to access such services will be included where required in a statement of support for an NDIS participant.  Example mainstream services are: <ul style="list-style-type: none"><li>• health</li><li>• education</li><li>• employment</li><li>• mental health</li><li>• palliative care</li><li>• aged care</li><li>• housing</li><li>• veterans affairs</li><li>• transport</li><li>• early childhood services</li><li>• income support</li><li>• justice</li><li>• child care</li></ul>
Participant Plan	The plan approved by the Agency CEO which contains the participant's statement of goals and aspirations and statement of participant supports. (NDIS Act 2013 s33)
Plan Implementation	A series of activities to connect with, and maintain, the supports outlined within the participant plan's Statement of Supports.
Plan monitoring	Monitoring the implementation, progress and continued appropriateness of the participant plan.
Service Provider	A person or body (for example a community service organisation) who provides funded disability services under the NDIS Act and is registered with the NDIA.
Support coordination	Assistance to strengthen a participants abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.
Supports	Services and products required by a participant to address the impact of a disability. Can include mainstream services, assistance from family and carers (informal) and NDIS funded items.

# Troubleshooting



If things don't go smoothly:

1. Contact your team's NDIS rep Maryclare Lane.
2. Request an appeal - If you don't agree with the access decision or a planning decision, you may request an internal review from the NDIA. If the internal review upholds the decision, you can appeal the decision to the Commonwealth Government's Administrative Appeals Tribunal.
3. Make a complaint - NDIS [Feedback and complaints](#)

# What will the NDIS fund?



The NDIS provides support to help manage everyday tasks, participate in the community and reach goals (while the DSP provides income support for everyday expenses such as food, travel costs and housing).

When you're thinking of goals and planning it would be great to think the sky is the limit, and if you want to get creative and aim high for your client – go for it. Keep in mind the NDIS only funds "reasonable and necessary supports". These have to:







- be specific to the client's needs
- give value for money
- be related to the disability
- be effective and beneficial to the client.

The NDIS will fund supports that assist activities of daily living and participation in the community. This could include:

- assistance with planning and decision making and household tasks
- assistance to build capacity to live independently and achieve goals, such as building social relationships, as well as financial management and tenancy management skills
- support to engage in community activities such as recreation, education, training and employment.

Participants can choose how, when and where to access their funded supports, for example through centre-based services, in-home, day services, community access and outreach services.

## Examples of supports

 <b>Planning and decision-making</b> E.g. A support worker to help plan to move into your own place	 <b>Help with household tasks</b> E.g. Help with cooking meals or cleaning or whatever else you need to love independently	 <b>Support with building social relationships</b> E.g. Help finding and participating in a film group or going to a concert (the cost of file or concert will e paid for by your own money)	 <b>Develop skills for budgeting</b> E.g. Help from a financial counsellor so that you can manage your money better	 <b>Tenancy Management</b> E.g. An advocate to help you manage a disputer with your landlord	 <b>Support with developing skills for getting to appointments and managing other important activities</b>
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## What won't it cover?

The NDIS won't fund current services such as:

- Education
- Income support
- Public/social housing
- Employment
- Public transport
- Health services
- Or living expenses (e.g. rent, vehicle payments, transport fares).

However it may fund supports that help people access and connect with these types of services.