**Breakfast Club Aug 2018**

SS: Hello everyone. Thank you so much for coming along to our presentation.

I’m going to do the formal bit of the morning of presenting the slides and then we have Libby and Jan here who will join us in the last half hour to, with the discussion and to answer, well, at least attempt to answer any questions that you might have.

We will try and keep most of the sort of meaty questions and discussion to the end, but if you’ve got any sort of quick questions or clarifying as we go through, please don’t hesitate to put your hands up.

Okay, just before we start, just to get an idea of people’s sort of level of experience and confidence with the NDIS, have we got anyone in the room who would sort of feel they’re pretty reasonably across what they need to be across, even perhaps a bit expert in the NDIS? Anyone put their hand up to that?

No one who works with the NDIS or the NDIA with us today?

Okay, all right, who have we got in the room who’s really not really encountered the NDIS yet, who’s just at the very beginning of this sort of understanding? Have we got anyone, just a couple of people, so perhaps like Libby, Jan and I, the rest of you are, we’re all in together in this kind of group who have had some experience, particularly perhaps as it relates to our particular area of work, but still feel we’re on a very steep learning curve, so we’ll do our best to share with you today what we’ve been learning so far, both in our clinical experience and also in the project that we’ve recently completed.

So who we’re talking about today, again, look, the NDIS is just massive, monstrous sort of complex thing, we’re just hiving off a little area here today. We’re talking about people with severe brain injury, living in shared supported accommodation or specialist disability accommodation as the NDIS call it, and with supported independent living funding or SIL funding which is for the shared support or perhaps people living at home with high levels of support. So that’s the sort of group we’re talking about and what we hope to do today is share our clinical experience in working with this group over the last couple of years, and also share with you some of the outcomes from our recent work where Libby was awarded an NDIS workforce fund project grant, and we’ve been looking at, which we’ll talk to you about towards the end and Libby will give you a tour of the website that’s come out of that project.

So this is what we all know, for those of us who’ve worked in brain injury for a long time over the years and a lot of what we know here has been shaped, we’ve been lucky in Victoria to have the Slow to Recover program. We’ve also had TAC for a long time and I think the sort of investment that both of those funding bodies have made in rehabilitation or what we now call capacity building, for people with severe brain injury, I think we would all sort of feel like we’ve come to know that this is the potential our clients bring in to their rehabilitation programs, that we’ve got often significant lifetime support needs, but despite that, there’s an opportunity to build skills over the person’s lifetime. We need to individualise and plan those programs and the more consistency and repetition and meaning that we can bring in to these, then the better the outcomes, and in the long term, probably many of us in the room have seen some really good results in terms of maximising people’s social role participation and we certainly have a lot in common with the NDIS when at that last point, which is really one of the sort of stated goals of the NDIS is to look for those kind of outcomes in terms of social participation.

So we come to the NDIS and we’re just going to do a little snapshot of where ABI perhaps sits in the NDIS, so this has come from their dashboard reporting in March this year, so you can see ABI here is 3% of NDIS participants.

It’s actually a really small number, although you’ve got some of the other neurological problems on this list as well.

This is their expenditure for brain injury and you can see that the bulk of the plans that people are getting, coming in at this sort of under fifty thousand dollar mark, they’re possibly not the type of people who, the level of disability that we’ve been, well, it’s hard to know what’s led to that, but I guess our clients are more focusing in on are more up this end and you can see that there are some much higher levels of funding provided to some clients, so they’re sort of, this is the end of the spectrum that we’re focusing on today.

So probably you already know this, I’m going to really whip through it, but it’s important to understand how people’s funding is structured because this definitely flows through to how we can deliver therapy programs within the NDIS.

So many of you know that there are three funding silos.

I reckon if any of you haven’t had any exposure, this was actually the most helpful document that I read when I was first trying to learn about it, it’s the NDIS price guide. You need to Google and make sure you get Victoria and make sure you get the new one that’s just come out on 1 July, but this really outlines the way the funding is structured and it gives you all the line items of support that can be applied for or may well be in a plan, and when the plan comes out, what you find is that you’ve got funding in each of these silos and we’re purposefully using the word silo because you can’t move between them.

It’s locked in these silos and it’s probably clinically what we’re finding is a really big limitation of the way the plans are structured, so let’s just go through them all.

The capital supports, they’re to do with assistive technology, equipment, home modifications, vehicle modifications and if someone is going to be, what’s the word, Kathy?

Awarded SDA, determined, there you go, there’s a new word for everything, okay, and a big tip, learn the language because they don’t speak our language, we need to learn theirs.

If you are going to ask for specialist disability accommodation and you’re determined to be able to have that, then that’s where that’ll sit as well in the person’s plan.

Then you’ve got the core supports, these are really where your sort of disability support worker, supports sit, where SIL funding sits, transport, any one-on-one community access that’s designed to support people’s social or community participation will sit in core supports.

Now the focus of today, so where we’re zeroing in today is on the capacity building supports because this is where the therapy funding sits.

It’s where support coordination sits which is a little bit like the old case management, behaviour support sits here, so people, where you’re looking at managing challenging behaviours, building independence, these types of skill building programs, the funding for that will sit under capacity building.

This is again from the March dashboard figures, it tells how you’ve been allocating or where most of the funding is being allocated and you can see that we’ve got about 70% of funding allocated to core supports overall in plans and we’ve got really a pretty relatively I think, we think low level of funding allocated to capacity building and to this is behaviour support here with the word relationships, so not a lot down there with behaviour support.

Another thing that’s important to know when you’re coming to look at what, how you can use the plan to maximise therapy support and capacity building is how the plan is being managed because that impacts on quite a few things and there are three ways that it can be managed: self managed, so self managed means the person through a family member is managing the funds, then you’ve got more flexibility there; plan managed which is an intermediary like Moira who many of us are aware of, but there are a whole lot of them now; or there’s NDIA managed which is the agency managed.

So as you go down this list, you lose flexibility, but from a therapy point of view, if you want, if you’re a private practitioner and you want to get paid, then this is probably the safest category to be working with. Not to say that you, that there are always problems with the other two, but certainly our experience is you strike more problems with those other categories.

It also comes to influence to who can provide the services because if it’s NDIA managed, then you have to use a registered provider.

If it’s plan managed or self managed, then the individual can choose any provider, you don’t have to be registered yet, but they’re rolling out a registration, actually, I’ve probably got a pointer here somewhere, yeah, they’re rolling out a national registration framework and it’s currently being trailed in New South Wales and South Australia, and it’ll come in to Victoria some time next year. So look, we’re not exactly sure how that’s going to all impact, but I’m presuming, Libby, I’m presuming that everyone’s going to need to be registered at this time, but just exactly what we’re going to have to do for that will depend.

Okay, so knowing all of that, how do we, how might we work to be able to maximise the therapy supports that are contained in a person’s plan or at least utilise the funding dollars most effectively that are in a person’s plan, and we’ve divided this up in to two sections, firstly, preplanning and secondly, then kind of working with a plan.

So sorry for all of this, I had put a transition thing on it, but it, we’ve lost it I think in, sorry, I’ll go through this line by line and I’m sorry for the amount on this slide.

So we’ve had, we’ve got a number, as many of you will, of existing clients who you’re working with who are then transitioning say from slow to recover or ISP, say on to the NDIS. So I guess we’ve taken, and I know Libby does the same thing with her clients, a kind of a bit of a lead role, really, in trying to organise or coordinate the team to be able to do some comprehensive preplanning.

Now I think if you get the opportunity to do that, it is really worth it, it’s a really good exercise to go through.

So we’re using existing funding with existing clients with the permission of their funding bodies to say, look, we helped this person get on to the NDIS, we want to divert some of this therapy funding or case management funding, whatever it is, on to, in to this activity and everyone’s been really happy to do that, to have that work done to really make that transition as well as possible. So if you get the opportunity to do that, I think it’s really a good thing to do and if you can take an overview of all the person’s support needs and what we’re tending to do is to produce a really comprehensive document that pretty well is, without trying to take away the role of the planner, pretty well outlines what the plan as a whole will need to be.

In NDIS language, using the language, using the phrases, using the support items, using all of the jargon of the NDIS, and then what happens is that we’re able to back all that up with reasonably short, perhaps two or three pages of therapy reports so the individual therapists then writing a report, but to be able to pull it together in to a comprehensive and cohesive plan, does work quite well. We are finding that planners often don’t bring that level of clinical understanding of brain injury etc, to this process and they’ve got a completely impossible job, anyway. They’re supposed to produce these comprehensive plans for complex people within an hour’s meeting with a client who may not have, to be able to really engage because of their brain injury in a sort of insightful way in that conversation, so I think it’s kind of set up to end up with really unsatisfactory plans the way the whole process is set up. So I think we can bring out knowledge and understanding of the client to bear and try to improve the quality of those plans.

I think it’s really important to back it up with published measures, so we’re finding again our clinical experience is that they’re wanting more and more evidence, more and more data, more and more sort of rationale for providing this, so we’re sort of responding with that, with doing a lot more use of standardised tools.

We’ve also, the other little tip that we’ve found is that they’re probably not so interested in hearing from us as therapists in these meetings and skilling up the client particularly and also the family to present themselves in to the meeting and ask, plus the use of documentation really helps to minimise a therapist’s kind of interaction in the meeting which I think helps. So we do things like support clients to make DVDs of things, come with photos, picture books/albums, their timetables, to talk about activities and things like that and that does tend to go well and clients certainly stating their goals, but not being asked on the spot for their goals, doing some work, helping them to develop goals that really under which all of the supports can sit.

So those goals are actually really important, those two, three goals that you create with the client are really important. So you do need to spend a bit of time thinking about them so that you can link all of the supports you’re asking for under those goals and the therapists writing reports to those goals is really important as well, so that produces a really cohesive level of documentation for the planner, so everything links back to those three, say key goals. And if you focus on a participation outcome, again, that is really good, as a family member, a worker, a volunteer, a pet owner, whatever, remembering that the NDIS is a social model of disability, not a medical model, although we are finding now, and this is creeping in, that they’re actually wanting a lot more medical evidence than probably compared to what we were being asked for 12 months ago, so you need to be really creating a much stronger link between the injury and the support needs than perhaps we were being asked.

The therapists will generally create some sub goals because, of course, you can imagine those three goals are really broad, they’re not, they’re really overarching broad goals and then what the therapists are doing are creating some sub goals from those where they can link them in to the NDIS outcome domains, which again are on that price guide, listed out on the price guide, and then of course, outlining the therapy treatment plan and documenting the expected outcomes sort of relative to the measures that you’ve put in place.

We then state the number of therapy hours and actually give the line item of what we think in terms of the NDIS item number and the meeting, we would ask for the email address of the planner, another little tip, you want to get that because they often won’t generally give it out without being asked, and then we follow up with giving them electronic copies of all of the documentation.

It’s much more effective than giving a hard copy. Hard copies, I don’t know where they will end up, but not on the computer system from our experience, and they’re not able to accept a USB, so you need an email address and then they will, I’ve had emails back saying that now it’s being saved in to the client file, so if you want to kind of be certain that something’s going to make its way in to the client’s file, it’s, our experience would be best to email.

Okay, so this is the item number where most of the therapy supports will sit, you will see here that that group therapeutic supports, that professional group is all of these people here, and the item number is this one individual assessment, therapy and/or training.

Now what you get in a plan is a lump sum for that, so that then needs to be distributed amongst all of the treating therapists who might be on the client’s team, which is a challenge that the support coordinator will have along with the family and client to work out the division of that funding particularly where they don’t approve the level of hours that have been requested.

The other place where therapists will tend to be able to work and have their support sort of categorised is under improved relationships with two professional item numbers here of specialist behavioural interventions support and then behaviour management planning and training. And you can see here that typically, for those of you who’ve worked in TAC or probably even Slow to Recover, where there have been challenging behaviours, the tendency is to engage your own psychologist in that role to take the lead, but the NDIS have a broader view of who is able to provide behaviour support and you’ll see here a number of professions listed, so it’s broadening out who can provide behaviour support. But a word of warning is that you have to be registered not only with the NDIS to provide behaviour support, but also with the Victorian State Government DHHS and that registration process is just, I don’t know, think of a word, terrible, extreme, no, the good woman in me can’t really say what I think about that, so it’s extreme, but it’s the kind of process that probably is going to be there in the national framework next year if you’re looking to work under this category.

So, that all can help get a good plan. The other group who we’ve got and for those of you and we’ve had a number of new referrals where the support coordinator rings you up and says, I’ve got 10 hours of speech pathology, can you go and see my client?

Okay, so that can be quite problematic when you’re obviously and some of you will have had that experience, you often won’t get a lot of information from the support coordinator, not even necessarily a diagnosis, so sometimes it’s hard to work out whether that person is actually within your field of expertise and you just don’t know what you’re walking in to, probably something complex, sorry, and you might only have 10 or 15 hours, so what are you going to do, and it’s a bit tricky, it’s taken us a while to sort of sort through how we respond to this.

I think triaging the referral and goals and expectations carefully is really important because it could be a huge expectation, 10 hours, so you need to really before you go in there, you want a triage it, really important then if you can to identify some sub goals, look, I can’t address all of that in 10 hours, but what I think I could do is address that, so maybe you hive something off that you think is achievable and you’re planning your therapy input to achieve a small goal. And that should be reflected in your service agreement that you need to create with the client and/or family and in doing this, what you want to think about is your model of intervention, so how are you going to work? How do you make 10 hours work with somebody really complex, and this is sort of where we’re going to next, okay, and this is what we’re slowly kind of learning and adjusting as we get more experience with the NDIS as to how do we adapt our model of therapeutic intervention to fit within this new framework, so there are a number of ways we can work.

We can go and meet with a client and meet directly with a client, we may or may not then engage allied health assistance or disability support workers in that intervention perhaps particularly if we want some follow up practice of something which is really the sort of Slow to Recover model of how we learnt to work. We could work in a secondary consultation model which works quite well for some issues, we could look at trying to train up this direct workforce, 70% of the funding is being directed to disability support workers and when you read about what the NDIS expect from a disability support worker, it’s generally up here where they, their idea of their role might be here, but the NDIS thinks that they should be doing this. So there’s a real gap we’re finding between sort of expectations and what’s generally making a bit of a generalisation here, but generally, where a disability support worker would see their role, so maybe we’re needing to do more to train up this workforce to sort of meet some of those expectations or do we work with a combination of the above?

So I thought I’d just present a short case just to sort of outline, really outline this sort of these sorts of options.

So this is a client of mine who had an extremely severe brain injury about 10 years ago, really complex, he had, he was homeless before with long-term substance abuse issues and a significant mental health condition and then as a result of assault, he got an extremely severe traumatic brain injury.

So he’s living in a shared supported accommodation setting with three other residents, so you can see here, this is his first plan, and budget is, you look at that and you think, wow, that’s a fair bit of money, and he’s certainly falling up that end of the spectrum when I showed you that earlier diagram of funding, but look at this.

Here’s his capacity building budget, nine thousand five hundred dollars.

He’s someone who hasn’t had therapy, he was on the Slow to Recover wait list for a long time, but never made it, so he hadn’t had much in the way of therapy, so 3.6% of his budget was capacity building and he’s got massive issues, and this funding was to support and to achieve my communication, mobility, behaviour support and skill development goals, and there was no allocation for funding for improved relationships which is where behaviour support sits.

So of course, all the therapists went to meet him and went, there’s not much I can do, he tried to hit me, he just screamed, what can I do, and they were all, everyone went, well, we need some behaviour support, so the OT got 18 hours under this budget of OT.

She wasn’t, she didn’t want to take up the behaviour support element of it, so they split the OT budget, so they provided behaviour support under this category of improved daily living which I’m seeing happen a bit because there are so few people registered to provide behaviour support.

It’s really hard to find a support clinician in brain injury, so sometimes to get around the registration requirements, they’re slipping the funding in to improved daily living.

Anyway, so she gave up 10 hours and that went over to behaviour support and that came to me, so this is his team. He’s got 24-hour active support, a dedicated house manager which is a critical factor in this whole story, he also got 15 hours a week for one-on-one support to take him in to the community, he had, he was initially allocated 18 hours each between speech, OT and physio, and as I say, the OT focused on the wheelchair prescription and then I focused on the behaviour management.

So what do you do with 10 hours? That’s the question.

So the first thing I did was administer the overt behaviour scale and totally recommend that.

Some of you I know were at Glenn Kelly’s training last week on the overt behaviour scale, it’s a terrific instrument that can be used, you don’t have to be a neuropsychologist to use that, you can be someone from another allied health background.

You’ll see as we go through we put some references here. I’m just going to segue a minute and point this out.

This is the new website that we launched last week as a result of our workforce innovation funding, www.mysupportspace.org, and Libby will show you at the end. But there’s a whole heap of resources on this website that I hope that people will find very helpful including a link to the overt behaviour scale.

So it looks at the presence, frequency and severity of nine most common behaviours, so these are his results.

Now just eyeballing this, this is a very high level of challenging behaviour, so five is actually the ceiling level, it’s the highest you can score and you can see here, in terms of frequency, verbal aggression, frequency of physical aggression towards other people, severity of behaviour and adynamia and severity levels are really very high as well, particularly here for the verbal aggression.

So we’ve got just multiple types of challenging behaviour occurring throughout the 24-hour period.

It’s extraordinary that there was nothing in his plan for behaviour support, but anyway, that’s kind of what can happen.

So what could, what can you do with it, because we are finding ourselves in this situation where we’ve got these small amounts of funding, how do we use it purposefully with people?

So just have a look at this as the framework for the next few slides, so what I’ve done here is divide it in to capacity building supports here, so we’ve got a therapist at this hourly rate that I showed you before, we could have an allied health assistant involved, and there is a line item in the price guide for therapy assistant.

They don’t actually mention the word allied health assistant, but they, there’s a therapy assistant line item and that is the hourly rate and then we could look at, we’re going to talk to you, a lot of our project was about looking at health professional students and potential roles that they can play in delivering capacity building, particularly in shared supported accommodation. But obviously, there, you can’t charge for a student, so they’re a free resource, although one obviously that needs to have a lot of support and supervision.

So we’ve got these options here in terms of utilising this funding which would be invoiced under that 3.6% of the capacity building budget, but of course, you’ve got all these other supports here, the core support, you’ve got a house manager, we’ve got 24-hour house staffing and we’ve got 15 hours of one-on-one support, so you’ve got a huge amount of support down here and a tiny little bit up here. So we need to think about how to utilise this whole kind of support structure.

So let’s look at our options.

One, I could use the hours, I could go and I could meet with him for an hour a week for 10 weeks. I actually don’t know what I’d do with him, I could perhaps spread it out, maybe he’d last half an hour over 20 weeks, but there’s no sort of direct working with him, he does not have the capacity at this point of his rehab to self regulate his behaviour, he doesn’t have insight, very severe.

In terms of managing his behaviour, there’s nothing I can do, I don’t think by directly working with him. Now that does go against some of you who have been in this situation, too, where someone will say to me, you’re a psychologist, you go in and tell him that he can’t hit the staff, he’ll listen to you.

Well, I could go and do that, but I don’t. I wouldn’t expect that to have any outcome at all, so that I think would be a waste of his funding for me to do that and that’s not what we did.

So another option that we might have with that funding is if I use half of it, five hours, and then direct the other half of the funding towards an allied health assistant, someone trained and able to deliver a therapy program, including working with me to work up a behaviour plan. Perhaps what we could do is pick one of his community access shifts because at the moment, he has just different workers coming in all the time, they take him out in his wheelchair, they go for a walk, they might go to a local cafe, generally then, he’ll get quite agitated and start screaming or might do something and then they have to leave, they go for a bit of a walk and then they come back, so it’s not a particularly purposeful shift.

It’s terrific that he gets out of the house, gets a bit of fresh air and all of that, but maybe there’s a way of working these community access shifts up to be able to embed some behaviour support in to that and to perhaps create some more meaningful roles in the community. So what I could do would be to engage an allied health assistant, take one of the three hours of community access, put the allied health assistant in there and work directly with them for, what have I said, seven weeks for them to try and work up a routine for a community access shift, then hand that over to a community access worker and they would continue with that shift. So I think that could be a useful, I don’t know, I’m really interested to hear how you’d use this funding, some of you might come up with some other ideas and we really came to hear them.

So obviously, this funding, this core funding is ongoing, whereas this funding is going to run out pretty quickly. So we could transfer that over and he might have one shift a week where he’s doing something, I don’t know what it would be, but something that’s perhaps a bit more in line with his interest and his key, the roles he’s keen to participate in.

Anyway, we didn’t do that, but we could’ve.

We’re just going to segue a little bit in to allied health assistants because I think there’s a lot of potential within the NDIS to really build this group of workers. So people who again, some of you worked in hospital settings, you’ll probably be used to working with allied health assistants and mainly being employed in hospitals and also in nursing homes and generally will hold a Cert 4 qualification in allied health assistants, but not necessarily.

When we’ve looked at some of the studies on who is an allied health assistant, a New South Wales study, about half had this qualification, the other half had qualifications say as a chef, in some sort of recreation/leisure worker, a personal trainer, or a gardener or a woodworker/tradesperson. Someone who’s coming in with a particular skill in an activity area can certainly be employed as an allied health assistant, there’s no necessity to hold this qualification.

It’s actually up to the therapist to certify that this person is working at that higher level and the therapist is the one who’s guiding and directing the allied health assistant and the one who kind of vouches for their capacity to be involved. So I think that what we would need to do and what we’ve looked at as part of this project is to sort of work out how do we transition that model that’s worked quite well in say hospital rehab settings in to a community setting?

So there’s certainly a clear division of role between a therapist and an allied health assistant and I think it’s really important for us as therapists in the room to really hold that line, that they are not a replacement for a therapist and we do run a bit of a risk that people might start to see them, they’re a lot cheaper, an allied health assistant we’ll get them, we can’t afford a therapist.

That is completely inappropriate because they do need to be guided by a therapist because they’re not coming with the same background.

It’s also we would be concerned if people just started classifying disability support workers as allied health assistants without any sort of level of supervision or sign off or any of that sort of thing, so used appropriately, though, under the guidance and the direction of a therapist and under the therapist’s professional indemnity insurance policy because that’s a really important aspect of this, they need to be properly insured, generally speaking, they will come under the same insurance as the therapist in a therapist’s practice or the hospital or the place where they’re being employed.

So therapists assessing and planning and then delegates, trains the allied health assistant and then ensures that they’re doing the job adequately.

They go ahead and do it, report back to the therapist, the therapist upgrades or downgrades the activity and moves the sort of progression of the client’s skill along. So I think there’s a lot of opportunity here to think about how we might use allied health assistants to deliver some of this very, particularly the sort of slow stream rehab where it’s really about getting lots of consistent practice in order to build the skill.

Funny, they, on one hand, the NDIS talk about the allied health assistants, but there’s actually as I say, no line item.

I think that probably will change, but they do talk about allied health assistants, provisional psychologists and students and their role within the NDIS, so there’s a kind of, they’re frequently asked questions, this was their answer about not being able to charge for students of course. But anyway, it needs to be said and also that a student can be employed as an allied health assistant or a provisional psychologist could be employed as an allied health assistant and if you’re employing that person and supervising that person, then of course you can charge for their time even if they’re at uni the rest of the time.

Now there’s a fair bit of work going on behind the scenes around allied health assistants, this is, this was produced by another working party if anyone wants to have a look through this.

This is all about how to use and work with an allied health assistant.

I said to Libby yesterday, I got to page three on this and I normally don’t mind sitting down, reading things like this, it is so complicated, there’s such a procedure in here about it, but I think for those of you and look, I probably shouldn’t have said that, but one day, I will sit down and read it, but there’s an absolute process in here that’s guiding therapists on how to use an allied health assistant in the NDIS.

Now we’re, what happened? Now we’re not sure, are we, Libby, that this is actually going to come in to action.

LC: Yeah, so it’s about to be launched, the disability version is about to be launched this month.

SS: Okay, and when we’re supposed to follow the guidelines, that’s the thing, so we’ve got the documentation, they’re running seminars and things and there’s someone who if you email Libby, we can give you the name of the person who’s running seminars if you want to go to them and learn about it, but how it’s going to roll out in to the NDIS is not clear, but there is likely to be something more coming about allied health assistants and it’s likely to have quite a framework around it.

If you can get through all that bureaucracy of it, I think the service will be a really good one to be thinking about expanding.

So anyway, we’ll come back to this. So thinking about how to use these hours, of course, if you look here, we’ve got a huge resource here that we probably should be looking much more to tap in to, and that’s actually where I went with what we actually did, so this is how I ended up using the funding.

So I did use all my 10 hours and five pro bono hours because it just wasn’t possible to do it in 10, I had a student on placement/work experience and he spent five hours unpaid, helping, he came to meetings and he helped then write up guidelines back in the office.

This is the one that I think was critical. This is 10 hours from the house manager.

Now I think really for those of you who’ve gone in to shared supported accommodation where you’ve got clients with challenging behaviours and you’ve had the experience of trying to sort support staff to implement a behaviour plan, you may agree with me that this person is critical.

Without the house manager, you just almost might as well forget it, not completely, but it’s very, very difficult to implement.

I think I probably would’ve gone with the allied health assistant and the community access worker if we hadn’t had a really good house manager, but we did, a fantastic house manager who really wanted to get on top of this behaviour, understand it and support her staff because they were being hit with enough frequency that it was of concern and she spent another easy 10 hours. In fact, she did a lot of the observation of the personal care where we ended up focusing and then the house staff, their long term staff, their permanent employees, they’d already had a lot of behaviour training, they’d had a lot of contact with therapists over the years and they were all there, 24/7 plus a hundred per cent attendance at house meetings which again, think about the last house you went to and a meeting with staff, did you get a hundred per cent attendance?

We pretty well got a hundred per cent attendance at two meetings, so that was fantastic and I really do think that it’s because of this core, really good core support that we could make this work. So I think that’s sort of looking at the whole picture, really, trying to just pick something out where you can make a difference and it’s not always straightforward, so that’s how we used the funding.

So I had three meetings with the house manager, two staff meetings, so given the odds, but the really good thing to do after you’ve administered the obs is then to set up some more specific recording and again, for those of you who were at Glenn’s session yesterday, last week, sorry, he certainly recommended that as a way to go. So you get more of the detail in relation to the specific situation where the behaviour’s been displayed and the key behaviour with this client was in the morning with personal care.

The level of behaviour was extreme, so we set up some behaviour recordings for the staff to implement so we could get some documentation and then that gave us some information about what was going on. The staff brought their observations to the meetings and we problem solved why this behaviour was occurring and what we were going to do about it and just that education, this guy is actually amnesic.

Staff didn’t realise he was amnesic, despite all their experience and how fantastic they are. They didn’t realise that every time they walked in to his room in the morning and just started to throw his blinds up and pull off his covers and come on, up you get, time for your shower, he had no idea who they were.

They couldn’t believe it, they said, we’ve known him for four years, of course he knows who we are, but hang on a minute, does he really, and then they went away and checked that out and they said, you’re right, he didn’t know who I was.

They were astounded, so they changed the whole greeting in the morning, the way they introduced themselves, where they oriented him, all sorts of different things and they were able to then take on board all these strategies as they sort of understood the brain injury and we collaboratively problem solved and agreed on the selected changes to personal care and we had one meeting because of course, there weren’t many, but the second meeting, we then reviewed and adjusted the strategy.

I wrote up guidelines and documented the new routine, so this is what happened, so these were our categories that they just did a frequency count, how often the verbal aggression, so we’re talking about the hour/hour and a half it takes to do personal care, so this is the level of verbal aggression to the carer, he used to yell out to the other residents and tell them he hated them a lot of the time, there was a fair bit of that going on and there’d be usually one or two attempts to hit the worker during that time, not very occasionally saying something positive and he had everything done for him as quickly as possible because he just wanted to get it over and done with.

So we problem solved a whole new approach and staff were great, they really got on board with this. So instead of coming in and just assuming he knew who they were and why there were there, two people talking to each other, talking to him, they had a very structured kind of approach in the morning which kind of eased him, oriented him, got him ready, got him agreeing to the first step and when they did that, and sought his permission in each step, the second staff member would come in only as required rather than sort of in there chatting to the first one.

Things just really improved and that’s, after three months, you can see the level of aggression towards the workers has gone down. There was none, interestingly, to anyone else, physical aggression didn’t occur and we’re getting 17 positive comments, thank you for helping me, I like you, this sort of thing, and one of the key things was this, this active participation.

He started doing things, he actually was shaving himself at the end of three months and he was doing a few other tasks as well, which was fantastic.

It did make the whole thing and that was the 90 minutes, when we first started, it was 60, now it’s 90, but the staff could come in and out and do other things in the meantime, so they weren’t particularly concerned about that.

So I think in conclusion around the workforce, I think what we would say from our experience is that we all really need to try and improve the level of knowledge that the planner has, the information we give them about the client to try and guide that planning process in a way that will get the outcome that we feel from a clinical perspective is the one the clients need, which include access to capacity building supports because we know that if we continue to deliver a level of capacity building over a long period of time that people will slowly improve in their independence and even in three months, he’s shaving, so that’s just fantastic.

There’s all this potential that sits there that’s often untapped when you don’t have that capacity building layer in the person’s team.

We also, I think we do need to get on board with this whole new model that’s there. We need to learn the language, we need to sort of, and we do this all the time, try and stop ourselves from complaining about it too much and going, God, you know what they’ve done now, and we go, no, not going there, what can we learn from that? Let’s move on, let’s look at it positively, let’s try to work out how to work within this framework, but at the same time, try to influence the way it’s evolving so that it’s more, it’s just more suited to our clients’ needs, and when we think about our limited hours, we need to make sure that’s reflected in our service agreements and risk management is a really big part of all of this which we haven’t really gone in to, but I’m just putting it there to just alert you to the fact that this is quite an issue.

We can use mixed models, we can think about how we can utilise a disability support workforce which is there funded in huge amounts and often huge numbers, whether we can introduce allied health assistants or make use of this gorgeous budding workforce of allied, of health professional students and then use spreading our hours out a bit more so they can work under our supervision and with our support.

Oops, sorry, I’ve gone to the wrong one, and then the last one is to sort of think about whether we need to be thinking of allocating training hours within the hours that we’ve been given, that that probably should be a factor in what we include in our plans to really build that disability support worker and knowledge.

We’ve kind of put the word mandatory with a question mark there and we’re sort of saying that because of our experience in the project where we offered health professional students allied health assistants, and disability support workers training, digital training.

We had full take up by the health professional students, allied health assistants and I am sorry to say, one of how many, Libby?

LC: Fifty.

SS: Fifty?

LC: Yeah.

SS: One of 50 disability support workers took it up on a voluntary basis which was really disappointing, so I don’t know, if you make it voluntary, I’m not sure how many people will avail themselves on it, so that probably needs some discussion as to just what training people should be bringing.

If you’re expecting this level of performance, you really do need to be able to provide people with training to sort of bridge that gap.

So I think in terms of that training, just to expand that last point a little bit more, within the NDIS, they really are and you can see just by the allocation of funding, 70% to core support, 30% to all the rest of it that there’s this big reliance on this core support workforce.

I think it’s possible to really work with this workforce and to really be able to do some really good stuff and I think what the outcome we got with AA probably we had some pretty ideal conditions and I think they kind of need to be there to get the results, the dedicated house manager, critical.

She’s on site, long-term permanent staffing, very few agency and casual staff, regular mandatory ABI training within that workforce and experienced health professionals coming in and being able to know how to use those hours, make quick kind of clinical decisions and when the workforce is knowledgeable, well trained, well managed, supervised, I think we can use those small hours quite effectively.

So what we have done is to, considering these training needs about the health professional students, and also the disability support workforce, what, when we’ve run this with Libby and Jan and our other partners which were Scope, Yooralla, and Victoria Community Living and MRG, I left, did I leave anyone else out, Libby?

LC: The foundation.

SS: Did I say Tipping, I didn’t say Tipping, what we did was try to pull together a whole lot of training resources and put them, as Libby’s brilliant idea to kind of bring it all together in to a website that is accessible, so there’s so much here and Libby’s going to take you for a tour through this website now and then we’ll probably go to questions and discussion.

LC: So thank you very much and as we said, we just really welcome you to use the training that is available on this resource for the workforce that you’re engaging with and also share this resource, so just to explain how the website works, we did try and really consider how we provided training, so there’s written information.

There are also videos on each topic, that’s interesting, it shouldn’t do that, so that you can either access this training through reading, through watching short item videos about three minutes in total or some longer training modules up to about 40 minutes per module.

There are a couple of modules we’re still editing, one on communication after brain injury, one on person-centred support by NRG that are going to come on to the website in the next couple of weeks, but a majority of the content is already on there and it sits in this library section of the menu which is on the left hand side, so as you can see, there’s also a tab about the aims of how you might use my support space, the website.

There’s a video on that as well as written information, there’s then a diagram of how you might use My Support Space and you can roll over that some information, again, just for people with different literacy needs, then we do know even highlighted the most recent activity commissioner report, the high reliance on the direct workforce, particularly coming in from other countries that may have English as a second language and how we might support them to access training and information.

You can then go to the library tab and on the library tab, there are six topics for you to look at and consider the training that sits within each of those topics, understanding acquired brain injury, support for community living, lifelong recovery, building capacity for participation, the NDIS and then there’s that tools and resource tab which has a lot of those assessment or published measures like the overt behaviour scale, care and needs scale and other measures that might be useful when either talking to someone around their goals for participation or thinking about structure and supports.

So if you go in to each of those sections, you then get a photograph, which has a key message on understanding acquired brain injury, for example.

You can then go to one of the topics that’s listed on a button here or you can search the website, so if you put in something like I want to learn about how you structure routines, you can type that in just directly, and then you can search the website and it’ll bring up in the website all the topics that relate to structure and routines and there’s another list there, but you can’t see it and this is weird for some reason, but it does work very nicely.

If you go to the topic of communication, for example, which Jan Mackey was very involved in developing all the resources on here, you’ve then got a list of different written resources and then you’ve got these short three-minute videos, so if we look at the fact sheet on choice making, it takes you to a sheet which provides you some information around how you build choice making when you’re working with someone with acquired brain injury as a photo or you can go back and go to one of the shorter videos on communication, for example, and as I said, these are up to about three minutes long, these videos and then there’s a 40-minute module on a number of topics. So we just really welcome you to share this resource and use what’s available on here because we would really love to continue to see the development of the ABI workforce in the NDIS and as Sue said, it’s something that we know is being very heavily relied on.

Probably two other things I was just thinking of in talking in your present discussion, Sue, was you look at some of those planning outcomes and go, we need a planning review, that actually was an inadequate planning outcome, and we have seen some real issues with actually getting a timely review, haven’t we? Would you like to comment on that, Sue?

SS: Yeah, I’m glad you brought that up, Libby, because I was going to say that clearly, the team came to understand with Mr AA, for instance, that we needed a heck of a lot more behaviour support and a lot more other therapy support, and there, but there was some talk of a review, but at that time, the timelines for reviews were 10, 12 months, so the support coordinator said, well, there’s no point going to review because we’ll have our year two planning meeting before we even get a review, so we didn’t do that. But what I did do which actually is a really important bit and particularly where you end up with a pretty inadequate year one plan is I think we can then really well document the issue, and we did that with Mr AA.

We gave them all the obs data, we gave them all the results of the personal care and laid all those issues out, really honed in on the risks to him, to carers, to his participation goals, etc, and created a really strong rationale and just two days ago, we got his second plan and I’ve got nearly 50 hours of behaviour support now, so I think that even if the year one plan isn’t great, you use those hours to then do almost the pre planning for year two and then other times, they will go to review, I think, when it’s really bad, we’ll go to review, but I don’t know what your experience is.

LC: And there was a report released just in March of this year indicating that there were 6200 reviews awaiting an internal review by the NDIA, and certainly, we were just talking yesterday and Jan was saying around the lunch table that we are seeing the agency at the most senior level trying to effect change, say if this is not working, we are trying to do this differently.

What we also is that is just such a massive reform and to even get the workforce and planners to be available to do planning means that we’re seeing what’s being aimed for and the work that’s being done to try to influence scheme design at a senior management level isn’t always filtering down to what happens on the ground. So we are in a time of monumental change and we think it will improve and we think we all have a role, everyone in this room has a role, to try and help to improve the scheme for people who we’re working with and that’s why we want to sort of step through some of these processes today.

I guess the other interesting thing we spoke about yesterday that I thought was worth flagging is Sue’s sort of given this structure of how you might go about working with the NDIS price guide, working with the budget that the person has to try and get the best support model to influence outcomes.

What we’ve seen from the most recent NDIS reporting is year upon year, we’re seeing of the funding allocated to NDIS participants, in the last year, only 66% of what was allocated in the plan was actually utilised, so unless you have this sort of expertise, the ability to self advocate, the ability to have a family or support coordinator or therapist who can work with you to try and harness the supports you get in your plan, there is a risk of under utilisation of what’s actually being put in to a plan, and we think there’s a range of reasons why that happens.

Number 1 is the planning hasn’t been correct, so you haven’t got what you needed. Number two, there may not be the workforce to purchase from and we know in regional and rural areas, that’s a really big issue, but it’s also an issue in metropolitan areas, or that you just may not know where to begin and we certainly hear that from NDIS participants and their families. So there are some factors at the moment that are creating challenge particularly for people with cognitive communication impairment that we all work with, but we think there are some solutions and we really value these sort of forums like the Summer Foundation run to be able to talk together as a group, so I guess we really welcome your comments and your learnings and your questions at this point in time. And sorry, just before we do that, I should just point out just one last thing, as well as the library of information and training resources on here, there is a whole big link to all external resources that might be useful to you.

The Summer Foundation have fabulous resources that we’ve listed on this page of external resources and they’re categorised by those six topics that the training, and then there are just details of our team and how to contact us if you want to get in touch, so that’s the finish of the tour, and we welcome you to use my support space, we welcome you to share the website with others to use it, too.

SS: Okay, yeah, so there was one somewhere.

Q: Hi, so I’ve got it from the other side via work here, actually, and we have been doing a lot of pre planning, so a huge amount of work trying to get appropriate and really great plans for our inpatients who are being discharged and I think it was really interesting to hear you say the capacity building funding is when we have planning meetings, planners say, yeah, wheelchairs, yes, yes, yes, and then we get to the capacity building, we think, yep, we need neuropsych, OT, behaviour support, physio and they just push back. So I think it’s one of the things to kind of be aware of is that the planners potentially aren’t really understanding why those things are required because it’s really obvious if you see a person who needs a wheelchair that they need a wheelchair, but it’s those other things and we’re really working hard on getting those things and what we’re doing, I guess my question is what sort of plan and what do you recommend we say or that we write in our because we do a whole lot of documentation that we handed over and sent through as you were saying, but I guess, and we’re going for maximum, we’re saying 50 hours of absolutely everything that we can, but the planners really aren’t I guess acknowledging a lot. We’ve had a few incidences where they’re actually saying to us, that’s not reasonable and necessary, or our community health team, that’s rehabilitation, so I think it’s a really challenging grey area and as the health team, we’re really trying to advocate people and for these services, but we’re hitting walls, I guess.

SS: Yeah, I’m just going to repeat, summarise and repeat the question for the recording so I don’t get in to trouble, so the question is despite intensive pre planning in an inpatient rehab setting, there’s push back from the planners around approving therapy supports for when the person transitions in to the community and perhaps what are any tips around maximising that?

Look, we’ve had some sort of problems. I don’t think that I’ve got any particular answer there and I think we pointed to some of the limitations including the planner’s understanding, this sense that community centres will provide this type of service when they won’t. I think one of the things is to sort of get ahead of it a bit. Now you’ve heard their push back, you come prepared with arguments against that, so you can say, well, we have investigated the local community centres and there is no community centre, or he’ll only get five hours of OT and then you ask for what’s on top of that, so you can say, well, we’re going to ask, we’re going to refer him and he’ll get five hours, but he’s going to need another 25, so you sort of ask for, because they don’t want to fund things that are already being funded by someone else, so you can start with your experience to anticipate what they’re going to say and push back on that. I think linking things to the goals is really important and we will always end our reports with the risks if this funding isn’t, if this funding’s not approved and this is what’s going to happen, and it is about that they won’t be able to maximise their social and community participation which is usually a goal. That’s two ideas from me, Libby or Jan, have you got any things to add?

JM: I think the obvious of linking to the disability, making sure they know that the disability requires that service and the risks of not providing it.

SS: Yep, so linking back to the disability and I think I’ve noticed that change is that they want more and more evidence around that, that disability, so I think that’s great.

JM: I think one solution we see as a quick fix is if we could get the agency to agree to what they call, offer fundability of those three silos that actually, if you got a plan and you had some adequate funding in core support, but you wanted to choose to purchase some capacity building supports, that you could actually do that with those core dollars. You could have that flexibility like we had in individualised support packages through the Department of Human Services in Victoria, so that’s something that we’ve been loving and we encourage everyone else to lobby, but I agree with all those suggestions, there was one other thing that came to mind for me and now I’ve, I think you’re in a really challenging position being, working in an inpatient setting, we’ve certainly seen the agency are really trying to reinforce anything that might be broadly a health funded service, so you are probably in the hardest of the hard positions in negotiating capacity building funds. And I think what, another thing that you might consider is acknowledging that this person is very early post injury, that if we invest now, we’re going to see good early intervention outcomes, you could ask for a shorter plan approval and try and push, no, still not getting that either.

Q: Yeah, we have tried that in the past, but as you were saying, it’s just, even if you requested a three or six-month plan, they’re just not, they say that they are, but then they’re not.

SS: Yeah, and then you’ve got year two and then to some, and I know this is terrible, I can’t even believe I’m saying this, but you just, that’s what you got, you try and work with it and then you write a really, someone, whoever’s seen him in the community and then tries to write a really powerful report and possibly...

Q: The thing we’ve tried to is to get quotes from possible providers, so we’ll say, well, we’ve had a quote from behaviour support team and they’re quoting this, so here it is and this is what we’re asking for, so that’s worked, hasn’t it or not, I’m just wondering because that’s the other thing, too, if it’s quite hard to find who will provide us quotes too.

Q: Yeah, absolutely, and I take your point, Sue, in that we are trying to not speak in NDIS planning meetings, we are very much trying to sit there as a support for the patient, but when the patients lacks insight and isn’t even aware of their challenging behaviours and we’re sitting there going, they need 50 hours in neuropsych, the planner I think finds themselves in a challenging situation because they want to hear the client, yet they can see the health team going, these are going to be problems and risks in the community, and yes, they always come back to is 50 hours or whatever it is really reasonable and necessary, so we are finding it really challenging.

SS: Yeah, sometimes what and where it’s difficult to say some of that really challenging stuff in front of the client, yeah, what we’re also doing where we want to is set the start of the meeting up with the client saying their goals, this is about me, telling them about their week, what their interests and having a nice kind of conversation, and then saying, look, they’re only going to cope with half an hour, they’re going to go, and then you keep people who can then give a more accurate account of what’s actually going on and that sort of can work all right, as long as you’ve got the client’s voice in there at the start, and then you come and kind of back fill it with all that detail that the client’s not going to report...

Q: Again, we have planners who agree that it’s about the client.

SS: Yeah, but also, if it’s about the client, then if the client’s fatigued or unwell or has got an appointment or something, then we’ve not had any issue where we presented that this is the benefit of the client, the client won’t manage this meeting well, you’ve got people who are pretty early on, we’re mindful of his concentration span, his fatigue levels and have we not had any push back from that?

XX: And I guess the voice then maybe can come from a family, so I still think the therapist’s not saying very much, but if when the client leaves, the family members are ready to take over.

LC: And just a last comment I’d make and Kath’s got one, too, is that where we do see most capacity building funding put in is where there is risk identified and particularly risk to the participant or to others. But what you would then want is to try and harness those capacity building funds in to that therapy line item, not in to the behavioural support line item which most often needs to be agency managed and then you restrict the choice for the participant as to who they can purchase from. So if often that discussion about risk is really an important one and again, I say to families, this is really challenging, but we need to highlight what are the potential risks to this person as Sue said and really close off if this funding isn’t secured, this is the risk to the community, this is the risk to the participant, this is the risk to their family, Kath, you had another comment.

CB: Yeah, I’ll just cheekily get up with the good women and add, just you guys are up against that health NDIS interface and we do have a podcast on this that you can listen to, and where you’re starting to move in to is changing from rehab in to small incremental gains, maintenance, maintaining your functional capacity and also preventing deterioration, so all those words that I’ve just used are all straight from the legislation and where we keep saying reasonable and necessary, to understand that actually, that is outlined, you can, it really suggests going and finding that at section 34 and looking at every single, yes, it’s burnt in our brains, looking at every single point and going to your planning meeting, unfortunately having addressed a, b, c, d, e, and lots of the things that you’re hearing from these three people actually you’ll find the same wording in that legislation, so it’s the same, but in a different way.

LC: And certainly, I sat with the technical advisory team at the NDIA last week and they said, yes, we think this sounds like something that this person could benefit from, yes, but we will be going to section 34 and we will be stepping through every element of the reasonable and necessary rule and that is the process a delegate will take, but just really acknowledge or challenge.

SS: Okay.

Q: My name is Toni, I’ve worked in the NDIS space, not as an allied health professional for about four or five years, I just wanted to share a personal journey because I wear another hat in that I’m the primary carer for my younger sister who has a brain injury who was on Slow to Recover. Just listening to all of you talking about the barriers with NDIS, we very recently managed to push through these barriers for my sister and get her 24/7, one-on-one care to come out of hospital and some of the key things that I think helped us to do that is number one, understanding the NDIS inside and out, understanding reasonable and necessary, just the operational guidelines and also the pressure points for like we said, planners. It’s luck of the draw, who your planner is, it could’ve been in a role for two weeks and certainly in Kate’s case, having a really clear strategy going in to that planning meeting, having the right people in the room, I’ve sat in many planning meetings and I see that there seems to be different, there’s not one consolidated voice in the room, but I’ve got to say as well, the squeaky wheel gets the oil and with my contacts in senior positions within the NDIA, they’re limited in what they can share with me, but I pick up enough to know what’s going on behind the scenes. I know that people there are working with broken systems, there’s a lack of communication, but I tell you what, they’re writing a very concise document that covers what the issues are and contacting the federal member for our area, I know that they’ve got a direct line in so I’d go through the process that the NDIA wants us to follow, and get brick wall, brick wall, brick wall, it took three and a half months of fighting for priority access, I was guaranteed we would have a planning meeting within two weeks, so it’s not easy, but those are the things and again, I’m hearing the conversations around risk and being really articulate and I wonder when I hear, we’re asking for 50 hours, we didn’t ask for hours, what we said is this is what is required and also having a comprehensive 90-page OT report that was actually written for legal reasons, but I was able to leverage that and that had very distinct recommendations that they could put hours and also when we’re supporting families, with the questions around that score, that was also key, knowing that and making sure we had the maximum WHODAS score which opens up the funding and then making sure that we have really clear evidence. So as I said, I provided that comprehensive OT report, but knowing that that planner is under enormous pressure to pump out these plans all over the place, she is not going to have time to read that, so my two page brief to her, I wrote everything in the plan, gave it to her on soft copy, I knew how many words she could put in to each section on their system so she cut and pasted exactly what I wrote in to, it’s all very strategic.

SS: And that idea of writing it up and then emailing it so they can email it as a Word, not a PDF, document and they will cut and paste it, it’s fantastic. And then the other little tip there about the WHODAS, you certainly answer those questions on the worst possible day, so you don’t, we started off and I think they started off wanting to know what the person could do and the potential and the goals and all of this, but it’s become very much one of the problems, what are the risks? What’s the disability, so we’ve segued in to that and certainly answer on the absolute worst day.

LC: Yep and the WHODAS is detailed on my support space under that tools and resources tab, but I agree and I think again, having the person with acquired brain injury who may not have insight actually responding to those questions actually won’t give a true representation of what is life like on the worst day.

Q: And that’s that funding, and look, on Kate’s plan, I’m happy to share, we got a six month plan, the agency was pushing for three months, but we got a five hundred thousand dollar plan with twenty five thousand dollars for allied health for six months and we will use that responsively and use that to open up the opportunities to demonstrate to the agency that this is money well spent and people with brain injury need this kind of support.

LC: Yeah, thanks for sharing your story and can I give you one other good news story. Just there is a pilot that’s been under way called my participant pathway and it’s being piloted geographically and I was just involved in my first planning meeting with someone who has a son who has an acquired brain injury, where you actually get to see a draft plan before it’s finalised and you get to sign off on that draft plan with the NDIS delegates sitting with you. It was three weeks from getting the planning meeting to seeing the draft plan, in the end, the family said, we’re so happy with this plan, so the LAC said, well, do you need to meet with the delegate? No, that’s fine, okay, we’ll just sign it off, it was the best experience. I’ve written to the CEO of the NDIA to say how fabulous it was. If you do get involved in that pilot or have anyone who’s involved in it or anyone who has a good experience, I think we need to try and articulate to senior management what were the features of that good experience. You’ve just articulated how having skilled advocacy, knowledge and I guess literacy to understand these very complex rules is so key and for many people we work with, they don’t just have family support to do that, so it’s what are the other features we need to build in to ensure people with brain injury get a good outcome and it’s challenging. Other questions?

Q: We work for a team who sees an NDIS client in a nursing home and it’s a new one and young-ish and this is our first NDIS client and we’re finding that that it’s not necessarily a lack of funding for us as therapists to see her, but to actually implement what we want to do at the nursing home is impossible, because they’re not funded to, she can do a transfer to therapy with supervision, but they won’t do side wall transfer too, and you can’t get agreement, she needs literacy and they can’t take it out.

SS: Is the longer-term goal for her to leave the nursing home?

Q: Yeah, well, that’s our plan, it’s probably one of the tips, so we’re looking at the budgeting of having her live independently or in supported accommodation.

SS: We’ll hand over to her.

Cath: Gosh, that’s a big question, so a young person under 65 in a nursing home and has it sounds like a good capacity building in the plan, there’s funding there, but it’s the limitations of actually living in a nursing home, I guess preventing that person from being able to reach their potential, summary.

Q: Yeah, that’s right.

Cath: Yeah, so I guess exactly as Sue said, the first thing is to get a goal in to that if that person wants to move out, okay, great, and that, get that goal in to the person’s plan and then get support coordination, so you talk at the planning meeting about getting support coordination and capacity building to develop a housing plan and explore all the options of where that person could move to, so that’s a quick summary.

Q: So do you guys do that as part of decisions, do you implement that and put that in case we ask that at the next plan, do we kind of go really consistently?

Cath: Yeah, if she’s got the funding at the moment, it sounds like then absolutely start right now, so we’ve got so many housing resources on our website that step you through all of that and ones that are specifically written for people living in aged care and Penny my colleague who’s here has written NDIS example plans of what that might look like, so I think the quick answer and Penny, jump in any minute, is check all those out, look at those resources and then call us if you need more, do you want to add anything?

SS: Yep, the thing I was just going to say is do you have any one-on-one support hours that are in the plan?

Q: Six hours a week for community access.

SS: Right.

Q: Just to get out of there, she needs to.

SS: Right, six hours isn’t a lot, is it, but...

Q: So listening to you, it seems like we need to go back on the plan.

SS: Yeah, even, I don’t know whether you’re allowed to in the nursing home, but even one three hour shift a week where it’s someone working under your direction to do the personal care a little bit differently if that’s possible, it might not be, to sort of just at least hive off some area where you can keep building skills or maintaining the skills. I know it’s not the whole thing, but sort of parking that because you haven’t got the resources and trying to focus on something where you could perhaps hive off some of those hours, pick one thing that you think helps and will help to increase her chances of or widen her options about where she can go, even to be able to just document what her potential is, that will certainly be something you would add in to the next plan, that you’ve actually achieved this with this bit of funding demonstrates the potential if the funding could be increased.

LC: Can I just say one other thing, too, which is a whole other breakfast meeting which maybe the Summer Foundation could lead because they’re experts in these areas, but it would be so important to understand the approach the agency’s taking to both supported independent living funding, which is the hours of support that are shared perhaps across people possibly and specialist disability accommodation funding, which is the bricks and mortar and at the moment, what we’re seeing is there are very few plans that are actually getting that payments for bricks and mortar where some might need a high level of physical design in housing where there might be a need to look at really targeted supports within their housing and it’s a problematic area at the moment. So that’s Kath’s point, that first step is that sort of exploring all the housing options, documenting for the NDIS, these are the range of possible options with that support coordination input and then you start on a whole journey around is this person eligible for specialist disability accommodation? Is it that they need supported independent living payments or is it that they need one-to-one support like
Toni spoke about for her sister? What is it the model of housing and support that’s needed for this person to get the best outcomes related to participation? So it’s quite a journey and Cath sort of outlined at the start of that journey which now is the window you are in with the next plan review. Penny?

PP: My comment to you in what has just been outlined is sort of the broad thing that workers can do, but perhaps for the participant, the most important thing is to think about how you fight institutionalisation for that person because come six months, come 12 months after being in residential aged care, moving out becomes a very difficult proposition for them personally, so I think do all that, but also in your work with her, really try and address what’s going on for her.

SS: Yeah, well, see, there’s a risk, you can lay that out.

Q: There are just no choices.

SS: And that’s their language, that’s how you write this up, so you write it up according to their framework. Okay, we’re finished.

CB: Sadly, we’ll have to finish. We’re done, thank you.

(Applause)