Practice Guide – Children at risk of requiring accommodation outside the family home

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The content of this document is OFFICIAL.

1. Purpose

The purpose of this Practice Guide is to support you to identify and plan (first plan and review) for the child participant (child) who is at risk of requiring accommodation outside the family home due to their high disability support needs.

This is not a standalone document and should be used in conjunction with the following planning resources:

- Practice Guide – Participants streamed as Intensive or Super Intensive
- Practice Guide – Complex Support Needs Pathway
- Practice Guide – Children living in a formal voluntary arrangement outside their family home
- Our Guideline – Reasonable and necessary supports
- Standard Operating Procedure – Complete the determine the funded supports task
- Practice Guide - Positive Behaviour Support and Behaviours of Concern.

2. To be used by

- Plan Developers:
  - NDIS Planners
  - NDIS Partners (early childhood partners and local area coordinators)
- NDIA Plan Delegates.

3. Scope

At any point in time, a small number of children are at risk of being unable to be cared for at home by their parents due to their high and complex care needs or challenging behaviours arising from their disability.

3.1 Out of scope

For children at risk of requiring accommodation outside the family home as a result or risk of abuse, neglect and/or family violence, do not use this Practice Guide. The responsibility to provide support to maintain the family unit and/or to seek alternative accommodation for the child lies with the child protection agency of the state or territory that the child resides in.

If you identify a child at immediate risk of harm refer to the Participant Critical Incidents page of the intranet. To refer the child to the Complex Support Needs (CSN) Pathway refer to Standard Operating Procedure – Referral for Complex Support Needs Pathway.

3.2 Guiding overarching statements

- It is in the best interests of children (including those with disability) to remain in their family home for as long as possible up to the age of adulthood (where safe to do so).
- Memorandums of Understanding (MoUs) between the Agency and each state and territory highlight the importance of upfront investment at the earliest points possible to prevent the need for children to live in accommodation outside their family home.

  The MoUs outline agreed roles and responsibilities, including in relation to NDIS funded early intervention supports.
- Reasonable and necessary NDIS funded disability supports are available to the child irrespective of where they live.
- NDIS funded supports are generally portable when the child moves to a new setting, however, a change in accommodation arrangements may trigger a plan review to account for the different circumstances (especially in relation to informal supports).

4. Identifying if the child's living arrangements are at risk

The reasons a child is placed in accommodation outside the family home may vary and are usually a combination of factors unique to the child and their family. The sections below highlight some high-level characteristics and indicators which could impact a family's ability to care for their child in the family home.

4.1 Child characteristics

- Severe and complex neurodevelopmental disability (typically Autism Spectrum Disorder II or III and/or intellectual impairment) where there are:
  - Escalating complex and challenging behaviours that put themselves, other people or property at risk of harm/damage.
  - Significant functional impacts across all domains, and particularly communication and learning (for example often non-verbal); escalation of

behaviours of concern. This may often occur when the child is approaching puberty.

- Severe and complex physical impairments with moderate to severe intellectual impairment as well as disability-related health care needs requiring high levels of one-on-one care (for example PEG feeding; continence issues; full assistance/prompting with eating, dressing, bathing, toileting).
- High levels of service coordination are often required, across multiple service types.

4.2 Family characteristics

- Large families or single parent carers are overwhelmed by the support needs of their child and/or other family members (including other children), who may also have a disability or complex health needs.
- Parents are experiencing relationship distress and/or breakdown.
- Parents' capacity to provide care diminished as a result of ageing, disability and/or poor physical and mental health.
- Parents are experiencing social isolation and do not have a network of family and friends for support.
- Parents have limited access to appropriate services due to rural or remote location or availability of appropriately qualified approved providers.
- Family has siblings with or without disability and expresses concern about the impact of the child's support needs or behaviours on other siblings.

4.3 Indicators

- Escalation of behaviours of concern. This may often occur when a child is approaching puberty.
- Parent has multiple caring responsibilities and is overwhelmed by support needs of their child and/or other family member.
- Parents are experiencing stress and exhaustion.
- Parents are experiencing relationship distress and/or breakdown.
- Deteriorating physical or mental health of parent.
- Parents are experiencing financial hardship and distress.
- Parents are experiencing increased social isolation and reduction of informal support from family and friends.

- Parents have limited access to appropriate services due to rural or remote location or availability of appropriately qualified approved providers.
- Family has siblings with or without disability and expresses concern about the impact of the child's support needs or behaviours on other siblings.
- Family has significant change in circumstances which impacts on the family's ability to support the child in the family home, for example death of a parent.
- School attendance (increase in non-attendance or suspensions).
- Repeated social admissions to hospital.
- Increased request for or use of short-term accommodation (respite).
- Plan underutilisation, particularly when a behaviour support plan has been funded but no funds have been used.
- Requests for unscheduled plan reviews.

These indicators must be used as a guide only and are to be considered alongside information shared with you by the child and their family during the planning process. Children and families will not be required to meet these indicators in order to receive early intervention supports and not all families meeting these indicators will require early intervention supports.

4.4 Joint decision making between the Agency and states and territories

The Party who first identifies the child who is likely to require accommodation outside the family home will, with the parents' consent, share this information with the other Party. The relevant state or territory agency and the NDIS Children and Young People team will meet to discuss and agree if the child is in the early intervention and prevention cohort outlined in the MoUs, based on the characteristics and indicators described in section Identifying if the child's living arrangements are at risk.

Once all Parties agree that the child is likely to require accommodation outside the family home in the future, the Agency will consider if the plan needs to be reviewed. The child and their family will also be formally referred to the state or territory for case conferencing and mainstream supports.

5. Early intervention supports

Where the child is identified as being at risk of not being able to continue to live at home you must take an early intervention and preventative approach to support the family to continue to care for the child.

The early intervention and preventative approach aims to put the right disability-related supports in place to increase the capacity of the child and their family. This should help the

child and their family to remain living together and reduce or remove the risk of the child moving into a voluntary out of home living arrangement. As the child or young person is formally agreed with states and territories as part of the Early Intervention cohort, states and territories will also provide connection to required mainstream supports for the child and their family.

You must place the needs of the child at the centre of your decision making to provide reasonable and necessary disability-related supports to support the family to continue to care for the child in the family home. This may involve a short period of intensive supports focussed on building the capacity of the family and carers.

A CEO initiated plan reassessment may be required so that sufficient funding is available for the child and family to access the necessary supports. This may be required if there has been a significant change in circumstances or a critical situation has arisen which impacts the safety and/or wellbeing of the child and/or carers. For example, the death of a parent or escalation of behaviours of the child posing a threat to their safety and safety of others.

Information below will assist you to identify risk factors, gather the necessary information and engage with planners in the Complex Support Needs (CSN) Pathway who will assist you in determining the types of reasonable and necessary supports required to implement an early intervention approach.

5.1 Participants younger than 9

Families/carers of children younger than 9 will be supported by an early childhood partner. In the rare circumstance that a child younger than 9 is at risk of requiring accommodation outside the family home, the early childhood partner will remain as the child's main NDIS contact.

The early childhood partner will collaborate with their state contact Assistant Directors within National Delivery to consider a referral to the Complex Support Needs Branch.

Children are not eligible for referral to the Children and Young People pathway until 7 years of age. Consultation however can be provided to ensure the child and family receives the right early intervention. Request for consultation can be directed to CSN Children and Young People.

Note: Children that are 7 or older before 1 July 2023 will not be supported by an early childhood partner.

5.2 Crisis response

If you identify a child experiencing a crisis, refer to the CSN Children and Young People (CYP) team who will respond. An example of a crisis is a parent refusing to pick their child up from respite or hospital due to their high disability-related needs (not requiring child protection involvement).

Note: the CYP team is not an emergency response team and do not work with children where child protection is involved or required.

Use the referral process below at Consulting with or referring to a CSN children and young people planner.

6. Child representatives and guardians

6.1 Parental child representatives

In most cases parent/s will be recorded as the child representative/s. When you add the contact role of mother or father, the role of the child representative is created automatically in the NDIS Business System (System). There can be more than one child representative. For more information on determining who has parental responsibility see NDIS Act 2013 (external) Section 75 – Definition of Parental Responsibility, NDIS (Children) Rules 2013 (external) Part 4 and Our Guidelines – Child Representatives.

6.2 Other child representatives

There are limited circumstances where it may not be considered appropriate for those with parental responsibility to represent the child for the purposes of the NDIS. For more information refer to Our Guidelines – Child Representatives.

6.3 Self-representation

In some cases, the child may wish to self-represent. When determining whether it is appropriate for the child to represent themselves, consider whether the child is capable of making their own decisions under the NDIS Act. For more information refer to Part 7 of the Our Guidelines – Child Representatives.

7. Pre-planning

During pre-planning, information is gathered to support the planning process and ensure the child has a high-quality plan to allow them to achieve their goals and outcomes. This section will guide you through additional considerations for children at risk of requiring accommodation outside the family home.

7.1 Verifying identity and recording consent

When having discussions regarding the child you must verify and record the identity of the person you are talking to and ensure they have authority to provide formal consent and their informed consent is provided.

Appropriate consent must also be recorded prior to giving information to or receiving information from a third party in relation to the child or family. For more information and

guidance, refer to the Information and Your Privacy guidance on the General resources intranet page.

7.2 Pre-planning checklist

- Add any relevant alerts to the System
- Identify who has parental responsibility for the child and who needs to be involved in the planning meeting or given the opportunity to contribute. For example, the child, parent/s, guardian or other family members.
- Allow all parties who hold parental responsibility to have an equal opportunity to contribute to the planning process. This may require sensitive questioning and potentially separate meetings for shared parental arrangements.
- Check all contacts are entered correctly in the System.
- Understand and respect any cultural sensitivities or barriers to communicate effectively with the child and their family. Refer to Practice Guide – Aboriginal and Torres Strait Islander planning support and Practice Guide – Assisting Communication.

7.3 The planning conversation

During the planning conversation, gather detailed and concise information regarding the family situation, informal support networks and engagement with community and mainstream supports. This is also an opportunity for the child / family to tell their story and voice their goals and aspirations where possible.

You may obtain information which indicates a family may require additional supports to allow them to continue to provide care for their child. See Identifying if a child's living arrangements are at risk.

Some families have more than one child with a disability living in their care. In these circumstances use a collaborative planning approach with the family to allow the needs of all children who are participants to be considered in the family context rather than in isolation.

Children at risk of requiring accommodation outside the family home are generally in complex situations, highly vulnerable and multiple parties may be involved. You must remain impartial and professional in all interactions with the child and their representatives.

If you have any biases or concerns related to the child's situation and you feel it would be difficult to work professionally with the child and/or their representatives, please discuss this with your team leader to ensure a positive planning experience for all involved.

If you have any concerns about the child's welfare or concerns regarding abuse, neglect or family violence please refer this matter to your team leader as soon as possible for further

discussion and decisions on appropriate action required. See Critical incidents and safeguarding.

The following points can support you to have a high-quality conversation. Only use the points below which are relevant to the child's situation:

- Questions should always be directed at the child where appropriate and where the child is able to understand and respond to questions. When questions are not able to be directed at the child they must be directed at the parent/s, child representative/s or guardian.
- The parent or legal guardian is the child representative and MUST be included in all conversations and decisions.
- Make note of any alerts or court orders regarding contact, for example, a domestic violence order.
- At no time should a service provider or support coordinator be given any decision-making power in relation to the child's plan.
- If the parent is identified as not being a suitable child representative refer to Standard Operating Procedure – Determine or revoke a child representative. Do not continue planning without the child representative in place.
- Be aware this is a sensitive conversation, and you are asking very personal questions. You may feel resistance. Make sure the family understand this is a confidential conversation and they can choose who does and does not attend the meeting.
- Never presume to know what the family is going through or why they are unable to care for their child.
- Encourage the family/carer to explain how the child's disability is impacting their capacity to care for their child.
- If this is a plan review conversation, discuss how supports in the current plan have been used to support the child to remain in or return to the family home.
- Ask the family/carer to identify disability-related supports which they feel could help them to care for their child.
- Refer to Disability Snapshots and the Disability Navigator for further guidance relating to the child's disability.

You must complete the Planning Conversation Tool (PCT) when planning for children at risk of living outside the family home. Complete all sections of the PCT with as much detail as possible to support the planning process and provide comprehensive information to the delegate during the plan approval process.

Refer to Standard Operating Procedure – Complete the planning conversation tool.

7.3.1 Consulting with or referring to a CSN children and young people planner

If you identify the child is at risk of requiring accommodation outside the family home, discuss with your EL1/EL2 who can seek consultation from the children and young people (CYP) team. The CYP team will guide the direction of a potential referral and consult with the relevant State or Territory to determine if the child meets the criteria for under the Early Intervention MoU (memorandum of understanding) for inclusion in the CYP Pathway.

If the child does not meet the criteria, you will be provided consultation with a CYP planner to support your decision making and make sure the child has the right disability related supports in their NDIS plan reduce any risks of requiring accommodation outside the family home.

Follow the steps below to request consultation with a CSN CYP planner or referral to the CSN CYP Pathway:

- record an interaction using the Interaction Template – Planning - Refer to CSN Children and Young People Pathway for referral OR Early Intervention consultation and assign the open interaction to the **CaYP/Children and Young people** CRM inbox.

Important: CYP planners do not work with families where child protection is involved. If the child has involvement with child protection please follow the guidance in the Standard Operating Procedure – Referral for Complex Support Needs Pathway to refer to the CSN Pathway.

7.4 Participant goals

When completing the Participant Statement and recording the child's goals, family engagement should be a primary goal, if appropriate. Goals must be achievable over the course of the plan.

7.4.1 Goal examples:

- 'I would like to continue to spend time with my family because having my family in my life is important'.
- 'I would love to go to school every day'.
- Sam would love to visit the beach and explore new social opportunities in his community.
- 'I would like to be understood by my family and those who support me'.

7.5 Streaming

s47E(d) - certain operations of agencies

s47E(d) - certain operations of agencies

7.6 Family Outcomes Questionnaire

The Family Outcomes Questionnaire in the System must be completed for children at risk of living outside the family home. The responses will allow the NDIS to see the impact community, mainstream and funded supports in a participant's plan are having on the family's capacity to care for their child over time.

Be aware that these questions were not designed with this cohort in mind and do not need to be asked word for word. You should be able to gather the required responses as part of a high-quality planning conversation.

Refer to Standard Operating Procedure – Complete Update the Family Questionnaire task.

8. Planning

Include reasonable and necessary disability-related supports in the child's plan as guided in the Our Guideline – Reasonable and necessary supports. The guidance below will give you additional considerations for funded supports when the child is living outside the family home.

8.1 Core supports

Include core support funding in the child's plan to provide support with:

- daily living skills such as self-care, personal care (including for supervision of behaviours of concern) and meal preparation
- access to social and community participation activities
- short term accommodation including respite to maintain informal supports
- social and community participation.

8.1.1 Short Term Accommodation including respite and supports which provide a respite effect

Short Term Accommodation (STA) including respite is described as - all expenses in a 24-hour period including assistance with daily personal activities, accommodation, food and negotiated activities.

Where it is identified the complex disability-related needs of the child means families and carers require additional support to enable them to continue their caring roles, the inclusion of STA including respite, may be a reasonable and necessary support.

For the child who has been identified as needing early intervention support due to the risk of the caring arrangement breaking down, additional supports may be included in their plan aimed at:

- preventing the deterioration of the child's functional capacity
- reducing the level of support required in the future
- alleviating the impact of the impairment upon the child's capacity to perform activities
- improving functional capacity
- strengthening the sustainability of informal supports, including building the capacity of the child's carer.

The provision of respite and other supports which can provide a respite effect, such as social and community participation, can be important to enable a family/carer to continue to maintain care for their child. This may be particularly important in cases where an early intervention approach is required to maintain a familial placement.

Capacity building and supports to increase the sustainability of the family/carer to continue to care for the child should be funded alongside any respite. This may include:

- in home support (including for supervision of behaviours of concern)
- training to assist with implementing a behaviour support plan, for example supporting the child to develop a sleep routine
- positive behaviour supports to address complex and challenging behaviours
- support for community access to allow the child and family to increase social participation and reduce social isolation.

8.1.1.1 Typical use case

The typical use case is when STA is used as respite. This may be determined as reasonable and necessary when a participant lives in the family home and where the family provides substantial informal supports that would not be required if not for the functional impact of the participant's disability.

For typical use you can include up to 14 days at a time, not exceeding 28 days per year.

8.1.1.2 Specialist children's use case

The specialist children's use case refers to the situation where additional STA, in combination with other capacity building and/or other supports, is determined as reasonable and necessary because the child is at risk of entering residential care.

When determining whether additional STA is reasonable and necessary, first consider other NDIS support options aimed at sustaining informal care arrangements. For example, in-home support, behavioural therapies and community access.

For specialist children's use you can include up to 30 days at a time, not exceeding 60 days per year.

8.1.2 Social and community participation

Where appropriate for the age of the child, support to participate in social and or community activities without their family can provide a respite effect. A support worker can be funded, so the child can enjoy age-appropriate activities outside their family home with their peers. This can be beneficial as it allows the child to build independence, provides a respite effect for the family as the family has a break from caring responsibilities while increasing the child's social participation.

8.1.3 Maintaining current family support

Parents have a valuable ongoing contribution to make to the lives of their children and to supporting their child to achieve their goals. You must respect the rights and dignity of parents, promote their inclusion in the planning process and facilitate access to supports to promote family engagement and capacity building.

8.2 Capacity Building supports

Include reasonable and necessary disability-related capacity building funded supports in the child's plan as guided in the Our Guideline – Reasonable and necessary supports.

The below will guide you through the additional considerations for capacity building supports when the child is living outside the family home or is at risk of requiring accommodation outside of the family home.

8.2.1 Support Coordination

8.2.1.1 Coordination of supports

The role of the support coordinator is to assist with and strengthen the child's (families) ability to implement and coordinate the supports they require in their everyday life relating to their disability. These supports include informal, mainstream and community supports as well as NDIS funded supports. It aims to support a participant to participate more fully in the community. Support coordinators should work alongside any mainstream supports in the participant's life (for example child protection case worker) to maximise outcomes.

8.2.1.2 Specialist support coordination

In cases where an early intervention approach is required, the appointment of a specialist support coordinator may be required to assist the family to access and engage with the supports and providers required to maintain care of their child.

The role of a specialist support coordinator is to assist the child to manage challenges in their own support environment and ensure consistent delivery of service. This support is time limited, focusing on specific outcomes such as:

- Identifying housing solutions to support a young person to transition to adulthood including planning for the transition to independent living (if the child's goal).
- Identifying strategies and solutions for managing risks such as school expulsion or non-attendance over extended periods. This includes the coordination of family, education and stakeholders to develop and implement programs and practices to build relationships that link the child to learning/education.
- Identifying and sourcing relevant assessment and associated service design for participants with risk behaviours and behaviours of concern (inclusive of restrictive practice reporting to the NDIS Quality and Safeguards Commission).
- Participation in any case conferencing arranged by state and territory services if there is a need to coordinate the participants disability supports with mainstream services.
- Capturing and presentation of required data for the Agency.

Specialist support coordination should be included in the plan as a stated support unless there are identified risks such as limited availability of specialist support coordinators in the area. If it is likely that when the child may require accommodation outside their family home in the near future and is receiving additional NDIS funding for supports on that basis, they will need specialist support coordination to help utilise that funding to access the disability supports identified.

Refer to Standard Operating Procedure – Include Support Coordination in a plan for further information.

8.2.2 Behavioural intervention support

Some children may require supports to address behaviours of concern (risk to self or others and/or 1:1 (or higher) funded supports that are greater than 30% of the day). Behaviour intervention and support is a vital inclusion if there are behaviours of concern that are impacting on the family dynamic to a point that the child is at risk of requiring accommodation outside the family home.

You should include strategies to support behaviour intervention to build capacity within the family and encourage family engagement for children at risk. In some cases, the behaviours of concern are significant and have resulted in the child not being able to spend time with family without high levels of support. Consider if behavioural supports can be included so the child can remain living safely in the family home.

These supports are recommended to:

- support the child's safety and wellbeing
- promote options for increasing the child's capacity, community and mainstream connections to achieve plan goals
- ensure long term sustainability of the child's plan and informal support systems.

As the child's capacity increases over time, you would expect to see a reduction in the intensity and level of 1:1 (or higher, for example 2:1) supports (greater than 30%) however, this will depend on the individual circumstances.

It may be reasonable and necessary to include behaviour supports in conjunction with other supports, such as STA for a temporary period, to allow a family/carer to continue to provide care for the child. Concurrent supports may be a successful early intervention strategy for highly complex situations where the child's care placement is at risk of breakdown.

8.3 Safeguards

The NDIS Commission assesses behaviour support practitioners and providers using The Positive Behaviour Support Capability Framework (external). This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner. In all states and territories (excluding Western Australia), providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards and any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018.

What this means for children in this cohort is that where there are behaviours of concern and restrictive practice, the child's behaviour support specialist and providers of core supports must be NDIS registered. Making parts of the child's plan Agency-managed is one way of guaranteeing a provider is registered.

Refer to Practice Guide – Positive Behaviour Support and Behaviours of Concern and Standard Operating Procedure - Behaviour intervention supports.

8.3.1 Building family relationships and capacity

The plan may include disability-related capacity building and training for the child's parents to support their child to engage with the family. These supports can be particularly important

where there is risk of the family no longer being able to care for the child and the child requiring alternate accommodation.

Capacity building supports can be included in the plan so the child remains living in the family home:

- **Behavioural intervention supports:** may already be in the plan and should include development or review of a behaviour support plan, behavioural supports (for example support and assistance to establish positive sleep routines) as well as training for family members.
- **Assessment, recommendation, therapy and/or training (including assistive technology):** for example, occupational therapy assessment and training to identify equipment and train the participant and their family in the use of the equipment in the family home.
- **Community access:** providing personal care (including supervision of behaviours of concern) to enable the participant to access the community.
- **In home support:** where personal care support needs (including for supervision of behaviours of concern) are above the needs of other children of similar age.

8.4 Capital supports

Include reasonable and necessary disability related capital support funding in the child's plan as in the Our Guideline – Reasonable and necessary supports. The information below will guide you through any additional considerations for capital supports when the child is living outside the family home.

8.4.1 Home modifications

Consider any home modifications which will increase the chances of the child being able to remain in the family home. Refer to Our Guideline - Assistive technology for further information.

8.5 Transition planning for children aged 16-17 requiring early interventions supports.

As a young person prepares to leave school and move to employment or daytime community activities, additional supports may be required to support them with their transition from education. This transition may also involve:

- transitioning to the disability support pension (DSP)
- transitioning to independent living.

When planning for 16 and 17-year-olds with a goal to live independently once reaching 18 years old, you should:

- Establish if an independent specialist assessment will be required if there is unclear or insufficient evidence about the young person's functional capacity or current and future support need requirements.
- Determine the capacity building supports that will develop independent living skills.
- Assess assistive technology and home modification needs in relation to any changes in the young persons living arrangement. This can be funded in a young person's plan and would be conducted by a qualified assessor, such as an occupational therapist, registered nurse or psychologist who is independent to the current provider's process. It would be anticipated that specific questions would be forwarded to the assessor, with this process being led by the support coordinator.
- Include an assessment for Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL) in the young person's plan, noting that in most cases it is in the best interests of the child to live in a family (or family like) environment until they reach the age for independent living (18 years). Only in exceptional circumstances should this be included for children 15 and under and will require General Manager approval.
- Consider arrangements for the appointment of a plan nominee if required once the young person turns 18 (as child representative roles will cease at this point). In some cases, the child representatives will become the nominee and in others they will support their child without being officially assigned as a nominee.
- Support the family to explore legal guardianship arrangements. While the NDIS does not have a formal role in this process, it may be helpful to raise this issue with the young person's representative, so they are aware of their options in this area.
- Determine if transport funding (additional to school transport) may be deemed reasonable and necessary if the young person is unable to use public transport.
- Consider if STA and assistance may be reasonable and necessary as part of a formal transition plan to support the move to a new living arrangement. For example, spending trial nights funded as STA (including respite) at the home they will transition to, can support the young person to build capacity and prepare for the transition.

9. Case examples

9.1 John

John is a 10-year-old boy who has Autism Spectrum Disorder Level 1.

9.1.1 Planning meeting

At the planning meeting John's father Dave provides the following information. John has escalating behaviours of concern including violence towards other children and adults as well as age-inappropriate sexualised behaviours directed towards other children. Dave is a single parent with responsibility for John as well as his younger brother Jeremy.

John has been suspended from school and is currently only able to attend for a maximum of two hours per day. As a result, Dave is unable to work and has lost his job. Dave tells the planner that his life is all about his son John's behaviour and he is not able to get any help or get out and spend time with friends or family. John's previous plan was underutilised because Dave was not able to find any behaviour support provider willing to support John.

9.1.2 Referral to CSN

With the risk factors identified above the National Delivery planner should consider a referral to the Complex Support Needs Children and Young People Team for consultation, to determine whether John can be referred as early intervention.

The Children and Young People team would consider whether John would benefit from being formally recognised as part of the early invention cohort of children covered by the MoU (noting this will require agreement with the relevant state or territory authority). With Dave's consent the Agency would share information about John's disability support needs and NDIS funded supports and request that the state or territory government provide case coordination and other mainstream supports to meet the needs of the whole family.

To meet John's needs the planner would discuss with Dave the right mix of in-home personal care (including for supervision of behaviours of concern), behaviour supports (including training in managing disability-related behaviour for Dave) and respite (in the form of Short Term Accommodation and age-appropriate community access).

9.1.3 Outcome

In this example subject to discussion with Dave, funding could be included in John's plan for disability related personal care to help provide supervision of disability related behaviours of concern. This funding may be included in John's plan for in home personal care during the school hours that John is not attending school for an initial period to allow a plan to be put in place for John's return to full time school.

John's plan may also include funding for a disability support worker for a few hours after school each day, so Dave has time to prepare the evening meal for his family. Additional hours may be funded in the evening depending on John's sleep patterns.

A disability support worker can support John to participate (for example three hours weekly) in a community activity with his peers on the weekend. Up to 30 days respite could be funded if required to help stabilise John's living arrangement.

Consideration would also be given to include the right amount of specialist support coordination, so John's plan is fully utilised. The support coordinator can participate in case

conferencing and advocate for John's return to full time schooling. This is irrespective of whether John is accepted into the MoU early intervention arrangements.

9.2 Michael

Michael is aged 12 years and is diagnosed with Autism Spectrum Disorder Level 3 and an unspecified intellectual disability. He lives with his mother and father and two sisters aged 13 and 7.

9.2.1 Planning meeting

Michael needs a lot of support with daily activities including personal care, hygiene, eating and drinking. Michael has behaviours which lead to significant stress on his family. Michael attends school for four half days a week from 8:30am when he is picked up by school transport. His mum picks him up from school at lunch time.

Michael does not attend school on Fridays. The support coordinator has submitted a Change of Circumstances as the family are not coping and the current plan did not meet Michael's needs.

Michael's current plan has utilised existing funding including limited supports of approximately $40,000.

9.2.2 Referral to CSN

A referral was forwarded by national delivery to the Children and Young People Pathway as the family indicated they were no longer able to cope with Michael's behaviours of concern.

The referral was raised with the State Government for consideration of an early intervention approach. The State Government agreed that the family were in crisis and supported the referral. The Children and Young People team assigned a planner to contact the family.

9.2.3 Outcome

The planner contacted Michael's mother by phone and after discussion with the Assistant Director and Director, did a Light Touch Plan Review to include specialist support coordination and short term accommodation and scheduled a planning meeting. The planner then undertook a plan review with the family to develop a plan that would provide supports to keep the family together and Michael to remain at home.

The new plan includes considerably higher levels of support with a focus on capacity building and support coordination, current plan value $240,000. At the same time the Children and Young People team met with the relevant State authority to engage with Education to undertake a case conferencing approach for Michael to be able to transition back to school full time.

This process is still underway and a plan for transition back to school is being developed. The planner continues to engage with the family and support coordinator to ensure supports are being implemented especially in relation to Behaviour Support planning.

10. Plan management

The plan management decision is made by the delegate with regards to the child representative's preferred plan management method and with consideration of whether self-management would present an unreasonable risk to the participant. Refer to Standard Operating Procedure – Complete the Risk Assessment task.

11. Plan implementation

After plan approval, the approved plan and plan approval letter are automatically sent to all child representatives. It is important that the contact roles are updated if the child's circumstances change, and correct addresses are recorded so the right people receive a copy of the child's plan.

Refer to Standard Operating Procedure – Complete the Implement the Plan task and Our Guideline – Your plan.

11.1 Handover to support coordinator

When sending your Request for Service to the support coordinator (coordination of supports or specialist support coordinator) chosen by the parents/child representative/s, make sure you include your contact details and request the support coordinator contacts you to arrange a handover.

The process for referral will depend on whether the provider is registered or unregistered. Some support coordinators will be unregistered; however all specialist support coordinators will be registered.

For registered providers, refer to Standard Operating Procedure – Make a Request for Service (support coordination and recovery coach) and for unregistered providers refer to Request for Service – Non-Registered Support Coordination Providers form.

Arrange a face to face (where possible) handover to the support coordinator/s, with the parents/child representative present. You should discuss:

- How the plan was developed.
- Who they need to liaise with to implement the plan and the responsibilities of all parties.

- How the plan can be used flexibly to meet the child's goals and how to monitor plan utilisation and make sure the plan can be fully utilised for the period of the plan.
- The roles of the specialist support coordinator and the coordinator of supports.
- Arrange regular checkpoints, in advance, to track progress and to make sure the plan is being implemented in line with the child's goals. This will provide opportunity to address any concerns the family or coordinators may have but will also promote effective plan utilisation.

11.2 Plan monitoring

The support coordinator will work with the child representative to monitor the plan usage, resolve any issues that arise and liaise with providers, other government services and the NDIS as required. Increased monitoring may be required to review the supports provided and ensure they are meeting the needs of the participant.

At the 12 week check-in meeting you will be able to monitor the plan usage and talk through any concerns with the child representative/s and the support coordinator.

If you identify an over utilisation of funding which may put the child at risk of running out of funding in one or more areas of their plan, work with the child representative/s and support coordinator to identify why there is an over utilisation. Arrange regular check-ins as required.

11.2.1 Critical incidents and safeguarding

If you are advised or have evidence of risks or abuse/neglect related to the child, this is a participant critical incident and you must take action consistent with the NDIS Act (which limits the circumstances in which the NDIA can disclose information) and with working arrangements with states and territories.

Refer to the Participant Critical Incident Framework for further information on this process and discuss your concerns with your manager to agree on and take appropriate action. Record an interaction detailing the crisis circumstances and actions taken in the System and an alert added if required. If you are unsure whether an incident should be notified, contact National Participant Incident Team. Ensure the specialist support coordinator and/or support coordinator is aware of the situation and is also responding to support the child.

Registered providers deliver NDIS supports and the NDIS Quality and Safeguards Commission regulates and monitors provider performance.

11.2.2 Change of circumstances

Where there is a significant change in circumstances which means the child may require additional funding based on their disability-related support needs, the specialist support coordinator and/or support coordinator is expected to support the child representative to request a plan review.

For example, a change of residential setting or accommodation provider, an extended hospital stay or significant or repeated school suspension.

Where there is risk to the child or their family and an early intervention approach is required, an Agency initiated unscheduled review may be necessary so a new plan can be expedited, and any additional support needs included as soon as possible.

This may include where the safety and wellbeing of the child or their family is significantly at risk and immediate and additional supports are required. Refer to Standard Operating Procedure - Create a plan reassessment (or variation) request (PRR) and follow the guidance in this practice guide.

12. Supporting material

- National Disability Insurance Scheme Act 2013 (external)
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (external)
- Planning Operational Guideline (external)
- Our Guideline - Specialist disability accommodation (external)
- Our Guideline - Child representatives (external)
- Including Specific Types of Supports in Plans Operational Guideline (external)
- NDIS Quality and Safeguard Commission (external)
- National Principles for Child Safe Organisations (external)

13. Feedback

If you have any feedback about this Practice Guide, please complete our Feedback form. In your feedback, remember to include the title of the resource you are referring to and to describe your suggestion or issue concisely.

14. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
4.0	CRG656	Class 1 approval Complex Support Needs Branch endorsed updates to referral	APPROVED	2020-06-26

		process using new interaction template.		
5.0	CRG656	Class 1 approval Guidance strengthened to ensure children at risk of requiring accommodation outside the family home are referred to the CSN Branch.	APPROVED	2020-07-09
6.0	EMN960 LJ0007	Class 1 approved. Updated to align with the early childhood age range change on 1 July 2023.	APPROVED	2023-06-20

Practice Guide – Children living in a formal voluntary arrangement outside their family home

IMPORTANT: For use by children and young people planners in the Complex Support Needs Pathway only.

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The content of this document is OFFICIAL.

1. Purpose

This Practice Guide (PG) will support you as a children and young people's planner in the Complex Supports Needs (CSN) Pathway through the considerations and sensitivities when planning (first plan or reassessment) for a child participant (child) living outside the family home in voluntary out of home care arrangements as acknowledged by the relevant state or territory authority and the National Disability Insurance Agency (Agency). For the purpose of this PG we will hereafter refer to these as voluntary arrangements.

Children who currently reside outside the family home either in full time or part time voluntary arrangements will be acknowledged by the relevant state and territory authority who will lead oversight of these arrangements.

Note: Under this arrangement parents or primary care givers continue to be responsible for all decision making relating to their child.

This PG is not a standalone document and should be used in conjunction with the following planning resources:

- Practice Guide – Participants streamed as Intensive or Super Intensive
- Our Guideline – Child representatives
- Our Guideline – Reasonable and necessary supports
- Standard Operating Procedure – Complete the determine funded supports task.

2. To be used by

Planners in the CSN Children and Young people Pathway who are trained to support children and young people and prepare plans where additional skills, knowledge or considerations are required.

3. Scope

3.1 Voluntary out of home care arrangements

Voluntary out of home care arrangements are the provision of care outside the family home when a child's parent/s or primary care giver are no longer able to continue to care for their child in the family home due to the child's significant disability support needs.

The voluntary arrangement is jointly coordinated and overseen by the relevant state or territory authority and the Agency. Under this arrangement, parents or primary care givers continue to be responsible for the decision making relating to their child.

Under voluntary arrangements the child usually lives full or part time with an accommodation provider, however there may be cases where the child lives with other family or care givers or in temporary accommodation type arrangements. The planning approach is the same for all voluntary arrangements.

Only use this PG when planning for children living outside the family home under voluntary out of home care arrangements as acknowledged by the relevant state or territory authority and the Agency.

A Memorandum of Understanding (MoU) has been developed with each state and territory that includes an agreed model for collaborative case coordination for children living or those at risk of living outside the family home. Under this arrangement states and territories have committed to lead case conferencing, with the exception of the Victorian Government who will work together with the Agency to coordinate regular meetings as required. The Agency will participate in state and territory led case conferencing.

3.2 Participants younger than 9

Families/carers of children younger than 9 will be supported by an early childhood partner. In the rare circumstance that a child younger than 9 requires voluntary out of home accommodation, the child will be s47E(d) - certain operations of agencies and the early childhood partner will remain as the child's main NDIS contact.

The early childhood partner will collaborate with their state contact Assistant Directors within National Delivery to consider a referral to the Complex Support Needs Branch. Children are not eligible for referral to the Children and Young People pathway until 7 years of age. Consultation however can be provided to ensure the child and family receives the right early intervention. Request for consultation can be directed to CSN Children and Young People.

The Children's Taskforce Partner Practice team will be available to provide advice regarding the disability-related capacity building supports relative to the participant's individualised needs.

Note: Children that are 7 or older before 1 July 2023 will not be supported by an early childhood partner.

3.3 Crisis situations

A crisis can arise when a child's parent indicates they urgently require accommodation for the child outside the family home due to their child's complex disability support needs. It may also occur when a child already recognised under the arrangements for children living outside the family home experiences a breakdown in their accommodation arrangement.

Disability and mainstream supports will be used to make sure the child is able to return to their longer term or family home as soon as possible. Where a return to the family home is not possible in the short term, the Agency and the state or territory will work collaboratively

with the parent to settle interim arrangements for new or ongoing accommodation outside the family home.

In a crisis situation it is important to act fast, so the child has all the support they need in a safe environment. This means you will:

- consider if the crisis is disability related. If not seek state/territory engagement to implement mainstream services as required.
- if the crisis is disability-related, make sure a planning meeting is held within 5 working days to determine the child's disability support needs going forward. The child's parent/s must be involved in this conversation

  Note: Planning must not progress without the child representatives. If the child representatives are unavailable, refer to your Assistant Director to raise with the relevant state or territory.
- check the current plan to see if immediate supports can be accessed with existing funds
- conduct a plan review where the current plan is not sufficient to meet the child's changed needs
- make sure the child has access to a support coordinator or specialist support coordinator
- check the plan utilisation to see if underutilisation could have contributed to the crisis.

3.3.1 A crisis during business hours

Where a crisis occurs during business hours, the Agency can be contacted through the support coordinator directly if known, and if not the Agency MoU Business Manager. The Agency will:

- confirm a child's participant status
- verify current plan funding levels
- assist the parent in identifying emergency short-term accommodation providers.

After the crisis has been dealt with, follow up with the parent for a more detailed discussion about the plan.

3.3.2 A crisis outside business hours

The Agency has an after-hours phone number to call if a crisis occurs outside business hours. Agency staff can use this number to:

- confirm a child's participant status

- verify current plan funding levels
- provide a list of emergency short-term accommodation providers to the parent.

The after-hours contact would then internally flag the need for a more detailed follow up (as with the parent during business hours).

Note: This after-hours number is not for general circulation and is provided to relevant stakeholders via the MoU Business Managers Committee. Speak to your Assistant Director before giving this number to a stakeholder.

3.3.3 When the crisis is disability-related

If the crisis is disability-related you will:

- conduct an initial assessment of disability support needs
- work with your state or territory counterpart and the parent to implement new arrangements outlined in the MoU
- conduct a plan review if required
- uplift the plan where reasonable and necessary to maintain informal supports.

If required, the NDIS provider will complete a critical incident report template and provide it to the NDIS Quality and Safeguards Commission.

3.4 Parenting Agreements

Parents or guardians will have the opportunity to develop and negotiate a Parenting Agreement with their child's provider of 24/7 staffing. This parenting agreement will assist parents to maintain their role as primary decision-maker for their child and assist the child's provider to carry out day-to-day care of the child.

The Parenting Agreement outlines the rights and responsibilities of parents or guardians in relation to the care and support of their child, including responsibility for decision making and an agreed pattern of ongoing contact to ensure the child remains connected to their family and culture.

Note: Where a child or young person does not have an engaged parent, consideration may be given to enact a referral to child protection. A Parenting Agreement is between the parent/s and the accommodation provider.

4. Pre-planning

During pre-planning, rich information is gathered to support the planning process and make sure a high quality plan is developed, allowing the child to achieve their goals and outcomes. This section will guide you through additional considerations for children living under voluntary arrangements.

4.1 Verifying identity and recording consent

When having discussions regarding the child you must verify and record the identity of the person you are talking to and ensure they have formal consent. Appropriate consent must also be recorded prior to giving information to or receiving information from a third party in relation to the child or family. For more information and guidance, refer to:

- Standard Operating Procedure – Use evidence to confirm identity
- Standard Operating Procedure – Complete a security check
- Standard Operating Procedure – Check third party consent or authority.

4.2 Pre-planning checklist

- Following confirmation the child is living in a voluntary arrangement, add an interaction to the NDIS Business System (System) explaining how this was determined.
- Attach any relevant documents to the System: for example, temporary care agreements or correspondence from states and territories.
- Add an alert to the System stating:
  - The child is living in a voluntary out of home care arrangement outside the family home for (insert number of nights) nights per week. Refer all enquiries to CSN Branch Children and Young People planner (insert your name) and include your user ID.
  - Details relating to any specific considerations or risks associated with contacting family members and/or planning for the child.
- Identify who has parental responsibility for the child and who needs to be involved in the planning meeting or given the opportunity to contribute. For example, this may include the child, parent/s, guardian, other family members or provider/s. Make sure all parties who hold parental responsibility (for example separated parents) are given an equal opportunity to contribute to the planning process. This may require sensitive questioning and potentially separate meetings for shared parental arrangements.
- Check all contacts are entered correctly in the System.
- Make sure the child's address is recorded as primary residence and the parent's address/es are recorded separately for receipt of information and communication purposes.
- Understand and respect any cultural sensitivities or barriers to communicate effectively with the child and their family. Refer to Practice Guide – Aboriginal and

Torres Strait Islander planning support and Practice Guide - Assisting Communication.

4.3 The planning conversation

The planning conversation allows you the opportunity to gather detailed and concise information regarding the family's capacity to care for their child and the reasons why the child is living outside the family home some or all of the time. This is also a great opportunity for the child to tell their story and voice their goals and aspirations where possible.

The following points can support you to have a high quality conversation:

- Questions should always be directed to the child where appropriate and where the child is able to understand and respond to questions. When questions are not able to be directed to the child they must be directed to the parent/s or child representative/s.
- The parent or child representative **must** be included in all conversations and decisions.
- At no time should a service provider or support coordinator be given any decision making power in relation to the child's plan.
- If the parent is identified as not being a suitable child representative refer to Standard Operating Procedure – Determine or revoke a child representative. Do not continue planning without a child representative in place.
- Be aware this is a sensitive conversation and you are asking very personal questions. You may feel resistance. Make sure the family understand this is a confidential conversation and they can choose who does and does not attend the meeting.
- Never presume to know what the family is going through or why they are unable to care for their child.
- Encourage the family to explain how the child's disability is impacting their capacity to care for their child in the family home.
- If this is a plan review, discuss how supports in the current plan have been used to support the child to remain in or return to the family home.
- Ask the family to identify supports which they feel could help them to care for their child in the family home.
- Refer to Disability Snapshots and Disability Navigator for further and specific guidance relating the child's disability.

You must complete the Planning Conversation Tool (PCT) when planning for children living in a voluntary arrangement. Complete all sections of the PCT with as much detail as possible to support the planning process and provide comprehensive information to the delegate during the plan approval process.

Refer to Standard Operating Procedure – Complete the planning conversation tool.

4.4 Participant goals

When completing the Participant Statement and recording the child's goals, family engagement should be a primary goal. There may be circumstances where we would not expect a child to be able to return to the family home to live full time. Where possible the child should be supported to maintain visits to the family home on a regular basis and maintain good family relationships and contact. Goals must be achievable over the course of the plan.

4.4.1 Goal examples:

- 'I would like to continue to spend time with my family because having my family in my life is important'.
- 'I would love to go to school every day'.
- Sam would love to see more of his family and enjoy visits to his family home.
- Sam would love to visit the beach and explore new social opportunities in his community.
- 'I would like to be understood by my family and those who support me'.

4.5 Streaming

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4.6 Plan duration

Children living in voluntary arrangements should have a plan duration no longer than 12 months as there is a high likelihood that their circumstances and support needs may change as they and their family build capacity. Refer to Standard Operating Procedure – Complete the risk assessment task and Our Guideline – Creating your plan for more information.

4.7 Child Representatives

In most cases when the child is living under voluntary arrangements, the parent/s retain parental responsibility and will be recorded as the child representative/s. However, there are limited circumstances where it may not be considered appropriate for those with parental responsibility to represent the child for the purposes of the NDIS.

In these situations, an alternate child representative may have been identified elsewhere such as by the family court or via a kinship arrangement. If no alternative child representative has been identified, you will need to identify and appoint an appropriate person to be the child representative. Refer to Standard Operating Procedure – Record the child representative request.

Note: A child who is under statutory orders cannot be in a voluntary arrangement. These arrangements are overseen by child protection. Refer to Practice Guide – Children at risk of requiring accommodation outside the family home and Practice Guide – Children Living in Statutory Out of Home Care.

Any decision to appoint a child representative or revoke an appointed child representative must be made by an Agency staff member with appropriate delegation. The decision to revoke the role of an appointed child representative is not a reviewable decision.

For more information refer to Standard Operating Procedure – Determine or revoke a child representative and Our Guideline – Child representatives.

4.8 Family Outcomes Questionnaire

The Family Outcomes Questionnaire must be completed for children living under voluntary arrangements. The responses will allow the Agency to see the impact community, mainstream and funded supports in a participant's plan are having on the family's capacity to care for their child over time.

Be aware that answering these questions is voluntary and the questions were not designed with this cohort in mind and do not need to be asked word for word. You should be able to gather the required responses as part of a high quality planning conversation.

Refer to Standard Operating Procedure – Complete Update the Family Questionnaire task.

5. Planning

Include reasonable and necessary disability-related supports in the child's plan as guided in the Our Guideline – Reasonable and necessary supports.

The guidance below will guide you through the additional considerations for funded supports when the child is living outside the family home.

For children formally agreed as living in a voluntary arrangement outside the family home, the NDIS will be responsible for funding:

- 24/7 staffing (except during hours when the child is attending school)
- disability-related supports
- assessment for Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL) eligibility from the age of 16
- specialist support coordination.

The individual state or territory will be responsible for:

- funding board and lodging
- working collaboratively with parents and support coordinators to find appropriate board and lodging
- providing case coordination of relevant mainstream services where needed and working with support coordinators to ensure a holistic approach tailored to the needs of individual children and families.

5.1 Property damage

The NDIA is responsible for funding damage to property when **all** of the following criteria are met:

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The NDIA will not fund repairs for property damage where there is no evidence the property damage is related to the child's disability. This includes where:

- the damage relates to ongoing maintenance and minor damage repairs to properties as a result of normal wear and tear
- reasonable steps have not been taken to provide appropriate board and lodging (including making reasonable adjustments to support the needs of the child)
- evidence (for example incident report and pre and post inventory description or photos of the extent of the damage) is not provided
- there has been repeated instances of property damage and the additional supports provided through an individual's plan to address the issue have not been appropriately implemented.

5.1.1 Preventing property damage

The types of funded supports which can be included in a participant's plan to reduce the risk of property damage are:

- **Capital:** reasonable and necessary home modifications of the long-term home
- **Capacity building:** behaviour supports (including a behaviour management plan and behavioural therapy)
- **Core:** funding for disability-related personal care (including supervision required as a result of behaviours of concern).

For many children living in a voluntary arrangement outside the family home, these supports may already be included in their NDIS plan.

5.1.2 Repairs to property damage

The process for managing and paying claims for property damage is:

- The relevant state or territory Business Manager emails a claim for property damage to the Agency's MoU Business Manager. The claim must include:
  - an incident report
  - details of what occurred prior to the incident
  - evidence of the behaviour support plan followed, and supports being implemented
  - photos of property damage
  - an invoice.
- The MoU Business Manager reviews the claim and either accepts or rejects the claim.
- Acceptance or declined email sent to the provider (with parent/s and SC cc'd) including next steps:
  - **Declined:** workflow ends here. A declined claim can be contested by emailing the MoU Business Manager.
  - **Accepted:** the provider will be instructed to claim the invoice amount from the child's **Core – Assistance with Daily Life** budget.

5.2 Core supports

Include core support funding in the child's plan to support with:

- daily living skills such as self-care, personal care (including supervision of disability-related behaviours of concern) and meal preparation
- access to community, social and recreational activities
- overnight supports including passive (sleep over) and active (awake) staff. Can be a combination of both if evidence supports this

Note: overnight supports are considered from midnight to 6am.

5.2.1 24/7 staffing

24/7 staffing is defined as support provided by a disability support worker to support a child with their disability supports needs. Consider the following when including 24/7 staffing:

- 24/7 staffing should not be included during school hours, assumed to be 9am to 3pm for 41 weeks per year with 12 weeks school holidays. An exception to this is where the child is unable to attend school – in this case, the child should have sufficient funding included in their plan to cover staffing at all times and to allow the specialist support coordinator to support parents to negotiate a return to school plan with the child's school.
- Where more than one child is living in the same house, overnight staffing may be funded through pooled funding, which allows the funds in a participant's plan to be pooled to pay for shared staffing costs.

Determine the levels or ratio (for example, 1:1, 1:3 or 2:1) of staffing based on your discussions with the child representative/s and the assessment of the functional impact of the child's disability.

5.2.2 Short Term Accommodation (STA), including respite

Children living under a voluntary arrangement either full time or part time are not expected to have STA including respite in their plan. An exception to this would be a 16 or 17 year old trialling accommodation as they prepare to transition to an independent living option.

STA including respite can be included in a plan for a child who is not currently living outside of their family home and has been identified as requiring additional supports to maintain the family as the primary carer. STA including respite can be included where the child will benefit from early intervention supports that will support the family to minimise the risk of the child entering or requiring alternate accommodation and supports.

In these instances, short term accommodation should not be considered in isolation to other supports which may be required to build the family capacity to maintain care. These other supports may include providing support in the family home and/or funding for supports which provide a respite effect such as in home personal care (including supervision of behaviours of concern) and social and community participation activities.

5.2.3 Social and family participation

When including 24/7 staffing for children living outside the family home, consider any support hours the child may need to engage with their family or the community. This will promote family relationship building and engagement and help to maintain contact between the child, their family and community. Supports can be linked to the child's goal of returning to live in the family home or any social participation goals.

Example 1: A child may only need 1:2 support within their accommodation setting but may require 1:1 or 2:1 support to spend time in the family home or attend family outings such as visits to the zoo or attending a family occasion.

Example 2: An indigenous child living in an accommodation setting in the city may require additional support to 'return to country' to spend time with their family and community and remain connected with their culture.

5.2.4 Maintaining current family support

In voluntary out of home care arrangements parents or primary care givers continue to be responsible for the decision making relating to their child. In recognition of this role as child decision maker, parental engagement is vital. Parents have a valuable ongoing contribution to make to the lives of their children and to the decisions about how to protect children's well-being.

At all times respect the rights and dignity of parents and support their inclusion in the planning process. Develop funding aimed at promoting family engagement and supporting the family to build and maintain relationships and caring responsibilities.

s47E(d) - certain operations of agencies

5.3 Capacity Building supports

Include reasonable and necessary disability-related capacity building funded supports in the child's plan as guided in the Our Guideline – Reasonable and necessary supports.

The information below will guide you through the additional considerations for capacity building supports when the child is living outside the family home.

5.3.1 Support Coordination

Children living in a voluntary arrangement could have coordination of supports, specialist support coordination or a combination of the two included in their plan.

A participant may have specialist support coordination as well as coordination of supports funded in the same plan. This could be in situations such as where immediate complex barriers have been addressed and the participant still requires more general coordination of supports for the remainder of their plan period. Others may have specialist support coordination in one plan, and coordination of supports in subsequent plans.

5.3.2 Coordination of supports

The role of the support coordinator is to assist with and strengthen the child's (family's) ability to implement and coordinate the supports they require in their everyday life relating to their disability. These supports include informal, mainstream and community supports as well as their NDIS funded supports. It aims to support the child to participate more fully in the community.

5.3.3 Specialist support coordination

The role of a specialist support coordinator is to assist the child to manage challenges in their own support environment and ensure consistent delivery of service. This support is time limited, focusing on specific outcomes such as:

- identifying housing solutions to support a young person to transition to adulthood
- assisting a participant to manage challenges in their own support environment and ensure consistent delivery of service
- capturing any required data for the Agency
- Identifying strategies and solutions for managing risks such as school expulsion or non-attendance over extended periods. This includes the coordination of bringing family, education and stakeholders together to develop and implement programs and practices to build relationships that link to the child's learning/education
- Identifying and sourcing relevant assessment and associated service design for participants with behaviours of concern (inclusive of unauthorised restrictive practice reporting to the NDIS Quality and Safeguards Commission)
- reporting on Parenting Agreements/engagement. This includes monitoring to ensure parents are included and actively participating in their child's daily life (school visits, medical appointments, sibling contact).

Include specialist support coordination in the plan as a stated support unless there are identified risks such as limited availability of specialist support coordinators in the area.

Parent/s maintain their guardianship role by fulfilling responsibilities including for example, acting as their child's key decision maker, ensuring ongoing family and community connections and advocating for their child's best interests. Refer to Standard Operating Procedure – Include Support Coordination in a plan for further information.

5.3.4 Behavioural intervention support

Some children may require supports to address behaviours of concern (risk to self or others and/or 1:1 [or higher] funded supports that are greater than 30% of the day). Behaviour intervention and support is a vital inclusion if there are behaviours of concern that have impacted on the family dynamic and have resulted in the child not being able to live in the family home.

To build capacity within the family and encourage family engagement, the inclusion of strategies to support behaviour intervention is key for children residing outside the family home. In some cases, the behaviours of concern are significant and have resulted in the child not being able to spend time with family without high levels of support. Consideration needs to be factored in planning to ensure that behavioural supports are included to the level that the child can maintain contact with their family on a regular basis.

These supports are recommended to:

- support the child's safety and wellbeing
- promote options for increasing the child's capacity, community and mainstream connections to achieve plan goals
- ensure long term sustainability of the child's plan and informal support systems.

As a child's capacity increases overtime, you would expect to see a reduction in the intensity and level of 1:1 (or higher e.g. 2:1) supports (greater than 30%) however, this will depend on the individual circumstances.

Refer to Standard Operating Procedure – Behaviour intervention supports.

5.3.5 Building family relationships and capacity

The plan should include disability-related capacity building and training for the child's parents to support their child to engage with the family.

If the child is already spending some of their time in the family home, consider any capacity building supports which can be included in the plan to maintain and/or increase this amount of time:

- **Behavioural intervention supports:** may already be in the plan and should include training for family members
- **Assessment, recommendation, therapy and/or training (including assistive technology):** For example, occupational therapy assessment and training to identify equipment and train the participant and their family in the use of the equipment in the family home.

5.4 Capital supports

Include reasonable and necessary disability-related capital supports in the child's plan as guided in the Our Guideline – Reasonable and necessary supports. The information below will guide you through any additional considerations for capital supports when the child is living outside the family home.

5.4.1 Home modifications

Consider any home modifications in the child or young person's long term home which will enable the child to return to their family home or live in a stable long term family based arrangement. Funding for home modifications will not be considered at the temporary or residential accommodation service setting, only in their long term home in a family like setting.

Refer to Our Guideline – Home modification for further information.

6. Transition planning for 16 to 17 year olds

As a young person prepares to leave school and move to employment or day time community activities, additional supports may be required to support them with their transition from education. For children living in a voluntary agreement outside the family home this transition also involves:

- transitioning out of their voluntary living arrangement into an alternative living arrangement
- transitioning to the disability support pension (DSP) and contributing to their board and lodging costs.

Consider the following when planning for 16 to 17 year olds living in accommodation outside the family home:

- Complete the Transition to Adulthood Checklist.
- Establish if an independent specialist assessment will be required if there is unclear or insufficient evidence about the young person's functional capacity or current and future support need requirements.
- Determine the capacity building supports that will develop independent living skills.
- Assess assistive technology and home modification needs in relation to any changes in the young person's living arrangement.

  This can be funded in a young person's plan and would be conducted by a qualified assessor such as an occupational therapist, registered nurse or psychologist who is independent to the current provider's process. It would be anticipated that specific questions would be forwarded to the assessor, with this process being led by the support coordinator.

- Will additional specialist support coordination hours be required to support the young person to plan for appropriate accommodation if a different living arrangement is required? Refer to Practice Guide – Identifying Housing Solutions for further information.
- Include an assessment for SDA and SIL in the young person's plan noting that in most cases this is not the best option for children under 18. Only in exceptional circumstances should this be included for children 15 and under and will require General Manager approval.
- Consider arrangements for the appointment of a plan nominee if required once the young person turns 18 (as child representative roles will cease at this point). In some cases, the child representative/s will become the nominee and in others they will support their child without being officially assigned as a nominee.

  Legal guardianship arrangements may also be explored by the young person's family. While the NDIS does not have a formal role in this process, it may be helpful to raise this issue with the young person's representative so they are aware of their options in this area.
- Determine if transport funding (additional to school transport) may be deemed reasonable and necessary if the young person is unable to use public transport.
- Consider if STA (including respite) may be reasonable and necessary as part of a formal transition plan to support the move to a new living arrangement.

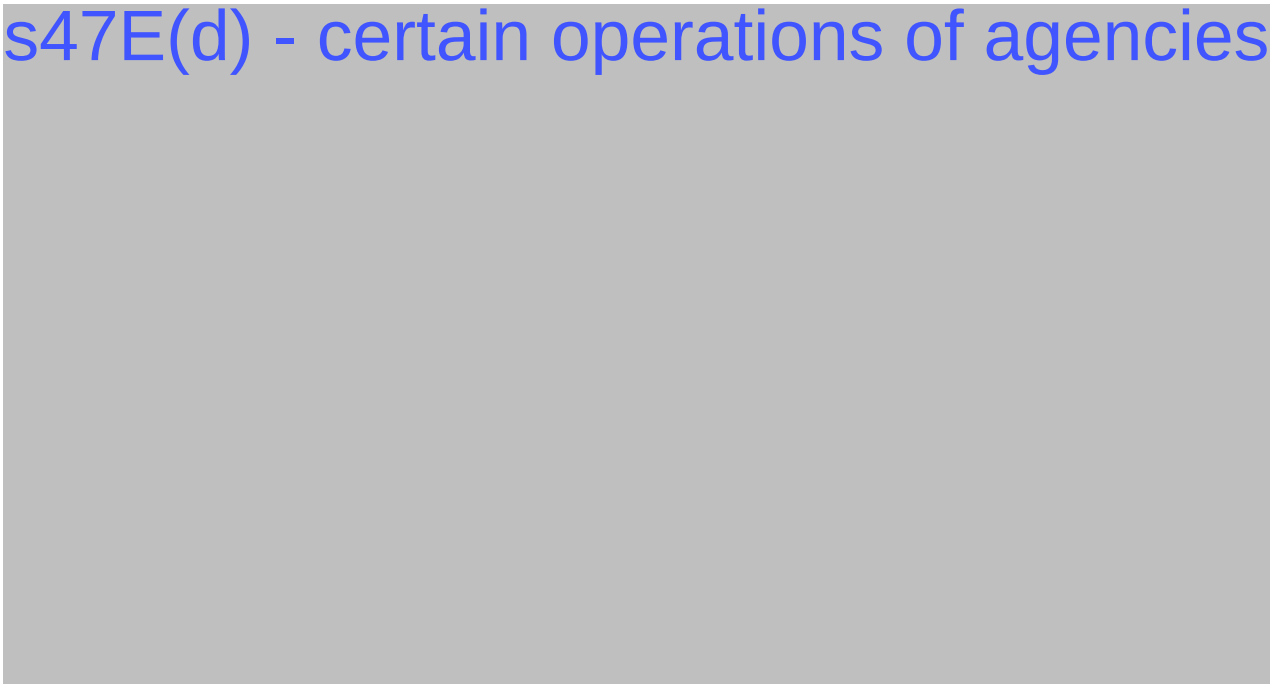
  For example, spending trial nights funded as STA (including respite) at the home they will transition to can support the participant to build capacity and prepare for the transition.
- Once the young person has a plan in place that incorporates transition to adulthood considerations such as SIL and is nearing 18 years or is 18 years of age, they will no longer be included in the Children and Young People team and will be transitioned to either Complex Supports Needs or Service Delivery and Performance for allocation as an adult. The process for transition is via the Complex Support Needs Triage Team.

  Refer to Standard Operating Procedure – Referral for Complex Support Needs Pathway.

7. Plan management

The plan management decision is made by the delegate with regard to the child representative's preferred plan management method and with consideration of whether self-management would present an unreasonable risk to the participant.

In some cases, it may not be appropriate for a parent to self-manage NDIS funding for a child living outside the family home due to risks identified. Below are the considerations in relation to risks for self-management and/or using a Registered Plan Management Provider (RPMP):



7.1 Self-managed or plan-managed

If plan or self-management is approved for children living outside the family home:

- Include an interaction detailing your justification for the decision.
- Make sure the child representative/s understand that it is highly recommended the accommodation provider is a registered provider. This will ensure they adhere to the quality standards and safeguards that minimise risk to participants and others.

Refer to Standard Operating Procedure – Complete the Determine Plan Management task.

8. Plan implementation

After plan approval, the approved plan and plan approval letter are automatically sent to all child representatives. It is important that the contact roles are updated if the child's circumstances change and correct addresses are recorded to ensure the right people receive a copy of the child's plan.

Refer to Standard Operating Procedure – Complete the Implement the Plan task and Our Guideline – Your plan.

8.1 Handover to specialist support coordinator and/or coordinator of supports

When sending your Request for Service form to the specialist support coordinator and/or coordinator of supports chosen by the parents/child representative/s, make sure you include your contact details and request the specialist support coordinator and/or coordinator of supports contacts you to arrange a handover.

The process for referral will depend on whether the provider is registered or unregistered. All specialist support coordinators will be registered, however some coordination of supports providers may be unregistered.

For registered providers, refer to Standard Operating Procedure – Make a Request for Service (support coordination and recovery coach) and for unregistered provider refer to Form Request for Service – Non-registered Support Coordination Providers.

Arrange a face to face (where possible) handover to the specialist support coordinator and/or coordinator of supports with the parents/child representative present. Make sure you cover:

- how the plan was developed
- who they need to liaise with to implement the plan and the responsibilities of all parties
- how the plan can be used flexibly to meet the child's goals and how to monitor plan utilisation and make sure the plan can be fully utilised for the period of the plan
- the roles of the specialist support coordinator and the coordinator of supports
- arrange regular checkpoints, in advance, to track progress and to make sure the plan is being implemented in line with the child's goals. This will provide opportunity to address any concerns the family or coordinators may have but will also promote effective plan utilisation.

8.2 Plan monitoring

The support coordinator will work with the child representative to monitor plan usage, resolve any issues that arise, and liaise with providers, other government services and the Agency as required.

Advise the support coordinator to notify you of any issues regarding utilisation of plan funds. This will allow you to be fully prepared for any implementation meetings with states and territories.

At the 12 week check in meeting, you will be able to monitor the plan usage and talk through any concerns with the child representative/s and the support coordinator.

If you identify an over-utilisation of funding which may put the child at risk of running out of funding in one or more areas of their plan, work with the child representative/s and support coordinator to identify why there is an over-utilisation. Arrange regular check-ins as required.

8.2.1 Critical incidents and safeguarding

If you are advised of risks of abuse/neglect related to a child you are expected to take action. Evidence of risks of abuse/neglect may in some circumstances be considered a participant critical incident. Action taken must be consistent with the *National Disability Insurance Scheme Act 2013* (which limits the circumstances in which the NDIA can disclose information) and agreed working arrangements with states and territories.

Discuss your concerns with your manager and agree on the appropriate action to take. Record the details of the crisis circumstances and actions taken in an interaction and add an alert if required. Ensure the specialist support coordinator and/or support coordinator is aware of the situation and is also responding to support the child.

Refer to the Participant Critical Incidents Framework for further information on the actions you should take and how to report a participant incident. If you are unsure about making the notification, contact the National Participant Incident Team.

8.2.2 Change of circumstances

Where there is a significant change in circumstances which means the child may require additional funding based on their disability-related support needs, the specialist support coordinator and/or support coordinator is expected to support the child representative to request a plan review. The Agency may commence an Agency initiated plan review where there are concerns, for example, about plan utilisation or other matters concerning the child's disability support needs.

A change of circumstances plan review may be requested where for example, there has been a change of residential setting or accommodation provider, an extended hospital stay or significant or repeated school suspension. A child entering accommodation outside of their family home, may also instigate a change of circumstance review.

Refer to Standard Operating Procedure - Create a plan reassessment (or variation) request (PRR).

9. Reunification supports

If the voluntary agreement is part time and the child is sharing their time between their family home and the accommodation provider, consider any supports the child and family may need in the home to maintain this arrangement, increase the amount of time the child spends living in the family home and reduce the risk of the child moving to full time out of home care. This could be:

- in home personal care supports (including for supervision of behaviours of concern) and community access
- behaviour intervention support
- other therapy such as occupational therapy or speech therapy

- core and capacity building funding in the home and community to support the family while they build capacity.

10. Appendices

10.1 Appendix A: Transition to Adulthood Checklist

To be completed by the Children and Young People planner for participants residing outside the family home aged 16 years and above eligible for SIL.

Transition planning to independence for participants in the Complex Support Needs Children and Young People planning team should start from the age of 16 to allow enough time to prepare for any changes of living arrangements and additional support required once they reach the age of 18.

Action	Pre-planning	Tasks	Checklist
Participant aged 16 to 17	**Questions** Is the participant residing outside the family home in a formal arrangement? Does the participant have an adult independent living goal for when they turn 18? Is the participant eligible for SIL? Is the participant able to continue to reside in the current placement now and after 18 years of age? **Other information** Consultation with state or territory in relation to transition to adulthood requirements including	Liaise with participants' family in relation to the child's adult independent living goals for when they turn 18 years. Arrange for assessment of SIL eligibility. For SDA arrange for assessment of home and living support needs and complete a Housing Application in the ACE Business System. The Operational Housing team will assess eligibility. Discuss adult living accommodation options with the participant and their family and explain the transition process.	

Action	Pre-planning	Tasks	Checklist
	availability of social housing or other adult accommodation options once the child turns 18?	Family and support coordinator to liaise with providers of adult living accommodation options, including where applicable providing information about the SIL quote and other related financial matters. If applicable SIL quote to be actioned as per Standard Operating Procedure – Include supported independent living supports in plans 6-8 weeks prior to plan review. Obtain a copy of current Case Plan from jurisdiction (where agreement is in place) or acknowledgement and agreement to engage early, to develop and provide a plan to support transition to adulthood at the appropriate time.	
Engagement	Family engagement history, has the family been actively engaged with the participant residing outside the family home? Confirm consent has been provided to share information?	Include in transition plan the current engagement with parents and family. Confirmation of consent updated in CRM.	

Action	Pre-planning	Tasks	Checklist
Decision maker	Confirmation of the young person's capacity to be their own decision maker or determination as to who is their identified decision maker, whether it be a family member, a public advocate or appointment of a guardian is required. If the participant does not have capacity to be their own decision maker, the parent may have been the decision maker to date, will this arrangement continue? Is this a family member, a public advocate or is appointment of a guardian required.	Follow up with the participant and their family in relation to decision making and have a conversation about future planning. Follow up with the family. If guardianship is required, family have limited capacity or unable to execute, refer to states/territories accordingly. Nominee form completed as appropriate.	
Pre-planning	What is the current plan review date? Has the planner made contact with family/significant others? What does the participant and their family see as the vision for their child to transition to adulthood?	Commence conversation with the participant and their parents/guardian – the child participant is now 16 or 17 and has been living away from the family home. For example - plan for where the participant is going to live once they turn 18. **Note**: Reminder – NDIA conduct planning with participants not with providers.	
Future Support	Identification of specific supports that should be assessed as part of a scheduled plan review,	Assess housing solutions and accommodation supports based on	

Action	Pre-planning	Tasks	Checklist
	based on participant's history and that align with their future goals. Is there an initial identification or suggestion of a suitable housing solution?	information gathered as part of a scheduled plan review and the participant's history so that they align with their future goals. Identify suitable housing solutions and/or accommodation supports that meets the participant's support needs. This could include remaining in the existing arrangement, or identification of an alternative housing solution and supports. If an alternative solution is identified, record all suitable and comparable housing solutions and justifications in the Transition Plan. In the transition plan, include supporting documentation held by the Agency and additional evidence required from suitably qualified health practitioners for reasonable and necessary decision making. If SDA is required create a Housing Application in the ACE Business System for consideration by the Operational Housing team. Document age appropriateness for alternative housing solutions, for example remaining with younger children, be placed in an age-	

Action	Pre-planning	Tasks	Checklist
		appropriate house or with older people, such as 30 or 40 year olds.	
Supported Independent Living (SIL)	Is the participant eligible for SIL? Start scheduled review at least 10 weeks prior to review date.	Where a SIL setting is likely to be most appropriate for the participant, the Transition Plan should highlight this and identify the SIL providers who may have been approached by the participant's family or coordinator of supports seeking supports information. SIL quote submission and assessment will be undertaken within the National SIL Process 6-8 weeks prior to scheduled plan review. Once the SIL quote has been assessed and budget agreed, include the quote in the participant's plan. Where a participant is under 16 years old and SIL is included in their plan, approval is required from the General Manager.	
Disability Support Pension	If the participant is aged 16 years and above they are entitled to apply for Centrelink Disability Support Pension.	Refer participant to Centrelink if not in receipt of Disability Support Pension.	

Action	Pre-planning	Tasks	Checklist
Education	Will the child participant continue to access Education or school past the age 18 years? Is there a plan for transition from education to employment or community access opportunities if school is not an option at this time or past 18 years of age?	Conduct plan review based on school attendance and any transitions that may occur such as finishes school during the plan period.	
Employment and Community Access	Will the participant be transitioning from school to employment or community day time activities?	Follow up on connection with processes for planning for transition through the education system.	
Mainstream	Are there identified and in place linkages to mainstream supports – acknowledging the transitionary period for the participant?	Follow up on connection with processes for planning for mainstream supports through coordination of supports.	
Scheduled review	Are you able to arrange a review meeting appointment at least 10 weeks prior to the plan review due date? Who will be attending? Where will the review take place? When will the review be undertaken? Plan for QA and approval process.	Develop the plan based on principles of disability supports, reasonable and necessary and the Disability Reform Councils decision of 28 June 2019.	

Action	Pre-planning	Tasks	Checklist

Handover	Will the participant transfer to Complex Support Needs Team or Service Delivery and Performance once aged 18 years?
	
	Make sure you include all relevant information in the handover and transition plan.
		Complete Complex Support Needs Suitability Checker – follow Standard Operating Procedure (SOP) for process.
		
		A referral for all participants transitioning out of the complex stream for handover and apply the Standard Operating Procedure, plus the Triage Team process.
		
		Provide a brief background of CSN Children and Young People team engagement to date:
		
		• Strategy for inclusion of, and consultation with, the young person and their family in the transition process.
		• A clear timeline that outlines key milestones and dependencies such as:
		  - the participant's 18th birthday
		  - current plan end date
		  - handover date to pre-determined pathway
		  - engagement commencement date with the participant, their family, decision maker, support	

Action	Pre-planning	Tasks	Checklist
		coordinator and service provider/s (if required) - dates by which information and evidence is required for upcoming plan review.	

11. Supporting material

- NDIS Act 2013 (external)
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (external)
- Planning Operational Guideline (external)
- Our Guideline - Specialist Disability Accommodation (external)
- Our Guideline – Child representatives (external)
- Including Specific Types of Supports in Plans Operational Guideline (external)
- NDIS Quality and Safeguard Commission (external)
- National Principles for Child Safe Organisations (external).

12. Feedback

If you have any feedback about this Practice Guide, please complete our Feedback form.

13. Version control

Version No	Amended by	Brief Description of Change	Status	Date
6.0	CRG656	Practice Guide strengthened to include advice that all children living under a voluntary out of home care arrangement should be referred to the CSN Branch, and that streaming value 'complex' is only for use by the CSN Branch.	APPROVED	2020-07-24
7.0	JS0082	Class 1 Approval From 30 November plan developers will create a Housing Application in the ACE Business System for consideration by the Operational Housing team, including the Housing Panel.	APPROVED	2020-11-24
8.0	EMN960 CRG656	Class 1 approved. Amended to state that the decision to revoke an appointed child representative is not a reviewable decision.	APPROVED	2021-12-22
9.0	EMN960 LJ0007	Class 1 Approval. Updated to align with the early childhood age range change on 1 July 2023.	APPROVED	2023-06-20