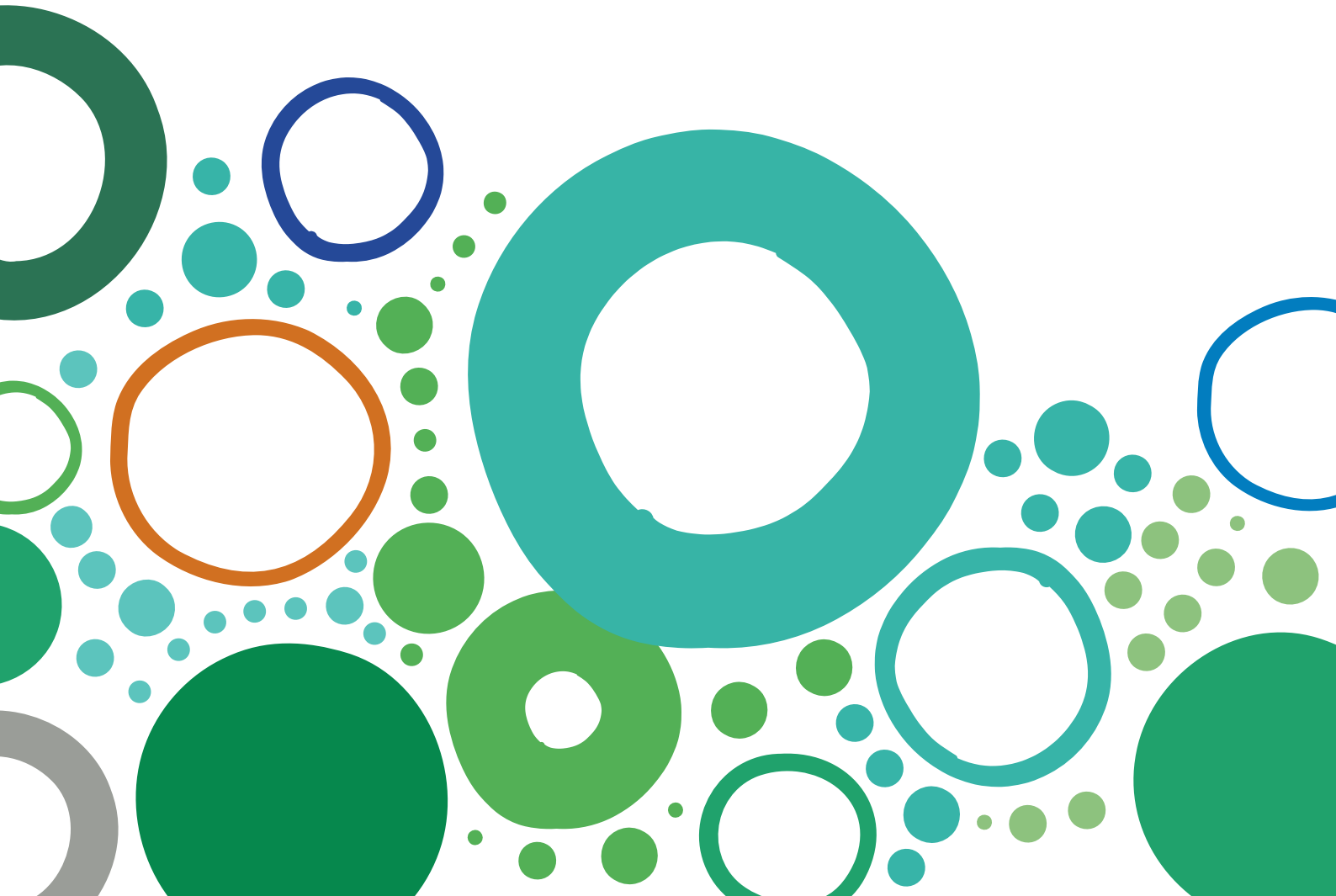
GOVERNMENT OF WESTERN AUSTRALIA

Mental Health Commission

Individualised Community Living Strategy (ICLS)

Program Guidelines



Version 2.0, November 2024

Table of Contents

1. Purpose

These program guidelines (Guidelines) provide an outline of the processes of the Individualised Community Living Strategy (ICLS) service model.

The Guidelines have been developed in collaboration between the Mental Health Commission (Commission), Psychosocial Support Package Providers (Providers), Community Housing Organisations (CHOs), Department of Communities (Communities) and the Health Service Providers (Clinicians) with the intention of outlining the parameters of the program, providing clarity on ICLS roles and responsibilities, and informing individuals, families, and carers on what to expect from the ICLS.

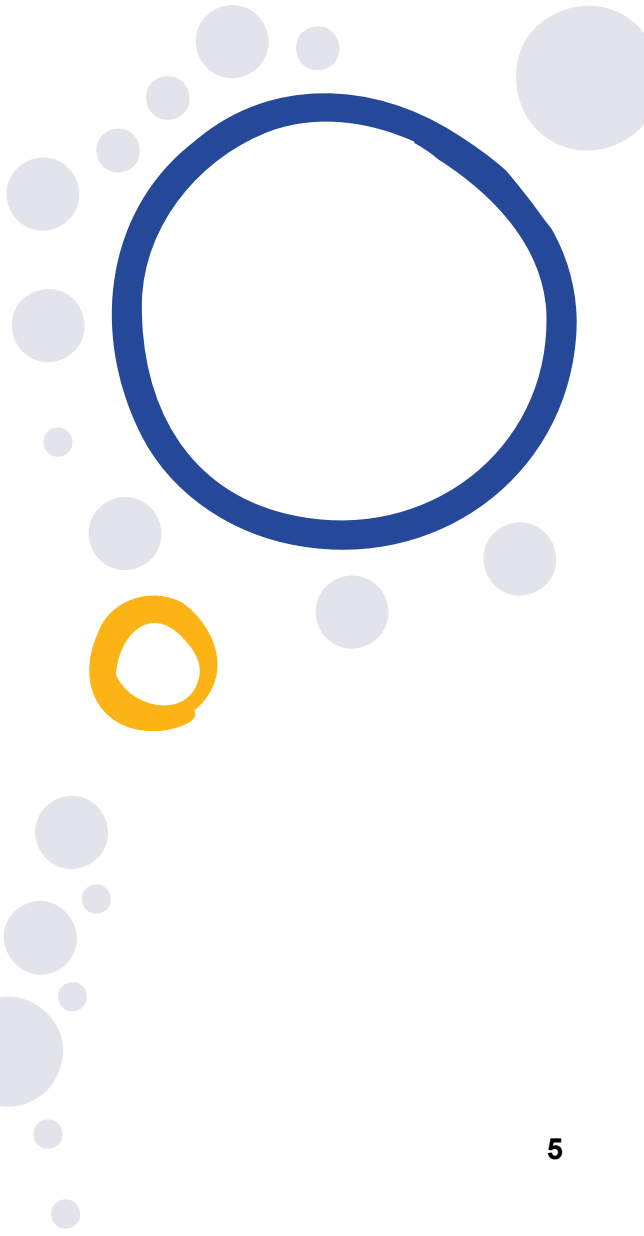
It is important to note that the ICLS it is a transitional recovery program comprised of standalone packages of support as well as supports linked to transitional accommodation. The ICLS is not a housing program and participants will be supported to increase their independence, capacity and to source appropriate accommodation.

2. Background

The ICLS was established in 2011 as a key initiative identified by the Commission to implement individualised support and funding as a contemporary approach for improving the appropriateness, accessibility and responsiveness, of mental health service delivery in Western Australia. The Commission's strategic policy, Mental Health 2020: Making it personal and everybody's business, and the Economic Audit Committee's Final Report, Putting the Public First (2009), clearly articulate the rationale for individualised support and funding, also known as self-directed supports and services. In particular, these reports highlight the positive benefits and outcomes of this approach for individuals, their families and carers and the community as a whole.

The ICLS is an innovative and collaborative partnership approach to provide clinical and psychosocial supports and services, in addition to appropriate housing[1] for participants to maximise their success in recovery and living in the community. The collaborative partnerships are demonstrated in Appendix F.

The ICLS program has been contemporised in response to the National Disability Insurance Scheme (NDIS), the Disability Royal Commission (2023), and to ensure a cohesive eco system of supports for participants.



1 Standalone packages of support are also available to individuals who already have appropriate housing but require additional support to live successfully in the community.

3. What is the ICLS

The ICLS is a Western Australia wide program that supports people with a severe mental illness to live well and recover in the community. The ICLS is a transitional recovery focussed program for a period of two years[2].

The ICLS consists of two streams: Standalone Packages of Support and Supports Linked to Housing.

3.1 Purpose and Aim

The purpose of the ICLS is to provide transitional recovery focussed coordinated clinical and psychosocial supports to participants in the program. The program aims to achieve the following outcomes:

1. Improved mental health and reduced hospital stays.
2. Improved physical health and wellbeing.
3. Increased social inclusion.
4. Reduction in criminal offences.
5. Safe and secure housing.

Participants of the ICLS can expect to:

1. Have an increasing ability to fully participate in their ongoing clinical and psychosocial support needs.
2. Develop and sustain meaningful social connections and relationships.
3. Participate and contribute to their community and relationships in personally meaningful ways.
4. Have an increasing ability to participate in educational, vocational and/or employment activities.
5. Develop skills to self-manage their lifestyle and wellbeing.
6. Develop skills to independently manage their accommodation.
7. Be supported to seek suitable alternative accommodation and supports.
8. Improve their quality of life.

The ICLS Providers will work with participants to identify goals and provide recovery focussed support in areas such as:

- Daily living skills such as how to manage finances, prepare meals or use public transport.
- Accessing mental and physical health services.
- Participating in social, leisure or sporting activities.
- Establishing, building and maintaining relationships with family, friends, and the local communities.
- Learning new skills, accessing education or help gain meaningful work.
- Finding accommodation.
- Accessing other supports such as the NDIS [3].

3.2 Target Group

18 – 65-year-olds with severe mental illness and a range of complexities and challenges[4].

Individuals can only be referred by a public or private mental health service[5].

3.3 Individualised Supports

Individualised supports are the various paid and unpaid supports that are identified through a personalised planning process to meet the unique circumstances of participants.

Individualised supports can be created from a vast array of sources including personal networks, peers, community and generic supports and services within the mental health sector.

2 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant. Participants who commenced in the ICLS prior to the implementation of the 2024 ICLS Program Guidelines will commence transition from the implementation date of the 2024 ICLS Program Guidelines.

3 If people are eligible for both ICLS and NDIS, the NDIS supports should be complementary to and not duplicative of those provided through ICLS.

4 Participants to be supported to transition to another service before they turn 65 years old if ongoing support is required.

5 Participants are required to transition to a public mental health service on entrance to the ICLS program to ensure maintenance of partnership relationships.

3.4 ICLS and NDIS Interface

Individuals with a psychosocial disability due to a mental health condition may be eligible for NDIS support. Many of these individuals may also be eligible for ICLS support. Individuals accessing the NDIS for supports other than psychosocial supports (non-mental health conditions) may also be eligible for ICLS support. If people are eligible for both ICLS and NDIS, the NDIS supports should be complementary to and not duplicative of those provided through ICLS.

It is recognised that NDIS participants may experience a temporary increase in psychosocial support needs and/or needs not linked with the primary disability under NDIS. In these cases, ICLS supports may accentuate NDIS supports for a temporary period.

Further, it is noted that some psychosocial needs are not funded through NDIS. In this case, ICLS supports that are complementary to and not duplicative of NDIS supports may be suitable.

It is important to ensure a cohesive eco-system of supports and that transition is integrated with NDIS, noting the ICLS is a transitional recovery program. As a result, there is an obligation and expectation for all NDIS plan content to be shared with ICLS Stakeholders. The Agreement to Share must be signed by the participant or their legal guardian.

ICLS Providers and Clinicians will advocate for and work with the ICLS participant and NDIS planners to assess what supports are needed for program transition (such as Home and Living Support) in alignment with the program's recovery planning and to identify alternate accommodation options.

If the remaining need outside of NDIS supports is accommodation, this is not the purpose of the ICLS program as it is a transitional recovery program.

3.5 Privacy and Confidentiality

The privacy and confidentiality of participant information is strictly upheld.

All nominees into the ICLS are required to sign a Consent to Share Information form prior to being assessed for the ICLS program. All sections of this form must be completed to consent to the sharing of information required for assessment into the program.

The Provider is required to develop and maintain policies and processes regarding confidentiality, privacy, and consent to share information that uphold individuals' rights to privacy and confidentiality, considering relevant privacy and other legislative requirements.

4. Accessing ICLS

4.1 Eligibility for Standalone Packages of Support

To be eligible for support through the ICLS, individuals will[6]:

a. Have been diagnosed with a severe mental illness.

b. Be an Australian citizen or permanent resident.

c. Be aged 18 – 65 [7] years (individuals aged 16-18 year or 65+ may be considered on a case-by-case basis).

d. Have agreed to fully participate in a recovery-oriented support initiative to work towards achieving identified goals.

e. Be able to provide informed consent or have a formally appointed guardian to agree to participate in all aspects of the program.

f. Be ready to and voluntarily want to live in their own home and be committed to engage in support from a mental health service and a community support organisation.

g. Have the capacity to live independently with drop-in supports (24/7 support is not available through the ICLS).

h. Agree to and participate in a range of mental health assessments to confirm eligibility and identify the level of support needed.

i. Agree to the sharing of NDIS plan content and transparency of supports (if an NDIS participant).

4.2 Eligibility for Support Linked to Housing

In addition to the criteria listed above in 4.1, individuals who apply to access support linked to housing through the ICLS will be subject to the *Interim Community Disability Housing Program Policy*. This policy outlines the eligibility requirements for access to housing, including the requirement for individuals to engage in community-based recovery focussed supports.

The key eligibility criteria for housing [8], in addition to the above, include that the individual:

a. Has a income that matches income support eligibility of Centrelink.

b. Does not own or part-own property or land or exceed the community housing income and assets limits as defined in the Department of Communities Community Housing Rent Setting Policy.

c. Has no outstanding arrears, debts, significant events such as property damage or violence or significant past evictions related to a previous tenancy.

6 It is noted that individuals continuing to receive funded psychosocial supports through alterative programs funded by the Commission are not eligible for the ICLS program.

7 Participants will be supported by their Provider and Clinician to transition to another service before they turn 65 years old if ongoing support is required.

8 The criterion for housing is as per Department of Communities Community Disability Housing Program policy community_disability_housing_program_policy.pdf (www.wa.gov.au)

4.3 Referral Process

The ICLS program does not manage a waitlist. As such, when there are vacancies in the program a call for nominations will be sent out to a distribution list which may comprise of public and private mental health services[9]. It is the responsibility of the referrer to ensure all requested documents are fully completed and submitted by the due date. Late or incomplete referrals are unable to be considered.

The individual who is referred, or their legal guardian, must give informed consent.

All referrals are formally assessed by an Assessment Panel (Panel) comprised of a representative from an existing Provider and a clinical representative, a representative from the Program Coordinator[10], and where possible a current ICLS participant[11]. The Panel will review the applications based on the following:

- The required mental health assessments (Client Management Plan).
- The level of support and care required to assist in the individual's transition into ICLS supports.
- Alignment of support needs with the parameters of the ICLS.
- Willingness to engage in clinical/non-clinical recovery focussed supports.
- History of and demonstrated ability and capacity to fully participate in recovery supports.
- Meaningful engagement with supports.
- Readiness to engage.
- Relevant risks.

The panel will shortlist applicants to a meet and greet panel to further assess suitability and eligibility, and to ensure the individual understands the requirements including the transitional nature of the ICLS.

If successful, the individual's referrer will be notified and provided with information on the next steps including the selection of a Provider for the provision of psychosocial supports.

4.3.1 Standalone Package of Support

When there are limited vacancies available in ICLS for Standalone Packages of Support, priority will be given to people based on the severity of their illness, circumstances or need. This can include people from target groups who:

- Live in public housing.
- Are at risk of being hospitalised.
- Need help keeping their housing because they need more psychosocial support.
- Are not currently accessing the NDIS.

4.3.2 Support Linked to Housing

In addition to the above, prior to shortlisting, prospective nominees' details will be sent to Communities to assess eligibility against the CDHP and assessment of tenancy history.

When there are limited vacancies available in ICLS for Support Linked to Housing, priority will be given to people based on the severity of their illness, circumstances or need. This can include people from target groups who:

- Are homeless or at risk of becoming homeless.
- Are in hospital for longer than needed because of their support needs.

The Panel will assess each referral against available properties to ensure appropriate allocation. Considerations include but are not limited to:

- Size of the property.
- Disability access.
- Pet friendly status[12].
- Location.
- Previous property history.

If successful, the chosen Provider will support the participant to engage with the CHO who manages the ICLS property to ensure a smooth transition.

9 Participants are required to transition to a public mental health service on entrance to the ICLS program to ensure maintenance of partnership relationships.
10 See Glossary
11 The Program Coordinator and the current ICLS participant are not voting members on the Panel.
12 Property conditions vary and there may be limits on or exclusions to pets in some properties.

5. Roles and Responsibilities

It is the role and responsibility of all stakeholders to:

- Respect the health, safety and welfare of themselves and others.
- Respect the rights of the individual, families, carers and others.
- Respect the parameters and requirements of the program.
- From the commencement of the first funding plan engage in and commence transition planning.
- Recognise the expertise of the community clinical teams.

5.1 Individual's Role and Responsibilities

5.1.1 Engage with transitional, recovery focused clinical and psychosocial supports.

5.1.2 Regularly review recovery focused supports to ensure they meet goals and needs.

5.1.3 Recognise the ICLS is a transitional recovery focused program and work towards goals and transition planning to transition from the ICLS as independence and capacity increases over the period of two years[13].

5.1.4 Engage with the Program Coordinator to report on satisfaction with services and transition planning.

If accessing Support Linked to Housing:

5.1.5 Be a good neighbour, pay rent on time and look after the property, take responsibility for damage to the property, not injure anyone, abide by CDHP policy and housing requirements.

5.1.6 Advise the CHO and the Provider when maintenance and repairs are required.

5.1.7 Advise the CHO and the Provider when circumstances change, including:

5.1.7.1 Income changes.

5.1.7.2 Change in the number of people who regularly stay in the house.

5.1.7.3 Other circumstances that might affect the tenancy.

5.1.8 Work with the Provider and the clinician to transition to alternative accommodation.

5.2 Family and Carer Role and Responsibilities

Family/Carers and support persons have the responsibility to:

5.2.1 Consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery, and rehabilitation services to individuals.

5.2.2 Engage, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery, and rehabilitation.

13 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

5.3 Psychosocial Support Provider (Provider) Role and Responsibilities

5.3.1 Work in collaboration with the participant, their family, carer's[14], Clinician and other appropriate stakeholders in planning processes to identify support needs and aims and develop a plan of recovery focussed supports.

5.3.2 Complete the Outcome Measurement Tool and consider individual outcomes when reviewing and updating individualised funding plans.

5.3.3 Develop and maintain processes to support participants to work towards their goals in a planned and gradual manner.

5.3.4 Provide flexible recovery focussed supports and maintain overall management and coordination of supports and activities identified in the individualised funding plan.

5.3.5 Work with the participant from the commencement of their first individualised funding plan to:

5.3.5.1 Remind the participant of the parameters and requirements of the program.

5.3.5.2 Work with the participant to achieve their goals to reduce supports to transition out of the program over the period of two years[15,16]

5.3.5.3 Work with the Clinician and other stakeholders to develop a transition plan and assist the transition to alternative accommodation and supports.

5.3.5.4 Support the participant to simultaneously be in the ICLS and on the Public Housing Waitlist.

5.3.5.5 In consultation with other key stakeholders support a participant to test their eligibility for the NDIS if they wish to do so including advocating for home and living supports within the NDIS plan.

5.3.6 Work collaboratively with the Clinician to develop, maintain and regularly review strategies and safeguards for the participant.

5.3.7 Work collaboratively with the Clinician and the participant to develop strategies for the management of limited/non-engagement.

5.3.8 Develop and maintain formal and effective partnerships with specialist mental health services and Clinicians and CHOs, and work in partnership to assist the participant in maintaining their tenancy.

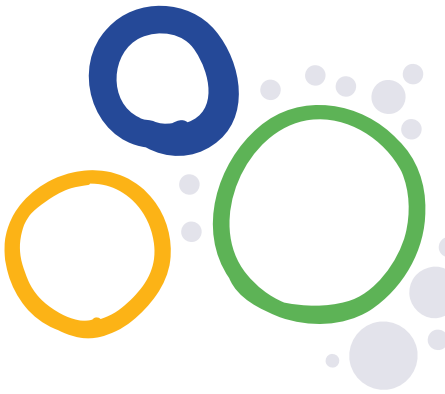
5.3.9 Advise the CHO, the Program Coordinator, and the Commission of any changes to the individual that may affect their tenancy or support funding arrangements.

5.3.10 Participate in joint problem solving, at an individual and/or program level.

5.3.11 In consultation with the participant's Clinician, the Provider should advise the Commission if a participant is no longer considered appropriate to remain within the ICLS program, and therefore recommending they be withdrawn.

5.3.12 Investigate all complaints in accordance with the Provider's established complaints management policy.

5.3.13 Participate as a voting member on Panels for assessing referrals for entrance into the ICLS.



14 The involvement of family and carers should be encouraged; the individual has the right to refuse the involvement of family. Where a person is recognised as a carer under the *Carers Recognition Act 2010*, the following applies:
- The role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and the role of carers.
- The views and needs of carers must be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers.
- Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

15 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

16 Participants to be supported to transition to another service before they turn 65 years old if ongoing support is required.

5.4 Community Housing Organisation (CHO) Role and Responsibilities

It is the responsibility of the CHO to:

5.4.1 Manage the property and tenancy, including undertaking maintenance and collecting rent, in accordance with the *Residential Tenancies Act* and ensure appropriate CDHP policy is applied.

5.4.2 Comply with contractual agreements with Communities.

5.4.3 Ensure any tenancy related decisions are taken in consultation with all relevant stakeholders.

5.4.4 Develop and maintain formal and effective partnerships with the relevant Provider in relation to a participant's tenancy.

5.4.5 Recognise the program is transitional for two years[17]. ICLS properties are not houses for life and a Housing First approach is not applicable to the program.

5.4.6 In consultation with other stakeholders, participate in transition planning to explore and support participants to secure alternative accommodation, such as housing 'swaps' etc.

5.4.7 Notify the Commission when the ICLS CDHP vacant property is ready for a new participant.

5.4.8 Develop and maintain formal and effective partnerships with the Commission.

5.5 Health Service Provider (Clinician) Role and Responsibilities[18]

It is the responsibility of the Clinician to:

5.5.1 Provide assertive clinical supports for each participant that is tailored to their individual needs.

5.5.2 Manage the provision of agreed clinical services in a timely manner.

5.5.3 Participate in reviews and evaluations as agreed between the Commission and the clinician.

5.5.4 Inform the Commission of critical participant issues (such as but not limited to disengagement from clinical management, increased support needs beyond the scope of the ICLS) in a timely manner.

5.5.5 Ensure a case manager or single point of contact is available and has a replacement, which is familiar with the participant if on leave or away, and to ensure the provider is made aware of any changes to the participant's primary clinical contact. This is to enable providers to easily make contact as appropriate in relation to participants they are supporting.

5.5.6 Allocate each participant a dedicated clinical case manager. The clinical case manager is responsible for:

5.5.6.1 Referrals and management of the client (where relevant) including the discharge of a participant from clinical care to management by a General Practitioner.

5.5.6.2 Notify the Provider and Commission should the participant be discharged from clinical care to management by a General Practitioner.

5.5.6.3 Work collaboratively with the Provider to provide input into the development of a participants funding plan and sign off on the plan.

5.5.6.4 In consultation with other stakeholders, participate in transition planning to explore and support individuals to transition from the program including seeking alternative accommodation. Provide consistent messaging to participants around this.

17 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

18 Please refer to Appendix D for additional roles and responsibilities.

5.5.6.5 Work collaboratively with the Provider to provide input into the development and review of a participant's Safeguarding plan.

5.5.6.6 Work collaboratively with the Provider and the participant to develop strategies for the management of limited/non-engagement.

5.5.6.7 Be point of contact for the Commission and the Provider for the individual's clinical care and participate in joint problem solving at an individual and/or program level.

5.5.6.8 Consult and collaborate with the Provider in the support of participants.

5.5.6.9 In consultation with other key stakeholders, support a participant to test their eligibility for the NDIS if they wish to do so including advocating for home and living supports within the NDIS plan.

5.5.6.10 Following regular review and assessment, advise the Program Coordinator if a participant is no longer considered clinically appropriate to remain within the ICLS program, and therefore recommending they be withdrawn.

5.5.6.11 Work with participants to achieve their goals to reduce supports to transition out of the program over the period of two years[19].

5.5.6.12 Participate as a voting member on Assessment Panels for assessing referrals for entrance into the ICLS.

5.6 Department of Communities Role and Responsibilities

It is the responsibility of Communities to:

5.6.1 Assess eligibility for CDHP and liaise with the Commission regarding potential ICLS participant's housing history and requirements.

5.6.2 Construct or purchase housing for lease to CHOs through the CDHP.

5.6.3 Recognise the program is transitional and ICLS properties are not houses for life, a Housing First approach is not applicable to the program and work with stakeholders to consider transition planning options.

5.6.4 Ensure all Communities housing managers and regional staff across the State are aware of the policy approving ICLS individuals to simultaneously be in the ICLS and on the Public Housing Waitlist if they so wish.

5.6.5 If the Commission requires additional ICLS CDHP properties to be purchased by Communities they will communicate, liaise and confirm with the Commission regularly and acquire the properties in a timely manner.

5.6.6 Annually cross check ICLS properties with the Commission to ensure accurate records.

5.6.7 Act as a point of escalation for grievances between Commission and CHOs.

19 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

5.7 Mental Health Commission (Commission) Role and Responsibilities

It is the responsibility of the Commission to:

5.7.1 Contract manage Providers and the Program Coordinator including negotiating, reviewing, supporting, monitoring and evaluating Service Agreements in line with outcomes and outputs.

5.7.2 Review and approve individualised funding plans, Outcome Measurement Tool and acquittals.

5.7.3 Notify the CHO and Communities of successful allocations to properties.

5.7.4 Provide overarching administration of the ICLS, including budget, maintenance of a database of individuals accessing ICLS, State and Commonwealth reporting, the release of funding to Providers and Clinician's, etc.

5.7.5 Annually cross check ICLS properties with Communities to ensure accurate records.

5.7.6 Notify each Provider of their current surplus position twice a year in May and November through a reconciliation.

5.7.7 Support service delivery through the provision of policy, guidelines, templates and other resources for the ICLS in collaboration with relevant stakeholders.

5.7.8 Maintain effective communication and working relationships with Providers, Program Coordinator, Clinicians, Communities and CHOs, including the participation in forums to enhance service delivery and continuous improvement of the ICLS.

5.7.9 Identify and provide information on training and development opportunities for Providers.

5.7.10 Recognise the program is transitional and ICLS properties are not houses for life and a Housing First approach is not applicable to the program.

5.7.11 Act as a point of escalation (for example plan content etc) should Provider, CHO and Program Coordinator resolution processes be exhausted.

5.8 Program Coordinator Role and Responsibilities

5.8.1 Provide oversight of the referral process and convene a Panel to assess referrals.

5.8.2 Provide information and support to prospective and current participants throughout the referral and assessment process.

5.8.3 Allocate the bandwidth of support and the maximum amount of funding available for participants.

5.8.4 Notify the Commission of successful referrals.

5.8.5 Remind Providers of submission dates for individualised funding plans and acquittals.

5.8.6 Receive and review individualised funding plans from Providers to ensure they are correct, activities and strategies are appropriate, and recovery focussed, individualised funding is relevant, necessary and costed correctly. Individualised Funding Plans are then to be submitted to the Commission for consideration and approval no later than four (4) weeks prior to the end of the previous plan [20].

5.8.7 If the individualised funding plan is not correct, the Program Coordinator will liaise with the Provider to revise the plan.

5.8.8 Receive and review the Outcome Measurement Tool for consideration when reviewing the updated individualised funding plans. This is then to be submitted to the Commission along with the individualised funding plan and at the time of the participant's transition out.

5.8.9 Receive and review acquittals to ensure they are correct, ensuring discretionary funding was approved in the plan and appropriate. Acquittals are then submitted to the Commission for consideration and approval, no later than four (4) weeks after the end date of the plan.

5.8.10 Once a choice of service provider has been made by a participant, inform the Provider and the Commission.

5.8.11 Work in collaboration with Commission, Providers and other stakeholders as required to support referrals, engagement and service delivery and continuous improvement of the program.

20 The Commission will not backdate funding without prior notification, reason, and approval from the Commission.

5.8.12 Undertake regular check-ins with each participant at least every 6-months including at the point of participants transitioning from the program to ensure their needs are being met, assess and report on participant satisfaction with service and transition planning.

5.8.13 Provide warm on-referrals to alternative services for unsuccessful referrals.

5.8.14 Working in collaboration with the Provider, Clinician and CHO to ensure the participant transitions safely to alternative support and/or accommodation.

5.8.15 Provide support to participants to change Provider if required.

5.8.16 Provide a letter to the participant on transition out of the program with a copy to be provided to the Commission and Provider.

5.8.17 Provide information and support on individual advocacy agencies to assist participants and their family or carer in resolving a complaint.

5.8.18 Maintain effective communication and working relationships with Providers, Commission, Clinicians, Communities and CHOs, including the facilitation and participation in forums to enhance service delivery and continuous improvement of the ICLS.

5.8.19 Promote the program including information sessions about the program to Clinicians, Providers and other relevant stakeholders.

6. Service Delivery Guidelines

6.1 Recovery Oriented Mental Health Service Provision

The term recovery-oriented practice is widely recognised as a core concept that underpins contemporary mental health service delivery. The focus of recovery-oriented practice is individualised support, centred on the aims of the person, with the support of the stakeholder to facilitate a person's recovery journey.

The Commonwealth Government's National Framework for *Recovery-oriented Mental Health Services – Guide for Practitioners and Providers and The Principles of Recovery Oriented Mental Health Practice (National Framework)* provide guidance to Providers on the way that mental health services can encapsulate recovery based mental health care and support.

The principles of mental health recovery practice are:

6.1.1 Uniqueness of the individual – service providers acknowledge that recovery is a personal journey and is about living a meaningful life with or without the symptoms of mental illness.

6.1.2 Real choices – service providers recognise that for a person to exercise 'real choice' they are supported to creatively explore choices to enable them to define their recovery goals.

6.1.3 Attitudes and rights – service providers promote an individual's legal, citizen and human rights; this includes commitment to supporting a person.

6.1.4 Dignity and respect – service providers treat individuals with compassion and respect regardless of presenting behaviour and are always culturally sensitive.

6.1.5 Partnership and communication – service providers believe in a person's recovery and work in partnership with them and their support network to help them realise their hopes, goals and aspirations.

6.1.6 Evaluating recovery – service providers support individuals to track their own progress and use consumer and carer feedback to inform quality improvement activities.

6.2 Culturally Appropriate Practice

All stakeholders are required to adopt cultural awareness and cultural sensitivity in all aspects of service delivery and be culturally responsive to the unique needs of Aboriginal and Torres Strait Islander Peoples.

Stakeholders should apply sensitive and respectful practices when working with people from culturally and linguistically diverse backgrounds.

Stakeholders should apply non-discriminatory entry criteria with respect to gender, sexual orientation, race, culture, religion and disability. Service provision and individualised funding plans should appropriately respond to the individual's cultural background, preferences, and specific needs.

6.3 Individualised Planning

To access funding and supports through ICLS the following planning process and approval of individualised funding plans must occur, please also see Appendix B for further clarification:

6.3.1 Prior to service commencing, the Provider must complete a planning process including safeguarding, limited/non engagement planning and transition planning with the individual and any other relevant parties[21] (the planning process used should be based on person centred planning principles and can be any tool the Provider chooses). This planning process should continue to be built on and reviewed over time as the Provider develops their relationship with the participant.

21 Relevant parties that may be involved are the individual's family/carers, guardian and clinician.

6.3.2 The information gathered through the Provider's planning process must then be used to populate the ICLS individualised funding plan which is submitted to the Program Coordinator.

6.3.3 The individualised funding plan will be reviewed by the Program Coordinator[22] to ensure that the support strategies are appropriate, activities and strategies are appropriate, and recovery focussed, individualised funding is relevant, necessary and costed correctly within the individual's allocated bandwidth and meets the funding parameters.

6.3.4 Following approval of the individual funding plan by the Commission, an engagement letter will be utilised with funding released through a Recipient Created Tax Invoice (RCTI).

6.3.5 If the individualised funding plan is not approved, the Program Coordinator will liaise with the Provider to revise the plan based on the recommendations/feedback received and resubmit the plan.

6.3.6 Once an individual funding plan has been approved, Providers will be required to review plans against the identified individual outcomes in partnership with the individual and any other relevant parties. Plan reviews will occur every three months and formally at the end of the plan period.

6.3.7 At the end of a plan period, the Provider will complete the Outcome Measurement Tool and submit to the Program Coordinator alongside a new plan. The information gathered through these reviews inform the next individualised funding plan. The Outcome Measurement Tool and Plan are to be submitted for approval and funding allocation[23] no later than four (4) weeks prior to the end of the previous plan[24]. The steps outlined above for the review and approval process will then occur for the renewed individualised funding plan.

6.4 Funding parameters

Funding provided through the ICLS is intended to be recovery focussed, transitional and flexible to optimise the individuals' opportunity to live successfully in the community.

The ICLS program funds reasonable and necessary supports that assist the participant to reach their recovery aims and aspirations. Funding provided through the ICLS must purchase supports that are clearly linked to the achievement of outcomes related to the personal support needs identified in the participant's plan (please also see **Appendix B** for further clarification) these may include:

6.4.1 Supporting the participant to build their capacity and skills to live independently (such as how to manage finances, prepare meals or use public transport).

6.4.2 Supporting the participant with opportunities to develop social relationships and to engage in active community participation.

6.4.3 Supporting the participant to build on their skills to further their opportunities to participate in educational/vocational and/or volunteer work or employment.

6.4.4 Provide opportunities for participants to make choices about and access a range of mental and physical health services.

6.4.5 Supporting and encouraging the participant to engage in social, leisure or sporting activities.

There are circumstances where supports will not be funded through this initiative:

6.4.6 Is not related to the participant's recovery goals as documented in their individualised recovery plan or not related to their mental illness.

6.4.7 Duplicates other supports already funded by another government department or agency.

6.4.8 Relates to day-to-day living costs (for example, rent or other household bills).

6.4.9 Relates to the provision of services for daily personal self-care (for example, bathing, showering, dressing, eating).

6.4.10 Relates to the provision of transport[25].

22 The Commission will also review individual funding plans once submitted by the Program Coordinator.
23 Funding requested through the individual funding plan should be reflective of the individual's current support needs and may be reduced in line with their support needs (refer to Duration and Level of Support for further details).
24 The Commission may request the individual funding plans are submitted earlier should circumstances require.
25 Transport may be approved for an initial 3-month period for new ICLS participants to foster early engagement, conversations and building trust. Beyond the initial 3-month period transport will not be supported to foster consumer independence such as transport training, support for driver's licence, or long-term solutions such as TUSS or other transport options.

6.4.11 Relates to the provision of services for ensuring medication compliance, particularly if a participant is on a community treatment order[26].

6.4.12 Is likely to cause harm to the individual or pose a risk to others.

6.4.13 Is for illegal activities or gambling.

6.4.14 Is considered income supplement for the individual, family members or carers.

It is recognised participants may wish to change some of the goals and activities stipulated in their individualised funding plan. Stakeholders are encouraged to work flexibly with participants to meet their changing needs, working within the above parameters. It is expected that the Provider and Clinician will contact the Program Coordinator and the Commission for advice when significant changes to a participant's individualised funding plan is warranted.

6.5 Duration and Level of Support

The duration and level of support a participant receives will be different for everyone based on their individual needs. The intention of the ICLS is to be transitional over the period of two years[27]. Supports for the individual should be as flexible as possible to support goals by working in partnership with the participant, their family/carer and any other appropriate formal/informal support.

For example, a participant may have a reduction in support needs due to successful recovery and transition into community life. This should be discussed with all stakeholders when reviewing their individualised recovery plan so that a reduced level of support is outlined in their revised individualised funding plan. Reducing the level of support provided can occur at any time. The Provider will discuss any significant reduction in supports with the Program Coordinator and any reduction of services should be reflected in a new individualised funding plan.

Alternatively, a participant may experience increased support needs that require a more intensive level of support than is within the provision of their current funding bandwidth allocation. If this occurs, it is essential the Program Coordinator is notified as soon as practicable, so they can work in partnership with all stakeholders to determine the best solution for all parties involved.

If the circumstances warrant an increase in supports and funding bandwidth to meet the changed needs, there will be a requirement for the written support from the participant's Clinician and for the Commission to provide approval of a temporary increase to services funding plan (Top-Up Plan). The Commission will not back date any increased funding levels without prior notification from the Program Coordinator and agreement of the changed circumstances by the Commission.

Where a participant refuses support (clinical and/or Provider supports), but clearly requires some form of assistance to live independently in the community, both the Clinician and the Provider will review the participant's needs and their suitability for ongoing access to the ICLS program. The Program Coordinator must be notified if it is recommended the individual be withdrawn from the ICLS program.

26 This is a clinical responsibility.
27 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

6.6 Accommodation and Tenancy

Having a stable form of accommodation is widely recognised as one of the most significant factors in achieving recovery for a person with mental health difficulties. Safe, secure, stable housing helps people keep in touch with family and friends and form new relationships with neighbours and local communities. It provides a basis for other areas of a person's life to improve, such as getting back to work, finding a new job, or taking up sport, education and other activities.

Participant's that access support linked housing through the ICLS program are required to meet all relevant Communities policies and guidelines in addition to the terms and conditions set out in the lease agreement between the individual and the CHO.

Communities reserves the right to refuse access to support linked to housing to any applicant with substantiated breaches of their tenancy agreement or the *Residential Tenancies Act, 1987*. This means that:

- The Commission may not be able to offer a property within the ICLS for individuals identified with outstanding arrears, debts, significant events such as property damage or violence or significant past evictions related to a previous tenancy.
- The Commission may not be able to offer an alternative property for individuals whose tenancy is terminated while in the ICLS program or has had significant tenancy issues[28] while in the ICLS program.

Additionally, due to the limited number of houses available and the high demand for housing, alternative properties are unlikely to be available. The responsibilities of participants accessing support linked to housing through the ICLS are described in the responsibilities section. Ongoing engagement with supports provided through the Provider and Clinician is important to assist with understanding and meeting these responsibilities.

As the program is transitional over the period of two years[29], in collaboration with all stakeholders, each participant will be supported by stakeholders with a transition plan to explore and work towards securing alternative accommodation.

6.7 Housemates and Live in Supports

The Commission recognises the potential benefits a supportive housemate may provide for some individuals experiencing severe mental illness, living independently in the community. A supportive housemate can assist individuals to develop independent living skills, maintain their tenancy and develop community connectedness. For some individuals, having a supportive housemate may reduce (though not necessarily replace) the necessity of more formal supports.

Where appropriate, ICLS funds may be used to assist the implementation of a supportive housemate model and Providers are asked to discuss individual proposals with the Commission prior to submission of a formal funding request (if there is a guardian involved with an individual, the guardian would need to be involved in this process). The Provider must inform the Program Coordinator and CHO of their intention to explore the possibility of a housemate or live-in support before any further action is taken.

Though the individual circumstances will govern the specific model employed, the following aims to provide Providers with information on some of the logistics in implementing a supportive housemate model.

6.7.1 Clarifying the role of a supportive housemate

The Provider should assist the participant to identify the specific types of support they require from a housemate. Clarifying the proposed role of the housemate along with the desirable competencies and qualities of an ideal candidate will assist the individual to develop a set of selection criteria.

The Participant's Clinical Case Manager should be consulted to ensure collaboration.

28 Significant tenancy issues may include antisocial behaviour or violence, outstanding arrears or debts, property damage etc.
29 An additional 12 months of supports may be provided if required on a case-by-case basis. A maximum of three years of ICLS support is available for each participant.

6.7.2 Selection of a housemate

There are numerous avenues for sourcing potential housemates. Examples include:

- Online community classified websites.
- Posting *housemates wanted* notices on community billboards in public locations.
- Via recommendations from friends, family members or other contacts.
- An existing friend to take on the role of supportive housemate.
- Another ICLS participant.

The Providers are encouraged to work closely with the individual to implement staged interview processes with potential housemates. This may include phone interviews and initial face to face meetings in the community, prior to inviting potential candidates to view the property. A supportive housemate should be subject to a successful police clearance along with any other formal requirements of the CHO.

6.8 Supporting the co-tenancy

Following the selection of an appropriate housemate, participants may require assistance to work with the supportive housemate to establish, clearly outline and formally agree to by all parties (with input from Provider and CHO):

- House rules.
- Roles and responsibilities.
- Grievance processes.
- In some existing co-tenancy arrangements, a regular house-meeting is convened. Depending on the specific situation, the Provider may participate in these meetings.

6.8.1 Rent

The supportive housemate will be subject to standard tenancy requirements as outlined in the WA *Residential Tenancy Act, 1987*. This includes the payment of rent. The Commission encourages service providers to discuss the proposed logistics of a particular housemate model with both the allocated CHO managing the tenancy and with the Program Coordinator, prior to implementation.

6.8.2 Lease

The specifics of the supportive housemate's lease will need to be determined prior to the commencement of tenancy, in line with the WA *Residential Tenancy Act, 1987* and subject to approval of the CHO. Provider's and individuals are encouraged to be aware of the various rights, responsibilities and legal ramifications of tenancy contracting arrangements prior to implementing a supportive housemate model.

6.9 Safeguarding

Safeguards are precautions and measures that are put in place to ensure a participant has the best possible chance of succeeding in their recovery. Safeguards may protect a person from exploitation and harm, and foreseeable unintended events. Importantly, safeguards should enhance and protect a person's human rights, and enable a person to make choices and decisions, take considered risks, and live a life as an active and equal citizen in the community.

The identification and establishment of appropriate safeguards is viewed as a fundamental component of person-centred planning and practice. When safeguards are understood in this way, there is a need to develop an appreciation of what safeguards are, and how they can be implemented to have maximum positive impact on the lives of individuals.

One perspective in looking at safeguards is to consider the extent of 'citizen capital' that each person has to identify areas of strength, possible areas of vulnerability, potential threats and hazards, and level of risk.

This concept provides a way of understanding the range of resources that everyone needs in their lives to enable them to live safely and well in their communities. The key aspects of citizen capital are:

6.9.1 Personal capital (who I am) – for example a person's ability to assert themselves, their resilience, self-esteem, and a person's key roles.

6.9.2 Knowledge capital (what I know) – for example, a person's skills, knowledge, education experiences.

6.9.3 Social capital (who I know and who knows me) – for example a person's relationships and connections, membership to groups, sources of support, informal and formal advocates.

6.9.4 Material capital (what I have) – a person's income and investments, employment/ occupation, safe and stable home, and other community resources that a person can readily access.

Providers are expected to utilise a holistic approach to developing multiple safeguarding strategies to support an individual to succeed in their recovery on their own terms. For examples of safeguarding in practice please refer to Appendix A of this document.

Providers are required to work with the Clinician to develop a Safeguarding plan for each participant at the commencement of their service and review the Safeguarding plan with each individualised funding plan. Completed Safeguarding plans must be stored by the Provider in accordance with their record keeping policies and procedures. Advice of the Safeguarding plan being in place must be provided to the Commission as part of the plan submission process.

6.10 Grievances and Complaints

The Commission is committed to purchasing high quality services and recognises that complaints and feedback provide information to improve the quality of services.

Providers and the Program Coordinator should ensure that participants are advised of their organisation's complaints procedure. Many complaints can be resolved quickly and effectively at a local level. Complaints should be dealt with in a confidential manner and will only be discussed with the people directly involved. Where a complaint cannot be resolved with the Provider or Program Coordinator the issue can be raised with the Commission or alternatively by contacting the Health and Disability Services Complaints Office (HaDSCO).

The Provider and the Program Coordinator will document all complaints in accordance with their organisation's formal procedures.

In instances where individual advocacy support is required to assist an individual and their family or carer in resolving a complaint, information about services will be provided by the Program Coordinator.

Should the Provider or the Program Coordinator wish to raise a complaint in relation to a stakeholder of the ICLS program, the issue can be raised with the Commission or alternatively by contacting the Health and Disability Services Complaints Office (HaDSCO).

6.11 Portability of funding

Participants choose their Provider and can transfer/ move between Providers subject to the following conditions:

6.11.1 A reasonable time[30] accessing a particular Provider is required before participants change Providers. This is to allow a plan to be established, developed and implemented effectively. The timeframe is negotiable based on the circumstances surrounding the request.

6.11.2 If a participant requests a change of Provider, the Program Coordinator will meet with the participant to explore whether the issue can be resolved.

6.11.3 If it is found the issue is unable to be resolved, a negotiated timeframe will be agreed prior to the implementation of a transfer. Where a transfer is requested, the Program Coordinator will ensure the timeframe is mutually acceptable to all parties to ensure appropriate administration tasks have been undertaken and allow for a smooth transition with minimal disruption to the participant. The principle of choice for individuals is paramount and every effort will be made to accommodate the choice and to resolve any issues quickly.

6.11.4 Services transferred during the course of a year will involve a pro-rata transfer (or based on an acquittal of funds to date) of the allocated funding for that year and the full allocation thereafter, unless otherwise negotiated between the Commission and the Provider.

6.11.5 Additional costs will not be incurred due to individuals transferring between service providers.

6.11.6 Where services are being terminated by the Provider, three (3) months written notice is required to the Program Coordinator and to the individual(s) who is/are receiving the service, to enable appropriate transition arrangements[31].

6.11.7 The services of the CoMHWA Peer Coordinator can be accessed to support the individual to choose another Provider. This may include over the phone or face-to-face meetings with the prospective Providers.

30 In most cases, a reasonable time is three (3) months; however, each case must be discussed with the Program Coordinator.
31 Where it is unsafe for a Provider to continue to provide services to a participant, this must be discussed with the Program Coordinator to ensure suitable alternative support is investigated prior to, or urgently after supports cease.

6.12 Transitioning from the ICLS program

Individuals will transition from the ICLS for a variety of reasons including when the person:

6.12.1 Achieves their recovery goals[32] and no longer requires support of the program in a planned and agreed upon manner.

6.12.2 No longer wishes to participate in the program.

6.12.3 Has moved interstate or has left Australia for an indefinite period.

6.12.4 Support is insufficient to meet their needs.

6.12.5 Is admitted to inpatient care, hospital or alternative supported residence (e.g. Rehabilitation centre), for an extended period of time [33].

6.12.6 Has transitioned completely to the NDIS for all psychosocial support needs.

6.12.7 Enters mainstream aged residential care.

6.12.8 Has support needs which are outside the scope of the ICLS.

6.12.9 Is incarcerated for an extended period. In most cases, an extended period is three (3) months; however, each case must be discussed with the commission.

Transition from the ICLS program must be in consultation with all key stakeholders.

If a participant is linked to a Clinician, the Clinician is required to formerly notify the Program Coordinator, in writing, that they support the individual's transition from the ICLS program. Once this is received the Program Coordinator will send a formal letter of transition to the participant and inform key stakeholders.

The Clinician must discuss this recommendation with the participant in consultation with other key stakeholders. If appropriate, the Clinician must ensure a transfer of care to another mental health service or General Practitioner has occurred before the participant transitions from the ICLS program.

If a participant is not linked to a Clinician, the Provider is required to formerly notify the Program Coordinator, in writing, that they support the participant's transition from the ICLS program. Once this is received the Program Coordinator will send a formal letter of withdrawal to the participant and inform key stakeholders.

To ensure that the participant transitions from the program safely, each participant is supported by the Provider and Clinician to engage in and continually review a transition plan. The transition plan must include steps for securing alternative accommodation[34].

In addition, the Provider and Clinician is required to ensure that participants have adequate support from other sources when they transition from the ICLS program.

32 Should an individual's circumstances change and supports are needed to be reintroduced, this will be possible by a new referral into the ICLS program by their clinical team.

33 If individuals are in hospital or alternative supported accommodation for an extended period, their personal circumstances no longer align with the strategic intent of the program which is to support individuals to live independently in the community. In most cases, an extended period of time is three (3) months. However, each case must be discussed with the Program Coordinator.

34 The Commission does not support termination into homelessness and all participants are supported by the Provider and Clinician through a transition plan to source suitable alternative accommodation prior to transitioning from the ICLS program. Should a participant remain in an ICLS property without ICLS supports, the individual must independently actively seek alternative accommodation while continuing to abide by all requirements of the Lease and stipulated by the CHO. The individual will be required to continue meeting the Department of Communities - Housing eligibility criteria i.e. low income level and not owing property, etc.

7. Relevant policies and strategies

The ICLS is guided by the following polices and strategies:

- Delivering Community Services in Partnership Policy, which applies to all Public Authorities that provide funding for, or purchase community services from, not for profit organisations
- National Standards for Mental Health Services 2010[35]
- Australian Government 2013 *A National Framework for Recovery-Oriented Mental Health Services – Guide for Practitioners and Providers*
- Australian Government 2010 *Principles of Recovery Oriented Mental Health Practice*
- *Australian Government Carers Recognition Act 2010*
- Community Disability Housing Program Community Disability Housing Program (www.wa.gov.au)
- Community Managed Organisations Mental Health Standards

The following Commission documents also provide guidance:

- Mental Health 2020: Making It Personal and Everybody's Business
- The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025
- Safeguards Framework for Individualised Support and Funding
- Notifiable Incident Reporting Policy
- Quality Assurance Framework

35 Mental Health Service Providers contracted by the Commission will be transitioning to the National Safety and Quality Mental Health Standards for Community Managed Organisations. Timelines have not been confirmed as yet.

8. Glossary

This Glossary contains terms that are common to some of the related documents, such as the Individualised Support Policy Framework.

Carer

In line with the *Carers Recognition Act 2010*[36], a carer is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:

(a) Has a disability; or

(b) Has a medical condition (including a terminal or chronic Illness); or

(c) Has a mental illness; or

(d) Is frail and aged.

Non-Government Organisations (Providers)

This is another term that is used for Community Managed Organisations.

Individualised funding and self-directed funding: Are both funding mechanisms that promote person-centred approaches where the funding is based on the support needs and identified solutions for individuals, families and carers. It is based on the principle that individuals and families are best placed to determine their own needs and solutions to those needs, and therefore have control over the purchasing of services and supports that they require. In some self-directed models, the funding is provided directly to the person with a mental health problem and/or mental illness or his or her family.

Individualised supports

Are the supports that have been identified to meeting the support needs and solutions of individuals with mental health problems and/or mental illness, and their families and carers. Individualised supports include paid supports, as well as freely given supports through organisations and members of the community.

Mental health services[37]

Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

Mental illness[38]

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

The person-centred approach

Puts individuals with mental health problems and/or mental illness at the centre of planning and decision making on how they would like to see their lives unfold. Supports and services provided to individuals are based on their unique wishes, interests, strengths, goals and needs.

36 The explanation of the word 'carer' is adapted from Section 5 of the Act.
37 Department of Health and Ageing, F*ourth National Mental Health Plan*, Australia
38 Australian Government, National Standards for Mental Health Services 2010, p.42.

Person-centred approach to planning

Is planning that is tailored to the unique circumstances of each person with a mental health problem and/or mental illness and distinguishes between what is important "to the person" as well as "for the person".

Personalised Plan

Refers to the individual support plan completed by the Provider in conjunction with the individual and any other related parties, which will be submitted to the Commission and reviewed by an Independent Panel.

Program Coordinator

NGO contracted by the Commission to manage the referral and assessment process for people nominated for the ICLS program and support eligible participants to choose their support provider under the program and throughout the term of the individual's Individualised Recovery Plan as required.

Recovery

Gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self [39].

Safeguards

Are individualised precautions and safety measures that are put in place to protect the person with a mental health condition from exploitation and harm, and provide protection against foreseeable unintended events, while at the same time enabling the person to make choices, take considered risks and live a life that reflects their personal preferences. An important safeguard is the building and supporting of relationships in a person's life as this increases the number of people who care about the safety and wellbeing of the person.

Service Agreement (for Panel of Preferred Service Providers):

The Service Agreement comprises:

(i) General Provisions for the Purchase of Community Services by Government Agencies – 2008 Edition (superseded by the General Provisions for the Purchase of Community Services by Public Authorities – February 2012 Edition);

(ii) Request for Individualised Community Living Strategy;

(iii) Response Form; and

(iv) Acceptance of Offer.

Social Inclusion:

Is a sense of belonging, sharing responsibility, contributing, having one's differences respected, and being seen to be of value regardless of one's circumstance. Social inclusion also refers to policies and practices which lead to the experience of being socially included for people who may otherwise be excluded because of disability, mental illness or disadvantage.

39 Australian Government, National Standards for Mental Health Services 2010, p.42.

Appendix A – Safeguarding Examples

Safeguarding differs from risk management in that it is highly individualised and tailored to an individual's specific support needs.

Inherent in safeguarding principles are the concepts of formal and informal supports. Safeguarding works best when it is within a partnership framework and involves contingencies of both a formal and informal nature.

Informal safeguards include: relationships with family, friends, personal networks and wider members of the community. These relationships and connections often need to be intentionally developed, as some people have become socially isolated over time, and have lost these natural connections.

Comprehensive safeguarding involves conceptualising, planning and action to ensure situations of risk are addressed from multiple angles by multiple stakeholders with an individual's unique circumstances and narrative at the forefront.

Example A

John lives alone in a two-bedroom house in the community. While he is pleased to be living in the community, he is socially isolated and regularly experiences feelings of loneliness in the evenings. John engages in excessive drug and alcohol usage and is vulnerable to the predatory behaviour of others – including people staying at his house against his wishes. John and his clinical team are concerned at the heightened level of risk and equate John's isolation with an increase in behaviours that compromise his safety and wellbeing.

A safeguarding approach would ensure that John is supported to manage his social isolation in ways that are supportive of his recovery. The Provider would work with John and his formal (clinical, any other service providers involved) and informal (family members, neighbours) supports to devise a safeguarding strategy to assist John to manage his social isolation, recognising that evenings are a time of heightened risk for John.

Examples of actions the Provider might[40] facilitate/support include to:

a) Work with John to identify his motivation for change, including assisting him to articulate his recovery vision.

b) Work with John and the clinical team to devise a clear graduated plan outlining steps John is taking to manage his recovery and maintain independent living, including an outline of formal and informal support roles and responsibilities.

c) Support John to identify key informal support people and clarify roles these people will play in his recovery. The Provider may need to take an intentional approach to supporting John to build relationships and networks to increase his connectedness in the community.

d) Provide increased support visits in the evenings to assist John to establish evening routines.

40 This is not exhaustive and is meant as a guide only.

e) Assist John to identify and participate in regular evening-based activities consistent with John's recovery vision. These might include social, fitness and education activities.

f) Ensure phone contact is made with John each evening via a coordinated schedule, involving a combination of Provider staff, family, friends and neighbours.

g) Support John to maintain and regularly update a list of people and services he can contact when feeling socially isolated. These might include clinical contacts, crisis support such as Lifeline, phone numbers of supportive friends and family members.

h) Explore with John the possibility of a housemate moving in with him (refer to guidelines on housemates for things to consider).

i) Support John to develop assertiveness skills, through participation in community education programs

j) Work with Alcohol and Other Drug (AOD) specific services to implement a tailored approach to support John to manage AOD use including the possibility of an AOD peer worker.

Example B

Mary lives by herself in her home in the community. She engages with her Provider daily. This includes contacting the Provider office by phone on average 5-10 times per day, with requests to speak to management staff, often to complain about the service and specific staff members. Mary is regularly verbally aggressive towards staff members, family and community members. The verbal aggression is often personalised and of a sexualised or racial nature. Mary regularly exhausts her mobile phone credit and is sometimes unable to make phone calls for days at a time. Mary's family are highly concerned by Mary's social isolation. Mary has sustained physical injuries in her home and been unable to contact services, during occasions when her phone credit has been expended.

A comprehensive safeguarding approach would seek to address the risks associated with Mary's aggressive behaviour and her social isolation, recognising the link between these two issues.

Examples of actions the Provider might[41] facilitate/ support include to:

a) Recognise the link between Mary's social isolation and her excessive phone calls to the Provider and endeavouring to support her engagement in socially appropriate activities in the community.

b) Explore multiple mobile phone and landline phone plans and options with Mary and her family.

c) Explore other options such as a personal alarm system/alerting device that can be activated by Mary in crisis situations should she have insufficient phone credit.

d) Engage Mary in specific budgeting supports.

e) Engage Mary in assertive behaviour training.

f) Engage Mary with activities during the day and evening to reduce social isolation utilising a variety of engagement methods to support Mary's participation.

g) Recognise the risk to staff by Mary's aggressive behaviour and implementing two person visits where appropriate. This may include ensuring male staff members are accompanied by female staff members on support visits following incidents of sexualised comments.

h) Regularly remind Mary of the Providers formal internal consumer complaints process and encouraging her to utilise this process in preference to contacting the office repeatedly.

i) Establish regular weekly scheduled phone contact between Mary and the manager of the Provider at a mutually agreed time.

j) Work with the clinical team to identify a comprehensive risk management plan.

k) Work with Mary and her family to develop a phone contact/visit schedule to ensure she is receiving regular phone calls and visits at coordinated times to so that she is not socially isolated.

l) Discuss with Mary potential involvement with neighbours to reduce social isolation and develop strategies for appropriate engagement with them.

41 This is not exhaustive and is meant as a guide only.

Appendix B – Use of ICLS Funding

Each participant of the ICLS Program is provided with an allocated maximum amount of funding for each 12-month plan period. The amount of funding relates to the recommended bandwidths of support ranging from Low, Medium, High and Very High.

The bandwidth of support is recommended by the Clinician at the point of referral and confirmed by the Panel when the participant is successful in their referral to the ICLS program.

The funding is paid to the Provider to provide recovery focussed supports (see Section 6 of the ICLS Guidelines for Portability of Funding). The Provider can request an increase in the bandwidth of support if after meeting with the participant it is recommended that more intense supports are required. This must be supported in writing by the participant's Clinician.

There are three individualised funding plan templates available depending on the participant's needs at the time of submission:

Full Year Funding Plan

- Full Year Funding plans cover 12 months and are developed in consultation with the individual, families/carers, Guardian, community clinical team, Provider and any other relevant stakeholders.
- The individual, families/carers and Guardian must sign the Full Year Funding Plan.
- The Provider and Clinician must sign the Full Year Funding plan.
- Full year funding plans are to commence 1 July or 1 January.

Interim Funding Plan

- Interim plans are plans longer than four (4) months, less than 12 months and developed in consultation with the individual, families/carers, Guardian, Clinician and Provider.
- The Interim Funding Plan should be utilised when a Provider has received a new referral and they need to align the Full Year Plan with either a 1 July or 1 January start date which exceeds three (3) months. Alternatively in consultation with the Program Coordinator when it is determined an interim plan is more appropriate for an individual than a full year plan (examples include transitioning to alternative supports, transitioning out of the program, or periods of severe instability for the participant).
- It is preferred the participant, families/carers and Guardian sign the Interim plan however is not a requirement.
- The Provider and Clinician must sign the Interim Funding Plan.

Provisional Plan and Temporary Increase to Services Funding Plan

- A Provisional Plan should be utilised when a Provider has received a new referral and they need to align the Full Year Plan with either a 1 July or 1 January start date which is three (3) months or less.
- A Temporary Increase to Services Funding plan (top-up plan) is developed if the Provider requires a temporary increase in funding through to the end of the participant's plan. The temporary funding must be within the individuals allocated bandwidth.
- It is preferred for the individual, families/carers and Guardian sign the Provisional Plans and Temporary Increase to Services Funding Plans however is not a requirement.
- The Provider and Clinician must sign the Provisional Plans and Temporary Increase to Services Funding Plans.

1. Developing and Submitting a Funding Plan

1.1 Use the Commission provided ICLS individualised funding plan templates (Full Year Funding Plan, Interim Funding Plan or Temporary Increase to Services Funding Plan templates).

1.2 This initial plan should be submitted to the Program Coordinator and provided to the Commission no later than four (4) weeks after the initial payment or for the 1st day of the following month. An initial plan payment is paid to the Provider for the development of the first 12-month plan. The Commission estimates the initial plan payment for plan development, depending on the individual's needs, should equate to approximately one (1) months' worth of supports[42]. During this time the Provider should begin meeting the participant, building rapport with the community clinical team and CHO, arranging tenancy (if accepted for a house and package of support), supporting participant to buy furnishings and move into their home.

1.3 If the individual is assigned an ICLS property, they are eligible for a once-off payment to contribute towards furnishings for their property. This funding is sent to the Provider and the full amount should be utilised for furnishings for the participant's property.

1.4 The hours of direct support and subsequent funding must be entered on the costing sheet of the individualised funding plan on a weekly basis (not annually) and the total costings (not hours) for the year entered.

1.5 The individualised funding plan should have the input of all relevant stakeholders. The Clinician needs to contribute to the plan and to safeguarding and transition planning.

1.6 The start date of all individualised funding plans should be clearly stated on each plan document.

1.7 An update on the participant's progress, against the previous year's aims as well as a report on any brokered services, is captured within the Outcome Measurement Tool template. This is to be submitted on an annual basis with the new individualised funding plan as well as at the time of the participant's transition from the ICLS.

42 Approximately 3 weeks - 6 weeks dependant on the time of onboarding to the 1st of the following month. The Commission will not backdate funding without prior notification, reason, and approval from the Commission.

2. Discretionary Costs

2.1 Discretionary funding is to be utilised for recovery focussed supports in the community that will aid the participant to connect to their community, gain employment or learn relevant skills.

2.2 If the discretionary funding is requested, it must be clearly stated what the funding will be used for, relating it to recovery focussed supports in the participant's individualised funding plan. In addition, a summary of discretionary funding and a description is required on the costing sheet of the participant's individualised funding plan.

2.3 Discretionary funding is based on up to 3% of the total funding bandwidth. For example, if the allocated funding is a High bandwidth, the discretionary funding would be 3% of $155,180 (Metro) which is $4,655 leaving $150,525 available for direct supports (based on 2024/25 figures).

2.4 The discretionary funding is not an automatic payment. The funding is up to a maximum of 3% of the total funding bandwidth and must be relevant to the participant's identified recovery goals. As such, some participants may not utilise discretionary funds.

2.5 For costs associated with training courses the participant is to be encouraged to contribute 50% of the fees, to motivate them to save money towards their recovery aims.

2.6 For costs associated with driving lessons, the participant is to be encouraged to contribute 50% of the fees, noting discretionary funding to cover driving lessons will be limited to a 12-month period only. Discretionary funding is not able to cover fees associated with driving tests (such as the practical driving assessment), hire vehicles, or other payments.

2.7 ICLS funding cannot be utilised for activities or items that can be funded through other sources, to acquire items, 1:1 personal training, home gym training etc[43].

2.8 Please discuss with the Program Coordinator if there is uncertainty around the appropriateness of how discretionary funding can be utilised.

3. Acquittals

3.1 The total of all funding provided by the Commission must be acquitted at the end of the funding cycle through a Final Acquittal form.

3.2 Final acquittals must be submitted by the Provider to the Program Coordinator for review and submitted to the Commission no later than four (4) weeks after the end date of the participant's individualised funding plan.

3.3 Funds for direct support, brokered supports, discretionary, temporary increase to services funding and the initial start-up funding for plan development must be included in the Final Acquittal. This does not include the once-off payment released for furniture if allocated an ICLS property.

3.4 As per the Service Agreement, funding should be reconciled and acquitted monthly by the Provider and may be requested at contract management meetings.

3.5 When a new individualised funding plan is submitted, the Provider must also provide a Preliminary Acquittal showing funding spent to date.

3.6 There is an acceptable 5% 'slippage' in acquittals on each individual's funding plan.

3.7 Funds that are surplus (i.e. over and above 5%) at the end of a funding period will be offset against funds to be paid by the Commission to the Provider for another ICLS participant. Details of offsets are described in the Payment Summary for each participant when payments are released.

3.8 The Commission will notify each Provider of their current surplus position twice a year in May and November through a reconciliation.

43 ICLS funding is to be used to support community and social participation such as access group classes, groups, or community sessions.

4. Change in Needs (including accommodation)

4.1 If a participant is supported to temporarily access other funded accommodation/ residential services, e.g. Step Up/Step Down (excluding hospital admissions), the Provider is required to communicate with the Program Coordinator as early as possible to ensure flexibility and accountability of the Commission funds and resources can be maintained. It is anticipated that ICLS funds will not be stopped during this period, rather reduced to maintain relationships and continuity of service provision.

4.2 Any change to the level of funding (e.g. an interim increase for a specific period due to need for more intensive supports; an increase in bandwidth whether temporary or permanent) will need to be requested to the Program Coordinator with written endorsement from the participant's clinical team.

4.3 Recommendations for a reduction in bandwidth do not require written endorsement from the individual's community clinical team.

4.4 If an individual has consistently decreased their supports during the life of the plan, the expectation is that a reduction in bandwidth will be reflected in subsequent plans.

4.5 Requests for brokered services must be submitted to the Program Coordinator and approved by the Commission prior to the service commencing. Such requests must include written endorsement from the participant's clinical team and include a timeline.

Appendix C – Communication and Information Sharing by the Non-Government Organisation

To support and maintain effective communication and working relationships with Provider's, the following notifications must be submitted to the Program Coordinator who will notify the Commission:

a) An individual is admitted to hospital due to their mental health or physical health via a 'Hospital Admission Form[44]' within three (3) business days.

b) The Provider is concerned that an individual has been/or is going to be discharged via a 'Discharge Hospital Form'.

c) An individual does not engage with their supports via a 'Limited or Non-Engagement Form' – when there have been three consecutive unsuccessful scheduled engagements[45].

d) The individual is not in their home for any length of time longer than four weeks, i.e. if they are admitted to hospital, if they go on holiday, if they go to a residential rehab.

- The Provider must ensure the house is secure and visit it from time to time to ensure it remains safe.
- The Provider must support the individual to maintain their tenancy to an acceptable standard including communicating with the CHO of any concerns or changes to supports. Please note, support does not include using supports for physical assistance such as for cleaning, tidying, gardening etc.
- If the property is at risk of inappropriate and uninvited guests, the Provider must notify the CHO as soon as is practicable as well as the Program Coordinator.

If there is a Notifiable Incident[46] relating to an individual in the ICLS, notification is required via the Commission general submission of NI forms – please see Commission website for further details and to access the updated NI form. These forms should be emailed to the Commission via the appropriate email address and note 'ICLS' on the email subject line.

44 **Hospital Admission Forms** should be submitted when an ICLS participant is admitted to hospital. This form should be utilised when a serious or notifiable incident has not preceded the admission, i.e. a planned admission by the clinical team due to a decline in wellness or change in medication – even if the police are called to escort the individual to the hospital.

45 If an individual is not engaging in the program this does not mean that the participant will be withdrawn from the program. People disengage for a variety of reasons and early notification of this allows the Commission to provide support to the Provider as appropriate, and to ensure that the clinician is also aware so that appropriate strategies can be developed to ensure the participant's needs are met.

46 **Notifiable Incident Forms** should only be submitted if a serious or notifiable incident has occurred (and/or resulted in a hospital admission) as outlined in the General Provisions (examples are also available on the Commission website).

Appendix D – Clinical Team Responsibilities

When necessary, each participant in the ICLS receives dedicated clinical support from the relevant community clinical team.

The Community Clinical Team should provide assertive community clinical outreach to individuals in the relevant area in the ICLS. In addition to the roles and responsibilities outlined in **section 5.5**:

(a) If appropriate and the participant indicates their interest, support existing ICLS individuals who would like to change providers, to utilise the services of the Independent Peer Coordinator from CoMHWA.

(b) Provide clinical input into each ICLS plan with particular emphasis on relapse prevention, safeguarding and discharge planning strategies.

(c) Provide written endorsement (via email) to the Program Coordinator if a request is made for an increase in support and an increase in bandwidth, whether permanently or as an interim funding package.

(d) Meet with all identified stakeholders at least quarterly for participant on a Low/Medium bandwidth and at least monthly for individuals on High or Very High bandwidths.

(e) In collaboration with the chosen Provider, support each participant to be linked with a General Practitioner (GP) in the community for their general health needs and encourage them to attend the GP at least three times per year.

(f) Ensure a case manager or single point of contact is available and has a replacement, which is familiar with the participant if on leave or away, for each individual and to ensure the Provider is made aware of any changes to the individual's primary clinical contact. This is to enable Providers to easily make contact as appropriate in relation to participants they are supporting.

(g) In consultation with other stakeholders, explore and support participants to secure alternative accommodation.

(h) Provide a referral back into clinical case management if needed after deactivation.

(i) Ensure integration of care between clinical and Provider services reflect the ICLS Service Program Guidelines.

(j) Attend meetings with the Provider's and Program Coordinator[47] as agreed.

(k) Notify the Commission when an individual is deactivated from clinical case management.

(l) Provide detailed reporting every six months in line with the current year's Commission Service Agreement.

47 The Commission may be involved in meetings with the Provider, Program Coordinator and/or Clinical as required and agreed.

Appendix E - Suite of Forms

1. Hospital admission form
2. Hospital discharge form
3. Limited or non-engagement form

Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

Hospital admission form

This form is used to notify your Commission contract manager of hospital admissions. Please complete and email to your contract manager / contact.

A Hospital Discharge form is to be used when a participant has been discharged.

Please continue to use the Notifiable Incident Form when appropriate.

Date of submission:	
Participant's name:	
Support organisation:	
Date of hospital admission:	
Name of hospital:	
Anticipated length of stay:	
Referral type: I.e., Police, MHERL, Self, Other	
Reason for referral:	

Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

Hospital discharge form

Use this form for hospital discharges and email to your contract manager.

Please continue to use the Notifiable Incident Form when appropriate.

Date:	
Individual name:	
Support organisation:	
Date of hospital discharge:	
Name of hospital:	
Length of stay:	
Plan on discharge:	

Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

Limited or non-engagement

This form is to be used to notify your Commission contract manager and the Program

Coordinator of concerns[48] relating to limited or non-engagement[49].

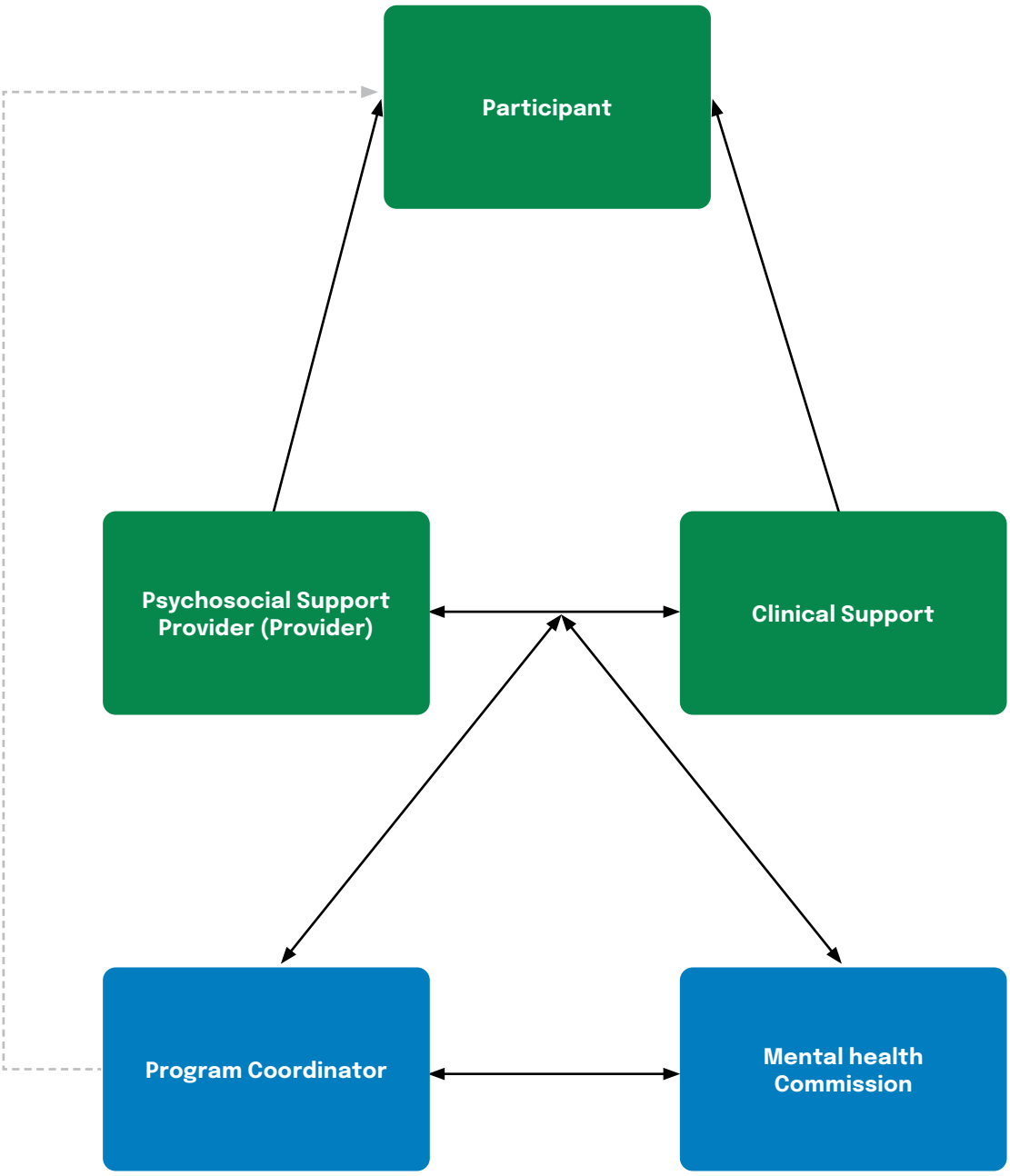
Date of submission:	
Participant's name:	
Bandwidth:	
Support organisation:	
Date organisation last had contact with the participant:	
Details of issues/ barriers to engagement experienced (include details on timelines, events and actions leading to disengagement):	
Strategies for engagement and proposed next steps:	

48 Please note this form is not required for participants who are living well in the community and no longer require the previous level of support. This can be captured at the end of plan reporting.

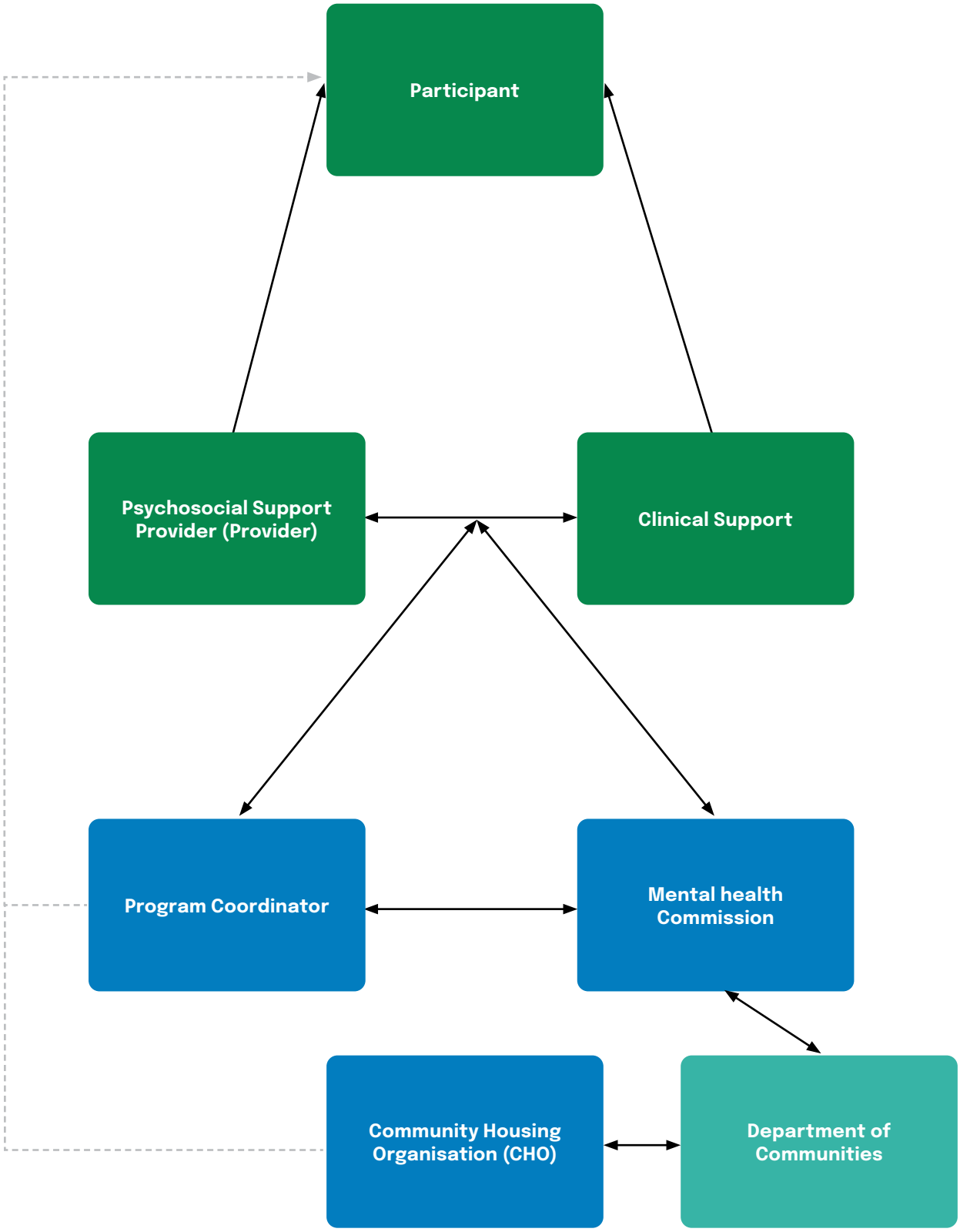
49 Limited or non-engagement is considered when there have been three consecutive scheduled

Appendix F - ICLS collaborative partnerships

Standalone package of support



Support linked to housing



Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

GPO Box X2299,
Perth Business Centre
WA 6847

Level 1, 1 Nash Street,
Perth, WA 6000

T (08) 6553 0600

mhc.wa.gov.au