BUILDING BETTER LIVES FOR YOUNG PEOPLE IN NURSING HOMES

SUMMER FOUNDATION

TRANSITIONAL HOUSING AND SUPPORT IN AUSTRALIA FOR PEOPLE WITH DISABILITY: ENVIRONMENTAL SCAN

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The Summer Foundation is a not-for-profit organisation, established in 2006, that aims to change human service policy and practice related to young people in nursing homes. Our mission is to create, lead and demonstrate long-term sustainable changes that stop young people from being forced to live in nursing homes because there is nowhere else for them.

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EXECUTIVE SUMMARY

Objective. Transitional services that bridge the gap between hospital and community can be effective in maximising the potential of people with disability and reducing admissions of young people to residential aged care (RAC). The purpose of this environmental scan was to scope current and recent transitional housing and support options suitable for people with disability and complex needs, and identify gaps in the system in order to provide an evidence base potential solutions. This report provides details of transitional housing and support options that fit the criteria of being 'home like' and are currently available across Australia. Details of options that were once available or are being phased out, primarily in response to the rollout of the National Disability Insurance Scheme (NDIS), are also provided.

Methods. A one-hour workshop was conducted to gather ideas regarding the broad range of transitional housing and support options that would ideally be available and beneficial for people with complex support needs exiting the health system and returning to community living. After this, a desktop scan, using an advanced Google search, was conducted to explore the transitional housing and support options that are currently available, or have until recently been available, across Australia for people with complex support needs who are exiting the hospital system and returning to community living. This search was limited to content dated from 2013 to 2018. Additional transitional housing and support options were identified by interviewing key contacts. When possible, additional interviews were conducted with knowledgeable key contacts representing the services described in this report.

Results. The workshop identified a range of potential alternative transitional housing options that could be accessed using flexible funding packages. It also identified a variety of transitional support options for people with complex support needs, including paid supports and informal supports.

The desktop scan and interviews identified 24 transitional housing and/or support services available in Australia. These consisted of 9 residential services and 9 non-residential services; an additional 6 services provided both residential and non-residential services, which varied depending on service structure and client needs. Out of these, only 1 service was specifically designed to provide culturally-relevant transitional support to Indigenous people.

The recent rollout of the NDIS has impacted how supports and housing are provided to people with disability, and thus how some services are funded. It was seen that 19 of the 24 services identified in this report received funding that was likely to continue post NDIS rollout, while the remaining 5 services were unlikely to continue being funded post NDIS rollout, or had already ceased operating. This latter group of services were included as part of this environmental scan because they provide useful examples of transitional services that have been successful in the past, and thus could be informative for development of new services within the context of the NDIS.

Conclusions. In the past, a range of transitional housing and support options have been developed in different jurisdictions in Australia to assist with the process of returning to community living after being discharged from hospital. There are pockets of good practice and effective transitional service across Australia. The Australian Government has committed to a new target of no people under 65 entering aged care by 2022. A national network of transitional services that maximise the potential of people with acquired disability has the potential to significantly reduce admissions of young people into RAC. A range of service options and flexible funding packages would enable people with disability to return to community living and avoid RAC.

Improved discharge planning and the timely receipt of NDIS funded supports alone is likely to improve the transition from hospital to community living for many people. However, for some people, a move straight from an acute or subacute health setting or residential aged care facility to community living will be too great a step and be, therefore, unlikely to succeed. Transitional housing and support services which embed opportunities for rehabilitation over an extended time frame within community settings would enable some people to optimise their potential. These services would enable NDIS participants to maximise their independent living skills and abilities, live in the least restrictive environment and, over the longer term, reduce life time support needs and costs.

CONTENTS

ABBREVIATIONS

24/7	24 hours a day, 7 days a week
ABI	Acquired Brain Injury
ACL	Assisted Community Living
AIHW	Australian Institute of Health and Welfare
BIRP	Brain Injury Rehabilitation Program
DHHS	Department of Health and Human Services
DSP	Disability Support Pension
FIM	Functional Independence Measure
HIS	Healthscope Independence Services
ISCRR	Institute for Safety, Compensation and Recovery Research
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
RAC	Residential Aged Care
SAIF	Shared Accommodation Innovation Fund
SCI	Spinal Cord Injury
SIL	Supported Independent Living
SIP	Spinal Interim Package
SPOT	Spinal Outreach Team
SSA	Shared Supported Accommodation
SSCIS	State Spinal Cord Injury Service
TAC	Transport Accident Commission
TBI	Traumatic Brain Injury
TCP	Transition Care Programme
TLC	Transitional Living Centre
TLP	Transitional Living Program
TLS	Transitional Living Service
TRP	Transitional Rehabilitation Program
TSU	Transitional Support Unit
VSCS	Victorian Spinal Cord Service

1. INTRODUCTION

People with a newly acquired disability typically commence their journey through the health system within acute services, until medical stability has been achieved. Once they progress to subacute services, a period of rehabilitation is provided to optimise recovery and prepare patients for successful discharge into the community. For most patients with less complex needs, this process is relatively straightforward since they can often return to their own home and access appropriate community-based support. However, for those with more complex support needs, the patient's home in the community may not be suitable as a discharge destination unless significant home modifications are completed or, in some cases, alternative housing with high levels of support needs may need to be found.

Sustaining an acquired brain injury often results in significant physical, emotional, cognitive and behavioural changes that impact upon a person's ability to participate in activities that were possible prior to the injury (Chua, Ng, Yap, & Bok, 2007; Colantonio et al., 2004; McCabe et al., 2007). The period of rehabilitation provided in subacute services may not be sufficient to allow those with ongoing complex support needs, such as those with acquired brain injury, the opportunity to improve their skills to the point where they are able to successfully live in the community, even with support. For these people, a period of transition between hospital and home is required.

In the context of acquiring a new disability, sudden illness or injury, major transitions are acknowledged to occur both at the time of admission to hospital and later at the time of discharge from hospital (Turner, Fleming, Ownsworth, & Cornwell, 2008). The transition from hospital to home is frequently described in the literature as being a stressful period for the person who has acquired the disability as well as their support network; thus, the importance of providing well-coordinated planning and support at this time is critical (Turner et al., 2008). In a follow-up study of people with a stroke and their close others during the first month after they had returned to community living following hospital discharge, Rittman and colleagues found that there was often a disruption of temporal order brought about by a necessary change in routines due to changes in functional capacity (Rittman et al., 2004). This led to the person with stroke having the perception that time had slowed down, bringing about a need to create new routines to prevent a sense of being idle. This period was also a time when limits were tested and a new sense of self emerged. Complicating this, as self awareness increases for people with brain injury following discharge, rates of depression tend to increase (Fleming, Winnington, McGillivray, Tatarevic, & Ownsworth, 2006).

Furthermore, close others of people with stroke were found to have high rates of depression both before discharge and at 6 - 10 weeks post discharge (King et al., 2001). Given these findings related to the complexity of the transitional period from hospital to home, it is clearly an important time during which support for the person with disability and their close others is required.

Unfortunately, across Australia there are many reported instances of people with complex support needs having extended lengths of stay within subacute hospital services and, in some cases, people are inappropriately discharged into residential aged care (RAC). In Australia, the Department of Health reported that there were 5905 younger people aged under 65 years living in RAC as at September 2018 and the Australian Institute of Health and Welfare (AIHW) reported that from 2017-2018, more than 2500 people under 65 years old were admitted to aged care (Australian Government Department of Social Services, 2019). Some of the reasons commonly cited include: a suitable discharge destination was unable to be identified or was unavailable; there were delays in receiving funding to enable independent living in the community; there was a need to await completion of home modifications and/or necessary equipment; and difficulties were experienced securing appropriate levels of support from appropriately trained support workers within the community.

A review of the literature revealed that transitional housing or Transitional Living Service (TLS) programs are described as fulfilling two functions. The first function is to bridge the gap between hospital and home/community living, while the second function is to provide ongoing support to facilitate the continued acquisition of skills required for successful community living following discharge from inpatient rehabilitation (Turner et al., 2008). Some transitional housing and support options are available across Australia and these include a range of TLS programs. They are defined as 'live in' residential programs that are part of the post-acute rehabilitation pathway (Potter, Sansonetti, D'Cruz, & Lannin, 2017), are generally 'home like', and are located in proximity to community facilities such as shops and recreational facilities (Turner et al., 2008). This is in contrast to rehabilitation provided within hospital-based subacute settings, which does not usually provide opportunities to access the community or home-like facilities, thereby limiting the practice of activities of daily living necessary for independent community living such as shopping, using public transport, cooking and participation in leisure activities.

Some people with acquired disability need access to transition housing and support services that can successfully bridge the gap between health and disability services. At present, some services are seen as part of rehabilitation and are funded by health; in contrast, other services are seen as the responsibility of the National Disability Insurance Scheme (NDIS) because they involve supports that lead to incremental gains over time post-health rehabilitation. The purpose of this environmental scan was to scope current and recent transitional housing and support options, and identify gaps in the system in order to provide an evidence base for potential solutions. Hence, this report provides details of transitional housing and support options that fit the 'home like' criteria and are currently available across Australia. Details of options that were once available or are being phased out, primarily in response to the rollout of the NDIS, are also provided.

Transitional housing and support programs cater to a wide range of disability types. These programs may provide transitional housing, transitional support, or a combination of the two. Many of the transitional housing and support options described in this report are designed to cater for people with acquired brain injury, including both traumatic and non-traumatic brain injury, which is not surprising given the significant impact of brain injury on people's lives and the ongoing support needs of this group. However there are also a range of transitional services detailed within this report that are tailored to the needs of people with spinal cord injury (SCI), progressive neurological diseases, intellectual disability and mental health issues.

2. METHODS

The environmental scan included three phases: (i) a focussed workshop that was used to gather internal perspectives on a range of transitional housing and support options; (ii) a desktop scan of publicly available information available on transitional housing and support options; and (iii) semi-structured interviews with key informants to provide additional information and fill in gaps following the desktop scan.

2.1 Phase 1: Workshop to Gather Internal Perspectives

The first phase of the project centred around a one-hour workshop that was conducted to gather ideas regarding the broad range of transitional housing and support options that would ideally be available and beneficial for people with complex support needs exiting the health system and returning to community living. The lead researcher (DW) and research assistant (SM) facilitated the workshop. Three other authors (GH, CB and VM) attended the workshop to provide key knowledge of transitional housing and supports that they had gained from many years of experience working with clients within health settings across Victoria and New South Wales who were transitioning back to community living.

To prepare for the workshop, all attendees were sent the following scenario for their consideration three days prior.

> In 2024 you sustain a severe traumatic brain injury (TBI) from an unprovoked assault on your way to a train station. You are learning how to swallow, talk and reuse your left arm. You are a wheelchair user. It is the start of winter and shaping up to be the worst flu season in 10 years – there is enormous pressure for hospital beds. You are almost finished your inpatient rehabilitation and need to be discharged from hospital in one week. You cannot be discharged straight home because your home is not wheelchair accessible – you cannot use the toilet or shower. It will take at least 6 months to finalise the home modification designs, get quotes, funding approval and implement the modifications. May be more like 8-10 months.
>
> What are ALL the possible options that you would like to be available to you in 2024?

During the workshop, attendees were asked to individually write down all of their ideas in response to the above scenario. Once this process was completed, the group came together to compare ideas and discuss responses in more detail.

A voice recorder was used to record the entire workshop and the audio recording was used to summarise the content discussed. This content was arranged into two categories: (i) types of transitional housing; and (ii) types of transitional supports; outlined in Sections 3.1 and 3.2, respectively. A summary of the workshop was sent to all attendees and they were invited to provide feedback.

2.2 Phase 2: Desktop Scan

The second phase of the project involved a desktop scan of publicly available information that aimed to explore the transitional housing and support options that are currently available, or have until recently been available, across Australia for people with complex support needs who are exiting the hospital system and returning to community living. Relevant literature already known to the lead researcher (DW) was included, along with grey literature, relevant websites and other online resources that were searched for via the internet using an advanced Google search. Searches were limited to content written in English, dating from 2013 to 2018, and published within the region of Australia.

The following search phrases were used:

- Transition package
- Transition options
- Transition funding
- Transition facility
- Transition housing
- Transition accommodation
- Transition living

2.3 Phase 3: Qualitative Interviews

The final phase of the project conducted semi-structured interviews with a variety of informants. Initially, several interviews were conducted with key contacts known to the lead researcher (DW) who had specific knowledge about a particular transitional housing and/or support option, or a broader understanding of transitional housing and support options that were available. These interviews helped to identify additional services that had not been detected during the desktop scan.

For each transitional housing and/or support option identified through those interviews or the desktop scan, and described in this report, an effort was made to identify a knowledgeable key contact representing the service who could be interviewed. These subsequent interviews were used to fill gaps in understanding and confirm the accuracy of information obtained from the Google search.

A total of 22 interviews were conducted either face-to-face or over the phone, ranging in length from 30 to 60 minutes. The informants who were interviewed, their affiliation and role, are listed in the Appendix. Interviews were recorded using a voice recorder; the audio recording was subsequently used to extract relevant information for the report. After the written description of the service was completed, it was sent to the interviewee for review.

3. RESULTS

3.1 Types of transitional housing

While there are many formal programs that provide different types of transitional housing (see Sections 3.3 and 3.4), there are other potential approaches that could provide a similar solution. During the workshop, examples of alternative transitional housing options that could be accessed using flexible funding packages, allowing people with complex support needs being discharged from the health system to return to their own community, were discussed. Suggestions included:

- Staying in an accessible serviced motel room close to the family home while home modifications were being completed
- Renting accessible accommodation in the private rental market or via mainstream online sites, such as Airbnb
- Completing minor home modifications to make a family member's home accessible, if able to be done quickly
- A portable bedsit located in the backyard or driveway
- A quick fitout of a double garage
- House swapping with someone in the community who had an accessible home
- Utilising an accessible granny flat in the community, similar to the idea of housing an exchange student, however this would instead involve housing a person with disability and their close other
- The person with disability selling their home and moving to a more accessible home
- The person with disability renting out part of their house while home modifications are completed, to offset the cost of renting accessible accommodation in their community in the interim

3.2 Types of transitional supports

Similar to the situation with transitional housing, as described above, there are many formal programs that provide a variety of transitional supports (see Sections 3.3 and 3.4); however, there are other options that can provide similar support. Potentially suitable transitional support options for people with complex support needs being discharged from hospital and returning to community living were also discussed during the workshop. This included accessing a variety of paid/formal supports and informal supports, as described below.

Paid/formal transitional supports

- A support coordinator with expertise in the relevant area of disability, an understanding of the broad range of potential supports, and knowledge/experience completing the necessary processes to secure these supports (e.g. housing plans)
- High quality contextual person-centred community/home based rehabilitation from experts in transitional rehabilitation, with allied health input, throughout the transitional phase
- Training and trialling of support workers as early as possible post injury to avoid delays in receiving necessary supports when ready for discharge into the community from a health setting
- Assistive technology, which is defined by the World Health Organisation as "any device or system that allows individuals to perform tasks they would otherwise be unable to do or increases the ease and safety with which tasks can be performed"[1]
- Support to participate in the community
- Continuation of rehabilitation within the transition phase as necessary
- Proactive home-based nursing/health services, based on health needs specified in an ongoing discharge plan

[1] The NDIS provides funding for assistive technology, adhering to the World Health Organisation definition of this support: **https://www.ndis.gov.au/media/204/download**
Easy English booklet: **https://www.ndis.gov.au/media/298/download**

Informal transitional supports

Sometimes flexible funding can be utilised in combination with short-term informal supports for an individualised transitional option. Workshop participants identified a range of ways that social support networks have assisted people to transition back to community living. These included:

- Adult child may take 6 months off from university study to provide support
- Partner may take time off work to provide support
- People around the person with disability, i.e. neighbours, family and friends, have their capacity developed to provide their informal support

3.3 Transitional housing and support services in Australia

Information obtained from the desktop scan and interviews was used to detail transitional housing and support services available in Australia. A total of 24 services were identified, each of which is described in detail in Sections 3.4 and 3.5.

There was considerable variation between the transitional services in terms of the support provided, however the following categories emerged:

- 9 residential services provided live-in housing and support, but did not provide additional community-based or in-home support. The facilities commonly were single-occupancy units or houses that had been specifically designed for people with complex needs, but could also be shared facilities. These transitional services usually provided 24/7 support, with many also having a team of allied health professionals to provide goal-directed rehabilitation. Most services did not provide ongoing support following discharge to home.
- 2 residential services were primarily focussed around live-in housing and support, but also provided separate in-home and/or community-based supports for some clients. 1 of these services could also provide ongoing community-based support following discharge to home.
- 3 services provided both residential services and non-residential services; these services were structured so that there were different pathways for support, based on need. These services tend to be structured so that clients could switch between residential and non-residential pathways if required.

- 1 service was primarily focussed around provision of community-based supports, where allied health professionals provided skill-based rehabilitation. However, if clients normally resided outside of the radius of service (e.g. remote areas), a limited number of live-in accessible housing options were available within the support radius.
- 9 services did not provide any form of live-in housing support, providing only in-home or community-based supports. The type of supports provided varied considerably between services, including home modifications, grants for equipment purchases, ongoing rehabilitation, case management, or personal support.
- Only 1 service was specifically designed to provide culturally-relevant transitional support to Indigenous people; this service provided live-in housing and support.

The location of transitional housing and support services also varied considerably. The Transition Care Programme (TCP) is a federally-funded service available in all Australian states and territories that provides short-term care and services intended for people aged 65 years and over after they leave hospital. As of 30 June 2019, there were 131 people aged under 65 years using a TCP funded by aged care (Australian Institute of Health and Welfare, 2019). The availability of other services was inconsistent. There were 3 services identified in New South Wales, 10 services in Victoria, 4 services in Queensland, 2 services in Western Australia and 1 service in South Australia. There was also 1 multi-state service that served New South Wales, Victoria and the Northern Territory, and 2 nationwide programmes in addition to the TCP. In contrast, no additional transitional services were identified in the Australian Capital Territory or Tasmania.

Another noteworthy aspect relates to the funding of services, particularly in the current funding context since the rollout of the NDIS, which is impacting how supports and housing are provided to people with disability, and thus how some services are funded. Most (79%) services detailed in this report received funding that was likely to continue post NDIS rollout, allowing for the fact that some modifications to service provision or business model may occur (see Section 3.4). In contrast, the remaining 5 services were unlikely to continue being funded post NDIS rollout, or had already ceased operating (see Section 3.5). This latter group of services were included as part of this environmental scan because they provide useful examples of transitional services that have been utilised in the past, and thus could be informative for development of new services within the context of the NDIS.

3.4 Transitional services in Australia that are expected to continue

3.4.1 New South Wales Service: NSW Brain Injury Rehabilitation Program (BIRP)

State	New South Wales
Location	Tamworth, Ryde, Newcastle, Goulburn, Albury/Wagga, Liverpool, Bathurst and Westmead
Organisation	NSW Health
Email	info@health.nsw.gov.au
Website	https://www.aci.health.nsw.gov.au/networks/brain-injury-rehabilitation/about/brain-injury-rehabilitation-program
Service type	Residential and non-residential
Service status	Service is currently active and likely to continue
Description of service	The Transitional Living Program (TLP) offered by Brain Injury Rehabilitation Program (BIRP) and funded by NSW Health is considered part of the rehabilitation pathway. A report by the Agency for Clinical Innovation described the TLP as offering three distinct clinical pathways (Agency for Clinical Innovation, 2016): **Transitional living** is a residential program for people who are not ready to transition from hospital to living in the community. It offers a rehabilitation focus by improving adjustment to life with TBI while building independent living skills and participation in the community. **Community resettlement** is a pathway whereby the TLP and rehabilitation services in the community work together to provide rehabilitation for clients. Clients usually only need to access the TLP for 1 to 2 weeks to complete assessments, establish goals and be linked to local services. Sometimes clients can revisit the TLP for a brief intensive burst of therapy or to have their home-based programs reviewed and modified. **Community management** is available for clients who have been living in the community prior to admission to the TLP, often due to being discharged directly to home from hospital or an inpatient rehabilitation facility. A change in circumstance, an event or decision relating to change of living situation can trigger admission to the TLP, during which goal directed assessments are completed followed by intensive living skills training.

Population served	The TLPs primarily cater for people with a brain injury who meet the following criteria: • Have a moderate to severe brain injury from trauma • Aged 16-65 years • Live in the catchment area of their local TLP Most people are reported to be referred by the inpatient BIRP or acute hospital when they are medically stable and able to do all or most of their own self-care. The timing of the admission is also described as being dependent on recovery and rehabilitation needs.
Supports available	Intensive multidisciplinary support is provided within a therapeutic environment to assist clients to achieve their rehabilitation goals. As programs are individualised, the client's specific needs will determine the composition of the multidisciplinary team. There is a particular focus on supporting clients to increase their skills in everyday situations, develop and achieve personal goals, reduce impairments and develop strategies for managing impairments arising from brain injury at home and in the community, as well as working on educational and employment goals. Intervention is provided in individual and group sessions 5 days per week, with clients having the option to return to their own home on weekends to reconnect with their families and the community (Agency for Clinical Innovation, 2016). It is reported that there is less support at the TLP overnight, which means that an allied health assessment is completed prior to admission to the TLP to assess suitability for the program.
Typical length of stay or duration of package	The mean length of stay across all TLPs between 2009 and 2011 was reported to be 66.5 days. However, it should be noted that there was variation in the length of stay between TLPs, with the median length of stay in the Albury TLP being 121.5 days compared to a median length of stay in the Tamworth TLP of 15 days.

Outcomes	Outcomes for clients accessing the TLP's 3 clinical pathways were evaluated using a standardised outcome measure, the Mayo-Portland Adaptability Inventory iv (MPAI – 4). This tool allows classification of functioning into 5 categories, which indicate the level of disability. Clients' functioning was classified using the MPAI – 4 at both admission and discharge and showed that 59% of clients across all TLP clinical pathways had a reduced level of disability at discharge, measured by change of category. Of the three clinical pathways, the transitional living pathway produced the greatest change with 64.8% of clients categorised as having reduced disability at the time of discharge (Agency for Clinical Innovation, 2016).
How is the service funded?	The TLP is considered part of the rehabilitation pathway and is funded by NSW Health. If people meet insurance scheme criteria then payments from the relevant insurer such as icare or a private health insurance fund will be made to NSW Health on their behalf.
What is the cost of the service?	The cost of the daily bed fee in a TLP is currently $886 per day.
Funding status	It is anticipated that the TLP will likely exist post NDIS rollout, as it is seen by health as part of the rehabilitation pathway and rehabilitation is the responsibility of health. However, the TLP model may need to adapt in response to the NDIS.
References	Agency for Clinical Innovation. (2016). *Client and service outcomes for transitional living programs in the NSW Brain Injury Rehabilitation Program. July 2009-June 2011. Evaluation Report.* Chatswood, NSW. https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/326439/Client_and_service_outcomes_for_transitional_living_programs_report.pdf Agency for Clinical Innovation. (2016). *Transitional Living Programs. NSW Brain Injury Rehabilitation Program*. https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/338400/TransitionalLivingFlyer.pdf

3.4.2 New South Wales Service: Lifestyle Support Options

State	New South Wales
Location	Multiple locations across Metropolitan Sydney, New South Wales
Organisation	NSW Health, Royal Rehabilitation Hospital in Ryde
Email	info@royalrehab.com.au
Website	http://www.royalrehab.com.au/lifestyle-support/supported-accommodation-services/
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	The Lifestyle Support Options program includes several shared supported accommodation (SSA) settings across the Sydney metropolitan area, which may be accessed on a long-term basis or for respite or short-term stays when vacancies occur.
Population served	Lifestyle Support Options aims to assist people who need ongoing accommodation and support once their inpatient rehabilitation pathway has been completed. People supported include those with high and complex support needs, such as acquired disabilities (brain injury, spinal injury), developmental disabilities (intellectual, autism spectrum disorder) and other degenerative neurological disabilities. People with extensive additional needs, including complex health care, co-existing psychiatric disability or significant behaviours of concern, are also supported.
Supports available	Intensive 24/7 support is available.
Typical length of stay or duration of package	Varies depending on individual need.
Outcomes	*Information not available*

How is the service funded?	Clients accessing Lifestyle Support Options receive funding from a variety of sources including compensable bodies such as icare; non-compensable clients are reported to be primarily funded by the NDIS. Clients are required to pay a percentage of rent and living expenses as well as a service fee to reside in an SSA. It is stated that to access the service, clients require funding approved for personal care/support services and community access services.
What is the cost of the service?	*Information not available*
Funding status	It is anticipated that this service will continue to be offered post NDIS rollout.
References	Royal Rehab – The Rehabilitation & Disability Support Network. (2018). *Supported Accommodation Services.* http://www.royalrehab.com.au/lifestyle-support/supported-accommodation-services/

3.4.3 New South Wales Service: NSW Spinal Outreach Service

State	New South Wales
Location	Statewide
Organisation	Royal Rehab Hospital
Email	*Not available*
Website	https://www.royalrehab.com.au/rehab-services/spinal-injury-rehabilitation/spinal-outreach-service/
Service type	Non-residential
Service status	Service is currently active and likely to continue
Description of service	Based at the Royal Rehab Hospital in Ryde, the NSW Spinal Outreach Service is designed to support people with spinal cord injury (SCI) and their close others to adjust and live successfully in the community following discharge from hospital, as well as avoiding medical complications. Local clinicians across New South Wales are also supported to provide appropriate supports.
Population served	The metropolitan service is available to people who have had a recent SCI and are being discharged from a spinal unit in the area contained within the Southern Highlands, Wyong and Lithgow catchments. People may also receive assistance if they have a previous SCI and are readmitted to a spinal unit or if they have an SCI and are transferring from a paediatric service. People living in rural locations who have been admitted to a NSW spinal unit are eligible to access the rural service, as are people with an SCI who require specialist medical and multidisciplinary reviews and clinicians requiring specialist education, support and advice.
Supports available	The metropolitan service provides multidisciplinary support from doctors, nurses, physiotherapists, occupational therapists and social workers. Education is also provided to community clinicians and there is counselling and advocacy through agencies that assist with employment, financial funding, relationships, vocations and mental health. Access to information and resources is available within the State Spinal Cord Injury Service (SSCIS). The rural service offers specialist medical and multidisciplinary clinics on an annual basis to regional and rural areas including, but not limited to, Coffs Harbour, Ballina, Tamworth, Dubbo, Wagga Wagga, Moruya and Bega. People with SCI who reside in these areas are informed about the clinics ahead of time and can request support.

	Priority is given to those who have been recently discharged from hospital or are experiencing difficulties that could contribute to medical complications unless attended to. Follow up is then provided remotely and/or via the local rural coordinator for 3 to 4 months following the clinic. The Spinal Outreach Service also provides education and clinical support to clinicians and service providers covering topics such as general health maintenance, skin, pain, sexuality and fertility, and upper limb management.
Typical length of stay or duration of package	The metropolitan service provides support to people with SCI for a period of up to 12 months following discharge into the community. In rural areas, people can continue to request support each time a clinic is being run within their region, however due to time limitations they will only receive support if their needs are judged to be a priority over others who may have also requested support.
Outcomes	In the 2017-2018 financial year, 98 clients were referred to the metropolitan service and 117 clients were assessed in the rural clinics. The rural Spinal Cord Injury Service provided education to 201 health professionals in 9 different locations across New South Wales.
How is the service funded?	NSW Health provides recurrent funding for the Spinal Outreach Service through Northern Sydney Local Health District.
What is the cost of the service?	*Information not available*
Funding status	It is not anticipated that there will be any change to the source or amount of funding that the Spinal Outreach Service receives in the near future.
References	Royal Rehab - The Rehabilitation & Disability Support Network. (2018). *NSW Spinal Outreach Service.* https://www.royalrehab.com.au/rehab-services/spinal-injury-rehabilitation/spinal-outreach-service/

3.4.4 Victorian Service: The Acquired Brain Injury Transitional Living Service (TLS)

State	Victoria
Location	Statewide, but based in Caulfield, Melbourne
Organisation	Alfred Health
Email	abicommunity&tls@alfred.org.au
Website	https://www.alfredhealth.org.au/services/acquired-brain-injury-transitional-living
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	The Acquired Brain Injury Rehabilitation Centre is described as offering a continuum of care, including 42 inpatient rehabilitation beds at Caulfield Hospital, the TLS and services for people with acquired brain injury (ABI) living in the community. The TLS is located a short walk away from the main Caulfield Hospital campus in a purpose-built home that has been designed to provide a home-like environment for up to 4 people at a time, allowing further development of independent living skills before transitioning back into the community.
Population served	The TLS provides a statewide service for people with severe to catastrophic brain injury who have complex care needs with lifelong consequences and will need an extended period of rehabilitation (3 to 24 months). To be eligible for the TLS people must meet the following criteria: • Have an ABI that is non progressive • Goals are identified to develop independent living skills • Goals for rehabilitation have been identified that can be best managed in a home-like environment • Medically stable • Can manage own personal care, mobility & transfers with minimal prompts • Can manage own continence • Can manage own medications • No behavioural issues that cannot be managed within staffing limits • Agreeable to house rules and consequences for rule breaking • Have a confirmed discharge destination within Victoria

Supports available	Staff working in the community team, including the TLS, are led by a community program coordinator and rehabilitation physician. The team consists of allied health staff in the disciplines of occupational therapy, psychology, physiotherapy, speech pathology and social work. This team of allied health therapists supervises the team of residential care workers and allied health assistants who provide support for people in the TLS in the evenings, over the weekends and overnight. A range of domestic and community living skills are targeted by the TLS, while continuing to maximise mobility, communication, self care and behaviour.
Typical length of stay or duration of package	It is reported that there is significant variability in the length of stay, as the program is individualised. On average however, the length of stay is usually between 8 to 12 weeks.
Outcomes	An evaluation of processes was undertaken during the first year of operation of the Alfred Health Acquired Brain Injury Rehabilitation Centre, between 8/9/2014 and 31/12/2015 (Lannin, 2016). The evaluation was completed by Natasha A. Lannin and was funded by the TAC, through the Institute for Safety, Compensation and Recovery Research (ISCRR). The evaluation examined data relating to patient demographics, patient and family satisfaction, process of care information, and recommendations for program improvement from both staff and consumers. Findings within each of these domains are detailed in that report. Functional Independence Measure (FIM) scores, which are a basic indicator of disability severity, were recorded for patients at both admission and discharge. Total FIM scores, which includes motor and cognitive functional independence, can range from 18-126; a score of 18 indicates the lowest level of independence, while 126 indicates the highest level of independence (Australasian Rehabilitation Outcomes Centre, 2018). At admission to the TLS, patients were described as having significant care requirements with a mean total FIM score of 56.2 (Median 54; SD 33.7; Range 18-126). When patients were discharged, they had a mean total FIM score of 91.3 (Median 111; SD 38.4; Range 18-126), which indicates the need for approximately 1-2 hours of support each day from another person to perform basic activities of daily living. However, 20% of all discharged patients had a total FIM score of <20 at the time of discharge.
How is the service funded?	Caulfield Hospital is part of Alfred Health and the Acquired Brain Injury Rehabilitation Centre receives public funding from the Department of Health and Human Services (DHHS) in Victoria.

What is the cost of the service?	The daily bed rate, reported in April 2019, was $756 per day and fully funded by the DHHS in Victoria, with no personal cost to the clients of the TLS. There is also reported to be one bed in the TLS which is fully funded by the TAC.
Funding status	Future options for funding streams are reported to have been considered at a senior level since the rollout of the NDIS, however no changes have been put in place as yet. It is expected that the TLS will continue to be funded by the DHHS and TAC into the foreseeable future.
References	Alfred Health. (2019). *Acquired Brain Injury Transitional Living.* https://www.alfredhealth.org.au/services/acquired-brain-injury-transitional-living Gill, L. (2011). *Acquired Brain Injury Rehabilitation Model of Care Project Report.* Melbourne, Australia. Lannin, N. A. (2016). *Process-ABI: Evaluation of the processes of developing a statewide specialist severe ABI rehabilitation service. Research report 108-0716-R01.* https://research.iscrr.com.au/__data/assets/pdf_file/0005/681350/process-abi-evaluation-of-developing-specialist-severe-abi-rehabilitation-service.pdf Summer Foundation. (2015). *Senate Inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Blackburn, VIC: Summer Foundation Ltd. https://www.summerfoundation.org.au/wp-content/uploads/2015/11/Summer-Foundation-Senate-Inquiry-Submission_lo.pdf

3.4.5 Victorian Service: Epworth Transitional Living Centre (TLC)

State	Victoria
Location	Thornbury, Melbourne
Organisation	Epworth Health Care
Email	tlc@epworth.org.au
Website	https://www.epworth.org.au/Our-Services/rehabilitation/Pages/transitional-living-centre.aspx
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	Located within a mainstream residential setting, the Epworth TLC consists of a 4-bedroom house, 3 self-contained units and an office area for staff mixed with other mainstream units. It is reported that an additional self-contained unit will become available at the existing site in the near future. The program is aimed at assisting clients who want to improve their skills to complete activities of daily living such as cooking, cleaning, shopping and paying bills, within a home-like environment, to prepare for independent living in the community. Two of the beds in the units are reserved for non-compensable clients.
Population served	The TLC is for people with acquired brain injury, however is not suited to people who require extended periods of rehabilitation, people who are very low functioning, or those with ongoing substance abuse issues since the TLC is a drug and alcohol-free site. Residents at the facility also need to be able to mobilise and toilet independently and manage without support for up to 4 hours at a time if necessary. Many clients are referred to the TLC directly from rehabilitation services, while others have been living in the community with family and friends and have the desire to become more independent. For some people, their disability is newly acquired, while others have been living with their disability for many years. Five beds are specifically set aside for clients in receipt of compensation, including insurance from the TAC and Worksafe. Two beds are allocated to clients who are non-compensable and are funded by the DHHS in Victoria.

Supports available	During the day, clients are provided with support from a specialist team consisting of staff with qualifications in occupational therapy, social work, psychology and allied health assistants. Due to the physical set up of the TLC, the support is delivered in a 'real life' context where clients have the opportunity to encounter issues and problem solve solutions in preparation for their transition to independent living in the community. The specialist team provides assessment, training, supervision and facilitation of independent living skills necessary for successful transition back into the community. One allied health assistant is available on-site overnight to provide support as required; on weekends allied health assistants are also available to provide support.
Typical length of stay or duration of package	Clients are able to stay at the TLC for up to 12 months, however the average length of stay is reported to be approximately 5 to 6 months.
Outcomes	While the outcomes of the service have not been independently evaluated, data has been collected by the service itself and presented at conferences. This data reports that when compared to the time of admission, at discharge there are large increases in the percentages of people completing a range of activities of daily living. The data also reports that 77% of residents have been recorded as living independently following discharge from the TLC.
How is the service funded?	The Epworth TLC is primarily funded by the TAC of Victoria and Worksafe. The two spaces reserved for non-compensable clients are funded by the DHHS in Victoria.
What is the cost of the service?	There is no cost to the residents as the bed fees are covered by DHHS for non-compensable clients or by the insurer for compensable clients.
Funding status	The funding for compensable clients is secure and will continue; however, since the introduction of the NDIS, Epworth TLC has been negotiating with the National Disability Insurance Agency (NDIA) and DHHS regarding how the two non-compensable beds will be funded in the future. Negotiations are reported to be ongoing.
References	Epworth HealthCare. (2012). *Transitional Living Centre.* https://www.epworth.org.au/Our-Services/rehabilitation/Pages/transitional-living-centre.aspx Gill, L. (2011). *Acquired Brain Injury Rehabilitation Model of Care Project Report.* Melbourne, Australia: Alfred Health.

3.4.6 Victorian Service: Spinal Interim Package (SIP)

State	Victoria
Location	Statewide
Organisation	Policy and Planning Branch, Health and Wellbeing, Department of Health and Human Services, Victoria
Email	sip@austin.org.au
Website	*Not available*
Service type	Non-residential
Service status	Service is currently active and likely to continue
Description of service	The Spinal Interim Package (SIP) is a support package available to people with non-compensable spinal cord injuries who are Victorian Spinal Cord Service (VSCS) inpatients, used for the purpose of avoiding delayed discharge from hospital when they are awaiting allocation of NDIS planning or funding.
Population served	SIPs originated due to the issue of significant discharge delay as a result of inpatients waiting for the allocation of a Victorian DHHS funded Individual Support Package. The SIPs are currently evolving to be used with participants of the NDIS. To be eligible for the package, inpatients must be non-compensable, aged under 65 years and have sustained a new spinal cord injury. Inpatients must also be eligible for the NDIS based on permanency of disability, age, resident status and region, with access to the NDIS confirmed and a participant number allocated. There must be a suitable discharge destination identified with home modifications either commenced, or a plan for home modifications completed, and equipment necessary for discharge must have been assessed and recommended.
Supports available	Funding made available through SIP is flexible and could be used to pay for personal care supports, home modifications and/or equipment. Occasionally funding has been used to pay for accommodation if this is the barrier to returning to the community, however this needs to be time limited.
Typical length of stay or duration of package	The normal length of the package is for a maximum of 12 months; however, it is reported that there has been some flexibility around this, with some individuals receiving a SIP package for significantly longer periods of time.

Outcomes	Outcomes of SIP were examined and key findings were: • Length of time for discharge from hospital significantly reduced for VSCS inpatients following the introduction of SIP packages. In the 2009-2010 financial year, 153 days per case was recorded, while in the financial years from 2012-2014, 68 days per case was recorded. • Patient flow improved, with patients being discharged home in a timely manner with appropriate supports in place. • Community integration was enhanced, such that 75% of patients (n = 6) returned to work/student roles held before injury within 2 years of discharge. • Further gaps and inequities in the system were identified, which contribute to difficulties with patient flow.
How is the service funded?	The program is funded by the DHHS (Health) in Victoria through residual "Restorative Care" program funds (similar to the Transitional Care Program but not age limited). There is an allowance for approximately 4 people to receive packages at any one time.
What is the cost of the service?	Funding is provided at an average rate of $384 per package per day.
Funding status	Funding for the SIP program is continuing at the present time, however it is reported that ongoing funding for the program is not guaranteed and will continue to be reviewed, especially in the context of the NDIS and what it can provide.
References	G. Hilton, personal communication, February 4, 2019.

3.4.7 Victorian Service: Transitional Support Unit (TSU)

State	Victoria
Location	Narre Warren, Melbourne
Organisation	Monash Health
Email	tsu@monashhealth.org
Website	*Not available*
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	The TSU is a new purpose-built residential setting providing a total of 10 bedrooms with ensuites for single occupancy, and shared facilities including a shared living room, laundry, kitchen facilities and outdoor areas. Residents at the TSU require support to live in the community successfully, either following discharge from hospital or after previously living in the community but requiring further support.
Population served	Must be aged between 18 and 65 with a primary diagnosis of a mental health disorder and a confirmed co-existing intellectual disability.
Supports available	The TSU is staffed by a team of doctors, nurses, allied health and support workers, who help residents to identify goals and develop a treatment plan. As the overall focus of the program is to support residents to live successfully in the community, residents are assisted to increase skills and independence for performing a variety of activities of daily living such as managing medication, using public transport, budgeting and preparing meals. Support is also provided to learn how to manage behaviours, general mental and physical health, and assistance can be provided to residents to access the NDIS.
Typical length of stay or duration of package	The TSU is designed to accommodate residents for between 6 to 12 months, however the individual needs of residents will be taken into account and there may be some flexibility in length of stay.
Outcomes	The TSU is a new service provided by Monash Health and has only been operational since October 2018. Therefore, it is still too early to evaluate outcomes for residents who have utilised the TSU and re-entered the community.

How is the service funded?	The TSU receives funding from DHHS via Monash Health.
What is the cost of the service?	There is currently no cost to residents of the TSU. However, in the future a contribution towards rent will be required; this amount has not been confirmed.
Funding status	As the TSU is a new service and funded to be part of the Monash Health pathway, it is not anticipated that funding for the TSU will be impacted by the rollout of the NDIS.
References	ClarkeHopkinsClarke. (2019). *Monash Health Transition Support Unit.* https://www.chc.com.au/project/monash-tsu

3.4.8 Victorian Service: Royal Talbot Rehabilitation Centre Brain Disorders Program – "Step 2" Transitional Unit

State	Victoria
Location	Kew, Melbourne
Organisation	Austin Health
Email	BDPV@austin.org.au
Website	http://www.austin.org.au/bdp/step2/
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	The Step 2 Transitional Unit is a 3-bedroom house located at The Royal Talbot Campus of Austin Health at the top of a small hill, removed by a short distance from the main hospital, to create more of a home-like environment. Goals are individually tailored to clients' needs and clients are regularly encouraged to participate in activities that will assist their transition back into the community.
Population served	People with cognitive impairment and psychiatric or behavioural problems who are aged between 16 - 64 years old may be eligible for admission to the unit. It is reported that approximately 80% of people admitted to the unit are already living in the community and require assistance to improve their ability to perform activities of daily living so they can continue to live in the community. The remainder of admissions are inpatients who are discharged directly into the unit, however a discharge destination in the community must be identified prior to admission to the unit. It is reported that people with moderate to high levels of aggression and/or substance abuse issues are not suitable for admission due to the staffing profile.

Supports available	There is support available at the unit 24/7 from nursing staff who have experience working with people who have cognitive impairment and psychiatric disability. The program is further supported by a specialist ABI GP consultant, psychiatric registrar, consultant psychiatrist, social worker and neuropsychologist. Residents at the Step 2 Transitional Unit receive support from staff in the areas of case management, assessment, training, supervision and improving activities of daily living, including hygiene, household chores, meal preparation, budgeting and shopping. Attention is also given to socialisation, communication, increasing independence levels and attempting to strengthen links to formal and informal networks in the community.
Typical length of stay or duration of package	The length of stay varies depending on the individual client's needs; however, it is reported to generally be between 3 to 6 months.
Outcomes	No reports containing outcomes for clients utilising the unit are publicly available. However, the Health of Nations Outcome Scale (HONOS) is used to assess clients' wellbeing at admission and discharge; this information is recorded and reported back to the government department that funds the program.
How is the service funded?	The unit receives funding from the mental health branch of the Victorian State Government.
What is the cost of the service?	It was reported in April 2019 that the out of pocket cost of the service for non-compensable clients was $10 per day, plus an additional $100 per week for food. Compensable clients such as those funded by the TAC and Worksafe are charged at the applicable rate.
Funding status	The Step 2 Transitional Unit receives recurrent funding and it is not anticipated that this will change post NDIS rollout.
References	Austin Health. (2019b). *"Step 2" Transitional Unit*. Retrieved July 9, 2019, from http://www.austin.org.au/bdp/step2/ Austin Health. (2019a). *About Us - Brain Disorders Program.* Retrieved July 9, 2019, from http://www.austin.org.au/bdp/about/

3.4.9 Queensland Service: Lawnton Transitional Accommodation

State	Queensland
Location	Lawnton, Brisbane
Organisation	Synapse
Email	info@synapse.org.au
Website	https://synapse.org.au/
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	Lawnton includes 4 self-contained units at the rear of the property and 4 double storey townhouses at the front of the property, which contain either 1 or 2 bedrooms. The site can therefore accommodate up to 8 individuals at any one time. The 4 units at the rear of the complex are wheelchair accessible and are for individuals who need the greatest support. The 4 self-contained units are positioned around a central training and rehabilitation hub.
Population served	Caters for individuals with a range of disabilities including acquired brain injury, neurodegenerative diseases and other mental health conditions, who display complex and challenging behaviours.
Supports available	Support is available 24/7 and individualised programs are focused on increasing each person's level of functioning and social integration. The behaviour management approach used by staff includes applied behavioural analysis, followed by putting a positive behavioural model in place. A plan is written for each person transitioning through Lawnton, which all staff follow to provide consistency.
Typical length of stay or duration of package	Lawnton is intended to be a short-term transition option for people with disability aiming to return to community living. However, it is reported that many of the current residents have been at Lawnton for 6 or more years due to a lack of available opportunities for transitioning back into the community.
Outcomes	*Information not available*

How is the service funded?	Development of the accommodation was funded by Disability Services Queensland and the support has until now been funded by Disability and Community Care Queensland. With the rollout of the NDIS, clients will become NDIS participants, therefore negotiations are currently occurring between Synapse and the NDIS as to how the Lawnton model of accommodation and support fits within the parameters of the NDIS. However, it is reported that clients have started accessing support provided via the Lawnton model through their individual NDIS plans. Clients who have not yet transitioned to the NDIS receive individual support packages from the State Government to access support.
What is the cost of the service?	The cost of providing the service varies for each service user depending on their identified individual support needs. Service users are reported to contribute to the cost of utilities and in some cases the cost of food and transport.
Funding status	As service users continue to transition across to the NDIS, it is anticipated that the majority of supports provided at Lawnton will be funded via the NDIS.
References	Queensland Government. (2007). *Minister opens accommodation facility for people with high-care needs.* http://statements.qld.gov.au/Statement/Id/53023 Synapse. (2019a). *Support Services - Lawnton Transitional Accommodation.* https://synapse.org.au/support-services/accommodation/lawnton-transitional-accommodation.aspx

3.4.10 Queensland Service: Warner Street/Synapse Cairns

State	Queensland
Location	Manunda, Cairns
Organisation	Synapse
Email	info@synapse.org.au
Website	https://synapse.org.au/support-services/indigenous-services/synapse-cairns.aspx
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	Warner Street is a transitional service aiming to provide culturally relevant independent living options for 8 Aboriginal/Torres Strait Islanders living in Far North Queensland. The concept of Warner Community Living Transitional Accommodation grew out of a need identified within the Cairns community – for a safe place of belonging for Aboriginal and Torres Strait Islander people with a disability, with the support and opportunity to access culturally safe support and increase their sense of autonomy to live a life of choice, connected with the things that are important to their identity and hold meaning for them. The Warner Street Community was designed and constructed by a consortium of Indigenous and non-Indigenous artists, designers and landscapers and in consultation with the Traditional Owners of the land. All aspects of the physical environment have been designed to promote a culturally safe environment. The 8 self-contained living units include spaces that promote external living and include both inside and outside cooking facilities. The Aboriginal/Torres Strait Islander design promotes the seamless integration of indoor and outdoor spaces. It is expected that after clients have completed their journey at the centre, they will either move back to country or to a longer term housing and support option.
Population served	This service is designed to meet the needs of Aboriginal and Torres Strait Islanders who have been diagnosed with a disability. The core initial clients were selected from a group of long-term patients with acquired brain injury at Cairns Base Hospital.

Supports available	Support workers at Warner Street provide culturally competent and sensitive support to service users. Many of the support workers at Warner Street have an Indigenous background themselves; those who do not have an Indigenous background receive training to enable them to provide culturally competent support. An effort is made by support workers to engage with service users on a personal level by "having a yarn" so that interactions are not just transactional in nature. There is also an emphasis on maintaining a service user's connection to their culture through facilitating participation in cultural events, as well as connection to community, family and country.
Typical length of stay or duration of package	Warner Street is a relatively new service and at this stage some clients have been residing at the facility for less than 12 months, with others for over 12 months. The length of stay will be determined by the needs of each individual and how long it takes to build capabilities that will enable successful discharge into the community.
Outcomes	The Innovative Workforce Fund Final Implementation and Reflection Report reported some preliminary outcomes (National Disability Services & Synapse, 2018). These outcomes reflect that the majority of service users feel comfortable to express cultural needs with a mentor and that the service user feels connected to the things that are most important to them, including culture, country and family either "always or almost always" or "often". Outcomes for support staff were also reported and reveal that the majority of staff feel supported in their role and have confidence in their skills to perform the role either "always of almost always" or "often".
How is the service funded?	The $4.6 million required to build this project was funded by the Federal Government Shared Accommodation Innovation Fund (SAIF) project. Service users are funded either by Disability and Community Care Queensland or the NDIS, allowing them to access the supports they require at Warner Street.
What is the cost of the service?	The cost of providing the service varies for each service user depending on their identified individual support needs. Service users are reported to contribute to the cost of utilities and in some cases the cost of food and transport.
Funding status	As service users continue to transition across to the NDIS from other sources of funding such as Disability and Community Care Queensland, it is anticipated that the majority of supports provided at Warner Street will be funded by the NDIS.

References	National Disability Services & Synapse. (2018). *Innovative Workforce Fund. Final Implementation and Reflection Report.* https://workforce.nds.org.au/media/projects/media/Synapse_final_report.pdf Synapse. (2019b). *Support Services - Synapse Cairns.* https://synapse.org.au/support-services/indigenous-services/synapse-cairns.aspx Summer Foundation. (2015). *Senate Inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Blackburn, VIC: Summer Foundation Ltd. https://www.summerfoundation.org.au/wp-content/uploads/2015/11/Summer-Foundation-Senate-Inquiry-Submission_lo.pdf

3.4.11 Queensland Service: Spinal Outreach Team (SPOT)

State	Queensland
Location	Statewide
Organisation	Princess Alexandra Hospital
Email	spot@health.qld.gov.au
Website	https://www.health.qld.gov.au/qscis/spot
Service type	Non-residential
Service status	Service is currently active and likely to continue
Description of service	SPOT supports people throughout Queensland affected by spinal cord injury (SCI), by providing consultancy, early intervention and education. Services are provided in the home or at other sites within a 200 km radius of Brisbane, with regularly scheduled visits to rural areas. Support and education may also be given via videoconferencing or telephone.
Population served	To be eligible for the program, people with SCI must have been an inpatient of the Queensland Spinal Injuries Unit at the Princess Alexandra Hospital in Brisbane or have been reviewed by the medical officers of the Queensland Spinal Injuries Unit. Carers and family members of people with SCI who meet the above criteria are also eligible to access the program, as are health professionals working with people with SCI.
Supports available	SPOT has an educational and consultancy approach and the staff providing the support who are qualified in social work, occupational therapy, physiotherapy and nursing can provide assistance across the following areas: skin care, equipment, finances, home modification, work and education information, obtaining services, pain management, counselling and support, activities of daily living, joint and muscle problems, posture and seating, bowel and bladder management and other allied health and nursing issues.
Typical length of stay or duration of package	Over a period of 12 months the SPOT early intervention team make regular contact with people discharged from the Queensland Spinal Injuries Unit to identify issues that SPOT can assist with.
Outcomes	*Information not available*

How is the service funded?	The Queensland Department of Health provides ongoing funding for the program.
What is the cost of the service?	*Information not available*
Funding status	Funding for the program is likely to continue as it is seen as part of the health rehabilitation pathway for people with spinal cord injury and is therefore unlikely to be impacted by the rollout of the NDIS.
References	Agency for Clinical Innovation. (2019). *Transitions to Community Living and Person-Centred Care for People with Spinal Cord Injury. Stakeholder Forum Briefing Paper.* Australia: Insight Consulting Australia. Queensland Government Queensland Health. (2017a). *Spinal Outreach Team.* https://www.health.qld.gov.au/qscis/spot

3.4.12 Queensland Service: Transitional Rehabilitation Program (TRP)

State	Queensland
Location	Brisbane, Gold Coast, Sunshine Coast and west to Ipswich. For those living in other locations in Queensland, accommodation is available at Windsor and Moorooka in Brisbane.
Organisation	Princess Alexandra Hospital, Brisbane
Email	trp@health.qld.gov.au
Website	https://www.health.qld.gov.au/qscis/trp
Service type	Non-residential, but residential available for people living outside of service radius
Service status	Service is currently active and likely to continue
Description of service	The TRP is delivered following discharge from the Spinal Injuries Unit and is described as offering a continuation of rehabilitation in a more home-like environment. TRP staff will visit clients in their own home 1 to 2 times per week for the duration of the program if they live within 120 kilometres of the Spinal Injuries Unit at Princess Alexandra Hospital in Brisbane. If clients live further away, there is an option for them to live in one of three houses located a 15-minute drive from the Spinal Injuries Unit. The houses have been modified to be accessible and also have spare bedrooms so that family and friends can stay over. The TRP is also able to loan clients equipment until their own equipment is ready, including manual wheelchairs, power-drive wheelchairs, hoists, cushions, mattresses, exercise equipment, and adapted aids.
Population served	The TRP is available to people with SCI who are discharged from the Spinal Injuries Unit at Princess Alexandra Hospital in Brisbane.
Supports available	TRP staff include physiotherapists, occupational therapists, social workers and nurses who are experienced in working with people who have an SCI. The program allows clients to build on the skills they have learned during inpatient rehabilitation within a home-like environment and further develop their independence. Support is also provided to the people around the person with SCI such as family, friends, carers, therapists and GPs.

Typical length of stay or duration of package	The TRP is often delivered over a period of between 4 to 8 weeks, however the length of the program is flexible as it is dependent on each individuals' goals and needs.
Outcomes	*Information not available*
How is the service funded?	The TRP receives State Government funding from Queensland Health.
What is the cost of the service?	There is no cost to individuals accessing the TRP, however clients are advised that they will need to cover the cost of their own food and transport.
Funding status	It is not anticipated that the source or amount of funding will change in the near future.
References	Queensland Government Queensland Health. (2017b). *Transitional Rehabilitation Program.* https://www.health.qld.gov.au/qscis/trp Queensland Spinal Cord Injuries Service. (2017). *Transitional Rehabilitation Program Fact Sheet.* https://www.health.qld.gov.au/__data/assets/pdf_file/0019/422056/trp.pd

3.4.13 Western Australian Service: Transitional Rehabilitation, Oats Street Facility

State	Western Australia
Location	East Victoria Park, Perth
Organisation	Brightwater
Email	welcome@brightwatergroup.com
Website	https://brightwatergroup.com/disability/brain-injury-rehabilitation/
Service type	Residential, with non-residential support for a limited number of clients
Service status	Service is currently active and likely to continue
Description of service	Oats Street is a purpose-built, community-based residential program for people with acquired brain injury who require ongoing rehabilitation to increase independence and participation within the community. There is capacity for up to 43 live-in residents and community-based support for up to 10 clients who live in their own homes. A further 5 floating places are available for moving clients through the phases of the program and to allow people considering participation in the program to stay for a short period to determine if they are willing to proceed. The accommodation consists of 3 5-bedroom houses and 5 4-bedroom houses, in a secure setting. 8 independent units are located on the same site but outside the secure area. There are also shared facilities including an education centre, gym, basketball court and gardens.
Population served	To be eligible for the Oats Street program, clients need to have an acquired brain injury and be aged 18 - 65 years old, medically stable and have the desire and potential to develop their skills. Clients who are 16 years old may access community-based rehabilitation services until they are 18, when they may, if required, transfer to site-based services. While many clients are referred directly from hospital, it is reported that some people are accepted into the program after having lived with their disability for many years. Therefore, acceptance of individuals into the program is primarily based on the potential for growth and change.
Supports available	An interdisciplinary team collaborates to assist clients to achieve their rehabilitation goals and to improve long-term outcomes. It consists of allied health professionals trained in psychology, clinical psychology, neuropsychology, occupational therapy, physiotherapy, speech pathology, social work and nursing and disability support workers.

	There is a specific focus on improving each client's ability to initiate, plan their day and self manage. A phased approach to service delivery is utilised as clients move through 10 separate phases of the program. As they progress through each phase they move to different houses on site with varying staffing and intensities of care. This phased approach to rehabilitation focuses on clients working towards goals that encourage individuals to re-learn or improve the skills they will need to live successfully in the community. Community integration coordinators are also available to assist clients to identify suitable and sustainable discharge options, including long-term housing and support options available in the community. They assist clients to connect to services in their local community, such as the pharmacy or doctor.
Typical length of stay or duration of package	The typical length of stay is between 12 to 18 months, however in some cases when the necessary funding or supports are unable to be secured for successful discharge, a length of stay is longer.
Outcomes	Outcomes from the program include increased independence, adoption of strategies to maximise abilities, and introduction of innovative care practices that reduce reliance on others. A social impact assessment prepared by ACIL Tasman in 2010 calculated that these outcomes will lead to a significant reduction in lifetime care costs (T. Dewar, personal communication, June 6, 2019). On average, for each individual the reduction in lifetime care cost was calculated at $4 for every $1 invested in rehabilitation.
How is the service funded?	The Western Australian Department of Health funds the program.
What is the cost of the service?	This information could not be disclosed due to the confidentiality of the agreement between Brightwater and the Western Australian Department of Health. In addition to funding received from the State Government, it is reported that clients are required to contribute the equivalent of 25% of the Disability Support Pension (DSP) and the Commonwealth Rent Assistance towards lodging costs with an additional 50% of the DSP contributing to board.

Funding status	It is not anticipated that the funding for the program will change in the near future.
References	Brightwater Care Group. (2018). *Rehabilitation for Life. The Oats Street model for acquired brain injury rehabilitation.* https://brightwatergroup.com/media/1446/brightwater-oats-street-brochure.pdf Brightwater Care Group. (2019a). *Brain Injury Rehabilitation.* https://brightwatergroup.com/disability/brain-injury-rehabilitation/ Summer Foundation. (2015). *Senate Inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Blackburn, VIC: Summer Foundation Ltd. https://www.summerfoundation.org.au/wp-content/uploads/2015/11/Summer-Foundation-Senate-Inquiry-Submission_lo.pdf

3.4.14 Western Australian Service: Transitional Accommodation, Long Stay Program

State	Western Australia
Location	Marangaroo, Perth
Organisation	Brightwater
Email	welcome@brightwatergroup.com
Website	https://brightwatergroup.com/disability/transitional-support/
Service type	Residential
Service status	Service is currently active and likely to continue
Description of service	The program is a residential program that can accommodate a total of 23 people. It was put in place to bridge the gap between hospital and living in the community, allowing people to be discharged from hospital who would otherwise have been likely to have an extended length of stay due to issues accessing appropriate supports and/or accommodation in the community.
Population served	People with complex disability or an acquired neurological disability who meet the following criteria may be eligible to access the program: • Aged between 16 and 64 years old • Referred by a Perth metropolitan hospital • Medically and psychiatrically stable • Eligible for the NDIS with the likelihood of a viable discharge option • Capable with support to set and work towards realistic goals that will facilitate transition to an appropriate supported independent living option of their choice

Supports available	The program consists of an interdisciplinary team of disability support workers, occupational therapy, speech pathology, physiotherapy and social work, which assists clients to set goals and work towards achieving them. Registered nurses are available to assist clients in managing their ongoing health needs and to support clients to establish sustainable health management supports in the community. The interdisciplinary team also provides assistance for clients to connect to the NDIS and/or other supports in the community. It also works with NDIA planners to inform them about the needs of the person as well as identifying suitable accommodation options within the community in preparation for discharge.
Typical length of stay or duration of package	The average length of stay is currently about 12 months, however it is reported that there was a wide variability with some people staying in the program for 3 to 4 years while waiting for funding to become available to enable them to transition out of the program and into the community. It is anticipated that once the NDIS has been fully rolled out and implemented across Western Australia, the typical length of stay will likely reduce to between 9 and 12 months.
Outcomes	Outcomes regarding the length of stay and diversity of discharge options for clients of the program are recorded and provided to the Western Australian Department of Health.
How is the service funded?	The Western Australian Department of Health funds the program.
What is the cost of the service?	This information could not be disclosed due to the confidentiality of the agreement between Brightwater and the Western Australian Department of Health. In addition to funding received from the State Government, it is reported that clients are required to contribute the equivalent of 25% of the DSP and the Commonwealth Rent Assistance towards lodging costs with an additional 50% of the DSP contributing to board.
Funding status	It is not anticipated that the funding for the program will change in the near future.
References	Brightwater Care Group. (2019b). *Transitional Support.* https://brightwatergroup.com/disability/transitional-support/

3.4.15 South Australian Service: SACARE Transitional Services

State	South Australia
Location	Adelaide
Organisation	SACARE
Email	Email via website
Website	https://www.sacare.com.au
Service type	Residential, with additional non-residential support after discharge if required
Service status	Service is currently active and likely to continue
Description of service	SACARE is a South Australian privately-owned provider of housing and support. There are several accommodation options located across metropolitan Adelaide, offering long-term, short-term and respite accommodation. The newly built facility called "The Gums", located in the suburb of Salisbury, also offers the option of transitional accommodation and support for clients who have recently been discharged from hospital. There are 20 beds, with 8 private bedrooms in the main building for clients with high care needs and 12 private bedrooms located within 9 residential units on the same site for clients with less complex care needs. This multi-phased approach provides the opportunity for clients to progress towards independence; assistive technology and home automation are incorporated into the accommodation to reduce the support required and prepare clients for living in the community. Support is provided for families throughout the transition process and a hydrotherapy pool and gym are available on site, as well as outdoor facilities such as a sensory garden and walking track. If required, SACARE provides additional transitional support to people once they return to living in their own homes.
Population served	People with a range of disabilities and complex comorbidities access the services, including people with neurodegenerative diseases, spinal cord injuries, autism spectrum disorder, acquired brain injury and amputees. Some clients also have complex care requirements such as being ventilator dependent and/or requiring tube feeding.

Supports available	Staff including disability support workers, allied health professionals and registered nurses are available to provide support on site 24 hours per day. Clients are assisted to set goals and depending on their goals, clients have the opportunity to participate in a range of on-site activities such as cooking and other organised activities, including art or using technology to create blogs, etc. Clients may also be assisted to participate in activities in the community such as volunteer work, leisure activities and activities of daily living such as shopping.
Typical length of stay or duration of package	The Gums is a new facility which opened in mid December 2018 and many of the clients have only recently moved in. It is therefore too early to know the typical length of stay.
Outcomes	Due to the Gums being a new facility, no outcomes data is available.
How is the service funded?	Clients accessing SACARE accommodation and support options are reported to be compensable, NDIS participants, funded via a trust or privately funded.
What is the cost of the service?	As at May 2019, it was reported that the base rate charged per week for each client is $6250, which includes treatment, support and care for up to 8.5 hours per day. Depending on individual clients' needs, this amount may need to be increased to cover the cost of appropriate care. Clients also contribute a further $342.79 per week towards the cost of rent and energy.
Funding status	It is not anticipated that the sources of funding are likely to change in the near future. However, it is expected that as more people with disability transition across to the NDIS, the percentage of clients funded by the NDIS may increase.
References	SACARE. (2017). *About The Gums.* https://www.sacare.com.au/thegums SACARE. (2018). *South Australia's Leading Provider of Disability Housing and High Care Services.* https://www.sacare.com.au/_literature_192902/Complex_Care_Services_Flyer

3.4.16 Multi-state Service: Healthscope Independence Services (HIS)

State	New South Wales, Victoria, Northern Territory
Location	15 locations across metropolitan Melbourne, regional Victoria, New South Wales and the Northern Territory
Organisation	Healthscope
Email	N/A
Website	http://www.healthscopeindependenceservices.com.au
Service type	Residential and non-residential
Service status	Service is currently active and likely to continue
Description of service	Healthscope Independence Services (HIS) offers short-term, long-term, transitional and respite accommodation options for people living with a disability and requiring support. In home support is also provided for people who have left hospital and returned home. HIS has a total of 15 residential facilities, accommodating between 3 and 8 individuals at each location. Some of the facilities are presented as group homes while others are presented as multiple units positioned around a central support hub. Clients all have their own bedroom and sometimes share a bathroom with other clients, along with shared living, kitchen and outdoor areas. Most of the facilities are fully wheelchair accessible and located close to public transport and shops.
Population served	People with acquired brain injury, disability and other complex conditions.
Supports available	Disability support workers provide attendant care services on site 24/7 and are recruited to specifically meet the individual needs of clients. Once selected, support workers are required to complete annual training sessions in the areas of personal care, community access, rehabilitation support and acquired brain injury, to ensure their skills and knowledge are up to date. Clients will often receive input from their own allied health team, paid for separately. Under the guidance of professional input used to identify goals and strategies, disability support workers will help support clients to work towards achieving their goals.

Typical length of stay or duration of package	It is reported that the length of stay varies greatly depending upon an individual's needs.
Outcomes	*Information not available*
How is the service funded?	Compensable clients will have their costs covered by the relevant statewide body such as Work Cover, icare, TAC or WorkSafe. It is reported that there are now many non-compensable residents within HIS facilities who have their costs covered by funding received from the NDIS.
What is the cost of the service?	The cost of the service for compensable clients is determined according to individual client's needs. Support is funded by the NDIS for participants residing in HIS facilities through a Supported Independent Living (SIL) payment, and is based on a quote detailing individual support requirements. Funding is also provided separately for accommodation.
Funding status	It is not anticipated that there will be any changes to sources of funding for HIS services in the near future.
References	Healthscope. (2019). *Healthscope Independence Services*. http://www.healthscopeindependenceservices.com.au/

3.4.17 National Service: Transition Care Programme

State	All states and territories
Location	Australia wide
Organisation	Commonwealth and State/Territory Governments
Email	RCS.Enquiries@health.gov.au
Website	https://agedcare.health.gov.au/programs-services/flexible-care/transition-care-programme
Service type	TCP may be provided in residential or non-residential settings; it is a flexible care programme
Service status	Programme is currently active and likely to continue
Description of service	The Transition Care Programme (TCP) is a joint Commonwealth – State/Territory Government program established under the Aged Care Act 1997 (Commonwealth of Australia, 1997). TCP provides short-term care that seeks to optimise the functioning and independence of older people, aged 65 years and over, after a hospital stay. By offering low-level therapy and support, it allows older people to continue their recovery out of hospital while appropriate long-term care is arranged. TCP can either be delivered in a bed-based care setting such as in a RAC facility or in the client's home. Where the client receives care will depend on the type of care and some people may receive care in more than one care setting (but not at the same time, e.g. commence in bed-based and then move to home-based, or vice versa) during their time on the program.
Population served	A person must meet the following criteria: • Must be an inpatient in a public or private hospital or determined as being an inpatient due to being under *Hospital in the Home* or an equivalent program • Has completed acute and subacute care as an inpatient, is medically stable and ready for discharge • Is agreeable to entering the Transition Care Programme • Is eligible for placement in RAC (if that is the long-term care plan)

	• Likely to have the capacity to benefit from low intensity, goal oriented and time limited therapy and supports that may improve skills and/or allow time to make plans for longer term care arrangements • Is an "older person" over the age of 65; however, it is reported that people aged between 60 and 65 are considered on a case by case basis
Supports available	TCP is not a form of rehabilitation; however, the program does have a therapy focus with clearly identified goals that assist older people to maintain and improve physical and/or cognitive functioning, thereby assisting them to return home after a hospital stay, rather than enter RAC. The TCP multidisciplinary team includes allied health professionals in the fields of physiotherapy, occupational therapy, social work and nursing. A case manager is allocated to coordinate and monitor the client's care plan and develop a discharge plan in consultation with the client and family. In an interview with a TCP service provider, the bed-based program was described as predominantly focusing on skills maintenance, with TCP recipients typically participating in group physiotherapy sessions a couple of times per week. If allied health staff identify that someone has the potential to improve and get back home with the right support, additional therapy may be provided. Purchased services for a person on the home-based program may include: personal care, nursing, domestic assistance, low level therapy such as provided by a physiotherapist, continence aids and equipment.
Typical length of stay or duration of package	TCP starts when the person leaves hospital and most people will stay on the program for 6 to 8 weeks. The maximum time a person can stay on the program is 12 weeks. Although, in an exceptional circumstance, a person may be approved for an extension of up to 6 weeks.
Outcomes	The Commonwealth Government engaged KPMG to complete an administrative review of the TCP to consider issues including more flexibility. Statewide working group meetings were held in Victoria in May, November and December in 2018 and in January 2019. The review showed that the TCP is an effective and important programme at the interface of Australia's health and aged care systems. It has resulted in substantial benefits to consumers by improving their functional capacity and facilitating their early discharge from hospital (KPMG, 2019).

How is the service funded?	The TCP is funded jointly by the Commonwealth and State/Territory governments. Commonwealth funding is provided in the form of flexible care subsidy under the *Aged Care Act 1997* on a per day/per bed basis. The amount of flexible care subsidy that is payable in respect of a care recipient per day is determined by the Minister by legislative instrument, in accordance with sub-section 52-1(1)(a) of the *Aged Care Act 1997*. State and Territory Governments provide direct and/or in-kind funding. Care recipients are also asked to pay a fee to contribute to the cost of the care provided. However, access to TCP should not be affected by the client's ability to pay fees and will be considered by the provider on a case by case basis. The daily fee for the bed-based program is a maximum of 85% of the basic daily rate of the single aged pension, while the home-based program is 17.5% of the basic daily rate. If TCP care recipients are compensable through either TAC or WorkSafe, the transition care service will request that these schemes cover the cost of the subsidy for the program normally provided by the Commonwealth and State/Territory governments.
What is the cost of the service?	The TCP provider will engage a suitably qualified residential service for the purpose of providing bed-based transition care based on a specified number of beds. This may be a residential aged care facility or, in some circumstances, the care may be provided on-site within a dedicated area in a hospital. A Service Agreement will be negotiated between the TCP Provider and facility for the provision of residential-based support and accommodation. Appropriately skilled staff should also be employed to care for the TCP client group. A daily bed fee is negotiated as part of the agreement. The TCP provider will also have a weekly budget for people receiving care at home to cover services such as nursing, personal care and equipment.
Funding status	Funding for the TCP is recurrent and it is not anticipated that there will be any changes to the model of funding in the near future, unless there is a change of policy.

References	Australian Government Department of Health. (2019). *Transition Care Programme Guidelines*. https://www.health.gov.au/sites/default/files/documents/2019/12/transition-care-programme-guidelines_0.pdf Australian Government Department of Health. (2019). *Transition Care Programme.* https://agedcare.health.gov.au/programs-services/flexible-care/transition-care-programme State Government of Victoria. (2018). *Transition Care Program.* https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/transition-care-program

3.4.18 National Service: Home Support Grant

State	All states and territories
Location	Nationwide
Organisation	Youngcare
Email	youngcareconnect@youngcare.com.au
Website	https://www.youngcare.com.au
Service type	Non-residential
Service status	Service is currently active and likely to continue
Description of service	Young people with disability can apply to Youngcare for a Home Support Grant to facilitate or maintain their ability to live in the community successfully. The grant is designed to provide funding where there are critical gaps in an NDIS participant's plan, but there is still clear evidence of need. It seeks to bridge the gap in essential services and support for families in need during the transitional period while the NDIS is being fully established.
Population served	Individuals aged between 18 and 65 may be eligible if they have a permanent disability and need essential funding to remain living at home, move back home from inappropriate housing, or to make their current place more accessible. When applicants have an NDIS approved plan in place, evidence of an additional need is required.
Supports available	The Youngcare Home Support Grant can be used to fund essential equipment, home modifications, services such as respite or in-home care, household items and utilities.
Typical length of stay or duration of package	*One-off payment*
Outcomes	*Information not available*
How is the service funded?	Philanthropic funding is used to make the grants available.

What is the cost of the service?	Grants of up to $20,000 per person are available for the current year (2020).
Funding status	Youngcare anticipates that funding will continue to be made available for the grants post NDIS rollout, however it is thought that the way the grants are used could change to reflect new gaps that emerge.
References	Youngcare. (2020). *Youngcare's Home Support Grant.* https://www.youngcare.com.au/what-we-do/grants/home-support-grant/

3.4.19 National Service: Youngcare At Home Grants

State	All states and territories
Location	Nationwide
Organisation	Youngcare
Email	ahcg@youngcare.com.au
Website	https://www.youngcare.com.au
Service type	Non-residential
Service status	Service is currently active and likely to continue
Description of service	Young people with disability can apply to Youngcare for an At Home Grant to prevent them from being admitted to inappropriate housing. The funding is designed to both enhance the quality of life for young people with high care needs and assist them to remain living in their own home with loved ones. It provides funding for equipment, home modifications and essential support/respite that is unable to be funded through other means (e.g. NDIS).
Population served	Individuals aged between 18 and 65 may be eligible if they have a permanent disability and are at imminent risk of entering inappropriate care. When applicants have an NDIS approved plan in place, evidence of an additional need is required.
Supports available	The Youngcare At Home Grants can be used to fund essential equipment, home modifications, services such as respite or in-home care, other items that will extend the recipient's ability to remain at home and pre-planning reviews/reports.
Typical length of stay or duration of package	*One-off payment*
Outcomes	*Information not available*
How is the service funded?	Philanthropic funding is used to make the grants available.

What is the cost of the service?	Grants of up to $10,000 per person are available for the current year (2020).
Funding status	Youngcare anticipates that funding will continue to be made available for the grants post NDIS rollout, however it is thought that the way the grants are used could change to reflect new gaps that emerge.
References	Youngcare. (2020). *Youngcare's At Home Care Grants.* https://www.youngcare.com.au/what-we-do/grants/home-care-grants/

3.5 Transitional services in Australia that are being phased out or have ended

3.5.1 Victorian Service: ABI Slow to Recover Program

State	Victoria
Location	Statewide
Organisation	Department of Human Services Victoria and Monash Health
Email	*No longer active*
Website	*No longer active*
Service type	Non-residential
Service status	Service is being phased out
Description of service	The program was a time limited extension of rehabilitation that could be provided within the person's residence and/or within the community, such as at a pool or gym. The focus was on attainment of goals and outcomes; aids and equipment could also be prescribed and introduced within the community context. An effort was also made to refer clients of the program to community-based disability and mainstream services to provide continuity of support at the conclusion of the program.
Population served	People aged 5 to 64 years old who sustained catastrophic brain injury and were not in receipt of compensation.
Supports available	Monash Health partnered with community-based providers of case management and allied health therapies, including physiotherapy, occupational therapy, speech pathology and treatment support agencies. The support provided aimed to be responsive to immediate needs, could be varied over time to meet changing needs, and provided specialist rehabilitation services, case management and brokerage assistance to purchase a flexible range of supports. The program funded therapy and disability supports related to rehabilitation goals, but would not fund supported accommodation. Many recipients of this package therefore lived in RAC.
Typical length of stay or duration of package	The duration of the package varied from person to person, however it was designed to provide long-term support until the person could manage their disability successfully in the community and had the ongoing supports in place to assist them into the future.

Outcomes	In 2008, it was reported that of 234 participants in the program, 62 had been discharged, 39 were deceased and 133 remained active participants in the program. Six-monthly reports were completed by treating teams to record progress and goals for clients in the rehabilitation phase, while 12-monthly reports were completed documenting progress and goals for clients in the maintenance phase. It was reported that these were confidential medical records and not available for release. The Acquired Brain Injury: Slow to Recover (ABI:STR) Program report of the therapy review project (Sloan, 2008) reports feedback from participants and their families about the program. As a whole, the reported feedback was positive, with it being stated that people interviewed were overwhelmingly appreciative of the services they received under ABI:STR program.
How is the service funded?	Department of Human Services Victoria provided funding for the program.
What is the cost of the service?	Details of the overall cost of the program are not available, however it was reported that the funding allocated per participant varied from $10,000 to $140,000 per annum, depending on an individual's needs.
Funding status	Since the introduction of the NDIS, the Slow to Recover program has been phasing out as people transition to the NDIS. There are still 35 to 40 clients accessing the scheme, however it is expected that they will have finished transitioning to the NDIS by October 2019 at which time the Slow to Recover program will cease to operate.
References	Monash Health. (2014a). *Acquired Brain Injury Slow to Recover Program (ABI:STR)* https://monashhealth.org/wp-content/uploads/2018/08/188285_1443417792.pdf Sloan, S. (2008). *Acquired Brain Injury: Slow to Recover Program. Report of the Therapy Review Project.* Melbourne, Australia. https://www.osbornsloan.com.au/wp-content/uploads/2018/01/Slow-to-Recover-Program-Report-of-the-Therapy-Review-Project.pdf Summer Foundation. (2015). *Senate Inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Blackburn, VIC: Summer Foundation Ltd. https://www.summerfoundation.org.au/wp-content/uploads/2015/11/Summer-Foundation-Senate-Inquiry-Submission_lo.pdf

3.5.2 Victorian Service: ABI Statewide Case Management Service – non-compensable

State	Victoria
Location	Statewide
Organisation	Melbourne City Mission Arbias IPC Health (formerly known as ISIS Primary Care) BrainLink
Email	enquiriesVIC@arbias.com.au admin@brainlink.org.au
Website	www.melbournecitymission.org.au www.ipchealth.com.au www.arbias.org.au www.brainlink.org.au
Service type	Non-residential
Service status	Service is being phased out
Description of service	Case managers assisted clients who had an acquired brain injury to coordinate their support services, including accessing specialist neurological, general disability and mainstream services as required, so that clients could develop skills and reach their post-injury potential to live in the community.
Population served	It was reported that people who have acquired a brain injury aged between 5 and 65 years accessed ABI Statewide Case Management Service.
Supports available	ABI Case Management usually commenced post discharge from hospital within a community setting, although for certain situations there was enough flexibility to allow case managers to provide support prior to discharge. The role of the case manager included ensuring that supports put in place post discharge were working effectively, as well as assisting with further identification of goals, relevant resources/packages, coordinating supports and being a point of contact in the event that issues arose. On average, support was provided for 2 hours per week per client, however some clients received more or less hours of support depending on their individual needs.

Typical length of stay or duration of package	It was reported that clients received case management for an average of approximately 5 years, however there were some instances where clients had been receiving case management for more than 15 years.
Outcomes	Outcomes for individuals were recorded and reported back to the DHHS, however no publicly available reports with collective results were able to be identified.
How is the service funded?	The DHHS provided funding for the ABI Statewide Case Management Service. Some clients also accessed the service utilising funding from their Individual Support Package (ISP) or through the Slow to Recover Program (see 3.5.1).
What is the cost of the service?	Block funding was provided for the ABI Statewide Case Management Service to deliver case management to non-compensable clients at a rate equivalent to approximately $61 per hour. For compensable clients receiving TAC/WorkSafe funding, ABI case management services were funded on a fee for service basis at a rate of approximately $90 per hour of service delivered, plus travel costs. Costings from a submission developed by Melbourne City Mission in 2010 to provide "planning" for 89 individuals under the "My Future My Choice Initiative" totalled $2246 per individual, which equated to approximately $56 per hour for 40 hours of planning/case management.
Funding status	Some clients have not yet transitioned across to the NDIS and continue to utilise their funding from the Slow to Recover Program or Individual Support Package (ISP) to access the ABI Statewide Case Management Service. It is expected that these clients will transition to the NDIS shortly and that this service will therefore phase out as funding will cease to exist.
References	Summer Foundation. (2015). *Senate Inquiry into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia.* Blackburn, VIC: Summer Foundation Ltd. https://www.summerfoundation.org.au/wp-content/uploads/2015/11/Summer-Foundation-Senate-Inquiry-Submission_lo.pdf

3.5.3 Victorian Service: Genesis Independent Development Program

State	Victoria
Location	Iris Court, Melbourne
Organisation	UnitingCare
Email	*No longer active*
Website	*No longer active*
Service type	Residential
Service status	Service is no longer available
Description of service	The service provided a residential program for people with disability, which aimed to provide participants with pathways to more independent living choices. This involved identifying goals for clients to live independently in the community, teaching independent living skills and developing support networks. There was also a focus on building meaningful connections in the community and identifying what would make a good life for each person.
Population served	People with disability who met the following criteria: • Have low to moderate support needs • Aged between 18 - 64 years • Have the capacity to live more independently in the community following intense training and skill development • Need no more than 35 hrs of staff support per week and no overnight support • Identify independent living as a goal
Supports available	Disability support workers were rostered to be on site for approximately 52 hours per week during the day, however no support workers were present overnight. The role of support workers was to provide prompts and assistance to residents to encourage them to complete routines and activities of daily living necessary for community living, while aiming to reduce their reliance on paid support. Progress towards identified goals was regularly monitored and support workers arranged weekly meetings in order to address any problems that arose, such as maintenance issues and difficulties due to dynamics between the residents.

Typical length of stay or duration of package	The program was designed to be completed over a period of 20 weeks.
Outcomes	An independent evaluation of outcomes for clients exiting the program was not completed, however it was reported that the majority of participants in the program went on to secure long-term tenancies in private rental, shared private rental or shared community housing. It was estimated that approximately 80-90% of participants used the program as a stepping stone to more independent accommodation in the mainstream housing space; very few would have moved on to state funded supported living options.
How is the service funded?	The model was funded via the Victorian DHHS and was block funded with annual targets. Before closure, some people moved into the program utilising funding attached to their NDIS plan.
What is the cost of the service?	$31,614.42 was allocated per client to cover the full 20-week program, which included both individual costs and group related costs.
Funding status	The service is no longer funded post NDIS rollout.
References	J. Tomlin, personal communication, December 21, 2018.

3.5.4 Victorian Service: Assisted Community Living (ACL) Package

State	Victoria
Location	Melbourne metropolitan areas divided into southern, eastern, western and northern regions
Organisation	Monash Health Community Disability Services IPC Health (formerly known as ISIS Primary Care) BrainLink Melbourne City Mission
Email	disability.packages@monashhealth.org
Website	www.monashhealth.org
Service type	Non-residential
Service status	Service is being phased out
Description of service	ACL Packages were small one-off payments to purchase supports aiming to encourage increased activity in the community for those experiencing social isolation, thereby leading to greater independence and a better quality of life. The package was designed to be used in conjunction with other supports and services.
Population served	People aged between 18 and 64 years with an acquired brain injury were eligible to apply, regardless of whether they lived independently, in an aged care facility, a supported residential service, or if they had recently returned to community living. Support from a case manager or other service provider was required to assist with the management of the package.
Supports available	The funding was flexible and used by individuals to facilitate greater independence in the community, including improved access to a variety of social, recreation and training related activities.
Typical length of stay or duration of package	There was a set amount of funding available per individual each financial year and applications could be made at any time. A system for prioritising which individuals qualified for funding was utilised and individuals applying needed to satisfy specified criteria. Funding was generally not given to facilitate access to activities that had previously been funded, as there was an expectation that sustainable support structures ought to be put in place to enable ongoing access to a desired activity.

Outcomes	It was reported that there was no requirement of the program for ACL recipients' outcomes to be recorded, therefore this information was not available.
How is the service funded?	Funding for the program was received from the DHHS regional offices in Victoria.
What is the cost of the service?	$5000 was available per person, however this amount increased in accordance with CPI and had become close to $6000.
Funding status	These packages were funded to continue up until 30 June 2019 and are not expected to be available after this date.
References	Monash Health. *Acquired Brain Injury Assisted Community Living packages.* https://monashhealth.org/services/services-a-e/acquired_brain_injury_assisted_community_living_packages/ Monash Health. (2014). *Assisted Community Living Packages (ACL).* https://monashhealth.org/wp-content/uploads/2018/08/187873_1424836829.pdf

3.5.5 Victorian Service: Behaviour Support Package

State	Victoria
Location	Metropolitan Melbourne
Organisation	Melbourne City Mission Arbias IPC Health (formerly known as ISIS Primary Care BrainLink EACH
Email	enquiriesVIC@arbias.com.au admin@brainlink.org.au
Website	www.melbournecitymission.org.au www.ipchealth.com.au www.arbias.org.au www.brainlink.org.au
Service type	Non-residential
Service status	Service is no longer available
Description of service	A Behaviour Support Package could be used to support people who demonstrated behavioural issues impacting on their ability to live successfully in the community, including those being discharged from hospital into the community. The supports were described as "flexible" and could therefore be tailored to meet an individual's specific needs.
Population served	People with acquired brain injury aged between 18 - 65 years who demonstrated behavioural issues could apply to the program for support. A system for assessing applications was in place that included giving priority consideration to those residing in RAC or a supported residential service (SRS) with no family supports in place.
Supports available	Given that the package was flexible in nature, the supports provided varied greatly depending on the individual's needs; however, funding was often included for allied health therapies as well as additional attendant support.

Typical length of stay or duration of package	The length of the package varied for each individual; however, it was not designed to be long term or recurrent. Rounds of funding were available on a monthly basis and recipients of the package could potentially reapply for an additional round of funding once their original package of funds had been used. In these cases, however, there needed to be strong justification for why this was required.
Outcomes	*Information not available*
How is the service funded?	The Department of Human Services in Victoria funded the program.
What is the cost of the service?	The total cost of the program is unknown. It was however reported that individuals who applied for the program received amounts of funding that varied depending on their needs and the cost of the specialised services required to meet their needs.
Funding status	Behavioural Support Packages are no longer available post NDIS rollout.
References	*Information obtained solely from interview*

4. DISCUSSION

People with disability and complex needs falling through the gap between the hospital system and disability services is not a new problem. Historically, many patients in this group have found themselves in hospital beyond the time they are clinically ready to be discharged. Discharge delays may occur when processes necessary for their discharge have not been completed (such as referrals to community-based supports or funding approvals to enable commencement of these supports), when support and resources are not in place for them to be returned to their own home, or when there is nowhere suitable or available for them to be discharged to. These discharge delays and lack of housing and support options increase the risk of young people with disability entering permanent RAC (Winkler, Sloan, & Callaway, 2007); indeed, over 2,500 young people aged under 65 years entered permanent RAC in the 2017-2018 financial year (Bishop, Zail, Bo'sher, & Winkler, 2019).

In November 2019, the Australian Government committed to new targets for the Younger People in Residential Aged Care Action Plan that, apart from in exceptional circumstances, will seek to ensure there are: (i) no people under the age of 65 entering RAC by 2022; (ii) no people under the age of 45 living in RAC by 2022; and (iii) no people under the age of 65 living in RAC by 2025 (Prime Minister of Australia, 2019). To facilitate this, there are a number of discharge planning pilots across Australia that are working to support the collaboration between hospitals and the NDIA to provide more timely access to NDIS funded supports (e.g. Summer Foundation Collaborative Discharge Approach (Summer Foundation, 2019), Metro North (Queensland), South Australian discharge planning pilot (University of South Australia, n.d.)). While some of these delays can be addressed by the timely provision of resources funded through the NDIS, some people still need a transitional housing option.

The interface between the health and disability sectors in Australia, and how they collaborate to ensure effective discharge planning of people with disability and complex support needs returning to live in the community, is undergoing transformational change in response to the rollout of the NDIS. In the past, a range of transitional housing and support options have been developed in different jurisdictions in Australia to assist with this process of returning to community living. Historically however, there have been numerous reports that many people in this group have had extended lengths of stay in hospital beyond the time they are ready for discharge (Winkler et al., 2007).

This situation is far from ideal because sub-optimal discharge processes have been found to contribute to a range of negative social, health and economic outcomes for the person, their support network, the health system and the broader community (Turner, Fleming, Ownsworth, & Cornwell, 2011).

It is clear that there are gaps in the system that have led to insufficient transitional supports being available. This includes issues relating to the scale of currently available options, leading to an undersupply of transitional housing and support options available to accommodate the number of people currently waiting in the health system who require these supports for successful discharge to the community. This has been particularly evident until recently for people with non-compensable support needs due to the cost of accessing these options.

Now that the NDIS is in place, people with disability are eligible for funding for the disability supports and equipment that they need to return to community living. This means the current challenge is related to the time that it takes to achieve access to NDIS funded services and finding suitable housing for people who are unable to be discharged home. After interviewing many service providers within the health and disability sectors, a critical problem highlighted was the timeliness of NDIS participants receiving their plans, and consequently their funding, to access appropriate transitional housing and support needed for successful discharge into the community. Lengthy delays to complete this process were regularly reported, which in turn led to lengthy stays in hospital while people waited.

Furthermore, one service provider described the strict division of funding between health and disability service providers in the community as hindering the discharge process, since it has led to less collaboration between the sectors. While at a national level the health-disability interface has been a problem for people with disability and complex needs for decades, there have been some pockets of good practice. Prior to the NDIS, some state governments funded programs to fill the gap between hospital and the disability service system. With the states and governments now both contributing to a federal NDIS, some of these services are no longer funded by state governments (e.g. Victorian ABI Slow to Recover Program (3.5.1), ABI Statewide Case Management Service (3.5.2)).

When there were case management type services in place, case managers could begin discharge planning in collaboration with hospital staff prior to discharge, allowing information about the patient relevant to discharge to be shared. Continuity of care could also be provided with the case manager acting as the key contact for the person being discharged from hospital, giving them flexibility to provide assistance in the event that any issues or barriers arose that might prevent successful reintegration into

the community. In contrast, since the rollout of the NDIS, roles have been redefined so that hospital staff remain involved in discharge planning only until the point of discharge; however, after discharge, if the person is an NDIS participant, a support coordinator will often become the new point of contact.

An additional problem occurs because support coordinators are only funded to do what is specified in the NDIS plan, however it is common for issues to unexpectedly arise during the transitional period. The only way for the participant to secure the appropriate supports to deal with these unexpected issues is to initiate a plan review, which is a lengthy process that can leave the participant without the required support in the meantime. However, if an early and flexible NDIS plan could be approved that includes support coordination, there would likely be a better outcome for people with disability in the transition period from hospital to home.

This also leads to the issue of continuing support for rehabilitation, since many people will require ongoing rehabilitation after discharge from hospital. In particular, people with severe acquired brain injury are likely to benefit from individually tailored support programs that are not time-limited, since they can achieve small incremental gains when rehabilitation occurs over a more extended period (Knox & Douglas, 2018). This ongoing rehabilitation requires a collaborative approach between health and the NDIS as tapering of rehabilitation maintenance support occurs and concurrent support is required.

Aside from the systemic issues already described, there are also gaps within the existing transitional housing and support services. While many of the transitional housing options included in this report offer a valuable service that leads to improved outcomes for service users, the majority of these options are located in metropolitan areas. Since the majority of the Australian population resides in metropolitan areas, this is to be expected; however, for service users from rural and remote locations, this has the effect of isolating them from their communities and their informal networks of family and friends. As discussed by Turner and colleagues, feeling isolated is a common issue following discharge from rehabilitation programs and returning to the community, and thus it is important to facilitate maintenance of these connections (Turner et al., 2008).

To prevent isolation from a person's community, some of the 'live in' transitional programs in Queensland, such as the Transitional Rehabilitation Program (3.4.12), Lawnton Transitional Accommodation (3.4.9) and Warner Street (3.4.10), offer accommodation for family on site or actively encourage and facilitate connections with family and the community through organising cultural/community events and making use of existing connections within the community (Kendall, Ungerer, & Dorsett, 2003).

Other services such as the NSW Brain Injury Rehabilitation Program (3.4.1), which has transitional housing located across several rural locations, encourage service users to return home on weekends when possible so they can put into practice what they have learned within their home environment and maintain connections with their family and the community. This period of 'adaption', whereby there is an opportunity to generalise skills learned in rehabilitation across different environments, is thought to be critical for sustaining outcomes over the longer term (Potter et al., 2017).

While many of the other services described in this report make an effort to communicate with the family members of their service users, this is unfortunately not a substitute for face-to-face contact and tends to exclude the active involvement of family and members of the local community during the rehabilitation and community reintegration process. To address this, in addition to the issue of scarcity of transitional housing options, flexible funding (if available) could be used to access suitable transitional housing options that would increase the likelihood that people could transition from hospital back into their own community. The Spinal Interim Package (3.4.6) in Victoria is an example of a program that provides funding that is flexible in nature and has been used to fund a variety of transitional accommodation options to allow people with Spinal Cord Injury to transition out of the health system and back into their community. However, funding for transitional accommodation is reported to be strictly time limited to avoid the cost of the program "blowing out".

Having the right support throughout the transitional period is equally as important as having access to the right housing. Thus, the current disconnect between the support provided in hospital and the support provided after discharge needs to be addressed. The effective and timely transition of people with disability and complex needs from hospital to the community has the potential for increased efficiencies and cost benefits to both hospitals and the NDIS. Ideally, transitional housing and support services would be jointly funded by health and NDIS, allowing people with acquired disability to access the disability supports and health services that they need to successfully return to community living. Having a timely, effective and jointly funded transitional system would decrease hospital lengths of stay, improve patient outcomes and independence and ultimately reduce the long-term liability of the NDIS and reduce hospital readmissions.

Recent funding commitments from the NDIA are aimed at remedying this issue, including: (i) funding of disability-related health supports enabling greater access to health services outside of hospital settings; (ii) Health Liaison Officers to support the development of processes and resources to reduce hospital discharge delays; and (iii) medium-term accommodation funding for up to 90-days where a long-term option has been identified. If successful, these new initiatives should improve the discharge planning process and transition from hospital to community living for people with disability.

Another issue that exists in transitional housing and support options is the ability of services to support people who exhibit 'behaviours of concern'. Such behaviours pose heightened challenges because the health system is often required to devote considerable resources to ensuring the security of the person, staff and other patients. The lack of appropriate community-based options has a detrimental effect on people with disability who have this added challenge of behaviours of concern. A limitation of the current study was that during the desktop scan and interviews, evidence was not obtained as to how (or if) psychosocial disabilities are supported within the majority of transitional housing and support options. This needs to be considered since people with disability and complex needs may face issues regarding accessibility of brokerage and flexible funding as they transition to community living.

Conclusion

Improved discharge planning and the timely receipt of NDIS funded supports alone is likely to improve the transition from hospital to community living for many people. However, for some people, a move straight from an acute or subacute health setting or RAC facility to community living will be too great a step and be, therefore, unlikely to succeed. Transitional housing and support services which embed opportunities for rehabilitation over an extended time frame within community settings would enable some people to optimise their potential (Winkler et al., 2007). These services would enable NDIS participants to maximise their independent living skills and abilities, live in the least restrictive environment and, over the longer term, reduce life time support needs and costs.

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