

PROJECT EVIDENCE

PROJECT EVIDENCE for Continuing Care of Persons with Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[7] Engagement with ongoing care

The conceptual framework of mental health services encompasses Prevention, Treatment, Continuing Care and Mental Health Promotion. Treatment covers Case Identification, Early Treatment and Standard Treatment. Continuing Care covers Engagement with services and the provision of Long-term Care. Continuing Care is the ongoing implementation of the treatment components summarised in the Case Management Plan.

The paper describing Case Identification (PE4) acknowledges that disturbances in psychosocial development and functioning may be recognized at a variety of places in society and that a system is required that enables assessment and appropriate management irrespective of the level of severity and place of engagement. The paper advocated a collaborative system of mental health consultancy services, intake/assessment and short-term intervention as a basic human right for all citizens.

We need is a system that provides:

- prompt intake assessment and short-term treatment, regardless of the level of severity,
- triage to appropriate facilities for specialist management when indicated, without additional intake barriers,
- ongoing long-term management when indicated,
- consultative services on an outreach basis when needed.

The goals of the prompt intake assessment would be:

- to determine whether functioning is sufficiently outside the normal range to be regarded as a disorder (case identification),
- to determine whether the pattern of symptomatology matches regularly occurring patterns described in the diagnostic lexicon (diagnosis),
- to state a hypothesis (case formulation) of:
 - the underlying pathophysiology of the disorder (biopsychosocial etiology),
 - what factors set the stage for the problems (predisposing factors),
 - why the disorder has occurred at this time (precipitating factors),
 - what factors maintain it as a dysfunctional pattern (perpetuating factors),
- to summarise the issues that must change to produce a desired outcome (goals for change), and
- to propose a means by which those changes could be achieved (treatment plan).

The latter two goals may be initiated by the professionals, but it is essential for success that they be collaboratively developed with clients so that they are mutually “owned” by the parties involved in any therapeutic process. The plan should address the whole psychodynamic system, not just the symptoms of an individual. For example, it may not be feasible to treat a depressive illness in a person without changes in another person’s interpersonal relationships.

The paper on Early Treatment (PE5a) suggests an initial choice between private or public sector assessment, but if the public sector option is selected, the location would be at the local Community Health Centre. The paper advocates a Zero Waiting List approach, with assessment and short-term treatment to a maximum of eight sessions.

At the conclusion of the brief intervention programs it is expected that most cases could be closed or monitored subsequently by their family GPs. Assessment revealing the need for longer-term treatment would not be involved in short-term treatment but streamed to the Continuing Care program.

The defining characteristic of a Continuing Care program is that, regardless of duration, it follows an agreed Case Management Plan. This is a comprehensive plan of care for an individual client that describes:

- The client's problems, needs, and desires, as determined from the findings of the client's assessment.
- The strategies, such as treatments and interventions, to be instituted to address the client's problems and needs.
- The measurable goals – including specific outcomes – to be achieved to demonstrate resolution of the client's problems and needs, the time frame(s) for achieving them, the resources available and to be used to realize the outcomes, and the desires/motivation of the client that may have an impact on the plan

Case Management Plans cover not only the individual but also the family and social circumstances including health, welfare, housing, employment and wellbeing needs. This often necessitates collaboration between the therapist and other statutory and non-Government agencies. This is particularly so for clients with special needs, such as physical and intellectual disability or acquired brain damage involving Disability Support or NDIS involvement.

Tier Two services should be the default service provider for the whole community. No person should be refused access to assessment, and all persons should be case-managed in Tier Two, notwithstanding that components of service may also be provided by Tier Three as necessary. The MHYFVic paper on Early Treatment by Tier Two (PE5b) proposes coordinated service responsibilities across the Tiers. Service delivery in Tier Two would include:

- 7a) Community Mental Health Services
- 7b) Outreach Services

[7 a] Community Mental Health Services

This would be the first port-of-call for all referrals in the public sector, of all levels of severity. This would require the availability of specialist expertise 24 hours daily for every day of the year. It can be done, without undue expense, by having a zero-waiting list intake system within office hours and the Community Assessment & Treatment Teams (CATT) of specialist services responding out-of-hours. This latter service is described in Project Evidence PE 5c.

Within office hours Tier Two Community Health services should provide:

- Face-to-face intake and brief intervention programs
- Family therapy programs
- Case management support and treatment monitoring
- Group therapeutic programs
- Specific purpose programs for substance abuse, domestic violence, parenting & child behaviour management.

Intake interviewing of referred clients is best undertaken by highly skilled clinicians. The methods and rationale are described in paper PE5b. This involves close collaboration with Tier Three services as this intake process covers clients who, previously, would have gone directly to the Tier Three specialist services. Clients who require Tier Three services would be admitted to those facilities without further intake processes because this intake would have that triage authority. Equally, patients discharged from inpatient Tier Three facilities would be followed up in the Continuing Care program of the Community Mental Health service without additional screening.

There are strong economic, as well as administrative, arguments in favour of this proposal for an integrated service. Some of the difficulties in cross-agency collaboration are considered below.

As part of the Case Management role, some cases require Disability Support programs and some may be eligible for services through the National Disability Insurance Scheme. Appendix One has notes about Disability Support. Appendix Two is a summary from Wikipedia about the NDIS.

The out-of-hours Community Assessment & Treatment Teams (CATT) are considered in PE7b.

ECONOMIC CONSIDERATIONS

Mental health disorders result in high rates of premature death and serious losses in economic productivity. The disorders are widespread and frequent but under-recognized and at risk of under-servicing. Compared to the management of physical health problems, the mental health services have serious difficulties with resourcing, efficient utilization of the available resources and inequitable access to appropriate care.

The difficulties with resourcing are primarily due to specialist services being directed towards the most seriously mentally ill (2%) and being relatively unavailable to the great majority of lesser degrees of disturbance (15%-20%). Hospital-based services are somewhat under-resourced but Community-based services are particularly under-resourced.

The difficulties with efficient use of the available resources are primarily due to the segmentation of service provision across multiple budgetary centres which attend to their own areas of responsibility to the detriment of coordinated collaboration. Wholistic care dissipates when, without collaboration, tasks are designated as the responsibility of other providers. The difficulties with equitable access to appropriate care are primarily due to the uneven distribution of multiple uncoordinated services that do not readily facilitate transition to the most effective forms of care.

Tier One services provide educative and preventative programs of benefit to the whole community. When alerted to symptoms potentially indicative of mental disorder it is important for Tier One services to have ready access to Tier Two services for assessment and management.

Tier Two services should be the default service provider for the whole community. No person should be refused access to assessment, and all persons should be case-managed in Tier Two, notwithstanding that components of service may also be provided by Tier Three as necessary. This does not happen adequately at present, mainly because of different centres of accountability and funding, which are not required to collaborate, but could do so if required.

General Medical Practitioners and their associated clinical psychologists funded through Medicare could deal with a high proportion of cases. The psychological treatment programs of Community Health Centres could deal with self-referred clients or those referred by GPs because of chronicity or difficulty too great for primary care.

MHYFVic proposes a system whereby specialist mental health (Tier Three) workers should provide sessional input for the Community Health workers to ensure that the treatment programs can cater for the needs of the clientele or facilitate transition to Tier Three services if necessary. This system has the advantages of one intake, regardless of severity, one location for most treatment (except brief inpatient admissions if necessary), and widely decentralised service availability in non-stigmatising local centres.

APPENDIX ONE – Disability Support Services

Disability Support Pension is available to persons meeting non-medical and medical criteria.

The non-medical criteria are age 16-65, Australian resident, subject to means test.

The medical criteria are a) suffering one of a list of specific major disabilities, or b) suffering a chronic disorder (of impairment rating 20 or more) but required to participate in an accredited program of support.

Apart from the pension, which is a Commonwealth Government benefit administered through Centrelink, there are other services provided through the State Government Department of Human Services. One of these is a program called “Integrated Care”. It is described by the Department as:

“**Integrated care** is the provision of well-connected, effective and efficient care that takes account of and is organised around a person's health and social needs. The benefits of an integrated care system extend to patients, carers, health care providers and the broader health care system and can include:

- joined-up health and social care that is easier to navigate
- better experiences and outcomes for patients
- increased system efficiency and
- expanded workforce competencies across sectors.

Integrated care is especially important for more effective management of chronic diseases and for people with complex needs.”

Mental Health Community Support Services (MHCSS) are distinct from clinical mental health services, and play a vital role in supporting people with a severe mental illness and psychiatric disability throughout the recovery process.

MHCSS support people with psychiatric disability to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment.

Individualised client support packages (ICSPs) provide rehabilitation and recovery support tailored to a person’s needs and preferences.

ICSPs can be for individuals or groups, depending on a person’s preferences and type of support needed.

Individuals will develop a recovery plan with their ICSP provider.

The recovery plan may include:

- mental health self-care and self-management
- daily living skills
- physical health
- housing and living arrangements
- social relationships
- family and carer relationships
- social connections
- education, vocational training and employment
- parenting and carer/family support needs
- needs of vulnerable children.

Separate, again, are accommodation, respite and self-help services to provide families and carers with support and other resources.

- **Supported accommodation**

- Supported accommodation services provide long-term psychosocial rehabilitation support in a residential setting to people 16–64 years of age with an enduring psychiatric disability.
- To access the services contact planned respite, mutual support and self-help, and carer support service providers.

- **Planned respite**

- Planned respite services provide a short-term change in environment for a person with a mental illness and a break for carers, and include both formal and informal psychosocial rehabilitation components.
- Planned respite services may involve social and recreational day activities, including in-home support, holiday and adventure activities, and residential components.

- **Mutual support and self-help**

- Mutual support and self-help services provide information and peer support to people with a mental illness and/or their carers.
- This can involve the sharing of experiences and coping strategies, the provision of information and referral services, and the promotion of community awareness.

- **Carer support**

- Carer support assists carers, families and friends of people with a mental illness through the provision of information, financial assistance and general support.
- Carer support can occur in the carer's home, Mental Health Community Support Services (MHCSS), or in the community. Carer support workers are located in Commonwealth carer respite centres across Victoria.
- Carer respite centres provide information about the range of services and support available for carers of people with a mental illness and links to relevant public mental health services, as well as relevant information and resources.
- Carer support workers can assist in arranging respite and provide links to mutual support and self-help groups.
- Adult residential rehabilitation (ARR) services provide psychosocial rehabilitation support in a residential setting to people aged 16–64 with a psychiatric disability.
- The aim of ARR services is to assist people to develop social and daily living skills, maximise independence, encourage them to participate in the life of the community and to develop the confidence and ability to move on to independent living.

- **Youth residential rehabilitation**

- Youth residential rehabilitation (YRR) services provide residential psychosocial rehabilitation support to young people 16–25 years of age with a psychiatric disability.

The aim of the YRR services is to help young people to achieve their recovery goals. This may include:

- learning or relearning skills and gaining the confidence required for independent living
- learning to better manage their mental illness
- developing social relationships, social connections, recreation, physical health, education, vocational training, employment and housing, and other needs
- support for alcohol and drug issues.

Although funded by the State Government, many of these services are actually supplied by non-government agencies under contract.

APPENDIX TWO - National Disability Insurance Scheme (NDIS)

The **National Disability Insurance Scheme (NDIS)** is a scheme of the Australian Government that funds costs associated with disability. The scheme was legislated for in 2013 and is expected to be in full operation nationally by 2020. It is administered by the National Disability Insurance Agency (NDIA).

The scheme entitles people with a "permanent and significant" disability (under the age of 65), to full funding for any "reasonable and necessary" support needs related to their disability (subject to certain restrictions). Funding is allocated to the individual, and the individual or their guardian chooses which providers supply the funded goods and services (subject to certain restrictions).

The scheme is entirely publicly funded: recipients do not purchase or contribute to an insurance policy, nor is funding means-tested. The term 'insurance' refers to the scheme's use of proactive insurance principles to manage long term financial sustainability, and that it aims to 'insure' any citizen will have costs covered in the event they are born with or acquire a disability.

Individual NDIS funding is independent of the Disability Support Pension and universal health care. NDIS legislation draws a distinction between health care and disability supports, only the latter being within the remit of the NDIS. In addition to funding for individuals, the scheme funds some general 'information, linkages, and capacity building' (ILC) programs.

History

During the 1970s, care of people with a disability in Australia shifted from institutionalisation to being cared for in the community. In 1974, Gough Whitlam proposed a national disability insurance scheme like the scheme offered in New Zealand. Academic Donna McDonald suggests it was Treasurer [Bill Hayden](#) who convinced Whitlam to focus on the introduction of Medicare instead. In 2005, the NSW government created the Lifetime Care and Support Scheme to cover ongoing care for people who had been severely injured in motor accidents.

In 2006, Bruce Bonyhady, chair of Yooralla, met with former Labor cabinet minister Brian Howe, who put him in touch with a group of people who became known as the Disability Investment Group. The Disability Investment Group made an independent submission to the Australia 2020 Summit in 2008. They then sent their recommendations to the Productivity Commission. The Productivity Commission released a report on the issue in 2011. Disability in Australia was framed as an economic issue, rather than a social issue. Research by PricewaterhouseCoopers in 2011 found that by approximately 2025 the cost of maintaining the status quo in relation to the care of people with a disability would be greater than the cost of an NDIS. In 2011, the Council of Australian Governments agreed the disability sector in Australia needed reform.

In 2011, it was recommended that psychosocial disability be included in the scheme. Due to the mental health sector's use of the recovery approach rather than a focus on permanent disability, this has been a culture clash.

A bill to establish the NDIS was introduced into Federal Parliament in November 2012 by then Prime Minister Julia Gillard. It was passed in March 2013 as the *National Disability Insurance Scheme Act 2013*. There is a COAG Disability Reform Council which continues to oversee the NDIS.

When the Abbott Government came into power in 2013, the assistant minister in charge of the NDIS was Mitch Fifield, who capped the number of employees the NDIA could have to 3,000, when the Productivity Commission had estimated 10,000.

The 2013 Australian federal budget committed \$14.3 billion to the NDIS, to be paid for by increasing the Medicare levy by 0.5%. As of May 2013, the Australian Government estimated the disability sector in Australia would need to double to meet the needs of the NDIS. The first part of the scheme rolled out on 1 July 2013. It was initially known as "DisabilityCare Australia" and commenced only in South Australia, Tasmania, the Hunter Region in New South Wales and the Barwon area of Victoria. The NDIS then commenced in the Australian Capital Territory in July 2014. The Medicare levy increased from 1.5% to 2% on 1 July 2014, to fund the NDIS.

In the first nine months of the scheme, 5,400 people with disabilities accessed an NDIS plan.

The 2016 Australian federal budget attempted to make savings of \$2.1 billion for the NDIS fund by re-assessing Disability Support Pension recipients' capacity to work and cutting compensation for the carbon pricing scheme. This included scrapping an ad campaign letting people know about the NDIS. Furthermore, this budget committed to

reduce the number of permanent employees in the NDIA to 3,000. Peak disability group People with Disability Australia expressed concerns the NDIS would become a 'political football'.

The NDIS was rolled out nationally on 1 July 2016. NDIS CEO, David Bowen, announced his resignation in March 2017, which took effect in November 2017. He was replaced with former Bankwest CEO, Rob De Luca.

In April 2018, the NDIA announced that Serco would be operating contact centres in Melbourne and regional Victoria for two years. This prompted concern from peak advocacy body People with Disability Australia and others about Serco's lack of experience with disabilities despite being at the first point of contact with clients.

The Financial Review noted that the NDIS was "becoming an economic factor in its own right", particularly in regional areas.

A report by Flinders University into the running of the NDIS found that half of all participants in the NDIS have either had their support reduced or have not experienced a change in their support levels since the NDIS has been introduced.

In 2018 it was reported that the NDIA had a budget of \$10 million for legal services that are employed to attempt to prevent people appealing for more money under the scheme or to prevent them from accessing the scheme. As of May, 260 cases had been resolved by the courts, with the NDIA losing 40% of them.

The NDIS has been developing a virtual assistant called "Nadia" which takes the form of an avatar using the voice of actor Cate Blanchett (see Artificial intelligence in government).

As of 30 June 2019, some 298,816 people with disabilities were being supported by the NDIS. The Tune Review, in 2019, made 29 recommendations to help the NDIS.

Services

The first stage of the NDIS aimed to provide reasonable and necessary support for people with significant and permanent disability.

Supports funded by the NDIS are split across three areas. "Core Supports" include everyday consumable items such as continence aids, personal care assistance, support with social and community participation and funding for transport. "Capacity Building" is intended to build the person with disability's independence and ability to manage their own life. The "Capital Supports" budget is intended for very expensive assistive technology and home or vehicle modifications.

It has been suggested that the creation of the National Disability Insurance Scheme will increase latent demand for services, rather than sate it.

The first year of the launch serviced:

- about 3,000 people initially drawn from the NSW local government area of Newcastle
- about 1,500 children with disability in South Australia from birth to 5 years of age
- about 800 eligible young people aged 15 to 24 in Tasmania
- about 4,000 people in the Barwon area of Victoria including the local government areas of the City of Greater Geelong, the Colac-Otway Shire, the Borough of Queenscliffe and the Surf Coast Shire, and
- the ACT getting ready for launch to support 2,500 residents from July 2014.

The ACT became the first state to complete a NDIS rollout.

The number of people assisted rose to 20,000 people with disability by 2015. It has been recommended to increase participation to 410,000 however this figure remains uncertain. There are two main entry points to the NDIS, through Early Childhood Early Intervention for those under 6 years old, and the general scheme for those between 6 and 65 years of age.

According to a report from the Australian Institute of Health and Welfare, demand for disability aid in Australia has seen significant increases in recent years. Job services and community support were the services most in need.

The NDIS is administered by the **National Disability Insurance Agency**.

The NDIS has an annual budget of \$700 million for specialist disability accommodation, this will be used to house 28,000 people with high support needs. As of 2015, over 7,000 young disabled people lived in aged care homes. A goal of the NDIS is to get younger people with disabilities out of residential age care settings.

Although the NDIS services are meant to be effective and disability-related, The Australian newspaper noted that tarot card readers and fringe therapy providers had become NDIS providers.

Therapies to treat dysphagia (swallowing difficulties, potentially life-threatening) were funded under the NDIS until late 2017, when they were discontinued.

Funding

The cost of the NDIS was a point of contention at a time when the Federal Government insisted upon a return to surplus in the 2013 Australian federal budget. In 2010, the Productivity Commission estimated it would cost A\$15 billion a year. Two years later a Government report revised that figure to \$22 billion in 2018. According to the Minister for Disability Reform, Jenny Macklin, the program will effectively double the cost of supporting those with disabilities. A number of state disability ministers initially described the draft legislation for the NDIS as lacking flexibility and criticised it for being too prescriptive.

The first state to fully commit to funding for the scheme was New South Wales on 7 December 2012, with costs roughly divided between federal and state governments. The then Premier of Queensland, Campbell Newman, wanted the federal government to fully fund the scheme, arguing the state cannot commit funds while the state's debt was high. On 8 May 2013, Campbell Newman signed the agreement in support of the program.

An agreement between Tasmania and the federal government was achieved on 2 May 2013. The state committed to \$134 million of initial funding. The Northern Territory signed an agreement to join the scheme on 11 May 2013. From 1 July 2014 the Medicare levy rose from 1.5% to 2% to help fund the NDIS.

The scheme's funding has been noted to be complex, with money being pooled from multiple sources at federal and state/territory government levels. Guide Dogs Victoria has complained that only half of its members are eligible for the NDIS, and that they are losing donations because the public thinks Guide Dogs Victoria is funded under the NDIS.

Scott Morrison announced in January 2017 that the Productivity Commission would be conducting an independent review of the NDIS. A Victorian man who lives at Moriac won a court case against the NDIS for only agreeing to fund 75% of his transport costs to Geelong for his work and "NDIS-supported activities".

The emphasis of the NDIS has been noted to stem from the 2011 productivity commission report that began it.

An 0.5% increase to the Medicare levy was proposed after the 2017 budget, but in April 2018 this was scrapped, as the government had found "other sources of revenue". Disability groups have urged the government to provide greater clarity. In 2018 the Morrison Government set up a Drought Future Fund for farmers using \$3.9 billion "repurposed" from the NDIS.

Staffing

The Productivity Commission reported that some areas had less than 40% of the number of disability services employees needed to cope with demand for NDIS services. The NDIA spent over \$180 million on consultants and contractors between July 2016 and October 2017, which Jenny Macklin argues is due to the NDIA operating under a staffing cap. Disability support worker only identified negative aspects to the NDIS on the quality of jobs in interviews with UNSW.

Access Issues

A my.gov account is used to access the NDIS, and the IT system is administered by Centrelink as a cost-saving measure. In 2018, Bruce Bonyhady said that a key issue that was yet to be resolved "is what the supports are going to be if you're not in the NDIS".

There has been concern that people with "mild" intellectual disabilities, as well as those who are socially marginalised, will find it difficult to engage with the NDIS.

In the year 2015–2016, only 76% of participants' funds were utilised, which the Productivity Commission has stated was concerning as this could lead to poorer outcomes for participants. As of 2017, approximately 90% of NDIS costs were related to participant funding packages.

Jan Pike, former Paralympian, has said that while having been on the NDIS, it has taken five months for a wheelchair to be delivered to her, and she cannot get contractors to come and install a shower handrail because they are worried they won't get paid due to the NDIS web portal being "broken". A Facebook page, "NDIS Grassroots" has been set up and is used by people with disability to discuss their experiences with the NDIS.

Dr Kirsten Harley, who has a terminal illness, has been denied augmented communication through the NDIS because her condition will deteriorate. Neurological Alliance Australia has said NDIS plans aren't being made with the input of people who understand neurological conditions and so are inadequate. Dr Justin Yerbury was denied wheelchair and accessible housing modifications due to being assessed as having a poor life expectancy. Tim Rubenach was in the NDIS, but his assistive equipment delivery was delayed until after his death. His family have said that the delays in receiving his equipment hastened his death.

The process of writing NDIS plans has reportedly been cut down to hours rather than over some weeks. People who ask for a review are reportedly cut off from basic services.

In the Barwon region, parents of adults with disabilities have noted that the administration time has gone up, but that services have not increased for their children.

Guidelines have been developed to show how the NDIS will interact with other systems (health systems, child protection, early childhood education, primary, secondary and tertiary education, etc.) These interactions have been described as being open to "cost-shifting" between the NDIS and existing services.

Childhood disabilities with a late onset (ages 2-3) were predicted to be underserved in the ECEI model.

The peak body for disability services in Australia, National Disability Services, has estimated that the NDIS may owe up to \$300 million to service providers. As 12-month plans expire, people continue to receive services while waiting for a review from the NDIS, resulting in unpaid bills. In response, the NDIA has established a Provider Payment Team for service providers to contact to resolve issues.

Multiple specialist services are closing due to not having block funding anymore making it harder for participants of the NDIS to be able to use their packages.

The NDIA has asked that an Aboriginal boy in Tennant Creek be placed into care.

How NDIS plans are managed

There are three ways a NDIS plan is managed: the participant or their nominee managing the plan, a registered plan management provider, or the NDIS. Where the participant self-manages their plan, they are told to keep records of all purchases in case of a future audit.

Safeguarding

The NDIS Quality and Safeguards Commission, which will allow participants in the NDIS to make complaints about safety and quality of NDIS services, is being rolled out in NSW and SA from 1 July 2018; the ACT, NT, Queensland, Tasmania and Victoria in July 2019; and in WA from July 2020

Information Linkages and Capacity Building (ICL) program

While the NDIS will support some people with disability in Australia, the ILC program aims to support all PWD in Australia by improving the community's ability to welcome PWD and helping PWD to access wider community supports. The ILC program provides grants to organisations.

Carers

While a 2014 government report on the NDIS predicted the scheme would enable carers to participate more in the workforce or in work-allied activities, as of 2018, there was limited evidence that this was the case.

This is a Wikipedia posting accessed on 24/5/2020 whilst still in disputed process.

https://en.wikipedia.org/wiki/National_Disability_Insurance_Scheme

[To go to Best Practice Model BP7a close this file and go via Best Practice Index]

[To go to Policy POL7a close this file and go via Policy Index]

Last updated 2 June 2020