

Disability Support and Rehabilitation:
Discussion Paper

December 2016



Mental Health Coordinating Council

Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

For any further information please contact:

Corinne Henderson
Senior Policy Advisor
E: corinne@mhcc.org.au
T: 02 9555 8388 # 101

Jenna Bateman
Chief Executive Officer
Email: jenna@mhcc.org.au
Tel: (02) 9555 8388 # 102

To reference this paper please use the following protocol:

Mental Health Coordinating Council (MHCC) 2016, *Disability Support and Rehabilitation: Discussion Paper*, Authors: Bateman, J & Henderson, C (MHCC)

© Mental Health Coordinating Council 2016

Disability Support and Rehabilitation: Discussion Paper

The purpose of this paper is to explore the difference between the terms 'disability support' and 'rehabilitation' with specific reference to people with mental health conditions and/or psychosocial disability.

With establishment of the National Disability Insurance Scheme (NDIS) the need to distinguish between these different categories of support and the associated workforce skills, attitudes and knowledge required has intensified. In this paper, we explore the implications for comprehensive service coverage, in an environment where the role and function of the NDIS within the mental health service system is a developing picture.

In this context, the distinct role of state-funded community sector mental health rehabilitation service streams need to be more clearly articulated and defined against that of NDIS disability support options. The mix of rehabilitation and disability supports required by any one individual will vary. Some people may only require rehabilitation services in order to progress their recovery goals and move on with their lives. However, the majority of people will benefit from aspects of both to support their recovery.

Effective holistic care must be characterised by multi-agency collaboration integrating disability supports, rehabilitation and clinical services (including general medical services) assisted by a specialist mental health coordinating service such as Partners in Recovery (PIR).

MHCC propose that whilst a recovery approach is key to best practice across all service contexts, that the necessary workforce skills and competences and role delineation be made as clear as possible to ensure there are no misconceptions as to what services are being delivered under which defined schemes, programs and services.

Describing the differences between recovery oriented disability support and rehabilitation

Disability support commonly refers to processes, activities and services that aim to assist an individual to maintain optimal levels of independence, within the limitations of a defined disability. This usually means that workers complete specific tasks for an individual when they experience difficulty in completing them without support. This differs from rehabilitation, which aims to increase independence by maximising the potential the individual has to live without disability

Purposeful and targeted recovery oriented disability support which assists a person to live well in the community is as important as rehabilitation interventions which assist an individual to live without disability. ¹ Both are different but crucial to supporting 'recovery' rather than interchangeable substitutes.

In describing what the NDIS can provide for people experiencing psychosocial disability, the NDIS funds "reasonable and necessary supports that help people with disability reach their goals in life, to work and to be part of the community." ²

¹ Government of SA 2012, "The Framework for recovery-oriented rehabilitation in mental health care", Mental Health and Substance Abuse Division, p.32.

² NDIS My Place website Available:

https://myplace.ndis.gov.au/ndisstorefront/html/sites/default/files/documents/supports_ndis_fund_mental_health2_0.pdf [Accessed August 2016]

The Scheme will fund supports that assist a person to undertake activities of daily living. This includes assistance with household tasks, support to build capacity to live independently, achieve goals, such as developing relationships and engagement in community activities such as recreation, education, training and employment. Participants can choose to access their funded supports through centre-based services, in-home, community access and outreach services.

Rehabilitation is a dynamic and evolving process generally utilising cognitive remediation or cognition-enhancing approaches.³ The ability to learn from, reflect upon, make sense of, and create meaning leading to new action, is the essence of personal recovery. Where rehabilitation is offered, the strategies implemented are part of a graded process based on individualised need, and as such, are likely to change frequently. The approach adopted must always be the least restrictive option and be as consumer-driven as possible at every stage of care. In this sense, rehabilitation differs from the intentions of the NDIS, where adaptive techniques⁴ may be used as a part of a plan to assist an individual to develop skills and abilities consistent with the recovery-oriented vision of self-determination and independence. Rehabilitation involves working beyond simple provision of services to promote self-determination and autonomy.

Question 1 – How useful is the language of 'disability support' as a distinct category of support to people with mental health conditions?

Duty of care, dignity of risk and supported decision-making in the context of rehabilitation practice

An aspect of rehabilitation practice is fostering increased self-determination, which requires a comprehensive knowledge of the principles of Supported Decision-Making (SDM) and awareness of the ethical tensions that arise with regards to duty of care and dignity of risk in practice.

Managing these ethical tensions, involves considerations surrounding maximising choice, supporting positive risk-taking versus medico-legal⁵ requirements, duty of care⁶ and promoting safety (e.g., the obligations of workers tasked with implementing a Community Treatment Order (CTO)). It is vital to differentiate between risks to be minimised and the risks which people have the right to experience. A rehabilitation approach involves working in an increasingly collaborative way which promotes people taking responsibility for themselves, whilst acknowledging potential risks.

³ **Cognitive remediation approaches** often resemble brain training exercises targeted towards improving attention, memory, visual information processing, language and executive functions. It is often delivered via a computerised or online program, or one-on-one with a trained clinician, where a person is supported to develop effective strategies to complete cognitive tasks. A cognitive remediation approach involves a tailored program to target a person's cognitive challenges, tailored to their needs. Through this process, the brain can be trained and functions such as memory, attention, problem solving can indeed be improved (Kern et al., 2009). Compensatory approaches can be applied and integrated with other support strategies such as adapted and compensatory approaches.

⁴ In **adaptive or compensatory approaches**, the main aim is not to improve cognitive ability, but to reduce the impact of cognitive difficulties on a person's ability to carry out activities in their everyday life (Kern et al., 2009). They are based on the idea that we can rearrange the environment and teach skills to help a person overcome the cognitive difficulties they experience. These assist the person to overcome or bypass challenges associated with cognitive difficulties through the use of environmental supports such as lists, prompts, reminders and activity simplification. Kern, R. S., Glynn, S. M., Horan, W. P., & Marder, S. R. (2009). Psychosocial treatments to promote functional recovery in schizophrenia. *Schizophrenia Bulletin*, 35, 347-361. doi:10.1093/schbul/sbn177

⁵ **Medico-legal** - Common law (case-based law) surrounding a doctor's interaction with a patient within the confines of a standard doctor-patient relationship determines that doctors have a legal obligation to patients to adhere to a standard of reasonable care. **Duty of care** exists between doctors and patients both ethically and with respect to common law and legislation. The definition of a 'patient' is interpreted broadly; a duty of care may exist between doctors and future patients, and even between medical administrators and hospital patients.

⁶ Rogers v Whitaker (1992) 175 CLR 479. [Search PubMed](#) Roylance v General Medical Council [2000] 1 AC 311; Fitzgerald v The Medical Board of Queensland [2010] QCAT 565. [Search PubMed](#)

It is often necessary to take risks in order to learn and grow. We suggest that this concept forms the basis of rehabilitation. Informed decision-making involves a general awareness of the consequences of the decision and the decision being made voluntarily without coercion.

Evidence has shown that outcomes are optimised where consumers and families have choice about, and access to whatever aspects of recovery and rehabilitation are needed to support their efforts to cope with, adapt to, or overcome the impact/s of a mental health condition.⁷

Rehabilitation and recovery occur in the context of a person's life, where families and carers are involved working with all perspectives of a person's recovery. This is a key aspect of best practice for a rehabilitation worker. The role of a disability support worker is to provide day-to-day functional support.

Question 2 - Is Supported Decision-Making a role that forms part of mental health work? Is Supported Decision-Making core to the role, skills and competences required by mental health workers to provide effective rehabilitation services?

Question 3 - How can legal and ethical issues with regards to duty of care align with promotion of (SDM) as part of best practice?

Question 4- Do mental health workers need skills and competencies to differentiate between risks to be minimised and the risks which people have the right to experience?

Question 5 – Do all workers need to understand the components of rehabilitation, whilst not necessarily be an expert in providing all interventions; but be skilled enough to refer appropriately?

Recovery oriented disability supports in the context of the NDIS

Experience from the NDIS launch sites in NSW and Victoria identified a need for clarity around 'psychosocial disability' for people with mental health conditions. What immediately became clear was a need to develop a more holistic understanding of mental health disability, which supports both a recovery orientation and evidenced-based practice. However, rehabilitation as a fundamental aspect of the recovery journey is absent from the literature.

Nevertheless, O'Halloran (2015) wrote that what was required in order to understand psychosocial disability support in the context of the NDIS is: "definition and differentiation of clinical and functional needs, thus supporting a more integrated approach to determining access, planning and implementation of necessary and reasonable supports."⁸ In his paper he explores the importance of the recovery approach as a framework of values and actions. This is to foster integration of the various domains of recovery supports including personal efforts at self-management, psychosocial disability services and clinical interventions.⁹ Using the language of psychosocial disability support to express the integration of a range of supports, O'Halloran wrote that "to create choice and a sense of control, and to optimise personal self-management efforts, can often entail the need to have access to clinical treatments, to assist in alleviating symptoms and managing the emotional distress and psychological aspects of the mental illness."¹⁰ He draws attention to the fact that the inconsistent language of clinical and disability support services can

⁷ O'Halloran P 2016, 'Psychosocial Disability and the NDIS: Introduction to the Concept of Holistic Psychosocial Disability Support', NDIA, Canberra.

⁸ O'Halloran P 2016, 'Psychosocial Disability and the NDIS: Introduction to the Concept of Holistic Psychosocial Disability Support', NDIA, Canberra, p.3.

⁹ Ibid, p.4.

¹⁰ Ibid, p.6.

be confusing and lead to misunderstanding. He also writes that often, this language fails to reflect the language and understanding of lived experience, and the voice of the consumer movement more generally.¹¹

The NDIS uses the International Classification of Functioning (ICF) for eligibility assessment. Often the language of disability embodied in this classification does not comfortably translate into the mental health space. O'Halloran cites the example of the concept of: "permanency/or likelihood of permanency of impairment" which, while a core eligibility criteria for access to the NDIS, is in tension with the recovery approach, which is the guiding vision¹² and core value for contemporary practice in the mental health field.^{13 14}

Question 6 – In what way/s is the use of the ICF to determine eligibility for the NDIS problematic?

Question 7 – What potential problems arise from the definition of access to necessary and reasonable supports for people with mental health conditions under the NDIS criteria?

Workforce Implications

There are different roles within mental health services requiring varying levels of rehabilitation intervention knowledge. In all these roles mental health workers need to understand the principles of recovery-orientation and be aware of the potential impact their approach to service provision can have.

According to Dowse et al., 2016,¹⁵ "the Australian Government has made explicit its commitment to connecting NDIS scheme participants to mainstream services and natural supports where at all possible," (Council of Australian Governments (COAG), 2013).

This approach aligns with the principles of the Australian Government's National Disability Strategy (COAG, 2011) and the UNCRPD (2006). However, concerns have been expressed that the existing and future workforce will be unable to effectively work with people with mental health and complex coexisting conditions and difficulties unless the NDIA take on board the different and higher skill sets required in this space. MHCC suggest that governments need to be mindful of the costs associated with the provision of recovery rehabilitation services additionally required to disability support provision.

Government have estimated that the broad disability sector workforce will need to more than double in size between now and full implementation,¹⁶ increasing from approximately 73,600 full time equivalent (FTE) workers to an estimated 162,000 FTE workers (i.e., a shortage of 88,400 FTE workers). Solutions to address this shortfall will likely include a significantly increased number of sole trader allied health professionals and a proportion of volunteer carers who are able to move into paid disability care roles. It will also require ensuring the sustainability of the existing Cert IV and Diploma qualified mental health VET workforce who can provide rehabilitation support services, as well as capacity building disability service delivery organisations with a focus on new roles,

¹¹ O'Halloran P 2016, 'Psychosocial Disability and the NDIS: Introduction to the Concept of Holistic Psychosocial Disability Support', NDIA, Canberra, p.6.

¹² Antony W 1993, Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, 16, 11-23.

¹³ Australian Health Ministers Advisory Council 2013, A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: Commonwealth of Australia.

¹⁴ Op cit, O'Halloran P 2015, p.7.

¹⁵ Dowse, L Wiese, M Dew, A Smith, L Collings S & Didi A 2016, 'More, better, or different? NDIS workforce planning for people with intellectual disability and complex support needs', Journal of Intellectual and Developmental Disability, 41:1, 81-84.

¹⁶ Disability Reform Council 2015, 'NDIS Integrated Market, Sector and Workforce Strategy', Australian Government, Canberra.

expanded services and consumer-led care models in the home and community(e.g. through a peer workforce).¹⁷

The ways in which mental health community support services are delivered is changing.¹⁸ While many examples of possible workforce development directions and implementation strategies have been proposed, there are no specific strategies as yet agreed to that will ensure a sufficient supply of workers with the right knowledge, values and skills to provide the services required by NDIS participants; especially in relation to the skills required to provide services and supports to people with mental health conditions. The Integrated Market, Sector and Workforce Strategy mentions the possible establishment of a 'Transforming the Workforce Program'.¹⁹

"... to ensure the NDIS meets the needs of participants with mental health issues, it will be necessary to engage the sector to define mental health support roles, related job design and training requirements and establish how these roles differ from, and overlap with, other disability support roles."²⁰

The NDIS must be mindful of the wide ranging skill set required to provide recovery oriented, trauma-informed psychosocial disability and rehabilitation support work for people living with mental health conditions. This includes understanding and demonstrating the competences to identify and work with people living with varying degrees of cognitive difficulty, and potentially being capable of offering SDM to support people to maximise their autonomy. Additionally it is necessary for workers to be skilled in working with people experiencing ongoing psychosis, delusions and suicidality, and have the knowledge to identify, support and appropriately refer.

Our concern is that the directions of the Integrated Sector, Market and Workforce Strategy²¹ may not sufficiently include consideration of what is already known about the skills required for effective mental health support work, particularly in an NDIS context, and give due consideration as to what level of support the NDIS will be capable of providing.

Development of the peer workforce is an important strategy to address projected workforce shortages. To ensure the quality of services and supports being provided, it has been suggested that there is a need to more fully articulate and strengthen both mental health rehabilitation support roles, as well as peer roles and workforce development directions as the NDIS progresses towards full implementation. Failure to do so is likely to lead to not only: "role strain and role confusion for peer workers" but loss of access to the core psychosocial rehabilitation skill set and "less than optimal outcomes for NDIS participants and their families and carers."²²

As a key component of recovery oriented mental health services, peer workers²³ can demonstrate to people receiving mental health services that recovery is possible; as is

¹⁷ MHCC 2015, 'Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis', MHCC, Sydney, Author: Smith, T. Available: <http://www.mhcc.org.au/media/67408/mhcc-hunter-trial-site-2yr-report-aug2015.pdf>

¹⁸ Victorian Department of Health 2014, 'Victoria's specialist mental health workforce framework Mental Health Community Support Services implementation plan 2014–19', Available: [at: www.health.vic.gov.au/workforce](http://www.health.vic.gov.au/workforce) (1406016)

¹⁹ MHCC 2015, 'Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis', MHCC, Sydney, Author: Smith, T. Available: <http://www.mhcc.org.au/media/67408/mhcc-hunter-trial-site-2yr-report-aug2015.pdf>

²⁰ Disability Reform Council 2015, 'NDIS Integrated Market, Sector and Workforce Strategy, Australian Government, Canberra, 2015.

²¹ Disability Reform Council 2015, 'NDIS Integrated Market, Sector and Workforce Strategy, Australian Government, Canberra, 2015.

²² MHCC 2015, 'Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis, MHCC, Sydney, Author: Tina Smith, Available: <http://www.mhcc.org.au/media/67408/mhcc-hunter-trial-site-2yr-report-aug2015.pdf>

²³ Peer support or peer workers are people who have a lived experience of a mental health condition either as a person who has lived with a mental health condition (or as a carer of someone who has experienced a mental health condition).

participation in social and employment activities, as well as providing people with support for their own recovery.²⁴ These roles could not only provide more effective service delivery whilst also providing employment pathways for people with lived experience; but also help to address workforce shortages.

In the current environment there would seem to be a real need to pursue peer workforce development, as well as an increasing recognition of the complexity of skills required in recovery rehabilitation support work, including the skills required for complex care coordination. Appropriately valuing and costing care/service coordination is an increasingly recognised NDIS support category known to be a critical skill set in recovery oriented service delivery (MHCC 2015b).²⁵

If governments acknowledge the vital need to understand how the NDIS compliments the high intensity rehabilitation services that require higher worker skill sets, targeted workforce development and learning strategies will be required. This is so that the workforce across NDIS and community based rehabilitation services have sufficient skills, knowledge and understanding to identify and meet the needs of all mental health services users including NDIS participants and their carers.

The gap in appropriately qualified mental health workers available during the transition period to full NDIS operation is of concern. Some people with mental health conditions now eligible for the NDIS may have had access to a skilled mental health workforce in both public and community managed services. In transitioning to the NDIS the pricing of workers will likely negatively impact the support clients with mental health and complex rehabilitation support needs can access.

COAG made an explicit commitment to build a support system responsive to the particular needs of those with complex support needs (COAG, 2011).²⁶ Dowse et al., (2016) suggest that a comprehensive national audit of workforce distribution, competence, and capacity are key first steps. Without an NDIS workforce plan that explicitly accounts for the needs of this group, honouring the Australian Government's commitment to their inclusion seems impossible.

Question 8 – What is the NDIS's role in supporting people requiring mental health and complex support needs?

Question 9 – Should the NDIS be providing complex rehabilitation support needs for people living with mental health conditions at all?

Question 10 – Should a rehabilitation skill set be part of the NDIS, or should States be responsible for the psychosocial rehabilitation skill set?

Question 11 – If the NDIS only has the capability (skills and dollars) to provide disability support, are people likely to get their rehabilitation needs met elsewhere?

Question 12 - What initiatives are necessary to promote an expanded peer workforce to address workforce shortages and to ensure the necessary skills required?

²⁴ Community Mental Health Australia 2015, 'Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project', Sydney: MHCC.

²⁵ Ibid.

²⁶ Dowse, L Wiese, M Dew, A Smith, L Collings S & Didi A 2016, 'More, better, or different? NDIS workforce planning for people with intellectual disability and complex support needs', *Journal of Intellectual and Developmental Disability*, 41:1, 81-84, DOI: 10.3109/13668250.2015.1125868

Limitations of the NDIS Pricing structure

This paper suggests that an appropriately qualified and competent rehabilitation worker must demonstrate a level of skill and expertise that the NDIS workforce is unlikely to be able to provide for two reasons:

1. The workforce under the NDIS is experiencing a degree of casualisation leading to less oversight of practice approaches.
2. The fee structure that has been established is well below rates that can ensure appropriately qualified workers with higher rehabilitation skill sets can be employed to undertake this role.

There has been considerable disquiet about the pricing and costing structure that has been developed since the initial roll-out of the NDIS. Many services have voiced their concerns that hourly rates are unrealistic. ^{27 28}

The need for further analysis of the true cost of providing the range of services is required. This must be in the context of a clear understanding of what the NDIS is intending to achieve in terms of outcomes for people with psychosocial disability.

“Unfortunately, NDIA data and assumptions about the weighted average cost of supports currently provided by the NDIS is not publically available. This information would help us understand the effective price that service providers are receiving” (MHA 2016). ²⁹

Professor David Gilchrist from Curtin's NFP Initiative said that: “it was clear the disability services sector would not be able to meet the demand for services in the medium and long term unless action was taken. There are two steps to addressing the issue. The first is coming together as a sector to define what the sector is capable of, and collating information about the real cost of service delivery and the capacity of organisations to be able to provide services. The second element is developing an industry reconstruction plan at a government level, “as they do in any other industry that's going through a massive reconstruction”, (2016).

This paper notes that the NDIA recently announced a benchmarking project which is likely to reflect current cost pressures, rather than identifying what an appropriate price is, based on the skills and training required to perform evidence-based, effective and safe psychosocial disability support work.³⁰

Question 13 – Is the pricing structure of the NDIS the only limiting factor to access to rehabilitation support services?

Question 14 – How might organisations provide services at NDIS rates through alternative costing structures utilising commercial models of price based on allocation of funds rather than based on real price levels e.g. by understanding costs across the organisation?

Q 15 – How do State and Commonwealth interests and responsibilities affect current outcomes – for example with regards to ensuring choice and control for people living with mental health conditions?

²⁷ Dowse, L Wiese, M Dew, A Smith, L Collings S & Didi A 2016, 'More, better, or different? NDIS workforce planning for people with intellectual disability and complex support needs', *Journal of Intellectual and Developmental Disability*, 41:1, 81-84, DOI: 10.3109/13668250.2015.1125868

²⁸ Mental Health Australia 2016, *Mental Health Costings and the NDIS* (unpublished)

²⁹ Ibid.

³⁰ Ibid.

Summary

O'Halloran (2016)³¹ suggests that the NDIS will particularly offer psychosocial disability support where "the impairment(s) result in substantially reduced functional capacity or psychosocial functioning in undertaking, one or more of the following activities":

- Communication;
- Social interaction;
- Learning;
- Mobility;
- Self-care;
- Self-management; and
- Social and economic participation

O'Halloran goes on to write that the NDIS: "is about putting the person at the centre of the process of determining need, exercising choice and optimising a sense of individual control. From a person-centred planning framework, the question becomes focused on what particular supports and assistance are required, in addition to self-management efforts, to pursue a better quality of life through greater community and economic participation" (p.16).³²

MHCC are concerned that the NDIS, as it continues to be rolled-out is unlikely to be able to provide the recovery rehabilitation supports that O'Halloran alternatively describes as 'psychosocial disability support'. Under current product and pricing structures the NDIS is only capable of delivering what we describe in this paper as 'disability support' services.

This discussion paper provides an opportunity to highlight the need to both clearly articulate the meanings attached to the different terminologies, and the necessity to foster two sets of workers both capable of offering recovery oriented services but at two different levels of skill and competency – that of a) 'disability support' (under the NDIS) and b) 'rehabilitation' as required across a diversity of service contexts. Furthermore, this paper suggests that there is a need to develop an overarching policy framework for recovery-oriented disability support and rehabilitation services in mental health space, in the context of the nationwide rollout of the NDIS.

Such a framework could describe the shared language and understanding of recovery across both disability support and rehabilitation service provision; and articulate how these fit together in a wider service context. A framework could guide service delivery by focussing on ensuring that people receive the right mental health services that meet their needs and goals, wherever and whenever they are required irrespective of eligibility to services provided under the NDIS.

Such a framework could likewise provide a guide to ensuring recovery-oriented rehabilitation policy and service development, planning and implementation in mental health services, and assume a commitment at policy and service levels to the implementation of recovery rehabilitation services across NSW. This would: "maximise opportunities to mitigate fragmentation of service delivery and to link the various aspects of rehabilitation services to promote continuity of care across both public and non-government mental health services".³³ Potentially, it could greatly enhance service experience for consumers, their families and carers.

³¹ O'Halloran P 2016, 'Psychosocial Disability and the NDIS: Introduction to the Concept of Holistic Psychosocial Disability Support', Western Sydney LHD, p.16.

³² Ibid, p.16.

³³ Government of SA 2012, "The Framework for recovery-oriented rehabilitation in mental health care", Mental Health and Substance Abuse Division, p.25.

Nevertheless, this paper does not suggest that a framework should be a manual dictating how recovery disability supports and rehabilitation must be implemented.³⁴ Best practice in rehabilitation is a dynamic and evolving field informed by robust research and evaluative processes, and should remain flexible to embracing new learnings and innovation.

Q 16 - How important is it to foster and maintain best practice in the mental health space through the development of an overarching national policy framework for recovery-oriented disability support and rehabilitation services in mental health space, particularly in the context of the nationwide rollout of the NDIS and the role of PHNs?

Recovery-oriented disability support and rehabilitation services and the strategies implemented are based on individualised need and as such, are likely to change frequently. The approach adopted must always be the least restrictive option and be as consumer-driven as possible at every stage of service provision.³⁵

Anthony and Farkas (2011)³⁶ wrote that:

“Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that significantly impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualised.”³⁷

With this in mind, we ask that the reader consider that disability supports provided under the NDIS could be seen as complimentary to rehabilitation services, and vital to many participants' recovery journeys. In order to achieve this it would be necessary to ensure that there are appropriately qualified workers to take on roles that require higher skill sets.

In the analysis undertaken by Mental Health Australia of the draft National Mental Health Service Planning Framework they demonstrate that based on COAG's own numbers, approximately 289,000 people with a severe mental illness will need individualised, intensive community supports in any 12-month period. This is approximately 5 times the estimated number of people with a psychosocial disability that are forecast to be eligible for the NDIS.³⁸

The overarching question running through this paper is what services should the NDIS be responsible for providing and how could governments take responsibility for those whose needs cannot be met by the NDIS? This is in terms of either client eligibility or the service type characterised by the need for a worker with higher skill sets. There are many consumers who may benefit from access to rehabilitation services, in order that they can progress their goals towards recovery; and who might be disadvantaged if assessed and categorised within a disability frame. This speaks to the significant ongoing need for mental health recovery focused rehabilitation services to be provided outside the NDIS.

Q 17 - What services should the NDIS be responsible for providing, and how could governments take responsibility for those whose needs cannot be met by the NDIS?

³⁴ Government of SA 2012, “The Framework for recovery-oriented rehabilitation in mental health care”, Mental Health and Substance Abuse Division, p.25.

³⁵ Government of SA 2012, “The Framework for recovery-oriented rehabilitation in mental health care”, Mental Health and Substance Abuse Division, p.25.

³⁶ Anthony W & Farkas M. The Essential Guide to Psychiatric Rehabilitation Practice. Boston: Boston University Center for Psychiatric Rehabilitation, Boston 2011.

³⁷ Government of SA 2012, “The Framework for recovery-oriented rehabilitation in mental health care”, Mental Health and Substance Abuse Division, p.25

³⁸ Mental Health Australia 2016, Mental Health Costings and the NDIS (unpublished)

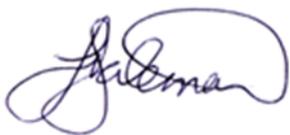
MHCC are keen to progress the discourse surrounding the need for both state and Commonwealth governments to acknowledge that the NDIS cannot be 'all things to all people'. Likewise, that governments acknowledge that the existing pricing structure of the NDIS is incapable of providing services that require the higher skill set identified as prerequisite to delivering rehabilitation services.

In this context, MHCC reiterate the point that many people who access rehabilitation services, will subsequently be able to progress their recovery goals and 'get on with their lives'. Frequently, people in recovery are not permanently disabled by their mental health condition, and would not necessarily benefit from being categorised under the NDIS eligibility criteria.

MHCC offer this paper as a springboard for consultation and deliberation, and to provoke further discussion for the development of policy and practice reform.

We welcome responses to the questions posed throughout this discussion paper, which will inform future advocacy in this context.

Please provide comments via email by 10 February 2017 to Corinne Henderson, E: corinne@mhcc.org.au

A handwritten signature in blue ink, appearing to read 'Jenna Bateman', enclosed in a light blue rectangular box.

Jenna Bateman
Chief Executive Officer

December 2016

Appendix 1

Discussion Questions

Question 1 – How useful is the language of 'disability support' as a distinct category of support to people with mental health conditions?

Question 2 - Is Supported Decision-Making a role that forms part of mental health work? Is Supported Decision-Making core to the role, skills and competences required by mental health workers to provide effective rehabilitation services?

Question 3 - How can legal and ethical issues with regards to duty of care align with promotion of (SDM) as part of best practice?

Question 4– Do mental health workers need skills and competencies to differentiate between risks to be minimised and the risks which people have the right to experience?

Question 5 – Do all workers need to understand the components of rehabilitation, whilst not necessarily be an expert in providing all interventions; but be skilled enough to refer appropriately?

Question 6 – In what way/s is the use of the ICF to determine eligibility for the NDIS problematic?

Question 7 – What potential problems arise from the definition of access to necessary and reasonable supports for people with mental health conditions under the NDIS criteria?

Question 8 – What is the NDIS's role in supporting people requiring mental health and complex support needs?

Question 9 – Should the NDIS be providing complex rehabilitation support needs for people living with mental health conditions at all?

Question 10 – Should a rehabilitation skill set be part of the NDIS, or should States be responsible for the psychosocial rehabilitation skill set?

Question 11 – If the NDIS only has the capability (skills and dollars) to provide disability support, are people likely to get their rehabilitation needs met elsewhere?

Question 12 - What initiatives are necessary to promote an expanded peer workforce to address workforce shortages and to ensure the necessary skills required?

Question 13 – Is the pricing structure of the NDIS the only limiting factor to access to rehabilitation support services?

Question 14 – How might organisations provide services at NDIS rates through alternative costing structures utilising commercial models of price based on allocation of funds rather than based on real price levels e.g. by understanding costs across the organisation?

Q 15 – How do State and Commonwealth interests and responsibilities affect current outcomes – for example with regards to ensuring choice and control for people living with mental health conditions?

Q 16 - How important is it to foster and maintain best practice in the mental health space through the development of an overarching national policy framework for recovery-oriented disability support and rehabilitation services in mental health space, particularly in the context of the nationwide rollout of the NDIS and the role of PHNs?

Q 17 - What services should the NDIS be responsible for providing, and how could governments take responsibility for those whose needs cannot be met by the NDIS?

Appendix 2

Rehabilitation within the recovery paradigm

Key messages

- Best practice rehabilitation is recovery-oriented.
- Recovery is the potential and actualisation of person's individual journey.
- Rehabilitation is the process and tools that practitioners utilise and provide to people to assist in their recovery journey.
- Rehabilitation should be available in all settings and begin as soon as possible.
- Rehabilitation practices should always encompass purposeful evidence-based best practice interventions.
- Rehabilitation techniques provide a range of tools that can be used to assist an individual to gain or regain their independence and strive towards their recovery.
- Rehabilitation occurs on a continuum. All workers need to understand rehabilitation but not everyone needs to be an expert in providing all interventions.
- Rehabilitation enables people to connect and become part of their community and be satisfied and successful in the living, working, learning and social environments of their choice¹⁹.
- People with lived experience of mental illness and their carers should be key collaborators in the development, implementation, evaluation and modification of individual and group rehabilitation programs.
- The process of establishing a positive therapeutic relationship is a part of the rehabilitation continuum. It takes effort and time.
- Rehabilitation requires effort and engagement. Although it may not 'just happen' it rewards both consumers and practitioners.
- Rehabilitation will not necessarily lead to consecutive gains for consumers. Setbacks and overcoming setbacks are part of the rehabilitation process. Rehabilitation opportunities should be offered time and time again.
- Rehabilitation services that are shaped by goals of promoting hope, healing and empowerment ensure mental health services foster an underlying attitude that recovery is possible, offer opportunities for consumers to maximise their own experience of recovery, and create a service environment that is flexible, responsive and accessible.
- Rehabilitation is cost effective and reduces requirements for acute interventions

Types of rehabilitation

Types of rehabilitation services commonly accessed and available to people with lived experience of mental illness include but are not limited to:

- > Psychosocial rehabilitation.
- > Vocational and educational rehabilitation.
- > Drug and alcohol rehabilitation.
- > Physical rehabilitation.
- > Clinical rehabilitation.

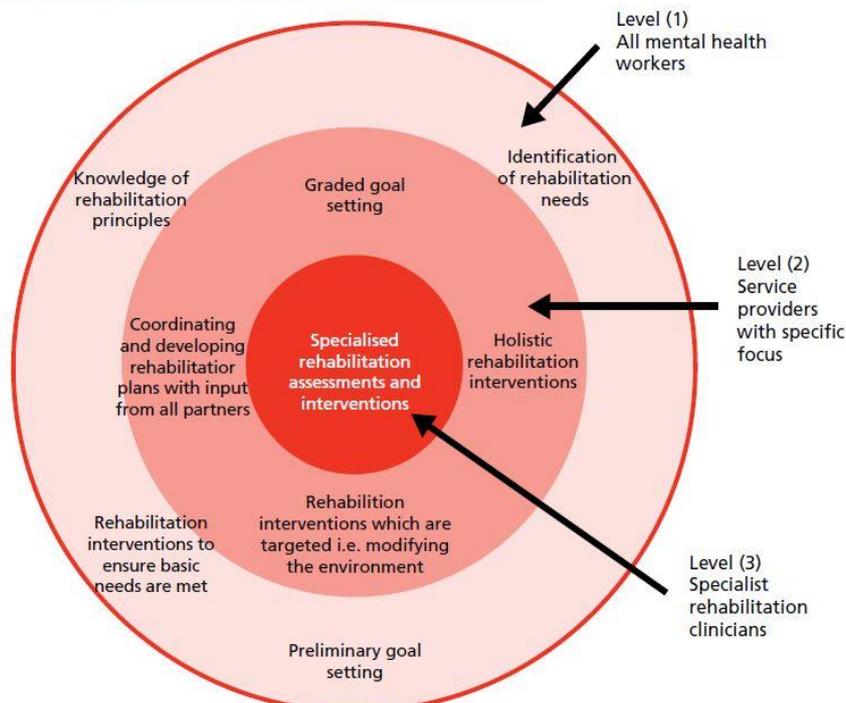
Components of the recovery-oriented rehabilitation services named above often combine and/or overlap. It should not be assumed that they operate in isolation from each other.

A variety of tools and approaches can assist service providers in providing rehabilitation services. Examples of strategies and tools that support recovery-oriented rehabilitation practice include but are not limited to:

- Positive therapeutic relationships
- Practitioner's behaviour
- Recovery-oriented assessment
- Recovery goals and care planning
- Individual's motivation
- Motivation and goal-setting
- Motivational interviewing
- Strengths-based recovery-oriented rehabilitation interventions
- Therapeutic use of environment.

Source: Government of SA 2012, "The Framework for recovery-oriented rehabilitation in mental health care", Mental Health and Substance Abuse Division, p.26. Diagram below p.37

Figure 6: Examples of rehabilitation services and interventions



Bibliography

- Ades A & Clarke ZJ 2003, 'Mapping the journey – goal setting', *Psychosocial Rehabilitation*, 2003:5.
- Anthony W 1993, 'Recovery from mental illness: the guiding vision for the mental health system in the 1990s'. *Innovations and Research*, vol. 2, pp. 17–24.
- Anthony W and Farkas M 2009, *Primer of the psychiatric rehabilitation process*, Boston University Center for Psychiatric Rehabilitation, Boston.
- Anthony W & Farkas M 2011, *The Essential Guide to Psychiatric Rehabilitation Practice*, Boston: Boston University Center for Psychiatric Rehabilitation.
- Australian Health Ministers Advisory Council 2013, *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Canberra: Commonwealth of Australia.
- Bora R, Leaning S, Moores A and Roberts G 2010, 'Life coaching for mental health recovery: the emerging practice of recovery coaching', *Advances in Psychiatric Treatment*, vol. 16, pp. 459–67.
- Commonwealth Government of Australia 2010, *National standards for mental health services*, Canberra.
- Corrigan P, Mueser K, Bond G, Drake R and Solomon P 2008, *Principles and practice of psychiatric rehabilitation*, Guilford Press, New York.
- Commonwealth of Australia 2013, 'The national framework for recovery-oriented mental health services: policy and theory', Australian Health Ministers' Advisory Council, Available: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol>
- Community Mental Health Australia (CMHA) 2015, 'Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project', Sydney: Mental Health Coordinating Council.
- Davidson L, Bellamy C, Guy K and Miller R 2012, 'Peer support among persons with severe mental illnesses: A review of evidence and experience', *World Psychiatry*, vol. 11, no. 2, pp. 123–28.
- Davidson L, Chinman M, Sells D and Rowe M 2006, 'Peer support among adults with serious mental illness: a report from the field', *Schizophrenia Bulletin*, vol. 32, pp. 443–50.
- Deegan P 1988, 'Recovery: the lived experience of rehabilitation', *Psychosocial Rehabilitation Journal*, vol. 11, pp. 11–19.
- de las Heras G. et al 2003, 'A user's manual for remotivation process: progressive intervention for individuals with severe volitional challenges', *The Model of Human Occupation Clearinghouse*, University of Illinois, Chicago, USA.
- Department of Health and Community Services 2008, 'Aged and disability program – risk management process', Department of Health and Community Services, Northern Territory Government, Darwin, NT, Australia, Available: www.nt.gov.au/health
- Department of Health 2011, 'Framework for recovery-oriented practice', State Government of Victoria, Melbourne.
- Department of Human Services 2009, 'Because mental health matters: Victorian mental health reform strategy 2009–2019', State Government of Victoria, Melbourne.

Disability Reform Council 2015, 'NDIS Integrated Market, Sector and Workforce Strategy', Australian Government, Canberra,

Dowse L Wiese M Dew A Smith L Collings S & Didi A 2016, 'More, better, or different? NDIS workforce planning for people with intellectual disability and complex support needs', *Journal of Intellectual and Developmental Disability*, 41:1, 81-84, DOI: 10.3109/13668250.2015.1125868

Eisen S & Youngman D 1994, 'Instruction manual for BASIS-32', Department of Mental Health Services Research, McLean Hospital.

Glover H 2012, 'Recovery, lifelong learning, empowerment & social inclusion: is a new paradigm emerging?' In: Ryan P Ramon & Graecen S (eds.), *Impowerment, Lifelong Learning and Recovery in Mental Health: Towards a New Paradigm*, London: Palgrave.

Government of SA 2012, 'The Framework for recovery-oriented rehabilitation in mental health care', Mental Health and Substance Abuse Division.

Green MF Helleman G Horan WP. Lee J & Wynn JK 2012, 'From perception to functional outcome in schizophrenia: Modeling the role of ability and motivation', *Archives of General Psychiatry*, 69, 1216-1224. doi:10.1001/archgenpsychiatry.2012.652

Kern, R. S., Glynn, S. M., Horan, W. P., & Marder, S. R. (2009). Psychosocial treatments to promote functional recovery in schizophrenia. *Schizophrenia Bulletin*, 35, 347-361. Doi:10.1093/schbul/sbn177

Leamy, M Bird, V Le Boutillier C Williams J & Slade M 2011, 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', *The British Journal of Psychiatry*, vol. 199, pp. 445-52.

Lieberman R & Kopelowicz A 2002, 'Recovery from schizophrenia: a challenge for the 21st century', *International Review of Psychiatry*, vol. 14, pp. 242-55.

Marathon Health 2015, 'Partners in Recovery Clinical Coordination Model' (PIRCCO).

Mental Health Australia 2016, *Mental Health Costings and the NDIS* (unpublished).

Mental Health Coordinating Council 2015, 'Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis', MHCC, Sydney, Author: Smith T, Available: <http://www.mhcc.org.au/media/67408/mhcc-hunter-trial-site-2yr-report-aug2015.pdf>

Mental Health Coordinating Council (MHCC) 2016, *Cognitive Functioning for Recovery, Learning Module MHCC LD*, Sydney Australia.

Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction', Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA).

Morgan, V Waterreus, A Jablensky, A Mackinnon, A McGrath, J Carr, V Bush, R Castle, D Cohen, M Harvey, C Galletly, C Stain, H Neil, A McGorry, P Hocking, B Shah, S & Saw S 2011, 'People living with psychotic illness 2010: report on the second national survey', Commonwealth Government of Australia, Canberra.

Murray CJ et al., 2012, 'Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010', *Lancet*, vol. 380, no. 9859, pp.2197-223, Dec 15 2012.

O'Halloran P 2015, 'About psychosocial disability and the NDIS: introduction to the concept of holistic psychosocial disability support', NDIA, Canberra.

Phelan M, Slade M, Thornicroft G, Dunn G, Holloway F, Wykes T, Strathdee G, Loftus L, McCrone P & Hayward P 1985, 'The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness', *British Journal of Psychiatry*, vol. 167, pp. 589–95.

Prochaska J & DiClemente C 1982, 'Transtheoretical therapy: toward a more integrative model of change', *Psychol Psychother Theor Res Pract*, vol. 19, pp. 276–288.

Ralph R 2005, 'Verbal definitions and visual models of recovery: focus in recovery model', in: Ralph R and Corrigan P, eds, *Recovery in mental illness: broadening our understanding of wellness*, American Psychological Association, Washington DC, pp. 131–35.

Repper J and Perkins R 2003, 'Social inclusion and recovery', Balliere Tindall, London.

Slade M 2009a, 'Personal recovery and mental illness', Cambridge University Press, New York.

Slade, M 2009b, 'Rethink recovery series', vol. 1, 100 ways to support recovery: A guide for mental health professionals, Rethink, London.

Slade M & Longden E 2015, 'The empirical evidence about mental health and recovery: how likely, how long, what helps?' MI Fellowship, Victoria.

Victorian Department of Health 2014, 'Victoria's specialist mental health workforce framework Mental Health Community Support Services implementation plan 2014–19', Available: at: www.health.vic.gov.au/workforce (1406016)

Victoria State Government 2015, 'Components of effective mental healthcare: Treatment, community-based rehabilitation and disability support', DRAFT Discussion paper – December 2015, Health & Human Services.

Warner R 2009, 'Recovery from schizophrenia and the Recovery Model', *Current Opinion in Psychiatry*, 2009(22):374–380, South London and Maudsley NHS Foundation Trust & South West London and St George's Mental Health NHS Trust, 'Recovery is for all. Hope, agency and opportunity in psychiatry', A position statement by consultant psychiatrists, London, UK, 2010.

World Health Organisation (WHO), *International Classification of Functioning, Disability and Health: ICF*, Geneva, WHO, 2001.