Discussion Paper:
Community-based Psychosocial Rehabilitation: A Casualty of the National Disability Insurance Scheme?

In Australia it is estimated that 1 in 5 people will experience some form of mental ill health each year (Australian Institute Health & Welfare (AIHW) 2016). In 2014–2015 approximately 18.3% of the South Australian population reported experiencing a long-term mental health or behavioural problem (ABS, 2015).

The Mental Health Coalition of South Australia is committed to advocating for a holistic approach to mental wellness in South Australia. This commitment includes a desire for those experiencing persistent and severe mental illness to have access to appropriate mental health treatment, community based rehabilitation and disability support to achieve recovery in ways that are meaningful to the individual.

The National Disability Insurance Scheme (NDIS), at full implementation is designed to have capacity to support 12% of those experiencing severe mental illness (O'Halloran, 2016). The National Mental Health Commission (NMHC) has defined severe mental illness as 'a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning' (NMHC 2014). Those experiencing this level of mental ill health have been characterised by three sub groups:

- **Severe episodic**: individuals who have discrete episodes, interspersed with periods of remission (about two-thirds of the overall severe population).

- **Severe and persistent illness**: individuals with chronic mental illness that causes major limitations on functioning (i.e. very disabling) and is chronic without remission over long periods. This group represents about one-third of the overall severe population.

- **Severe and persistent illness with complex multiagency needs**: this group represents those with the greatest disability among the severe population and who require significant clinical care (including hospitalisation), along with support to manage most of the day-to-day living roles (e.g. housing support, personal support worker domiciliary visits, day program attendance) (NMHC, 2014).

Those who do not fit these subgroups and are experiencing episodic or chronic (persistent) conditions, not confined to specific diagnostic categories with both severe disability and those who have complexities that are not disability-related (e.g. chronic physical illness, high suicide risk, require coordinated care etc.) are considered to be experiencing severe and complex mental illness (NMHC, 2014). Severe mental illness may result in either, or both psychiatric disability (impairment in one or more areas of functioning, such as occupational, academic and social) and psychosocial disability (effects that impair or restrict functioning, capacity think clearly, physical health and social emotional activities and relationships). (Hayes et. al. 2016; National Mental Health Consumer & Carer Forum 2011; Stein et al. 2010).

For those experiencing mental illness WHO recommends the implementation of:
'… community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; the continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers and the promotion of self-care, for instance, through the use of electronic and mobile health technologies' (WHO, 2013, p.14).

The concept of a sector built primarily on community mental health services is reflected in the current National Mental Health Policy (2008) which aims to ensure consumers are supported

via a variety of connected services ranging from primary health care and acute mental health services through to community mental health services delivered by both the government and non-government sectors (FNMHP, 2009-2014; NMHP, 2008; Whiteford & Buckingham, 2005). With clients' needs being the focus of service delivery, the national goal is 'for people with mental health problems and mental illness to have access to the right care at the right time', and for services to be provided in a manner that places prevention and early intervention as a priority for sustainable recovery outcomes (FNMHP, 2009-2014; NMHP, 2008). This was based on people having access to an inter-connected sector including acute, clinical, and community services. This was evaluated against a downward spend trend in stand-alone psychiatric institutions and increased funding to general hospital mental health beds, community mental health services and non government mental health services. Reports show that in South Australia this transition was slow, with only approximately $2m or 1.7% of South Australian Mental health funding allocated to NGO delivered community based services in 1992-1993 rising to $3m in 2002-3 (National Mental Health Report, 2013). To the credit of the SA Government this increased to 9.5% in 2007-2008 and 11.5% in 2012-13. In the last two years this has declined alarmingly with the defunding of programs such as Intensive Home Based Support and Crisis Respite (Mackay & Goodwin-Smith, 2016; National Mental Health Report, 2013). This is in contrast to the literature that shows that consumers supported by systems built on collaborative, integrated community services, with rehabilitation elements have notably better recovery outcomes and quality of life than those treated in institutional care (Anderson et al. 2000; Carter, Burke & Moore, 2008; England & Lester, 2005). Evidence has also shown the importance and value of good quality acute and clinical based care where required (Mansell, 2005). We would argue that this demonstrates that effective mental health support must address three core areas - clinical treatment, community based rehabilitation and disability support - and that these areas must be linked to the mainstream health, mental health, housing and other social health services people need (Mackay & Goodwin-Smith, 2016).

The Productivity Commission estimates that under the proposed NDIS model, only 60,000 of the 489,000 people identified as experiencing a serious mental illness will qualify for a NDIS package of support based on the proposed criteria requiring to prove a 'permanent impairment', or more specifically in the mental health context, a 'serious and persistent mental illness with complex interagency needs' (Mental Health Council of Australia, 2013, p.01; Productivity Commission, 2011).

The Mental Health Council of Australia (MHCA) have proposed that, while not all 489,000 people estimated to be experiencing mental illness will require a package, the qualification criteria is confusing and will result in a large number of people who require support being excluded from accessing individualised packages (2013). Furthermore, the Productivity Commission's (2011) estimate that only 10% of those who qualify will require the most intensive levels of support has been noted by MHCA to underestimate the level of need for support and the complexity of mental health issues (MCHA, 2013). Concern has also been raised with regard to consumers who will not qualify for individual funding and their continued access to existing services and supports (which have been noted to already be insufficiently coping with demand), given the expected reduction in service funding to accommodate expenditure for the NDIS model (MCHA, 2013).

To underline the complexity, note must also be made of a potential 'unseen' cohort of people who may require access to mental health services, the NDIS and psychosocial rehabilitation programs. Eddie Bartnik (2016) noted that at existing roll out sites the NDIA have found that a reasonable proportion of people (an estimated 50%) entering the NDIS with a psychosocial disability are "new", that is, not currently known to the mental health system. Given that of the estimated 7.3 million Australians aged 16 to 85 experiencing mental illness less than half will access specific mental health treatment (Morgan, et. al. 2011), this is not surprising, and suggests the Productivity Commission's target of 60,000 people with severe mental illness to qualify for an NDIS package may be a significant underestimate of need. If service options are decreased to fund the Scheme and the Scheme is unable to provide packages to these people, we will see increased crisis, and detrimental effects to people's lives.

In 2010 three in ten people with a psychotic illness were recipients of a non-government

mental health service and 6,200 people were engaged solely with a non-government organisation (NGO) (Morgan et. al. 2011). These organisations are the primary providers for community-based rehabilitation programs in the mental health sector. Unlike disability focused services which aim to reduce impairment, activity restrictions and participation limitations through assisting with daily living, community inclusion and other social and physical requirements (Department for Communities and Social Inclusion (DCSI) 2016), rehabilitation programs are aimed at 'recovery, improving independent functioning and reducing disability through education, support and individual recovery plans' (Morgan et. al. 2011). Almost a quarter of people with a psychotic illness in 2010 had utilised an NGO group rehabilitation program and one third of people had participated in community rehabilitation programs, with a majority of these reporting the programs as beneficial to their recovery journey (Morgan et. al. 2011).

The NDIS model, underpinned by consumer directed care, provides those with disabilities with an annual individual funding sum from a central government agency to 'purchase' a variety of government and non-government specialist services of their choice (Davis & Gray, 2015; MHA, 2014). The scheme is based on the World Health Organisation International Classification of Functioning, which defines disability as 'a consequence of a health condition or changes to bodily structures that lead to impairment, activity restrictions and participation limitations' (Hayes et. al. 2016; O'Halloran, 2016). Available policy and literature states that the scheme will offer psychosocial disability support only where impairment impacts on functioning in communication, social interaction, learning, mobility, self-care/management and economic participation (Hayes et. al. 2016, O'Halloran, 2016). This suggests the NDIS will be focused on reducing restrictions to activity, via supports with daily living, community inclusion and other social and physical requirements not on rehabilitation to reduce impairment (Hayes et. al. 2016, O'Halloran, 2016). Thus the Mental Health Coalition of South Australia argues that based on available literature the NDIS will clearly provide a disability support focus. This is of significant concern, not only for those that will be ineligible for any NDIS support but for those that require psychosocial rehabilitation in addition to disability services to achieve their recovery goals and maintain meaningful mental wellness.

The Mental Health Coalition of South Australia consistently advocated that people experiencing mental ill health may also require coordinated support for their social health needs. In addition to this mainstream support, as people with severe mental illness gain and maintain a higher levels of wellness they can get their needs met through primary health and mental health care services (general practitioners, psychiatrists, psychologists, nurses, allied health professionals, pharmacists, Aboriginal health workers, etc). There is, however, an undeniable percentage of people that are able to get their health and mental health care needs met in primary care settings but also require community based rehabilitation and/or disability support. Unless the Commonwealth changes its approach there will be a decline in access to community based psychosocial rehabilitation support as part of the transition to the NDIS and consequently we would predict increasing frequency of crisis and mental ill health for individuals and their families. It is not clear what the SA Government response will be to this impending crisis.

The South Australian mental health sector has historically provided support through two of the three key elements required for an effective mental health system, clinical treatment and community psychosocial rehabilitation services. The Mental Health Coalition of South Australia supports and applauds the Commonwealth and South Australian Governments for their intent to improve disability support for people with a long-term disability as a result of severe and persistent mental illness. This is an area that has traditionally been poorly serviced in South Australia (Mackay & Goodwin-Smith, 2016). People with mental illness as the primary diagnosis have historically had little support for their disability needs from both disability services and the mental health system. The NDIS will reduce this need in relation to restrictions impeding activity and participation. Despite the stated intent for the NDIS to work in partnership with clinical treatment and psychosocial rehabilitation, however, it is evident that the transition in both funding and policy is shifting the core system elements from a clinical treatment, community rehabilitation focus to a clinical treatment and disability support focus. This loss of psychosocial rehabilitation and gain in disability support will again result in ineffective, unbalanced system and the increasing risk of increasing mental ill health within

our community (Mackay & Goodwin-Smith, 2016). This will also be compounded by decreased funding and access to early intervention and prevention focused programs.

It would appear that neither the Commonwealth nor the South Australian Government intended to reduce the availability of community based psychosocial rehabilitation services to fund the full implementation of the NDIS. Yet, with the agreements to transition mental health program funding to provide NDIS packages it has become evident that, unless there is a significant change in approach, governments will dramatically reduce access to rehabilitation support in the community resulting in loss of service, especially for those who don't meet the NDIS eligibility criteria. Notably, Commonwealth programs such as Personal Helpers and Mentors Service (PHaMs) and Partners in Recovery (PIR) appear destined to no longer be available, and the future of South Australian services such as Individual Psychosocial Rehabilitation and Support Services (IPRSS) remains unclear. The Primary Health Networks have been charged with the local planning and commissioning of services however the Commonwealth Department of Health guidance appears to specifically exclude community-based psychosocial rehabilitation programs. Unfortunately, therefore, the NDIS will, in improving disability support needs, do so at the expense of community-based rehabilitation.

This approach to funding NDIS is particularly disappointing given the strong evidence base for community-based rehabilitation, in partnership with treatment services, being effective and efficient in assisting people with severe and persistent illness reduce the disabling impacts of mental illness. Research undertaken by Mackay & Goodwin Smith (2016) in South Australia consolidated concerns that the NDIS will not accommodate all people experiencing mental ill health, in particular concerns for those that will not be eligible for a package. This reflects unease within South Australia about the lack of clarity around if or how psychosocial services for those outside of NDIS will be funded, as well as growing concern about availability for rehabilitation style support services for those that do receive NDIS funding (Mackay & Goodwin-Smith, 2016).

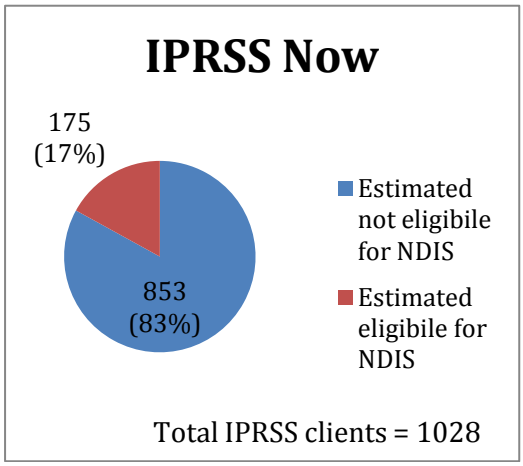
Some jurisdictions have agreed to the complete defunding of all psychosocial rehabilitation programs. Some jurisdictions have alternatively proposed that dollars should follow people. That is, if for example, 25% of people currently engaged in a mental health funded program are eligible for NDIS then 25% of funding should be transitioned to the NDIS. Whilst the second approach is clearly better, both approaches will create a significant gap in continuity of care for those experiencing mental ill health, via reduced availability of community psychosocial rehabilitation support to those who become unwell in the future. Analysis of data collected by the MHCSA in 2016 gives insights into the scale and growth of the gap in services, if jurisdictions proceed with either of the aforementioned funding transition scenarios**.** The MHCSA survey asked NGO mental health service providers to state the number of participants in their programs during the 2015/2016 financial years and to estimate the number of those who would be likely to be eligible for NDIS using the definition of "a life-long disability caused by a mental illness". Responses were received from 11 organisations over 15 programs meaning that the numbers derived from the survey underestimate total numbers and any projections can therefore be considered conservative. Although likely eligibility for NDIS is estimated, there is a concerning reality that a significant number of people may no longer receive, or have access in the future to community based psychosocial rehabilitation services upon full implementation of the NDIS.

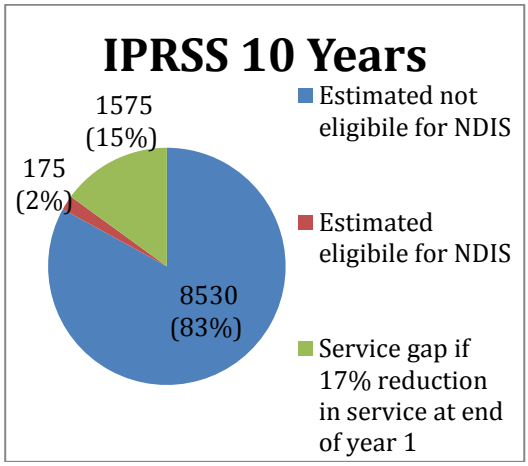
Responses for State funded programs reported a total of 2,985 participants with 606 or (20%) estimated as potentially eligible for NDIS, thus, 2,379 people estimated to be ineligible.

Responses for Commonwealth funded programs reported a total of 4,012 participants with an estimated 967 or 24% likely to be eligible for, leaving an estimated 3,045 people ineligible for NDIS.

If both state and Commonwealth funded psychosocial services cease, this could result in a total of 5,424 people without access to services, and 1,573 NDIS participants without access to rehabilitation type support options. Projections over time further compound the detrimental impacts of this for people with severe mental illness.

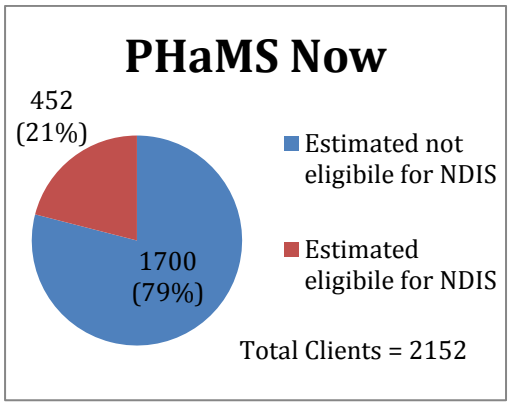
For example: If the IPRSS program continues at the current level of funding it will deliver community-based rehabilitation to 10,280 people over 10 years (assuming 12 months average length of service). If IPRSS funding is reduced by 17% (equivalent to estimated access rates to NDIS), this looks like a reasonable approach in the first year. NDIS numbers, however, are not projected to grow except in line with population growth. This means that over every subsequent year there is a gap of 173 people per annum that will no longer have access to the reduced IPRSS service or to NDIS. Reducing total funding by 17% would result in a gap over 10 years of *1,557 people who will receive neither IPRSS services nor NDIS.*

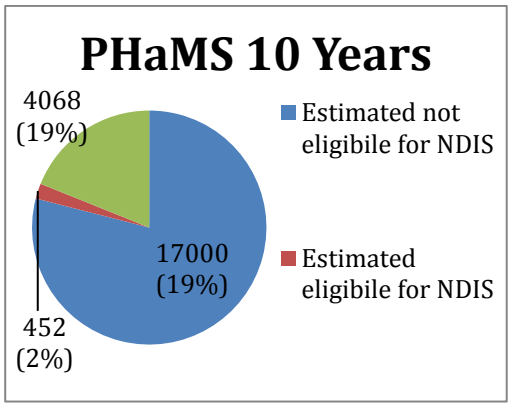




The impact of the loss of Commonwealth funded programs upon full implementation will similarly result in major loss of access to service for many people with severe mental illness. As with State mental health programs, the Commonwealth programs are designed as relatively short term interventions and so the projections demonstrate an increasing gap over time of people who will lose access to service. Based on our sample, if Commonwealth programs are completely defunded from services available in South Australia, in the first year 3,045 people will be looking to the State Government for services, and this will grow annually.

Although we have been unable to source reliable throughput data for Commonwealth programs, it is our understanding that a reasonable estimate for PHaMS program is that participants on average receive support for 12 months. Using this estimate, over a ten year period the PHaMs program would support 17,000 people. Therefore, defunding of this service over a 10 year period means creating a gap 17,000 people who will not be able to access an effective self-referral psychosocial rehabilitation service.





Given that funding guidelines for PHaMs, Mental Health Respite: Carer Support and PIR have all been changed to require programs participants to be potentially NDIS eligible, these programs have become transition vehicles for NDIS rather than providing services to the

population originally intended. There is an urgent need to review this imminent gap in service. It can only be assumed, that without both Commonwealth and State funded psychosocial programs we will only see an increase in the levels of mental ill health and crisis experienced by individuals and in turn, increased pressure on remaining NGO programs and other parts of the mental health system including acute care and emergency departments. This cohort of people without a service will begin on 1st July 2017.

The Commonwealth has stated that they will support people with mental illness through the transition. The value of this guarantee however is tempered by the change in criteria of Commonwealth mental health programs such as Personal Helpers and Mentors (PHaMS) and Partners in Recovery (PIR) to target people who are likely to meet the criteria for entry and to support clients into the NDIS. Whilst there are valid reasons for this change, it will also mask the extent of the service gap that will open up as these programs are defunded as we move to full transition to NDIS.

The Mental Health Coalition of South Australia applaud the SA Government's intention to continue to care and support those people requiring mental health services who will not be eligible for NDIS (Minister Snelling, 2015; Bi-lateral Agreement).

There remains however ongoing concern about the lack of clarity on how these assurances will be implemented in practice.

There is a risk that vital mental health services may be defunded, wholly or in part, thereby reducing access for people experiencing mental ill health to psychosocial rehabilitation services.

Discussion Paper Recommendations (to be discussed at tables)

It is evident that if funding to psychosocial rehabilitation services during the transition to NDIS is reduced, this will adversely affect the ability of thousands of South Australians with severe mental illness to manage their illness. This will result in poorer quality of life for individuals and families and increasing reliance on acute and crisis services.

Both the SA and the Commonwealth Governments have given assurances that people will not be disadvantaged by the transition to NDIS.

Giving effect to these assurances needs urgent attention as from 1 January 2017 people in SA will start to be able to test their eligibility for NDIS. South Australians with severe mental illness and their families need assurances that they will continue to have access to high quality community-based rehabilitation services whether eligible for NDIS or not.

The Mental Health Coalition of South Australia therefore recommends that:

The South Australian Government upholds its commitment as outlined in the bilateral agreement to continuity of service by undertaking the following:

1. Recognising the need to ensure balanced investment in a three-part system for mental health services and disability support for people with severe mental illness through clinical treatment, psychosocial rehabilitation and disability support.
2. Continuing to retain funding at the same level in community-based rehabilitation regardless of the percentage of consumers who get access to NDIS. This will maintain continuity of access for people with mental illness to this important part of the mental health system.
3. Working with consumers, carers and NGO service providers to establish a transition planning process for the mental health component of NDIS
4. Advocating to the Commonwealth to continue providing rehabilitation services (such as PHaMS, Mental Health Respite: Carer Support, Day to Day Living etc) regardless of how many people gain access to NDIS. Reduced funding of these services will result in poorer mental health for people with severe illness and increased need for crisis and acute care services provided by the State.
5. Increasing investment in psychosocial rehabilitation programs if the Commonwealth withdraws funding to current programs in the transition to NDIS.