COMMUNITY MENTAL HEALTH AUSTRALIA

Design of Individual Supports for People with Psychosocial Disability Project

Stakeholder Feedback

December 2015

Executive Summary

The Individual Supports Design Project (the Project) is a collaboration involving the National Disability Insurance Agency, Mental Health Australia and Community Mental Health Australia. The Project has been established to document optimal packages of individual supports for people who have a psychosocial disability associated with a mental illness. In order to best equip the Project to produce a report summarising the project outcomes, the following pieces of investigative work were commissioned, namely:

- Development of a report investigating typical support packages (prepared by Synergia Consulting)
- Stakeholder feedback (prepared by Jane Forward Consulting)

Stakeholder feedback provides valuable insight into current performance, as well as future needs and opportunities. This report presents the key findings of feedback from mental health consumers, carers, service providers and other informed stakeholders across Australia.

In September 2015 in Queensland, New South Wales, Australian Capital Territory, Victoria, Tasmania, South Australia and Western Australia, and in November 2015 in the Northern Territory, 173 individuals participated in consultation workshops organised and hosted by the peak bodies in each jurisdiction. Consultation materials were developed using a building block framework for individual psychosocial disability supports contained in the Synergia report (Appendix A), individual case stories (Appendix B), example NDIS individual supports mapped by the NDIA to the building block framework (Appendix C) and learnings from the trialling of preliminary materials conducted in Victoria, the ACT and South Australia in June. The correlated results of these workshops are at Appendix D.

Workshop engagement processes in each location varied dependant on local needs and preferences, but all addressed the following research questions:-

Identify the optimal individual supports.

- Identify the types of optimal supports currently listed under each building block.
- Do they cover the full range, if not identify the additional supports required.

Mapping examples - NDIA supports for people with psychosocial disability

- Identify gaps in the NDIA example supports.
- Suggest clarification of language and definition to the NDIA example supports.

Building Block descriptions

- What, if any opportunities exist to further strengthen the description of the Building Block functions of support?

A strong correlation of response was found throughout the data, with overwhelming feedback that the development of an optimum list of supports can only be achieved once three overarching themes have been addressed, namely:

Theme One: Engagement, preplanning and readiness

It was perceived that the NDIS structure connects with participants under an assumption of 'readiness' or 'preparedness' for planning. Participants expressed that many, if not most, people with psychosocial disability won't be ready to engage in an adequate conversation with a NDIA planner the first, second or third time that they meet. Instead, investment is required to support the person work through a range of issues before they can identify how they might best take advantage of the NDIS and what supports they will need in the long term to help them realise their goals and aspirations. The current 'preplanning workshops' delivered by the NDIA or other initiatives currently offered to educate and support people understand the NDIS, do not target the development of capacity to a point of the participant being recovery-ready. Through 'engagement/preplanning and readiness' investment more efficient and effective plans will be developed, yielding better outcomes.

These supports go beyond information exchange and could include, but are not limited to

Table1: Short term, entry plan support items

Support	Explanation
Access and Engagement	Building rapport and the development of a trusting relationship. Assertive outreach and culturally appropriate engagement mechanisms. Trauma informed engagement process.
Recovery Planning	Development of participant narrative as to what recovery means to them.
Preplanning	Being ready to have a plan conversation *'Supporting someone to work out their 'wants' and 'needs' is an experiential process, not an interview process. It takes time, skilled workers and advocates to ensure the participant's voice is truly being heard.'(Victoria)*
Capacity Building	Supported decision making, self-advocacy and advocacy.
Support Facilitation	Identifying support needs. Assisting with coordinated care and community based recovery. Collaborating with support and service providers. (Partners In Recovery was provided as a good example of how this can occur)
Peer	Strengthening of connection and recovery planning.

Theme Two: Recovery framework

Participants felt that the current workings of the NDIS have yet to be fully governed by principles of wellness, person centred, recovery, family inclusivity, culturally secure and trauma-informed. Application of these principles focuses on the development of strengths and wellness, shifting away from models of impairment and deficit. Participant feedback was that while the Building Block Framework provided a conceptual framework that assisted understanding some specific characteristics for mental health in the NDIS neither it nor the supports identified by the NDIS appear to be fully congruent with these principles. Evolution of the foundational ideology to a recovery framework would see increased flexibility (supporting better planning and responses to the episodic and fluctuating nature of mental illness), increased capacity for review with increased capacity to respond to the episodic presentation of acuity and periods of relative wellness and illness. Once the scheme is delivered through this different lens it becomes apparent that a high level of skill and sophistication is required in the delivery of recovery-oriented psychosocial services, which should supported by the pricing structure.

Theme Three: Co-design, co-evaluation and co-delivery

Participants stated that for true 'choice and control', things need to be done, with people not for them. This can only be achieved through the development of a relationship which takes time and investment; as such the consumer and the staff member must meet often, over a period of time, in a manner which is flexible, may include outreach and is based on a solid understanding of mental health and demonstrated skill in engaging with mental health consumers. Under this methodology relationships are stable and transition with the consumer along their journey and can be evidenced by a strong occurrence of consumer advocacy and investment in the development of stable and supportive relationships based on mutual trust and respect.

Language

In addition to the identification of additional support items, participants reviewed current use of language within the scheme and opportunities for improvement. Stakeholders were unanimous in a belief that there is significant opportunity to improve language, in the use of definitions and descriptions that are familiar to the lived experience of psychosocial disability and that promote recovery and growth.

A consistent theme was that language needed to honour the strengths that individuals, carers and families have and to support models of aspiration, recovery and wellness. Stakeholders identified the following additional supports to the suggested list provided in the Synergia report and to the current NDIS example of draft supports, incorporating descriptions and definitions in language reflective of recovery and growth:

Table 2: List of additional supports and descriptions for inclusion in NDIS example supports

Suggestions for individual psychosocial disability supports contained within the Synergia Report		**DRAFT Examples of the outcomes and supports used in NDIS plans**		**Additional support items identified by consultation participants (stakeholders)**
Building blocks	**Suggested supports for people with psychosocial disability**	**Some examples of outcome domains (linked to reporting) that will be in an NDIS plan**	**Some examples existing NDIS support items that a participant could choose to use**	
				Extra layer of supports to be included - *Short term, entry plan support items* (Refer Table 1, above for detail)
Building Block 1. Person-centred planning and self-direction	Individual engagement and capability development support: A confidence and skills development support that can work in people centred advocacy and support roles in	Support to improve daily living skills support items Support to improve my home arrangements Support to improve	Coordination of supports (including higher intensity rates) Training in planning and plan management Development of skills for community, social and recreational participation	Recovery support coordination (similar to Partners in Recovery (PIR) support worker role). Supported Decision Making and advocacy would be key supports in this area Support to plan for next NDIS plan

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	developing the planning partnership with services Family/carer education and skills development support Aligned/shared psychosocial support planning Self-directed plan initial implementation and execution support Support coordination: that provides continuity and review components and escalation support processes	health and wellbeing Support to plan and choose preferred options	Mentoring and peer support, focussing on individual skill development to improve personal skills Training for carers Training for carers and others in behaviour management strategies Individual social skills development Assistance with decision making, daily planning, budgeting	period Education in planning and plan management Crisis response coordination and support (risk assessment and mitigation strategies) Facilitation of integration, coordination and inclusion; the inclusion of carers, family, and other natural supports Bridging the gap between clinical referral and uptake – transportation, transitional support, system navigation, development of trusting relationship
Building Block 2. Promoting independence and functional gain	Support to find, get and keep a job - Individualised Placement and Support and beyond Support in life-long learning: vocational or other training supports	Support to find, get and keep a job Support to improve my home arrangements Supported independent living	Employment preparation and support in a group Individual employment support Assistance with accommodation and tenancy obligations Transition to school and other	Independent living and planning support e.g. paying rent, bills and food – initial and ongoing as needed to ensure things aren't overlooked during periods of crisis– maintaining a household Pet therapy

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	Housing options support, including investigation of suitable independent housing arrangements desired by the individual and assistance to maintain a tenancy or living arrangement Opportunities for community engagement and social inclusion Peer support (more about this later in this report)	arrangements Support to improve access to social and community activities Support to improve daily living skills	education programs – program design, planning and implementation Assistance in a shared living arrangement Short term accommodation and assistance in centre or group residence Development of skills for community, social and recreational participation Assistance to access community, social and recreational activities Assistance with decision making, daily planning and budgeting Skills development in a group Mentoring and peer support, focussing on individual skills development to improve personal skills Individual assessment and/or therapy	Interpersonal skills development Respite and accommodation Recovery-oriented practice Facilitation of integrated response Support to employers Peer worker/support to assist recovery, hope and positivity Psycho-education and recovery for individuals, carers and supports CBT and other therapies to manage disabling effects of mental illness

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Building Block 3. Developing and maintaining resilience and self-care	Supports to improve health and wellbeing: promoting good physical as well as mental health Supports to improve relationships, including carer training and family intervention services Support for peer support services Support to plan and choose preferred options (particularly where this care is provided by agencies other than the NDIS) Assistive technology such as e-mental health supports, designed to provide private and easy to use self-care support Support to improve daily living skills - tailored to meet fluctuating	Support to improve health and wellbeing Support to plan and choose preferred options Support to improve daily living skills	Exercise physiology in a group Personal training Exercise physiology Training for carers Individual life and personal skills development Mentoring and peer support, focussing on individual skills development to improve personal skills Coordination of supports (including higher intensity) Individual assessment and/or therapy Development of skills for community, social and recreational participation Assistance to access community, social and recreational activities Assistance with accommodation and tenancy obligations	Support for diversity of individual life experience and identity Support to address self- stigma One-on-one support for rural and remote services Cultural responses Resiliency support/training Use of technology – e.g. Apps for training or remote alert Support to carers e.g.: self-care, respite, counselling Capacity building – self care Peer support with self-care, strategies to manage disabling effects of mental illness Psycho-education and support with strategies to manage anxiety and other disabling psychosocial issues including peer-led Recovery training CBT and other therapies to

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	participant requirements Support to improve access to social and community activities: focused on community engagement and social inclusion		Assistance with decision making, daily planning and budgeting Skills development in a group	manage disabling effects of mental illness Strengthen and develop support networks Building strengths to solve own problems Alcohol, tobacco and other drug support and treatment Sexual and physical health advice and prevention Work readiness skills
Building Block 4. Mental health services/net work support	Regular or 'relapse' planning including family, peer support and clinical input as appropriate Flexible step up 'call in' support e.g. through peer workers to help stabilise and utilise individual and social strengths, recognition of increased time demands on this providing daily living	Support to plan and choose preferred options Support to improve daily living skills	Support coordination (including higher intensity) Assistance with decision making, daily planning and budgeting Mentoring and peer support, focussing on individual skills development to improve personal skills Development of skills for community, social and recreational	Proactive and collaborative planning – what to do when participants feel out of control Training to recognise early warnings/trigger signs Extra supports – maintain and sustain critical relationships Continual wellness and recovery plan Regular review planning as

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	support Include additional volume of support in an NDIS plan if respite is needed Support to plan and choose preferred options: focused on helping to stabilise housing and employment and prevent additional stressors and coordination and navigation support to help access clinical or other service supports		participation Short term accommodation and assistance in centre or group residence	scheduled with the NDIA plan Increase supports as needs arise To cope with additional stressors Coordination of supports to access clinical or other services supports Case coordination Planning support for holiday periods Facilitation of integrated care Maintenance of relationships with supports during periods of hospital or residential care Including the role traditional healers Preserving the aboriginal connection to country and elders
Building Block 5. A coordinated response to mental	Inclusion of proactive planning for response to an acute phase of distress (e.g. maybe initiated once building block four has been triggered). A support coordination	Support to plan and choose preferred options	Support coordination (including higher intensity) Assistance with decision making, daily planning and budgeting Mentoring and peer support, focussing on individual skills	Support for integration facilitation/coordination, inclusive of natural supports, service providers, primary and allied health Action planning – how to capitalise on periods of wellness as well as agreed

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illness	response package that can be triggered by an Emergency Department attendance or admission to help cover time in liaison with health services and organise or coordinate changes in individual support services. Similar arrangements may be necessary with Crisis Assessment and Treatment Teams operating as part of the existing mental health system. In-reach support response package that can cover the maintenance of contact, e.g. with social service provided peer support. A flexible 'stand-down' support package that can be used help to maintain		development to improve personal skills Development of skills for community, social and recreational participation Short term accommodation and assistance in centre or group residence	identification of triggers–planning and supports Engagement ('buy in') with remote communities to assist with identifying and understanding the type of support available in communities Engagement, planning, selection and scheduling supports Concept of "hospital in the home" – medications / support Preplanning and trusting relationships Advocacy for individuals/carers/families Carer/family/significant other support Advanced care directives Involvement of supports in clinical decisions/conferences (carer/family/friends) Legal assistance

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	and stabilise essential social support structures that would otherwise jeopardise or delay return to home and prior level of functioning achieved.			Home maintenance/pet care/home safety during periods of sickness Triggers for increasing support coordination need to be articulated in plans Plan must cover acute phases of distress and support to stay at home i.e. • Anticipatory planning – 24/7 • Medication support – 24/7 • Advocacy for appropriate housing allocation • Emergency responses/training – educational emotional CPR for emergency staff, paramedics and nurses • How to connect • How to facilitate a person's needs (empowerment) • Vitality to re-engage with community • Coordinated response to mental illness not a useful descriptor – coordinated response to service

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				system - as in coordinated between various clinicians, service provider, client and support system (family, partner etc.) • Use of technology to coordinate supports/responses

Conclusion

In conclusion, a shared belief was held that while there are specific support items and important language requirements for psychosocial disability in relation to the NDIS, outcome improvements of the NDIS will ultimately be achieved through the development of an insurance scheme system which is flexible, develops meaningful relationships with participants, allows them to return at multiple review points, focuses on strengths not illness and is founded on concepts of person centred, family inclusive, culturally secure and trauma informed support.

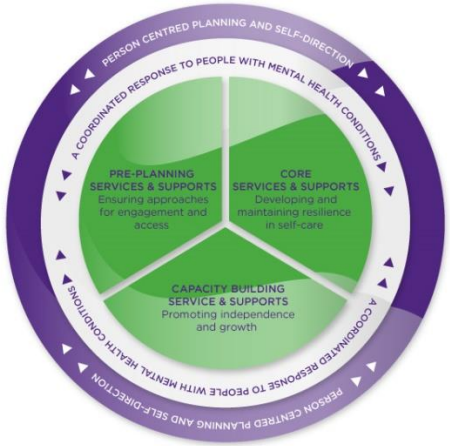
Correlated Consultation Responses (NSW)

Summary of Consultation Outcome

Key themes arising from discussion across the day and notes are:

- The Building Block Framework:
  - Advocacy need to be in every Building Block
  - Add new domain 'Engagement and Access'
  - Keep primacy of 1: 'Person centred planning and self-direction' (we note some feedback that this could also have merged with 2?).
  - Merge 4 & 5 – new name: 'A coordinated response to people with mental health conditions'. Elevate in model.
  - Make both the above domains, and in the order presenting above, all-encompassing of the mutually inclusive categories of:
    - Ensuring approaches for engagement and access (ie, pre-planning services and supports)
    - Developing and maintaining resilience in self-care (ie, core services and supports)
    - Promoting independence and growth (ie, capacity building service and supports).

A diagram illustrating this possible alternate approach to thinking about NDIS optimal supports for people with psychosocial disability is over below.



- Gaps in service types include, but are not limited to:
    - Employment, education & training support – as understood in the evidence-based practice (EBP) Individual Placement and Supports (ISP) Model and including the need for employer focused disability supports
    - Family & carer support (to person and may involve family) – especially McFarlane type multi-group family 'therapy' as understood in long standing EBP and including access to respite (for the person and/or family)
    - Counselling/psychotherapy (support and therapies) – NDIS responses here appear to vary widely
    - Paid peer work roles
    - Legal/criminal justice related support services (Building Block 5)
    - Co-existing mental health and substance use services
    - Hoarding and squalor services
    - Capacity building services for consumers and carers at all times
    - Advocacy to ensure quality and safeguards in place for participants
    - Cultural competency.

- Language issues include, but are not limited to:
    - Remove any use of term 'clinical' or 'non-clinical' and replace with more specific language
    - Remove medical model and disability specific language as appropriate and replace with person-first language (eg, functionality)
    - 'Functional gain' = 'growth' or 'recovery'
    - 'Illness' vs 'psychosocial disability' vs 'mental health condition' (be alert to what terms are used where; these are not always interchangeable)
    - Change 'step-up'/call-in support to flexible, higher level support
    - 'Volume' instead of 'intensity'
    - Remove 'stand-down'
    - Remove maintenance
    - 'Behavioural management strategies' is offensive
    - Any reference to 'risk' should be about 'safety'

- There needs to be a greater support loading for people around becoming unwell (ie, psychiatrically unstable) and/or at other life transition points, e.g., risk of entering, and existing, hospital (ie, either psychiatric and/or physical); changing service providers, etc.

Unfortunately, the ultimate goal of identifying the type and quantity of 'optimal supports' within the timeframe and recommended process was not achievable. Furthermore, in not reaching the stage of identifying 'optimal supports' this meant that the very important planned discussion of roles and

functions delineations that was to extend beyond the clouded 'clinical/non-clinical' discourse that has predominated to date (ie, for psychosocial support/non-government, informal supports/families, treatment/clinical mental health services and other mainstream services) was unable to be progressed.

Other

Both in planning the Individual Supports Project and during the 21/9 consultation MHCC noted work funded by NSW Health and undertaken by us in 2012/13 to identify optimal community managed mental health sector supports for people impacted by 'severe and enduring mental illness'.[1] These can be assumed to be people with very high levels of psychosocial disability as a result of a mental health condition.

The methodology of the Sector Benchmarking Project included establishment of a:

- partnership with a University of Sydney population health specialist (Dr Ilse Blignault, Project Consultant)
- project Steering Committee and Reference Group with expert and representative memberships to guide on processes and findings, and
- three focus groups with consumers, carers and service providers in metropolitan, regional and rural communities to validate project findings.

This extensive research and consultation work, undertaken as a necessary pre-cursor to later population health benchmarking planning for NSW also undertaken, found that an optimal non-acute recovery/disability supports are 26 hours per week as indicated in the table over page.

CMO service types	No. contact hours per person per year	No. contact hours per person per year
Personalised support	280	5.4
Group support activities	208	4
Mutual support & self-help	260	5
Employment, education & training (support)	234	4.5
Counselling, information & referral (support)	104	2.1
Family & carer support (to person and may involve family)	260	5
Total Support Hours	1,352	26

[1] MHCC (2013). *NSW Community Managed Mental Health Sector Benchmarking Project: Final Report* (confidential document), MHCC, Sydney.

The service categories used are further explained in Attachment and definitions are available upon request. This work could be extended upon for the NDIS Catalogue of Supports/Price Guide. However, this would not seem to be useful in an environment of increasing innovation, choice and control in a person's services received.

Three additional considerations are:

1. The MHCC Sector Benchmarking Project 'optimal supports' of 26 hours a week are understood to vary according to individual need and may be considerably less or more – in both quantum and type - depending on circumstances and preferences

2. The 26 hours per week excludes service delivery/practice related to care/service coordination and, as this is a critical component of recovery oriented service delivery, this addition would likely increase the proposed quantum of annual/weekly 'optimal supports'. This increase is estimated to be an additional 3 hours a week on average (ie, for optimal supports of 29 hours per week)

3. While the type and quantum of NDIS supports needed/wanted by a person with psychosocial disability are important the findings/recommendations of the MHA NDIS Mental Health Workforce Project being undertaken by MHCC for CMHA indicate that it is the costs of the skills/qualifications of the workforce required to deliver them that are critical to ensuring sustainable pricing for, and effective participant outcomes in, NDIS implementation.

Note: Responses taken from participant notebooks are provided in *italics*

Exercise 1: Identifying the optimal individual supports.

The proforma provided and included as in the Facilitator's Manual Attachment 3 was not used and nor were the proposed case studies used. This was agreed to be too 'blank slate'. This activity was not achievable in the time allocated for the consultation and thus work undertaken by MHCC's Sector Benchmarking Project to identify 'optimal supports' for a typical person with a mental health condition has been previously shared.

The two Exercise groups identified similar types of services required but varied greatly in their recommendations about the amount of services required (ie, a mostly service provider group identified a need for more support hours than a mostly consumer and carer group). Both groups noted that hours could vary as a result of phase of illness/disability and choice.

Furthermore, in not reaching the stage of identifying 'optimal supports' this meant that the very important planned discussion of roles and functions delineations that was to extend beyond the clouded 'clinical/non-clinical' discourse that has predominated to date (ie, for psychosocial support/non-government, informal supports/families, treatment/clinical mental health services and other mainstream services) was unable to be progressed.

There was discussion that different support types/work roles may require different skills (eg, support worker, PIR Support Coordinator, PHAMS worker, centre based activity/day program worker) and also general agreement that this should be at the Certificate IV level or equivalent across all recovery/disability support services, where possible. However, disability 'mainstream' services may not require such qualifications (eg, 'mainstream' housekeeping, lawn/gardening services, etc).

One group provided the following summary of typical support services in a written response:

Typical support services
Assertive outreach available 9AM to 10PM, responsive daily liaison with clinical/treatment mental health services
Initial contact – phone service – to make initial contact and to proactively contact person as planned/required
Ongoing contact coordinator – makes personal contact as required
Liaison with funded supports – negotiating increases or changes to supports.
Liaison with family – refer to wellness plan
In-reach to hospital – continuity of care, discharge planning, liaise with employer/landlord/Centrelink
Manage home life while in hospital (mail, pets, lawn/garden).
Getting back to work
Social connections (i.e. PHAMS like)
Day/group activity
Return to work program post-discharge
Typical support hours over a week: 3 hrs coordination, 2 hours home based support, 10 hours community based activity

Exercise 2: Mapping Examples - NDIA Supports for People with Psychosocial Disability

The way in which the Building Block Framework is currently structured perhaps not being optimal for thinking about access to NDIS services and support for people with psychosocial disability.

Gaps identified across Building Block Framework include but are not limited to:

- Transportation type services (note NDIS issues in regard to this)
- Cultural competence
- Criminal justice support/continuity when in prison as should be the case if a person is in jail?
- Hoarding and squalor services
- More transparency about flexibility of funding (ie, recommended that 100% of people with psychosocial disability have access to flexible/bundled funding sooner rather than later).

Building Block X – ENGAGEMENT AND ACCESS
• Pre-planning support and advocacy • Inreach/outreach • Consumer knowledge of towards recovery principles • Access support • Care planning support • New 'establishment fee' set too low for mental health pre-planning work
Building Block 1. PERSON-CENTRED PLANNING AND SELF-DIRECTION
Identified gaps in the NDIA example supports. • <u>Families, friends and</u> carers (ie, more focus on natural support systems). Not just training for families and carers but the supports that participants need/want to manage and enhance their natural relationships. • *Support to manage a better life* • *Support to understand the system, organisations and people I am engaging with so I can make informed decisions* • *Support to build a trusting relationship (peer, advocate, support services)*
Suggested clarification of language and definition to the NDIA example supports • Enhance notions related to people's natural support systems (ie, beyond just 'carers'). • *'Behaviour management strategies' is offensive* • *'Growth' or 'Recovery' preferable to 'Functional Gain' (the latter is very impersonal and objectifying)*

Building Block 2: PROMOTING INDEPENDENCE AND FUNCTIONAL GAIN

Identified gaps in the NDIA example supports

- Individual Placement and Support (IPS) mental health best practice employment model not well understood – employment disability support that is ongoing as needed and not just about obtaining a job that may not be kept without ongoing support.
- No items for employer supports (ie, to help them better understand the reasonable accommodations/affirmative actions that can be made for people with psychosocial disability; employer capacity building.
- *See Block 3 re employment preparation.*
- *Self-care*
- *Improved understanding of legal rights*
- *Cultural activities – to promote independence*
- *Education*
- *Carer support and respite*
- *Transport to and from services*
- *Assistance with IT*
- *Hoarding and squalor services*
- *Advocacy*
- *Cleaner when I am unwell, support to clean up myself when I can*

Suggested clarification of language and definition to the NDIA example supports.

- *"Support Facilitator' confusing*

Building Block 3. DEVELOPING AND MAINTAINING RESILIENCE AND SELF-

Identify gaps in the NDIA example supports.

- Family group work a la McFarlane EBP family 'therapy' model which is more about information. Education and peer support
- I.e., Time limited family/friend/carer peer group work (e.g., 8 week course)
- *Employment assistance/ISP – Support to both get and keep work (3)*
- *Coaching services for people with mental health issues; motivational interviewing and other talking therapies*
- *Dental Care and podiatry – but are these 'clinical';* ie, people still need support to access and/or not be traumatised by accessing such services
- *Parenting skills (2)*
- *Family and carer support – training/education, support, respite*
- *Education – generally and about physical and mental health (2)*
- *Telephone based support*
- *Training for e-mental health support*
- *Ongoing support that is not necessarily time-limited*

- *Assistance with legal issues, probation and parole*
- *Trauma services and trauma informed care*
- *Conflict resolution – building and maintaining family relationships*
- *Support for employers – education for employers about mental health*
  - *To increase mental health understanding and literacy*
  - *To improve communication*
  - *To promote mental health awareness in the workplace*
  - *Employer capacity building*
- *Support to access creative self (personal and community)*
- *Support to get to and from potentially upsetting therapy and other appointments*

Suggested clarification of language and definition to the NDIA example supports.

Building Block 4. MENTAL HEALTH SERVICES/NETWORK SUPPORT

Identified gaps in the NDIA example supports.

- Feedback as per 3 above
- *Employment/vocational*
- *Support of daily living activities*
- *Develop living and domestic skills*
- *Physical health support*
- *Advanced care directives*

Suggested clarification of language and definition to the NDIA example supports

- *Step-up 'call in' support - flexible higher level support might be better*
- *'volume' vs 'intensity'*

Building Block 5. A COORDINATED RESPONSE TO MENTAL ILLNESS *Should be Building Block 1*

Identified gaps in the NDIA example supports.

- *Coordinated response to mental illness*
- *Exchange of information between services, appropriately dealing with privacy and confidentiality, ie, coordinated responses dependent on exchange of information (2)*
- *Respite care, short-term support, for carers*
- *Group based activities (2)*
- *Financial counselling*
- *Crisis support*
- *Discharge planning*

• *Step-up/step-down support* • *Case collaboration meetings and review of plans (2)* • *Connecting to GPs* • *Escalating supports* • *Supports during periods of hospitalisation (ie, who is looking after the dog, home, carers)*
Suggested clarification of language and definition to the NDIA example supports • *Support coordination – may be better expressed as higher level support* • *"Stand-down' is a term often used in some mental health environments to describe seclusion and restraint practices* • *Not 'mental illness' – 'psychosocial disability or 'mental health condition' are preferable*

Exercise 3: Building Block Descriptions

- Where is advocacy/supported decision making? Needed and missing from every stage.
- Do 1 and 2, and 4 and 5, cross-over?
- Respite? (in Building Block 3)? Family and carer issues not adequately covered; eg, funded for respite but can't spend it because I'm so poor)
- Does numbering add value if the 'building blocks' are cumulative (other than for identification of concept?)
- 5. service coordination cuts across all of the Building Block Framework – make it another circle encompassing the key elements of the framework
- Importance of engagement and access (ie, pre-planning)
- For mental health the focus needs to be on capacity building at all stages of the Building Block Framework
- Language is important (remove 'clinical' and 'non-clinical' from the entire Building Block Framework document and replace with the specific service/intervention being referred (and including consideration the skills/qualifications required by workers to deliver them)
- Standards/neutrality – where do these fit within the framework (service delivery quality assurance and managing conflict of interest; especially with for-profit providers but not exclusively so)
- *'In addition to matters discussed, capacity building is required in all Building Blocks, not just Block 1. Capacity building extends to carers, service providers and others in the system including NDIA itself. It is a new system and it needs extra capacity building to allow stakeholders to understand and apply it.'*

	Functions of Support	Opportunities to further strengthen the description
Building Block X		**Engagement and access** • Having a trusted relationship with someone pre-NDIS access • In-reach and outreach support for 'hard to reach' people

Building Block 1:	• Support planning across a wide range of levels of awareness and engagement • Engagement and pre-Planning • Recognise the cognitive, social and practical difficulties many people with psychosocial disabilities will have in being active partners in processes of planning: • Address the understanding and knowledge needs of families and carers for them to participate in planning processes • Utilise shared planning approach and processes that support integrated recovery planning and action	**Person centred planning, coordination and self-direction** • • NDIA planners need to have training in mental health as a pre-request to working with people with psychosocial disability • Need NDIA planners with mental health expertise • Need to talk with people about their hopes and dreams (aspirations) • *Advocacy*
Building Block 2	Planning and communication processes that recognise and capitalise on periods of wellness • Ensure a complete understanding of the life-goals of participants • Close relationships with the broader range of service providers • Carer support and goal realisation • Activities designed to support social inclusion	**Promoting independence and growth** • Term 'functional gain' not comfortable, it/'recovery' not always about functional gain • *Advocacy* • *Through all of this there needs to be a check on NGOs not doing a good job (NDIA as a control for consistency and quality)*
Building Block 3	• Strengthen and develop resiliency skills and support network • Utilization of strengths to solve own problems • Ability to live well in the community, at a place of their choosing • Sustainable and ongoing family support • Focus on stable mental and physical health	**Developing and maintaining resilience and self-care** • *Advocacy*
Building Block 4	• Awareness, recognition of early warning signs. • Proactive anticipation and planning • Alternative supports	**Mental health service/network support** • Merge with 5? • Service coordination cuts across all aspects of the Building Block Framework • *Advocacy*
Building Block 5	• Proactive anticipation, planning and execution coordination • In reach supports, coordination and navigation • Continue working with a person when they are unwell or even in hospital	**A coordinated response to illness** • Merge with 4?

NSW Response -Attachment

Alignment of MHCC Sector Mapping Categories with Australian Institute of Health and Welfare Taxonomy: First and second analysis

Australian Institute of Health and Welfare (AIHW) taxonomy[1]	MHCC 'as-is' analysis categories	
	First analysis 2008—09 data	Second analysis January 2013 data
1. Counselling—Face-to-face	1. Counselling, support, information & referral	1. Counselling, support, information & referral
2. Counselling, support, information & referral—telephone		
3. Counselling, support, information & referral—online		
4. Self-help —online		
5. Group support activities	2. Group support	2. Group support
6. Mutual support and self-help	3. Mutual support and self-help	3. Mutual support and self-help
7. Staffed residential services	4. Personalised support— linked to housing	4. Staffed residential services
8. Personalised support— linked to housing		5. Personalised support— linked to housing
9. Personalised support—other	5. Personalised support—other	6. Personalised support—other
10. Family & Carer support	6. Family & carer support	7. Family & carer support
11. Individual advocacy	Out of scope	Out of scope
12. Care Coordination	Out of scope	Out of scope
13. Service Coordination	Out of scope	Out of scope
14. Education, employment & training	7. Education, employment & training	8. Education, employment & training
15. Sector development & representation	Out of scope	Out of scope
16. Mental health promotion	Out of scope	Out of scope
17. Mental illness prevention	Out of scope	Out of scope
		9. Step-Up/Step-Down (new)