National NDIS MENTAL HEALTH CONFERENCE

#NDISMH2017 #towardsagoodlife

Elizabeth Crowther

President

Community Mental Health Australia

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Kerry Hawkins

Carer/President

Western Australian Association
for Mental Health

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NDIS and mental health

On living at the intersection of hope and despair

Jackie Crowe

Her messages in 2017

Co-production

Family centred approaches

Cultural change

Reform, revolution, disruption

The Great Narrative Wars 2012-2017
Sense-making of the disability and mental health worlds colliding

- Where I’m coming from
- What we’re talking about when we talk about disability
- What we’re talking about when we talk about mental health
- On liberty (and citizenship)

Jackie’s words

- Despite the work of well-intentioned providers, organisations and government entities, our fragmented mental health ‘system of care’ is struggling with increasing costs, uneven quality, human rights issues, rising suicide rates and people who are unable to live a full, contributing life of their choosing.
- Given the entrenched interests and practices of many decades, expecting mental health transformation that only comes from within (reform) is unrealistic.

NDIS and hope

- For the 64,000 individual package recipients:
  - Promise of revolution from without when we'd given up on reform from within
  - Promise of (our) needs-adapted supports rather than (service) needs-adapted rationed resources
  - Promise of inclusion, citizenship, person-centred, individualised, recovery-oriented supports and an understanding of social role valorisation impacts
  - Promise of new workforce to support trauma-informed psychosocial disability needs

NDIS and hope

- For people ineligible for the individual packages:
  - Promise of an integrated, linked up, coordinating service to make services accessible when we need them
  - Promise of building welcoming supportive, informed communities, enabling activation of social networks and livelihood opportunities
  - Promise of increased, educated workforce addressing psychosocial disability needs

NDIS and despair

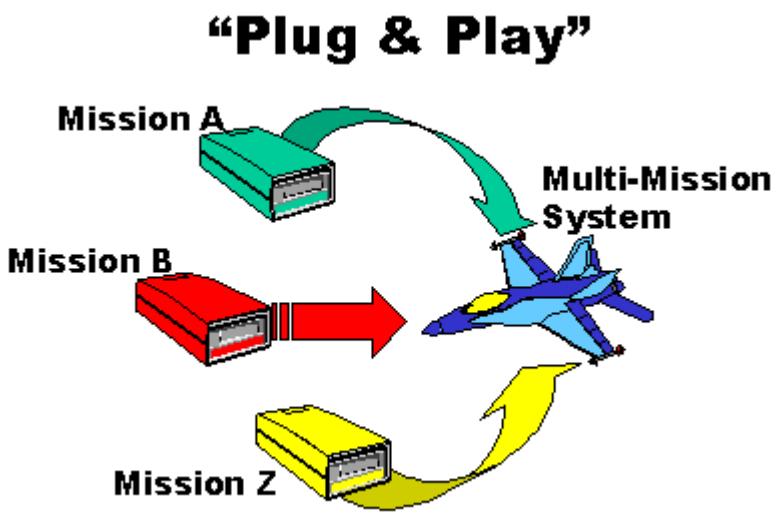
NDIS and despair

- Late inclusion in scheme - all departments (federal and state), professional groups, mental health sector scrambling to deliver – no lived experience expertise included in the ‘nothing about us without us’ flagship design.
- No long rich intellectual history, advocacy and activist service development that disability sector has drawn on – Wolf Wolfensburger, John O’Brien, Connie Lyle-O’Brien, Jack Pearpoint, Linda Perry, Marsha Forest, John Armstrong, Michael Kendrick, Simon Duffy, Stella Young, Bruce Bonyhady and Rhonda Galbally
- Psychosocial disability is still contested space in mh sector

NDIS and despair

- Rollout rush hour further sacrificed and compromised implementation of key internal capacity building initiatives
- Inadequate recognition of capacity building required for community managed mental health sector to transition towards individual packages, work required to support people into the scheme

Plug and play approach – shoehorning mental health into the social model of disability doesn't work.



"It fits!!"

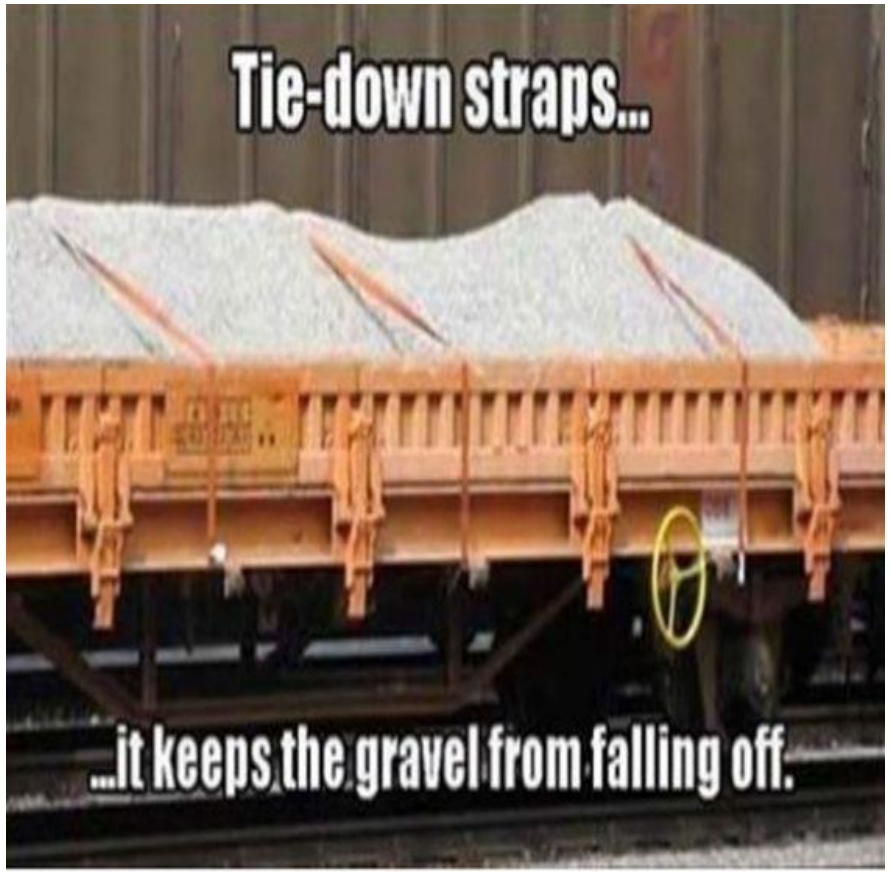
Focused on sustainability and disability principles, and headline-avoidance

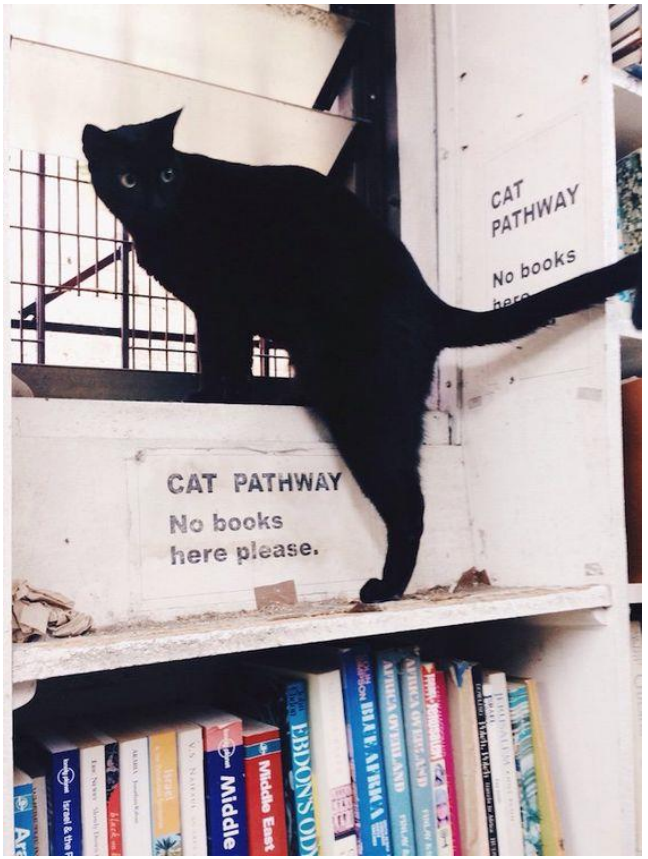
Green shoots….

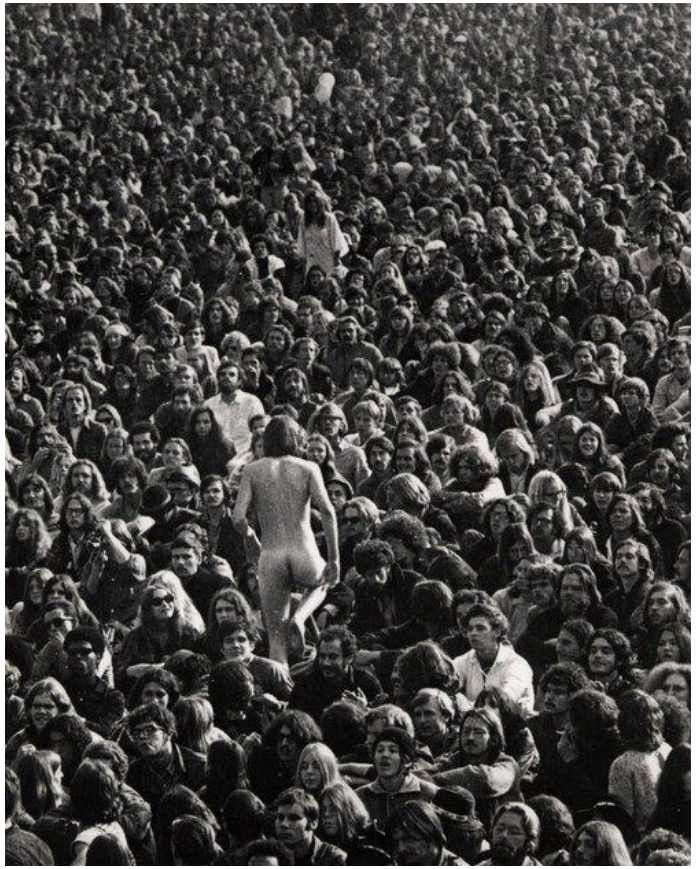
- Establishment of NDIS sector reference group and MH team
- Establishment of MH Access team
- Establishment of MH Community of Practice (currently on hold for operational reasons)
- Good news stories (glimmers of possibility)
- Retention of mental health input into IAC
- Strengthened mental health input into the NDIA Board
- Continuity of support recognised as needing to be addressed
- Psychosocial funding increased and being matched by states

Green shoots

- JSC, PC recommendations and new ‘pathway’

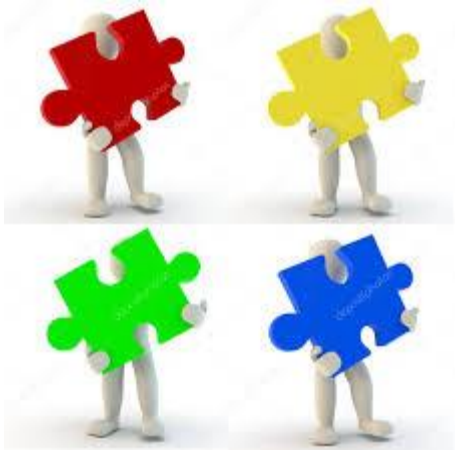






MH landscape – ‘reform’, multiple commissioning frameworks

Lived Experience, Psychiatry, CMMH, other professionals, community voices



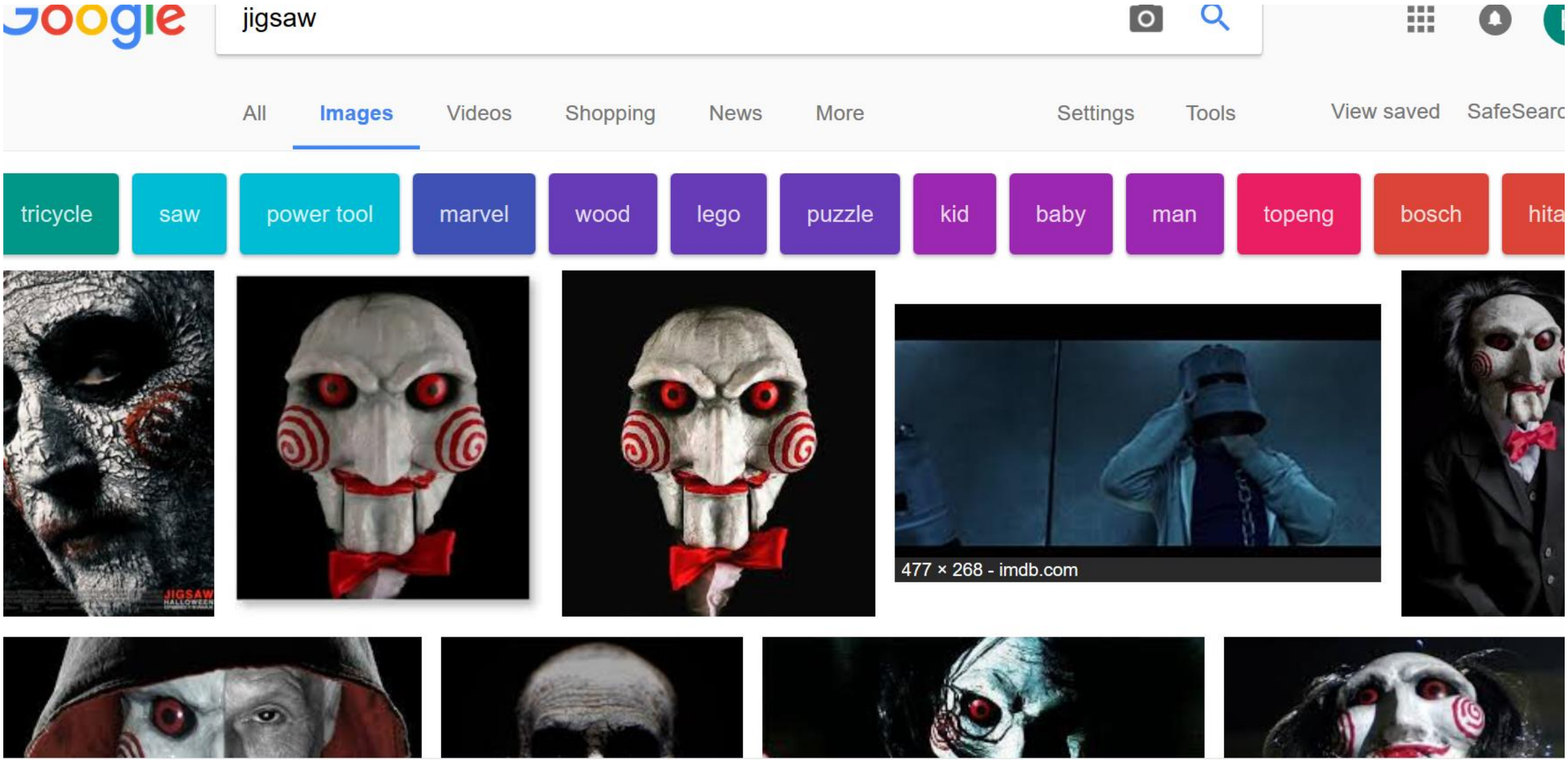
PHN’s, NMHC, 5th NMHP, NMHC review, NDIS

Drug and Alcohol services, corrective services/criminal justice system, housing services, Centrelink

Family services, social services, Aboriginal services, CALD services, Youth services

State systems and commissioning frameworks

Jigsaw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Rhetoric gap, integrity gap, mixed messages…we're at that intersection of hope and despair again

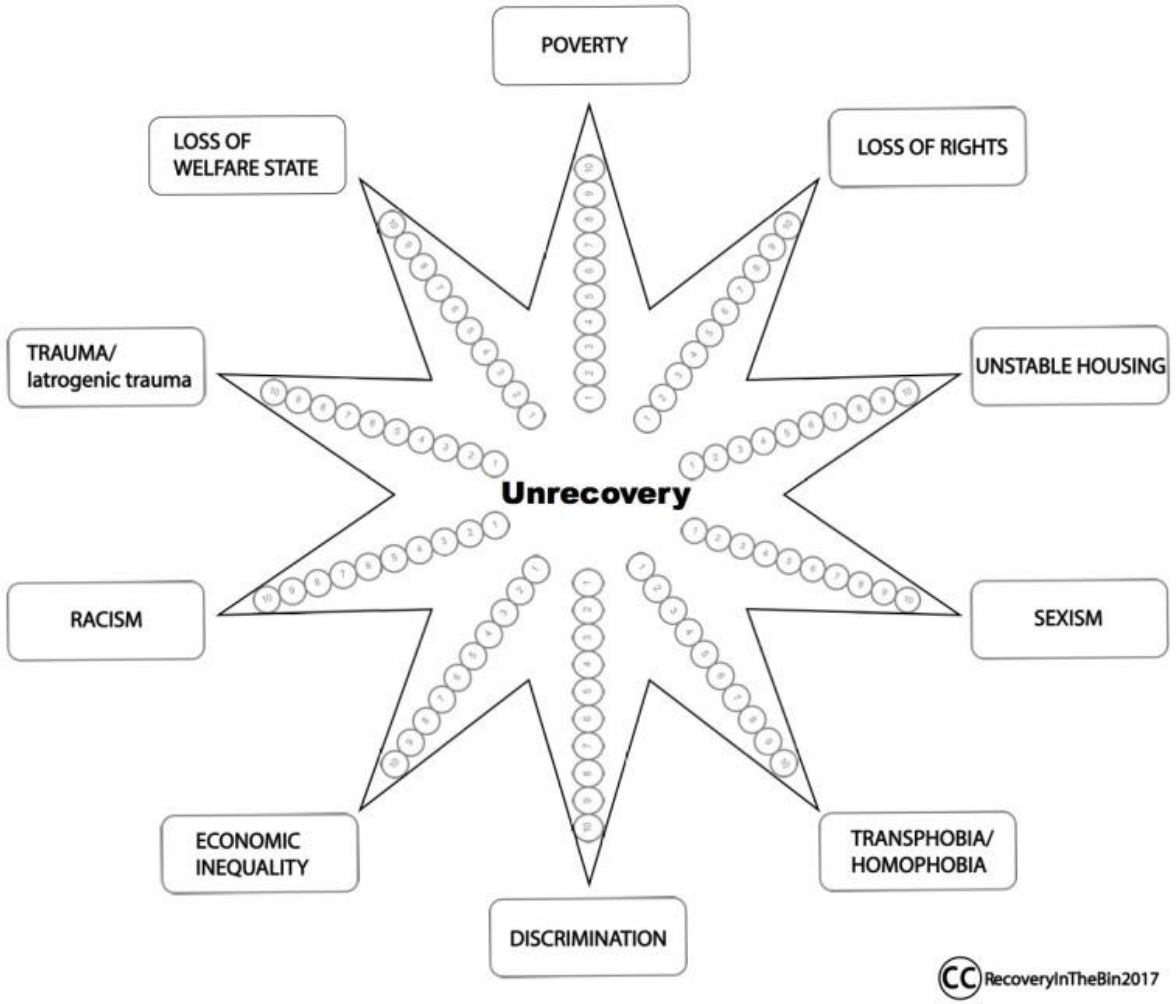
(Don't read it horizontally)

On liberty (and citizenship)

- Time to recalibrate our narratives
- Research reboot – the contested problem formulation and knowledge production of of 'impairment, psychiatric condition‘, driving policies and service commissioning.
- Co-production from problem formulation down
- Role for NMHC

Jackie and Jacqui

“The personal is political”



Jackie and Jacqui

- “We have entrenched systemic cultural issues of providers, workplaces, organisations and government entities telling people what is good for them. It is past time to end that.”
- “We must view the “problems, issues, and solutions”, “through the eyes” of the people who have lived the experience of mental ill conditions and their families or carers. “
- “Stigma, discriminatory policy, and social structures often deprive people with mental health conditions of their universal human rights, while also limiting their livelihood opportunities, thus compounding social inequities.”
- “Their families suffer many inequities as well.”
- “Having knowledge of this is very different to understanding it; there are many people who know us but very few who understand us and what we have been though or are going though.”
- On her last blog for Mental Health Day, Jackie called for a change towards cultural behaviours of kindness respect and understanding in the way we all think, act and communicate.

What will good look like?

- Just because everything is different doesn’t mean anything has changed

- It is difficult to convince a (wo)man to change their opinion when their salary depends on it not being changed

Damian Griffis

CEO

First Peoples Disability Network

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Ivan Frkovic

Queensland Mental Health Commissioner

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Senator Carol Brown

Shadow Minister for Disability
and Carers

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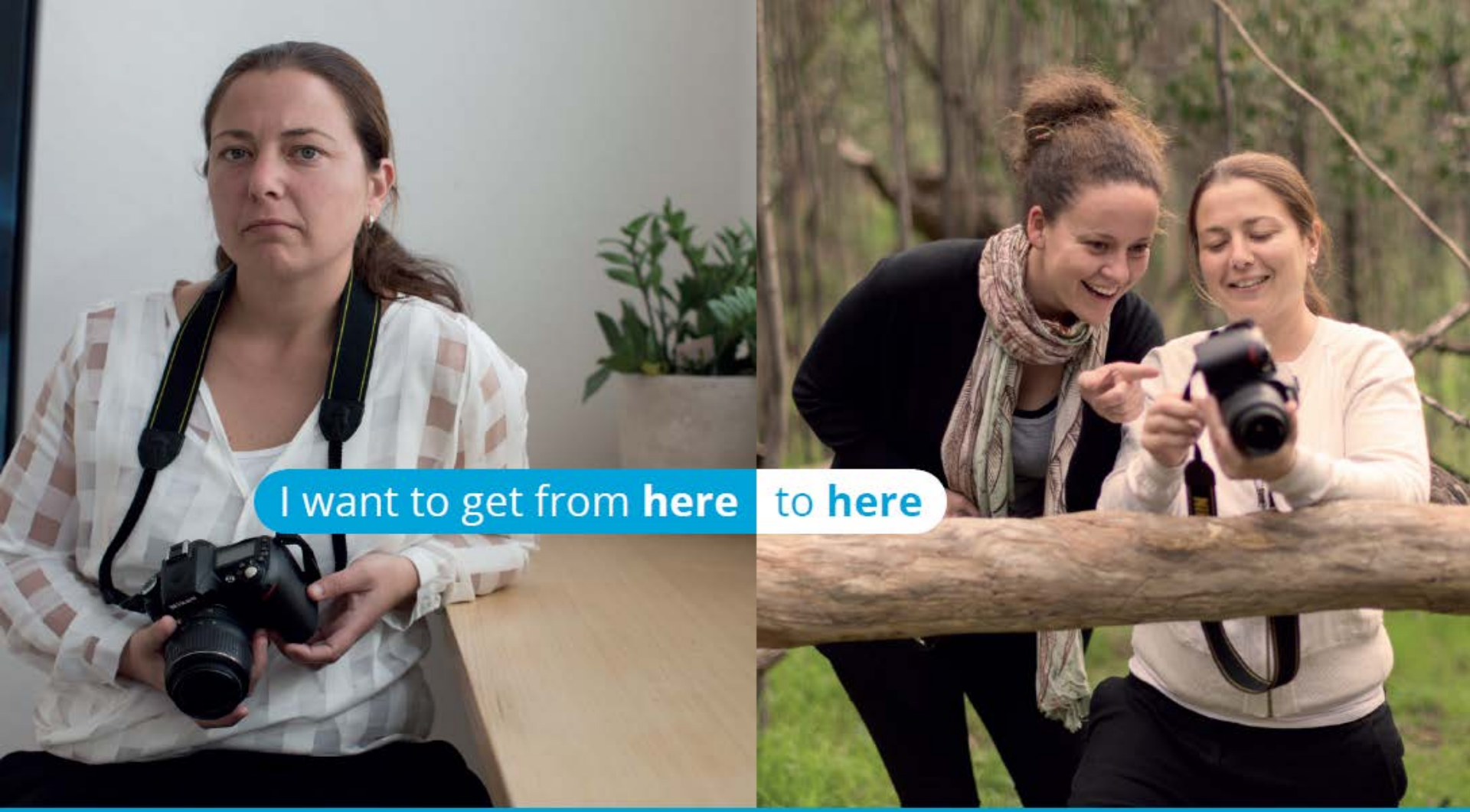

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MORNING TEA

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Gerry Naughtin

CEO, Mind

NDIS Independent Advisory Council Member

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The NDIS and psycho-social disability: Where we are up to and where we are heading

Gerry Naughtin

“Just Get on with it”

Where have we come from?

Where are we now ?

Where are we going ?

Where Have We Come From?

- Mental Health a late starter to the concept of the National Disability Insurance Scheme.
- Scheme designed around the needs of 400,000 people with physical and sensory disabilities estimated to be part of the Scheme
- Not designed around the needs of estimated 64,000 people with psychosocial disability
- Recognition in 2012\13 that further design work would need to be done on the operations of the Scheme for people with psychosocial disability
- Broad community acceptance through consultations that the concepts of **participant empowerment, choice and control and insurance principles** were equally relevant to participants with psychosocial disability
- Acceptance of a change agenda not just transfer of funding responsibility from State and Territory to Commonwealth

Where Have We Come From?

- In 2014, NDIA recognised that there were a range of design and implementation issues for people with disabilities related to a mental health condition
- Independent Advisory Council (IAC)produced a major report on these issues in 2014 and the Board adopted a strategy plan for psychosocial disability
- Design and implementation issues have been a strong focus of the IAC and the Agency since 2014
- *Report: www:/ndis.gov.au/about-us/IAC/icc-advice-mental-health*
- Mental Health Adviser (Eddie Bartnik) appointed and a specialist mental health team appointed (Deb Roberts and Kerry Hawkins)
- Program of work undertaken : language, information& advice, reference groups undertaken
- Specialist access team established in 2016

Where Have We Come From?

- Recognition that the NDIA would be taking responsibility for a diverse and fragmented set of state and territory based service provisions arrangements and integration of @ $700M of Commonwealth programs funding (PIR , Phams, respite etc.)
- Lots of focus on who would miss out and that the NDIA was operating in mental health systems across the country that were different and had major supply and quality problems
- Role and focus of PHNs emerged and focused in this period
- **Recognition of a number of inter-twined issues for psychosocial disability:**

  The need for a stronger focus on principles that increase recovery and the connection between recovery and insurance principles

  Better articulation of the technologies and approaches to reduce the functional impacts of psychosocial disability and increase social and economic participation.

  How to manage the episodic nature of psychosocial disability

  Need for a clearer picture of what participants want and what works for which groups

Where Have We Come From?

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- Lots of focus on who would miss out and that the NDIA was operating in mental health systems across the country that were different and had major supply and quality problems
- Role and focus of PHNs emerged and focused in this period
- Recognition that there are some difficult design and implementation issues:
  - Insurance principles
  - Need to incorporate recovery principles

Where Are We Now

Disability Reform Council expectation that the NDIA will deliver access assessment and plans for 64,000 people by July 2019

Plus: Expectations that reviews will be undertaken every 12 months

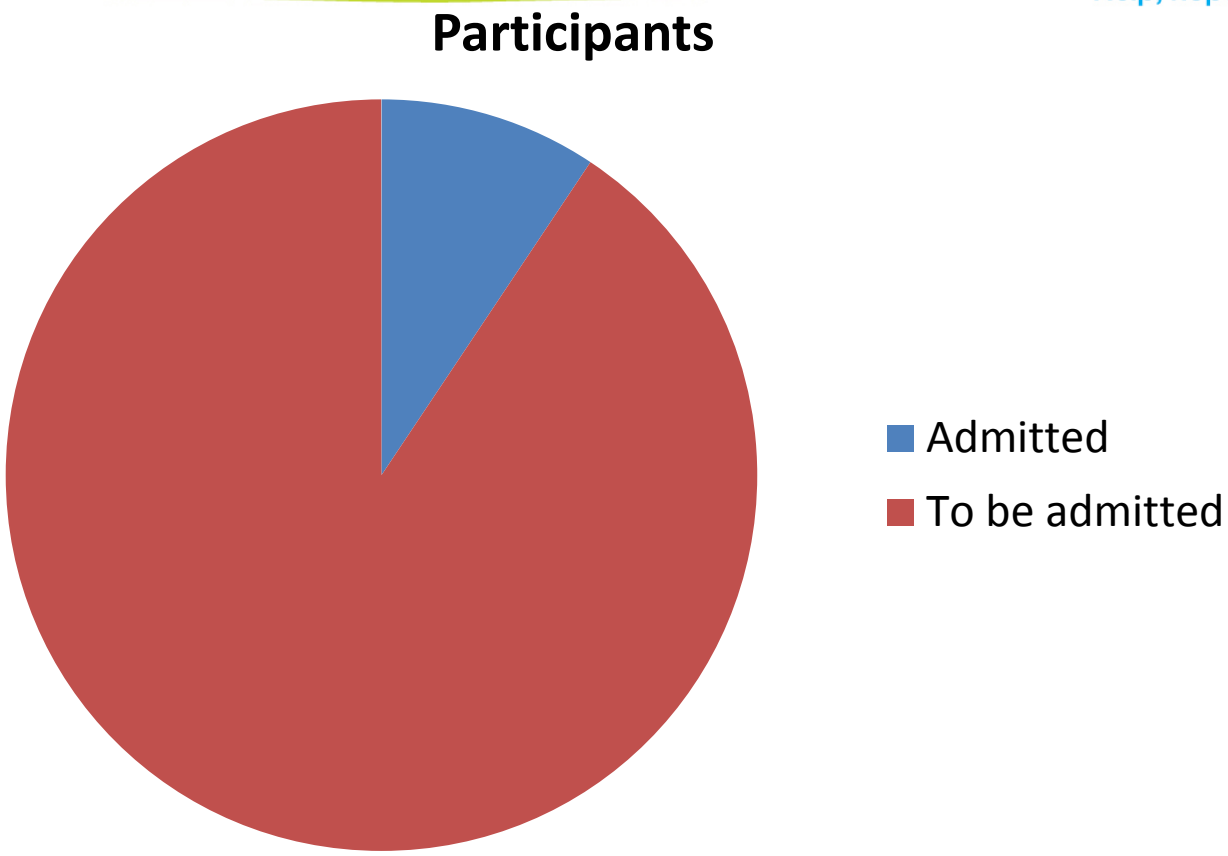
Expectations that service providers will respond to major change in clients and their families and carers, adapt existing service and business models and re-configure their service offerings

Expectations that service providers will undertake this major change WHILE reducing their organisational overheads by 6% to 8% and a reduction in unit pricing to what is currently provided by state and territory governments

Expectations that participants as they get to know and get more confident with the NDIS will drive further change

Continuing stories and evidence that peoples lives are being changed in mores significant ways than was being achieved by historical approaches. Signs that transformation ic occurring.

Numbers



Significant Work Load

TASK	NUMBERS
Access Plans	80,000 to 90,000
Service Plans	60,000
Annual Reviews	65,000 to 75,000
Information, guidelines and educational materials	On-going

Notional $ for Psychosocial disability

State	Projected $m	Projected participants
NSW	660	21,100
Vic	500	16,000
Qld	400	12,800
SA	160	5,100
WA\Tas\Territories	280	9,000
TOTAL	2,000	64,000

Where Are We Now

Consumers, families and carers, service providers and mental health professionals all learning to understand how to work, receive and deliver services in changing environment

Major sector restructure of unprecedented proportions

We are in the eye of a transformational storm

Jane Prenctice in her presentation talking about the NDIS being a program of life transformation

NDIA carries the expectations of the nation in regard to improving the lives of people with disabilities in this country

Change is occurring in an environment in which the Agency is expected to deliver ion a generational shift in policy and funding

Community inclusion underpins the NDIS, consistent with recovery. Both are consistent with the insurance principles of the Scheme. Important not to confuse the principles of social insurance with the delivery of supports through a market.

Where Are We Going?

NDIA has

a strategy, infra-structure and people

to guide and steer through the storm of transformation that it and we are all involved in.

It continues to be committed to working with consumers, families and carers and the mental health sector in improving the responsiveness of the Scheme, listening to what happening, working towards improvements

Rob De Luca, Chief Executive NDIA

"The Agency is aware of the issues raised recently by the Joint Standing Committee on the NDIS and Mental Health and the recent Productivity Commission Report.

The Agency is committed to continuing to improve the responsiveness of the Scheme to eligible participants with psychosocial disabilities….

The NDIS is committed to working with the mental health sector in further improving the responsiveness of the Scheme".

Key elements of the work plan moving forward

- Developing client pathways for psychosocial disability with the mental health sector and opportunities to contribute
- Considering and responding to the recommendations of the Joint Standing Committee, PC and McKinsey Report on pricing
- Managing a major work plan implementing the Scheme for psychosocial disability

• Need to build a better evidence base of **what works** at **what cost** in assisting people with psychosocial disability to have a better life

• Priority Areas

  - Improving the planning process
  - Investment in participant capacity development
  - Refining psychosocial disability reference packages
  - Shared responsiibilty for workforce development
  - Improve the responsiveness of mainstream services

NDIS $ for Psychosocial disability

- NDIS represents the most significant reform of psychosocial supports services since deinstitutionalisation
- Delivers significant new $ for psychosocial disability
- Challenge to get the $ to work in ways that meet consumer expectations and supportindustry development and restructure
- Major challenge for Scheme is that good psychosocial outcomes also relies on adequate clinical mental health, housing and employment support services, **which the Scheme does not control**

Achieving Change

- Change of this scale will take time
- The Agency is committed to listening and continual improvement
- Need to recognise that Rome will not be built in 2- 3 years
- AND we need to build the policy, funding and practice architecture for reform over the next two decades

Help, hope and purpose

Thank you

Diversity, Mental Health & the NDIS

Damian Griffis, CEO - First Peoples Disability Network

Stella Topaz QLife National Project Manager - National LGBTI Alliance

Helen Egan CEO - TeamHEALTH

Dwayne Cranfield CEO - National Ethnic Disability Alliance

Margherita Coppolino President - National Ethnic Disability Alliance

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LUNCH

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BREAK SESSION STREAM:
SERVICE PROVIDERS

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NDIS for an Aboriginal health service

Kim Soppa

Carbal Medical Service (QLD)

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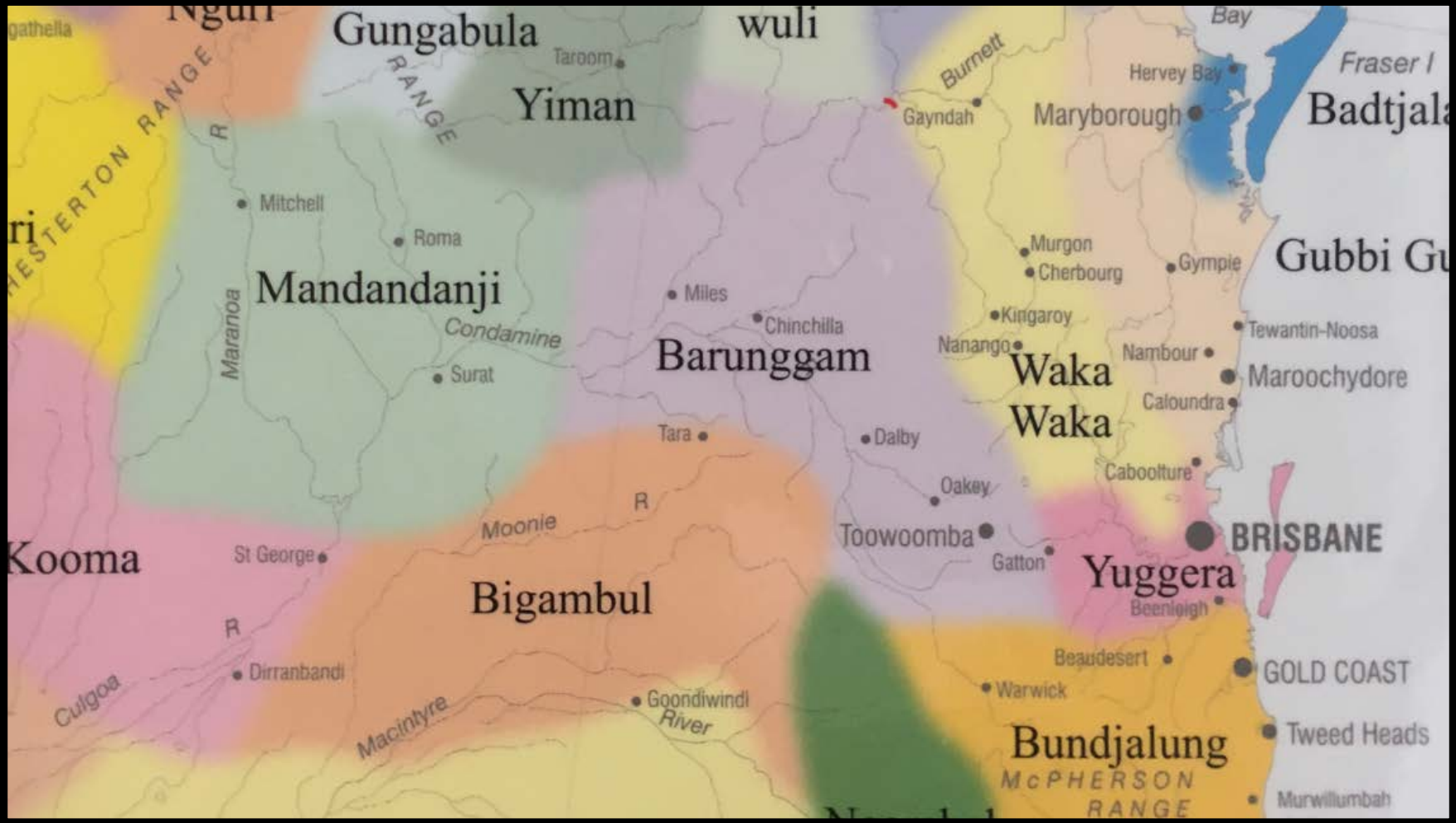
Carbal Medical Services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Client Barriers

- Need for assessments that they couldn't afford
- Reluctance to engage with government org
- Lack of literacy and numeracy, IT
- Lack of stability – housing, MH, family, phone
- Lack of access to IT

Organisation Barriers

- Lack of knowledge
- Change in budgeting arrangements
- Change to staffing contracts
- Community centred did not = fee for service
- Staffing instability
- Multiple processes to develop

Hard work

- Give people time to talk and process
- Seek out records
- Worked with local agencies
- Educate GPs
- Work with local uni to find low cost testing
- Stay positive and client centred


Carbal Medical Services
Carbal Medical Centre

- Genuine improvement in health and well being
- Staff are linked with clients that suit their background and skill set
- Choice and control for the first time

Still all about community

Questions?

WA NDIS - collaborative practice - a local example

David Turton

Rockingham and Peel Group
Community Mental Health (WA)

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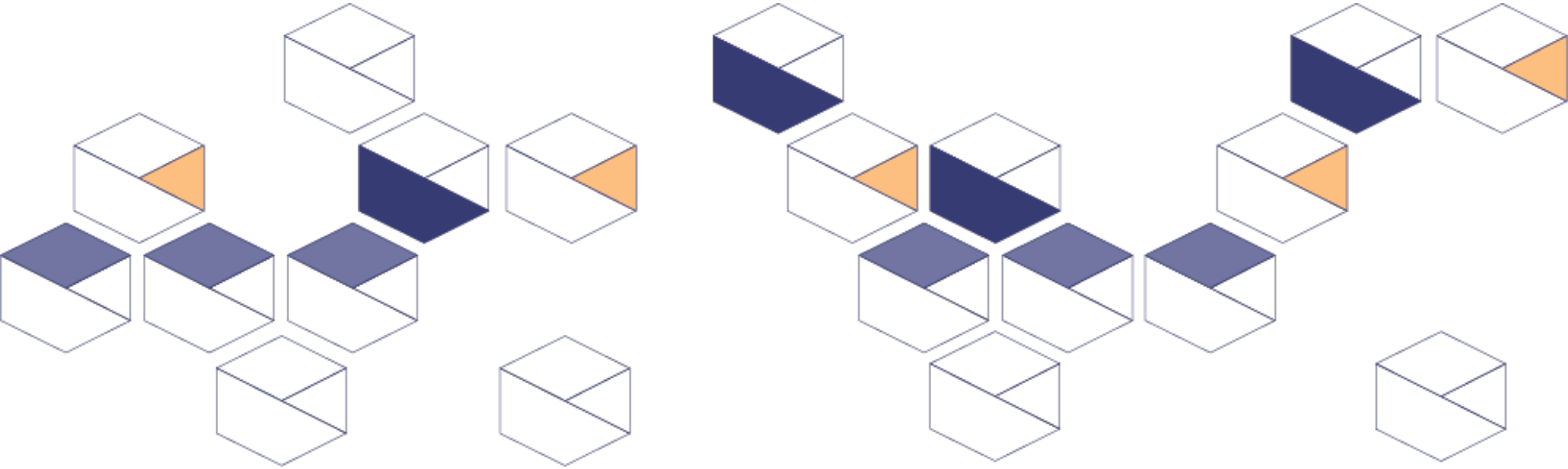
Government of **Western Australia**
South Metropolitan Health Service
Rockingham Peel Group

NDIS – Collaborative Practice

A local example by the Rockingham Peel Group (RkPG) Assertive Community Team (ACT)



Presentation Outline

First bit (Setting the scene)

- Demographics and service description
- Our ACT team
- WANDIS

Second bit (RkPG Portfolio Plan)

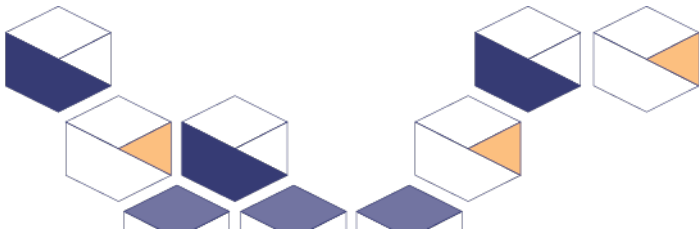
- Assumptions of the plan
- The plan (before, now and after)

Third bit (Collaborative practice in action)

- Case study

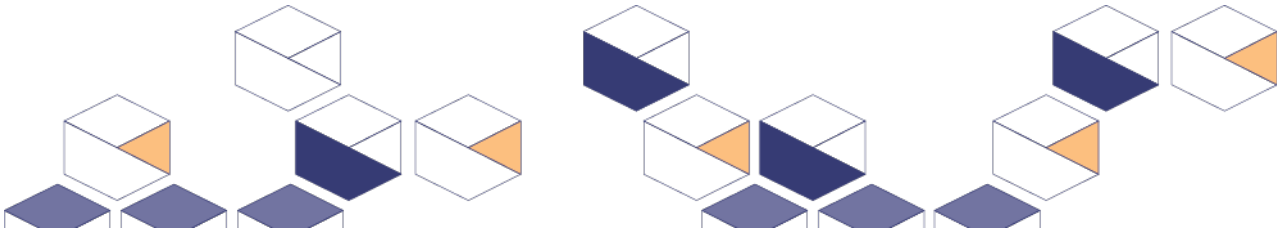
Fourth bit (Reflective practice)

- Reflections and conclusions



RkPG MH Service

- RkPG Mental Health Services provides acute, sub acute and older adult MH services for the catchment population of 280,000 people;
- Funding is provided by the Mental Health Commission WA for 2% of population;
- Local estimates from the PSOLIS data and ED presentations estimates closer to 4%.



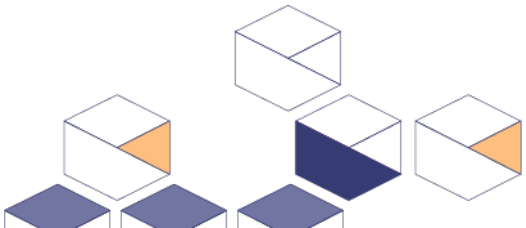
Some Statistics - WANDIS

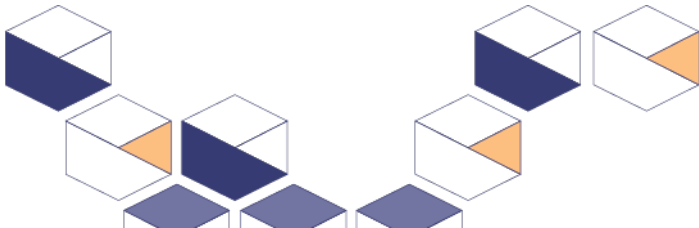
- 38 (7.4%) out of 515 deemed eligible in the June Quarter of WA NDIS had psycho-social as primary disability;
- 361 (9.6%) out of 3,743 current and pending WANDIS plans have psycho-social as primary disability;
- 56% (N=203) are 45-64yrs.
- 282 (8.8%) of plans out of 3,202 for psycho-social disability cost $5,486,196 (4.72%) of total plan costs at an average cost of $19,455 / plan. (Avg. plan cost is $36,021)
- 1,730 active plans with 300 (17%) having psycho social as the primary disability (Kwinana / Cockburn)

Assertive Community Team (RkPG)

ACT's role and functions?

- Support people with a serious mental illness to live a fulfilling life in the community;
- Build rapport and engage with consumers to meet their needs;
- Reduce acute health service usage and therefore increase the time that people spend in their own environment;
- Improve psychosocial functioning that may have previously led to relapse of mental illness;

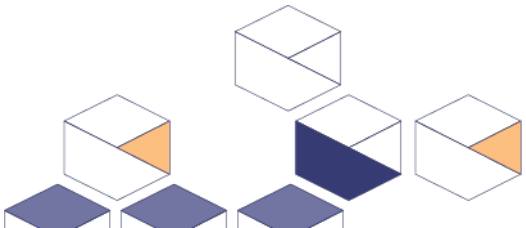


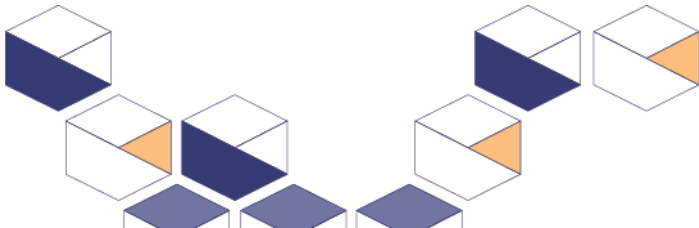


Assertive Community Team (RkPG)

How are we different from other teams?

- Care coordination for each consumer;
- Support is provided by the whole team to promote continuity of care;
- Communication within and without the team is prioritised;
- Support is recovery oriented using MDT expertise;
- Consumer and carer contact is frequent and inclusive.

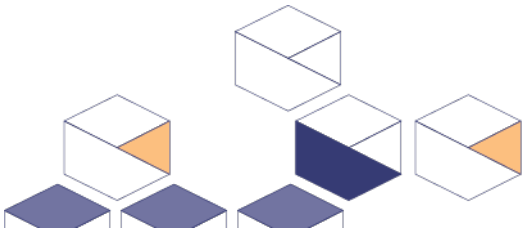


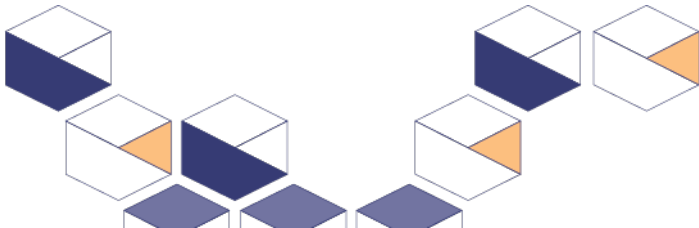


Assertive Community Team (RkPG)

Who are our consumers?

- People with serious and chronic MH disability;
- Socially isolated;
- Income support;
- Social housing or supported accommodation;
- Multiple health problems (A&D, diabetes, malignancy, medical issues – thyroid, epilepsy etc);
- Culturally diverse;
- Long careers as MH consumers with multi agency involvement and frequent admission history;
- Community Treatment Orders.

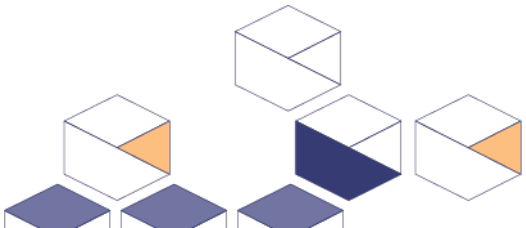


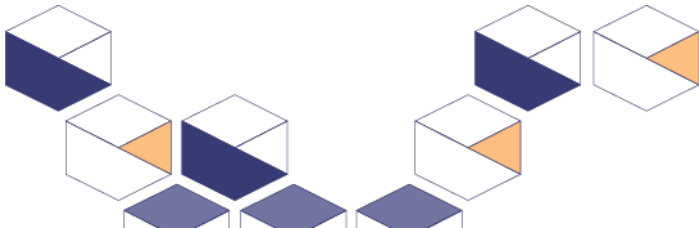


Assertive Community Team (RkPG)

Who’s on the team?

- Team leader (Snr. OT) 1FTE (AMHP)
- Psychiatrist .5 FTE and Psychiatric registrar .5 FTE
- 2 Community MH Nurses 2FTE (AMHP)
- Social worker 1FTE
- Occupational therapist 1FTE
- Peer recovery worker 1FTE

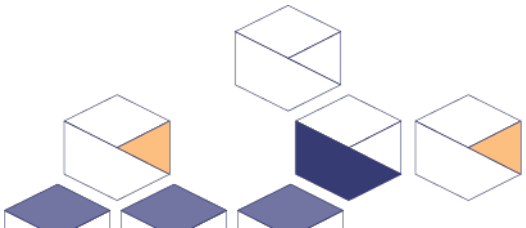


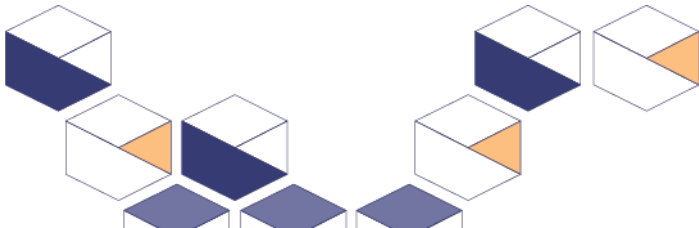


Assertive Community Team (RkPG)

What does the ACT do?

- Care coordinates 48 consumers (12 per C/C);
- Establishes Care Coordination Plans for each consumer;
- Weekly meetings for scheduled reviews;
- Morning team meetings, daily routines;
- Ongoing assessment and monitoring;

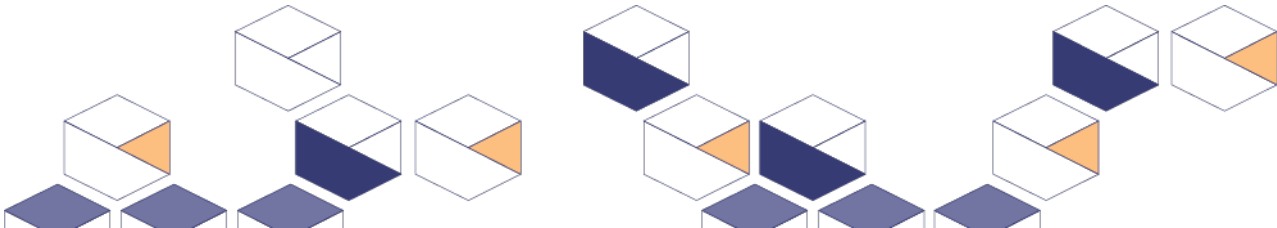




Assertive Community Team (RkPG)

What does the ACT do? (...Cont)

- Provides depot injections, ensure medication supply and delivery;
- Maintain outpatient medical review schedules;
- Escort consumers to GP, OP appointments.
- Coordinate acute admissions, in-reach to acute setting, IP treating team liaison, and assist with transfer of care planning.
- Liaise and case conference with CMO’s

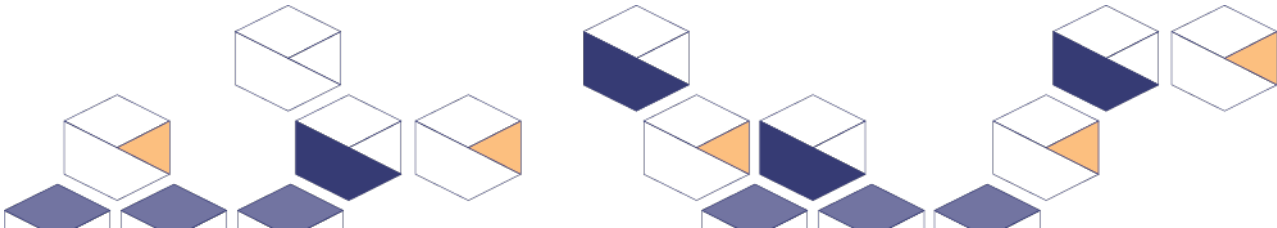


WANDIS

What is WANDIS? (by its own description)

General

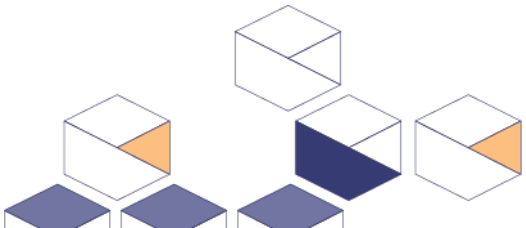
- The national scheme delivered locally;
- Committed to the national principles of the NDIS;
- Consistent with national system on eligibility, portability, and necessary and reasonable supports;
- Will use the national quality assurance system;
- Is funded by the Commonwealth and State Governments.

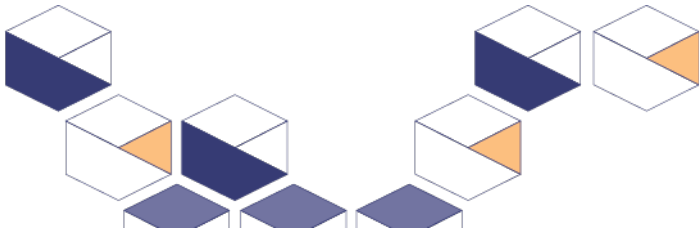


WANDIS

What is WANDIS? (... Cont)

- People based with a focus on relationships;
- LAC play and integral role;
- Focuses on early engagement in individualised planning;
- Has local decision making within local communities;
- Has a strong focus on informal networks and community based supports;

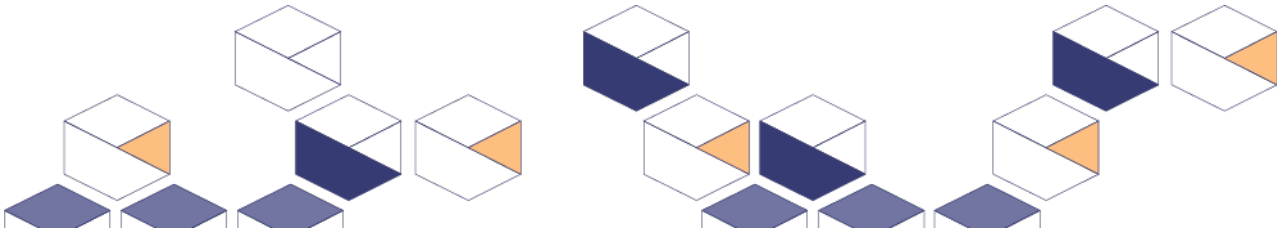




WANDIS

Brief history

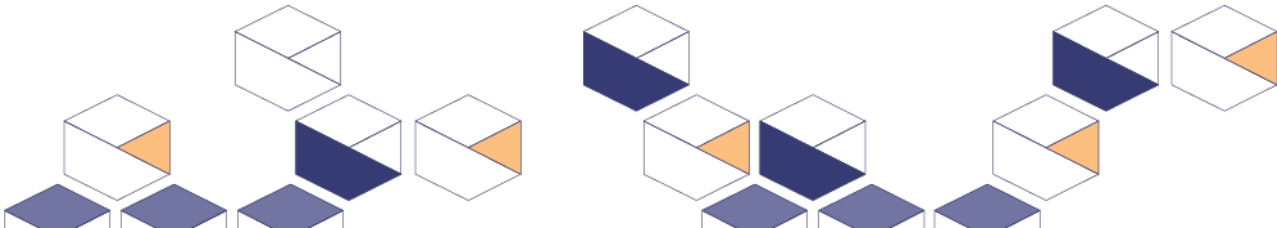
- 2012 - WA State government committed to best practice and a federated model to ensure local accountability;
- 2013 – Two year trial with two NDIS models in 3 trial sites (NDIA and WANDIS) with DSC implementing in Lower South West 2014 and Kwinana 2015 / Cockburn;
- 2017 – Bi-lateral Agreement was signed by the Barnett Government and rolled out in regional areas.



WANDIS

How is WANDIS structured?

- Regions have local teams of LAC’s, Area and Regional managers, support staff, with expertise in eligibility, allied health and complex needs, technical skills and community development;
- RkPG has 3 regions: Kwinana, Rockingham and Peel.
- (That’s the first bit)



Collaboration: RkPG NDIS

Second bit

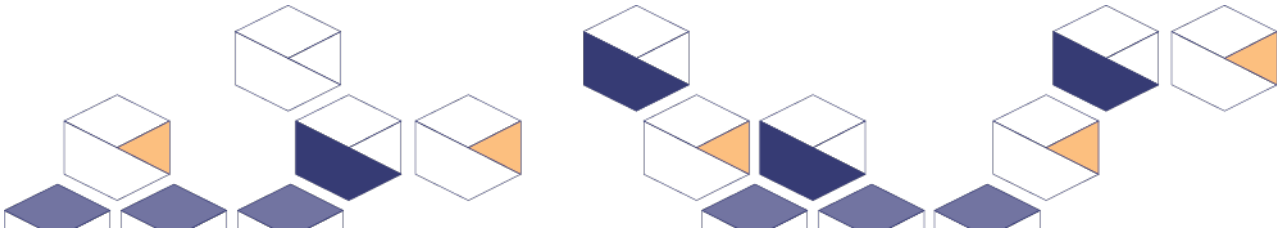
- RkPG Steering Committee approved the development of an NDIS portfolio plan (2016 – 2018) which would shape the collaborative framework of the service with NDIS services in the catchment.

Service assumptions:

- That NDIS is the single most important development in community based service provision for MH consumers in recent times;
- That RkPG has a responsibility to advocate for MH consumers access NDIS resources;
- That RkPG acknowledges that it has an essential role in becoming an *expert referrer* to NDIS by informing staff and developing collaborative relationships with stakeholders;

Collaboration: RkPG NDIS portfolio plan (...Cont)

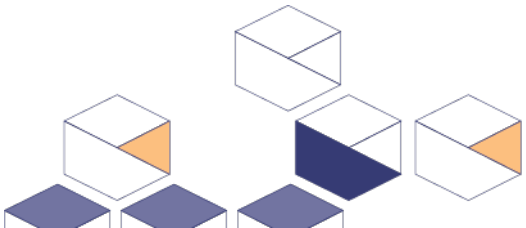
- RkPG accepts a responsibility to share clinical expertise with NDIS agency and stakeholders;
- MH consumers have experienced considerable disadvantage in community based service provision;
- Psycho-social consumers are more to experience challenges in many areas of daily living including;
  - Accommodation, homelessness and economic disadvantage
  - Social and family isolation
  - Reduced physical health (metabolic syndrome)
  - Substance and alcohol misuse
  - Poor access to resource information

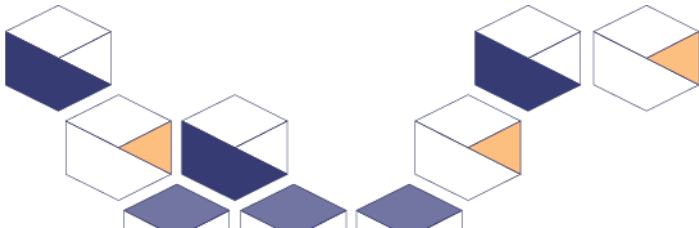


Collaboration: RkPG NDIS portfolio plan (...Cont)

What we have done.

- Established face to face relationships in the NDIS space;
- Familiarised our selves with NDIS policy and procedure;
- Scrutinised case loads;
- Invited NDIS participation with RkPG staff;
- Encouraged NDIS coordinators and MH; coordinators to co-engage in NDIS processes;
- Assisted with NDIS and MH consumer interaction;





Collaboration: RkPG NDIS portfolio plan (…Cont)

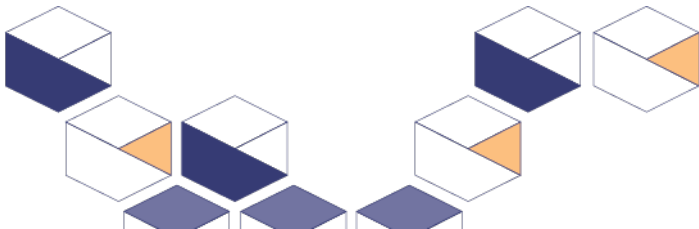
What we are doing now.

- Encouraging consumers to consider NDIS support;
- Assisting with consumer referral processes;
- Assisting with consumer engagement with NDIS coordinators;
- Direct involvement with assessment and plan design;
- Inviting NDIS staff to RkPG business meetings to share information;
- Encourage RkPG case managers to engage with NDIS in all stages of the service support processes;
- Provide opportunities for staff information sharing and attendance at NDIS community stakeholder meetings;
- Assist NDIS service delivery by educating and offering clinical expertise.

Collaboration: RkPG NDIS portfolio plan (…Cont)

What we plan to do.

- More of the same;
- In collaboration with consumers and stakeholders, develop a data base, use existing tools and apply new tools tools to measure improved MH and psycho-social functioning, resulting from NDIS support;
- Assist stakeholders and consumers determine best practice processes to further define the collaborative framework;
- Provide a local newsletter for electronic circulation to RkPG staff with NDIS updates.

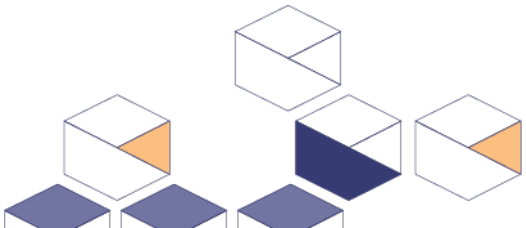


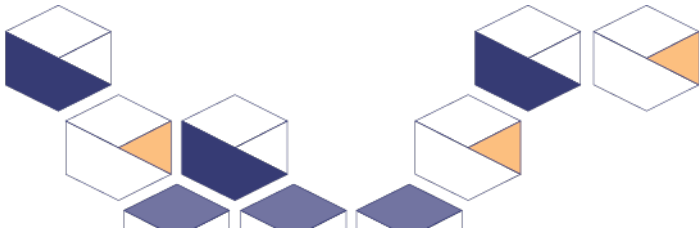
Case study – MH recovery and NDIS

Third bit (Collaborative practice in action - Case study)

Brief Background

- 42yr indigenous man;
- Diagnosed with schizo-affective disorder as a teenager. Daily cannabis usage;
- Abusive history and religious education;
- Daily contact with family (Mo and five brothers);
- With ACT for many years and well known to RkPG ED and IP team.





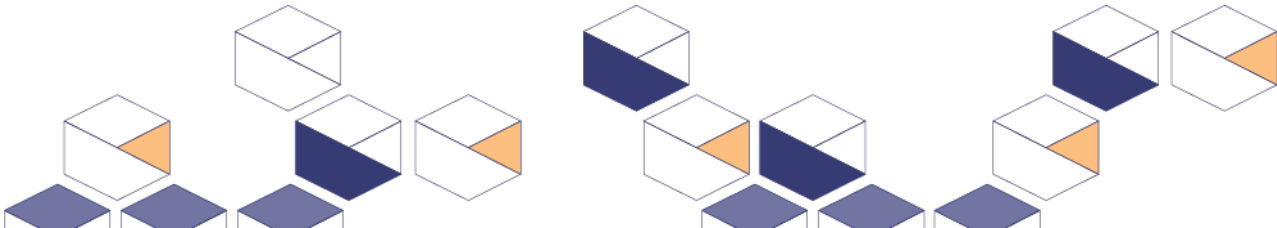
Case study: MH recovery and NDIS Collaboration

Barriers to recovery:

- Delusional constructs on religious themes;
- Emotional dysregulation and verbal aggression;
- Frequent admissions and presentations to RkPG;
- Psycho-social stressors including violent family conflict;
- Cannabis and alcohol overuse and family culture of same;
- Forensic history;
- Dependency on formal MH services to re-establish;

Strengths to recovery:

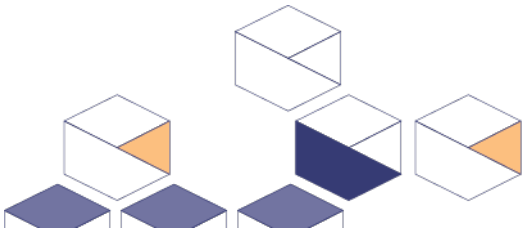
- Help seeking;
- Acceptance of depot and oral medication;
- Positive relationship with case manager;
- Well informed.

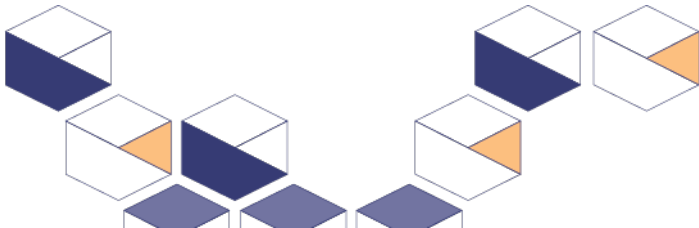


Case study – MH recovery and NDIS Collaboration

What was in RkPG mental health plan?

- Support maintenance of settled MH;
- Identify risk and respond to relapse indicators;
- Encourage greater independence and self management including living skills;
- Reduce ED and admission frequency (add possible alternatives to manage crises);
- Reduce impact of psycho-social stressors by environmental adjustments in line with consumers recovery goals;





INDIVIDUAL PLAN FOR

PREFERRED NAME:

DATE OF BIRTH: AGE: 42

RESIDENTIAL ADDRESS:

PREFERRED CONTACT: Mobile Phone David Turton Rockingham MHS

PLAN STATUS: Draft PLANNING START DATE: 20/07/2017

VISION - HOW I WOULD LIKE LIFE TO BE

To make my new home my sanctuary. To be positive and healthy, and connected to my family and to my community.

CURRENT SITUATION - MY/OUR STORY

Including strengths and vulnerabilities

is a 42 year old native Australian man who has experienced schizophrenia since he was 16 years.

recently moved into a Housing Authority home in Medina. He is living independently for the first time. Darryl previously lived at Medina.

He still maintains close contact with his mum Winnie who lives in the family's Parmelia home with his brothers . He also has brothers plays an important support role to

Family is very important to , especially his mum. He is also very proud of his native Australian identity.

is generally able to manage his schizophrenia through fortnightly depot medication. On occasions in the past he has required acute care at Mimidi Park or Graylands. is capable at identifying when his mental health is poor and he will initiate his own admission to acute care if he feels he is struggling.

is very well supported by his mental health case manager David Turton who has assisted in the process of developing this plan, and was instrumental in ransitioning to his own accommodation.

As has never lived independently before, the next 12 months will be a big step for him. He is excited about learning more skills, especially cooking, so that he can manage in his own home. He is learning about the importance of maintaining his tenancy, and the responsibilities that this involves. He is being supported in this process by his family (especially his brother Bill), his Mental Health case worker, Local Coordinator and support workers.

believes that a positive mindset is very important. He always tries to relate with other people with a similar positive energy. He values people who are peaceful and generous.

is a deeply spiritual person. He will often see himself as a spiritual warrior who is attempting to make his world a better place. is sensitive to other people's emotions and he is grateful that he is able to provide comfort to other people in his life.

PLAN GOAL - P01

To develop skills and routines so that I can live independently.

REF	HOW I WILL ACHIEVE THIS	WHO WILL HELP?	SUPPORT REQUIRED	FUNDED
S05	I will be supported in my home to develop skills and routines required to live independently. This includes cooking, cleaning, budgeting and maintaining my household.	Mifwa	will access a support worker who will assist him to develop his independent living skills, so that he builds his capacity to live independently. (5x2hrs=10hrs/wk)	Yes
S06	I will be supported by my family in my transition to living independently. This includes support to assist me to understand my responsibilities as a tenant and maintain my tenancy agreement.	Bill (brother),	; brother will support him in his transition to living alone by providing advice and support. Bill will work collaboratively with , other supporters to assist him to maintain his tenancy responsibilities.	No

PLAN GOAL - P02

To stay connected with my community.

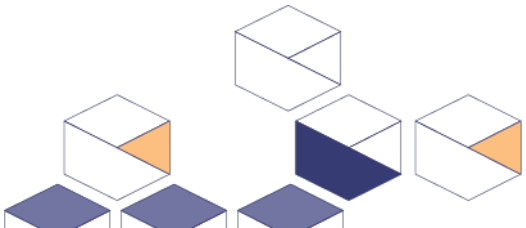
REF	HOW I WILL ACHIEVE THIS	WHO WILL HELP?	SUPPORT REQUIRED	FUNDED
S01	I will access a support worker who will assist me to access the community, including supporting me to attend my fortnightly depots. My support worker will also assist me to attend community-based activities and any preferred recreational activities that require support.	Southern Cross Care	will access a support worker who will assist him to attend activities in the community, including support to access his fortnightly depots. Support worker will assist to attend group activities provided in his local area. (2x3hrs=6hrs/wk)	Yes
S04	I will be supported to develop positive relationships with others in my local community, especially with those who I share common interests.	.ocal Coordinator, Case Manager, Community First	to be encouraged to develop connections with people in his community and to maintain relationships independent of formal supports. is able to attend the Community First group activities that interest him, including their walking group, art group and men's group.	No

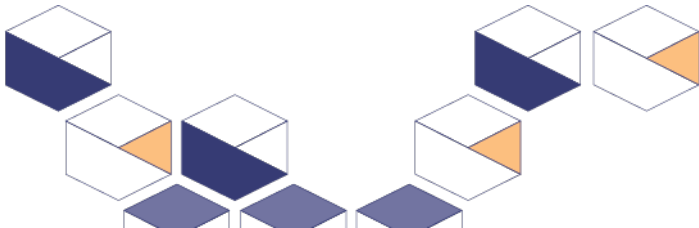
PLAN GOAL - P03

To maintain positive mental health.

NDIS Plan (…Cont)

REF	HOW I WILL ACHIEVE THIS	WHO WILL HELP?	SUPPORT REQUIRED	FUNDED
S02	I will continue to receive support from my Mental Health case manager.	David Turton (RMHS - ACT)	will continue to be supported through access a support worker on an "as needed" basis, to assist him with complex situations. This includes support around justice/legal obligations, and any other assistance to attend mental and physical health-related appointments or engagement with other critical interventions.	No





NDIS Plan (…Cont)

FUNDING SUMMARY

REF	MANAGED BY	SUPPORT REQUIRED	TOTAL UNITS	UNIT RATE	TOTAL FUNDED	SPR	W.C.
S01	Southern Cross Care WA Inc	Darryl will access a support worker who will assist him to attend activities in the community, including support to access his fortnightly depots. Support worker will assist Darryl to attend group activities provided in his local area. (2x3hrs=6hrs/wk)	312	$59.00	$18408.00		
S05	Mental Illness Fellowship of Western Australia Incorporated	Darryl will access a support worker who will assist him to develop his independent living skills, so that he builds his capacity to live independently. (5x2hrs=10hrs/wk)	520	$59.50	$30940.00		
TOTAL FUNDING					$49348.00		
TOTAL FUNDED PACKAGE					$49348.00		

SPR = Superannuation applied
W.C. = Workers Compensation applied

NDIS Plan (…Cont)

SIGN OFF

My signature below indicates I have reviewed all pages of this plan and confirm it reflects agreed goals and strategies developed during planning.

PREPARED WITH	NAME	SIGNATURE
INDIVIDUAL		DATE SIGNED: 13/9/2017
FAMILY MEMBER(S) OR CARER(S)		DATE SIGNED:

PREPARED WITH	NAME	SIGNATURE
COORDINATOR	Cockburn 8 Local Coordinator (Matthew Ford)	M.T. Ford
AREA MANAGER	Cockburn LC Area Manager (Fiona Taylor, Gavin Pitman, Leanne Beches, Rel Morris, Victoria Graham)	

PROPOSED REVIEW DATE: 13/9/2018

Please notify the Department of Communities as soon as possible if an event or change of circumstances happens, or is likely to happen, that might affect your plan.

Collaboration: RkPG / NDIS /CMO’s

Collaboration: RkPG / NDIS /CMO’s

Collaboration: RkPG / NDIS /CMO’s

Case Study: MH Recovery RkPG and NDIS

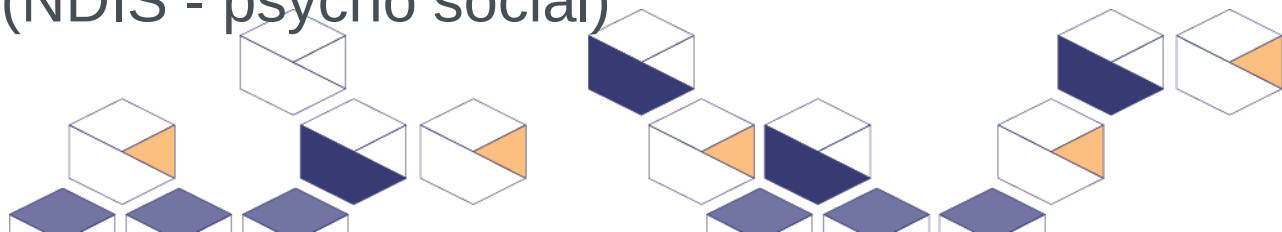
Integrating the MH Plan and NDIS Plan (clinical and psycho-social)

How?

- Client centred planning sessions, reviews with stakeholders;
- Lots of phone and email contact;
- Meeting with family and communicating with them.

What?

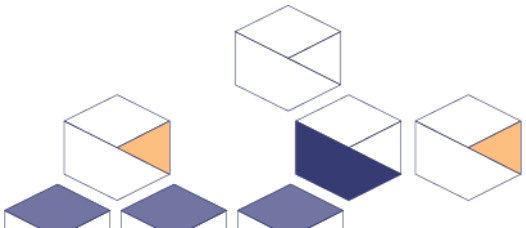
- Supported transfer of depot administration, metabolic screening and GP reviews with a GP MH plan and CTG;
- Established an objective to progress to alternative accommodation to minimise psycho-social stressors;
- OT functional capacity assessment (RkPG - clinical), LS development (NDIS - psycho social)

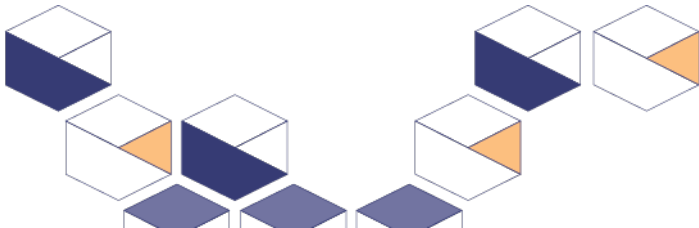


Case Study: MH Recovery RkPG and NDIS

What? (... Cont)

- Applications to public housing and supported accommodation, advocacy and trouble shooting issues;
- Negotiating court and forensic systems;
- Building in reviews and ensuring medication provision and monitoring and encouraging compliance;
- Assisting with establishing and supporting two new living arrangements;
- Continuing LS development;
- Celebration of transition to independent accommodation.





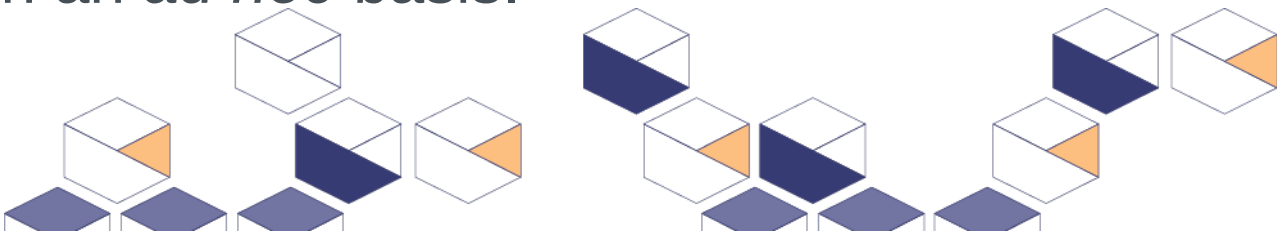
Case Study: MH Recovery RkPG and NDIS

Where?

- Everywhere, including RkPG MH clinic, GP rooms, supported accommodation, social housing, NDIS Kwinana Office, cafe's, the car ... !

When?

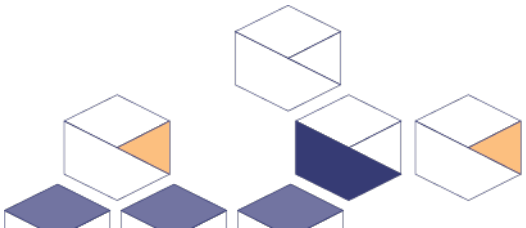
- Not a linear and ordered progression;
- Missed service provision;
- As the need arises;
- 12 monthly formal NDIS reviews but with tweaking case conferencing on an *ad hoc* basis.

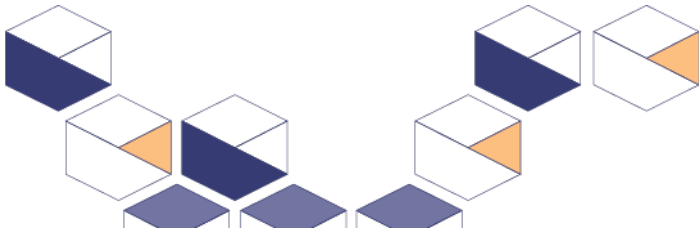


Reflections and Conclusions

Fourth bit (Reflections and conclusions)

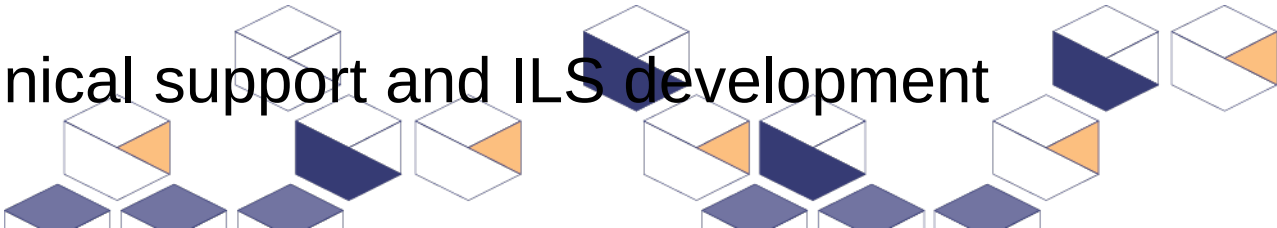
- Strengths of collaborative practice with psycho-social consumers:
- Psycho-social consumers are less likely to fall between the cracks;
- Better targeted plans, realistic goal setting and more informed choice of service providers;
- Results in continuity and consistency of service delivery because of improved communication between the supportive team;
- Better risk management and relapse prevention;
- Opportunities for learning and sharing of ideas;
- Flexibility in service provision as circumstances and needs change;
- Greater support for carers and service providers in the helping effort.





Reflections and Conclusions

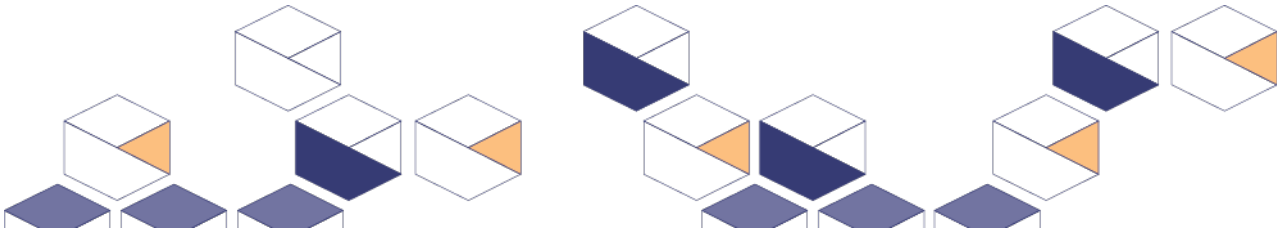
- Further considerations for collaborative practice
- Privacy and confidentiality;
- Collaboration is time consuming;
- Supporting the supporters;
- Role demarcation between co-ordinators, MH case managers, CMO support providers (who is best placed to do what and when)
- Skill levels and training;
- Outcome measurements with recovery focus. How do we know when recovery goals have been achieved?
- Promoting the goals of decreasing dependency and increasing independent living and self management skills;
- Where does clinical support and ILS development begin and end;



Reflections and Conclusions

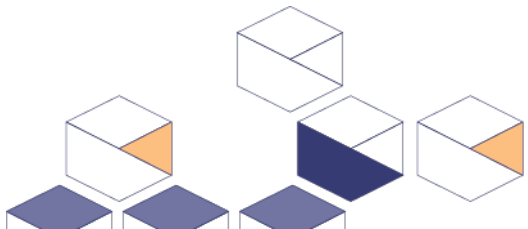
Conclusions:

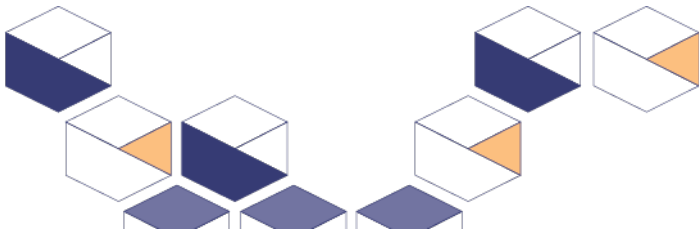
- Publicly funded MH service providers have an important contribution to make in the NDIS space and should plan for collaborative practice engagement with stakeholders;
- Collaborative practice can provide opportunities for partnering innovation and creative approaches in supporting MH consumers in the recovery journey;
- Collaborative practice builds communication, supportive linkages, opportunities for psycho-education and skill development;



NDIS – Client perspective – Audio clip

Questions





Embracing recovery in an NDIS framework

Paul Russel and Pam Boyer,
Woden Community Service (ACT)

#NDISMH2017 #towardsagoodlife

Mental Health Recovery in an NDIS Framework

Pam Boyer and Paul Russell

Woden Community Service

17 November 2017

Woden Community Service
working together, enriching lives


SUPERCHEAP
AUTO
visitnsw.com
NISSAN
WESTERN STAR TRUCKS
VOLVO
Wilson Security
PAYCE
VALVOLINE
CALTEX
autObarn
Red Bull
Holden
ACDelco
FUCHS
HUNGRY JACK'S

“I haven’t felt this well in years”

- Quote from John after he got back from Bathurst

Woden Community Service
working together, enriching lives

“I can't believe that things are as good as they are now. I feel really proud of my volunteer work at the youth centre. Every week I get more comfortable with the work and the young people are starting to trust me and confide in me. I never really had any close friends and now really enjoy spending time with Cameron, Jesse and Adam.“

- David

Woden Community Service
working together, enriching lives

Thank You

Pam Boyer

pam.boyer@wcs.org.au

Paul Russell

paul.russell@wcs.org.au

www.wcs.org.au

Woden Community Service
working together, enriching lives

Outcomes measurement as way to assist in planning and continuous improvement

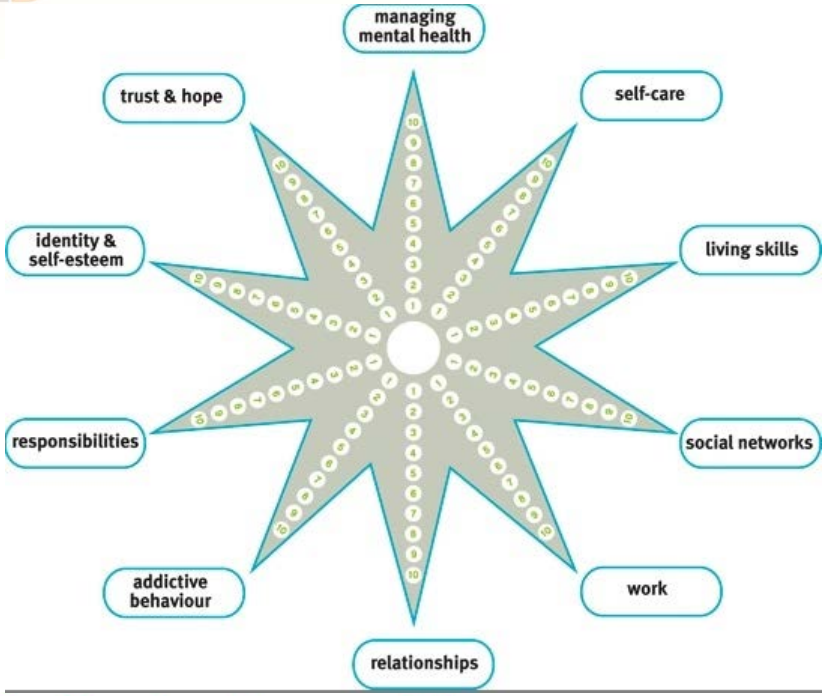
Kim Brooklyn

UnitingCare West (WA/QLD)

#NDISMH2017 #towardsagoodlife

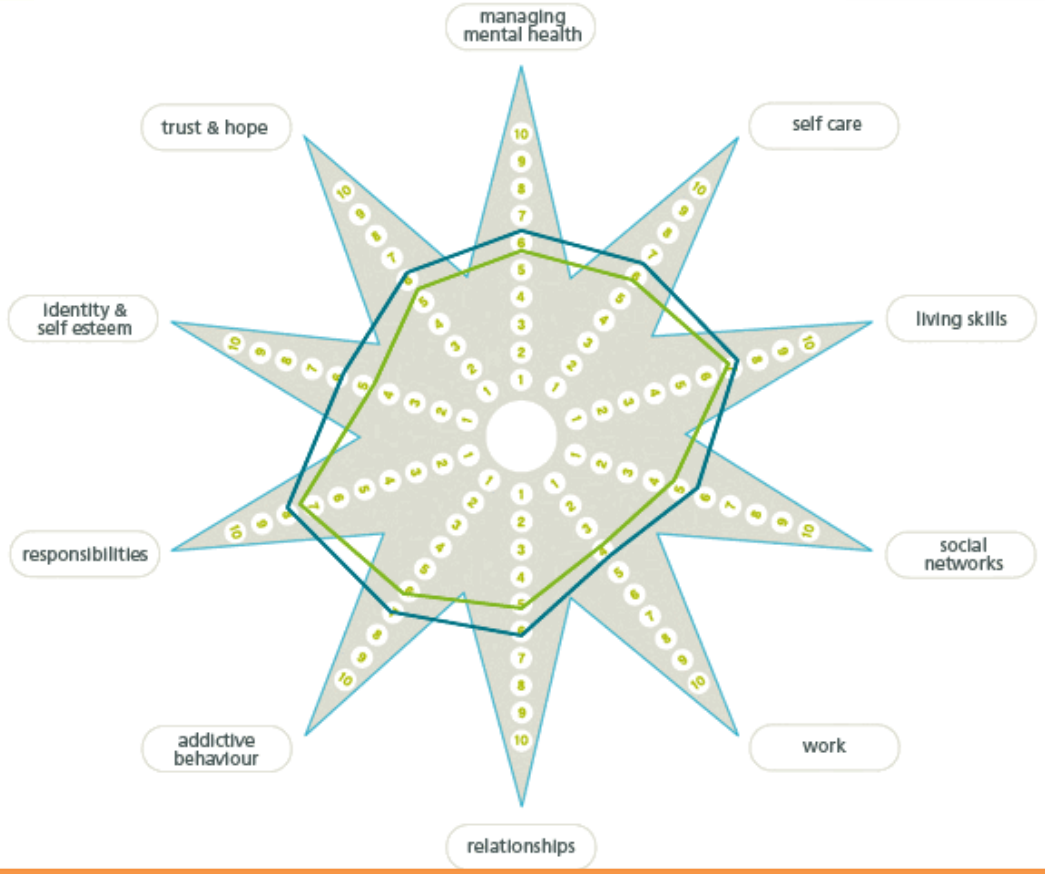
Uniting Care West

Outcome Measurement, Planning and Service Improvement



The five-stage Journey of Change

Journey of Change scale	Description of scale	Number	Staff member's role
Stuck	People at the stuck are generally unengaged, at risk to themselves, or unable to see things changing	1-2 or (1)	Worker led involvement, where pressing issues should be resolved, information provided and trust built.
Accepting Help	At this stage people want change, but are unsure on how to make it happen, they accept support some of the time but often pull back and change their mind.	3-4 or (2)	Worker led involvement, involve the person to their capacity and help them build confidence to make change on their own.
Believing and Trying	This is the turning point for people where they become motivated to take the lead and have insight into how they would like their life to be, while it is still early days and news things they try don't always work, they keep trying.	5-6 or (3)	Equal involvement. Participants take the lead with workers to provide guidance and praise where appropriate.
Learning	At this stage, people have learned what works and what doesn't, things don't always go as plan, but generally they require little support.	7-8 or (4)	Participant led. Worker provides advice when needed.
Self - Reliance	At this stages, participants are completely independent and require no support	9-10 or (5)	Participant led – No staff input required. Except at time of crisis.



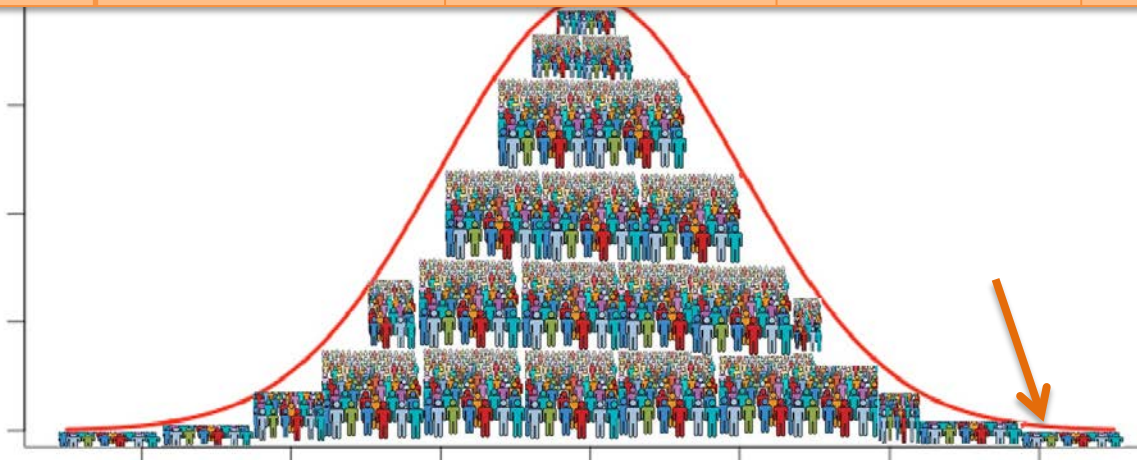
Overall Average Score		
N= 117	Initial Star	Final Star
Average	5.34	6.29
2 tailed paired t-test and result	0.013	sig

The importance of work (or meaningful use of time), social networks, identity and self esteem

- An analysis of the first measurement point indicated that people experienced greater concerns in the domains of work (x = 3.73), social networks (x=4.73) and identity and self-esteem (x=4.55).

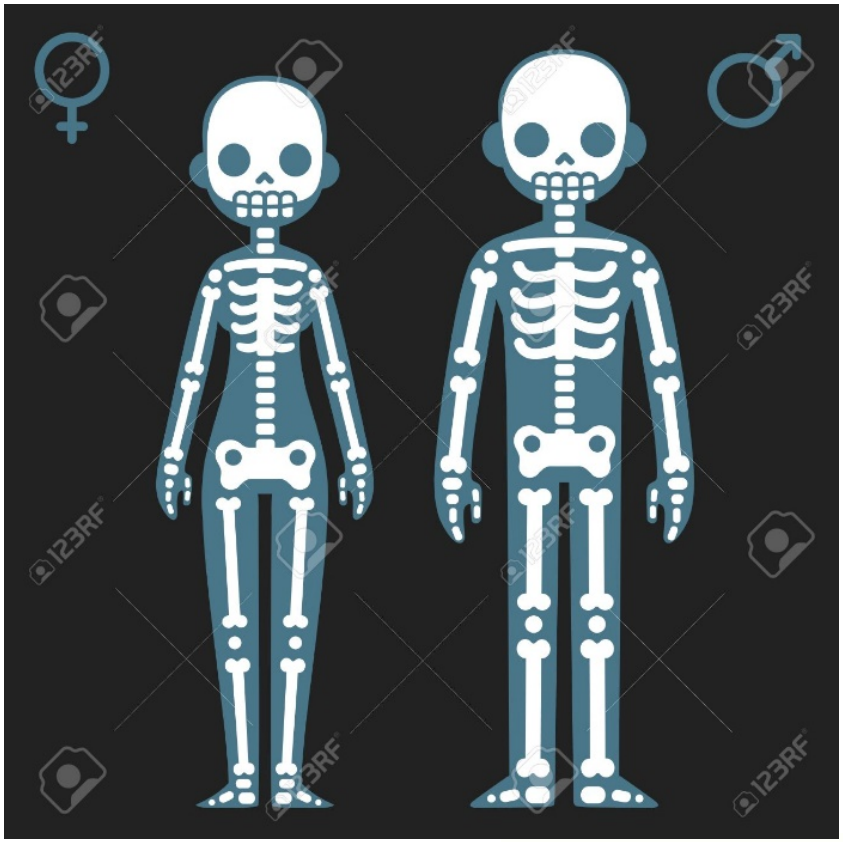
- 2 tailed T testing
- Statistically significant P = < 0.05
- No difference in this result as a function of location

Domain	Initial Star	Final Star	Paired t-test	t-test result
Managing mental health	4.81	5.96	0.036	sig
Physical health and self-care	5.78	6.89	0.014	sig
Living skills	7.41	6.93	0.34	Not sig
Social networks	3.96	5.74	0.0026	sig
Work	3.56	4.04	0.33	Not sig
Relationships	4.56	6.19	0.04	sig
Addictive behaviour	6.41	7.63	0.082	Not sig
Responsibilities	7.44	7.81	0.405	Not sig
Identity and self-esteem	4.22	5.78	0.00838	sig
Trust and hope	5.22	5.96	0.24	Not sig



Gender Differences

- Welch test: p =/< 0.05
- Gender differences found
- Men were able to improve the wellbeing domains of work, identify and self esteem and managing mental health to a greater extent than women
- Females fared better in building relationships and addressing addictive behaviour
- Men of Hope
- Gender differences in additional responsibilities

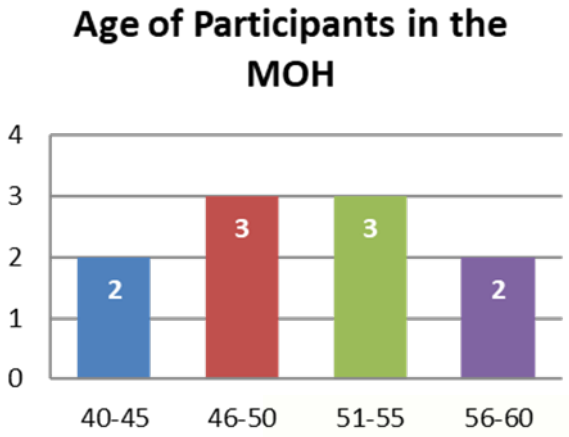



TRUST
CARING
INCLUSIVE
SUPPORTIVE
COLLABORATIVE
WELLBEING
HONEST
MENTAL HEALTH
OUTCOMES
INSPIRING
RECOVERY
DEDICATED
HOPE
EMPATHY
LOCAL
INDIVIDUALISED
PROGRESS
CONNECTING
SUPPORTIVE
SKILLED
GOALS
CHEERING
TRUSTWORTHY
SUCCESSFUL
RELATIONSHIPS
MEANINGFUL
PERSON-CENTERED
ASPIRATIONS
RESPECT
PEERS
CHANGE

One reason for the gender differences:

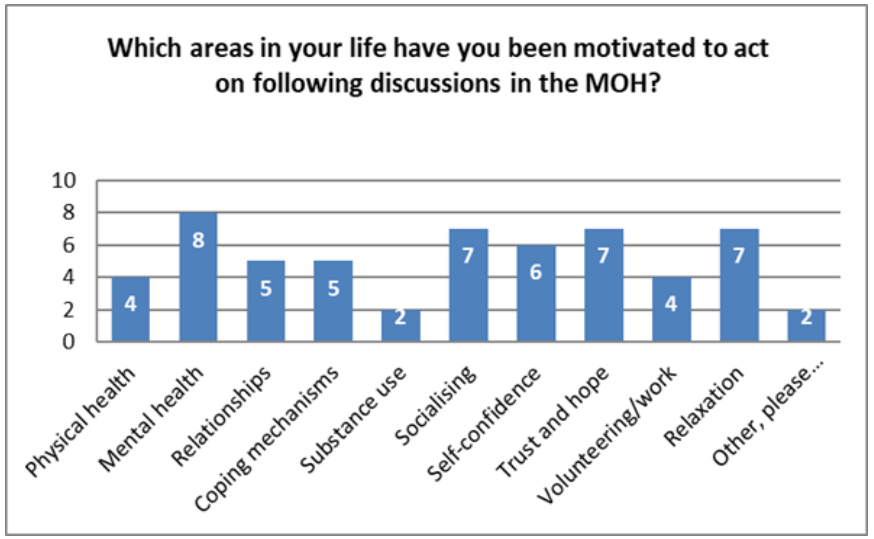
Men of Hope (MOH)

- **Goals of MOH**
  - Encourage social inclusion
  - Build relationship
  - Build self esteem and self awareness
  - Share life experiences and challenges
  - Share coping strategies
  - Have fun
- **Vision of MOH**
  - **Get in**: Connect with other men in the MOH
  - **Get healthy**: Build self confidence, self awareness and healthy relationships
  - **Get strong**: Gain and exercise social skills
  - **Get going**: Enjoy life



The MOH 'Tool Box'

- The issues discussed include;
  - Suicide and self-harm
  - Coping strategies
  - Drug and alcohol use
  - Relationship breakdown
  - Anger management
  - Parenting
  - Relaxation (mindfulness) strategies like swimming, walking, gym
  - Sleep patterns
  - Nutrition



** The toolbox is a visual reminder that everyone has different tools for different occasions, and that tools can be stored and shared.*

"I brought a red tool box to our meeting. We all have tool (skills) in life in all the areas of our lives. Some of us have forgotten which tools we have, some of us have stopped to use these tools. Some of us don't have the required tools we need to a certain job, some of our tools are rusty and blunt and needs a good clean and sharpening. The guys related to this and we agreed not to sell ourselves short but to encourage each other to use our tools and acquire more where we need to. We will continue with this discussion" (Gerhard Rousseau 2017).

Kim Brooklyn

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AFTERNOON TEA

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Where to from here...?

Elizabeth Crowther, President – CMHA

Ivan Frkovic Queensland Mental Health Commissioner

Frank Quinlan CEO - Mental Health Australia

Eddie Bartnik Strategic Adviser for Mental Health, Local Area Coordination and Community Capacity Building – NDIA

Debbie Hamilton Mental Health Advocate, NDIS Participant

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Prof Allan Fels AO

National Mental Health Commission

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National NDIS Mental Health Conference

Professor Allan Fels

Chair, National Mental Health Commission

Australian Government
National Mental Health Commission

Objectives

- Overview of the National Mental Health Commission
- Australian context of mental illness
- The economic case for mental wellbeing
- The NDIS and mental health reform in Australia

About the Commission

- Established 2012
- Executive agency in Commonwealth Health portfolio -> independent
- CEO reports to Commonwealth Minister for Health

9 Commissioners – Advisory Board

- Prof Allan Fels (Co-Chair)
- Prof Ian Hickie
- Prof Harvey Whiteford
- Prof Helen Milroy
- Prof Wendy Cross
- Ms Lucy Brogden (Co-Chair)
- Mr Samuel Hockey
- Dr Ngaire Brown
- Dr Peggy Brown

*Report 6 monthly to PM and Minister for Health

The Commission's role

- **Monitor and report** on mental health and suicide prevention systems
  - We aim to hold the government and system accountable for its performance
- **Provide advice** to Government and the community
  - We deliver insight into ways to continuously improve Australia's mental health and suicide prevention systems
- Act as a **catalyst for change**
  - By engaging, collaborating, facilitating, influencing, leading, researching and seeding initiatives

NMHC: Foundation documents

Since the Commission was established in 2012, our foundation pieces of work include:

- Our *Contributing Life* framework –released in 2012
- Our annual National Reports on the state of our mental health system and suicide prevention in Australia (our 2016 Report is now available online)
- In 2013 we provided a Report to the Council of Australian Governments (COAG) on *Mental Health Targets and Indicators*
- In 2014, we released our *Contributing Lives, Thriving Communities Report of the National Review of Mental Health Programmes and Services*.

Contributing Life

The size of the problem

~1M Australians live with Depression

1 in 5 women

1 in 8 men

~2M Australians live with Anxiety

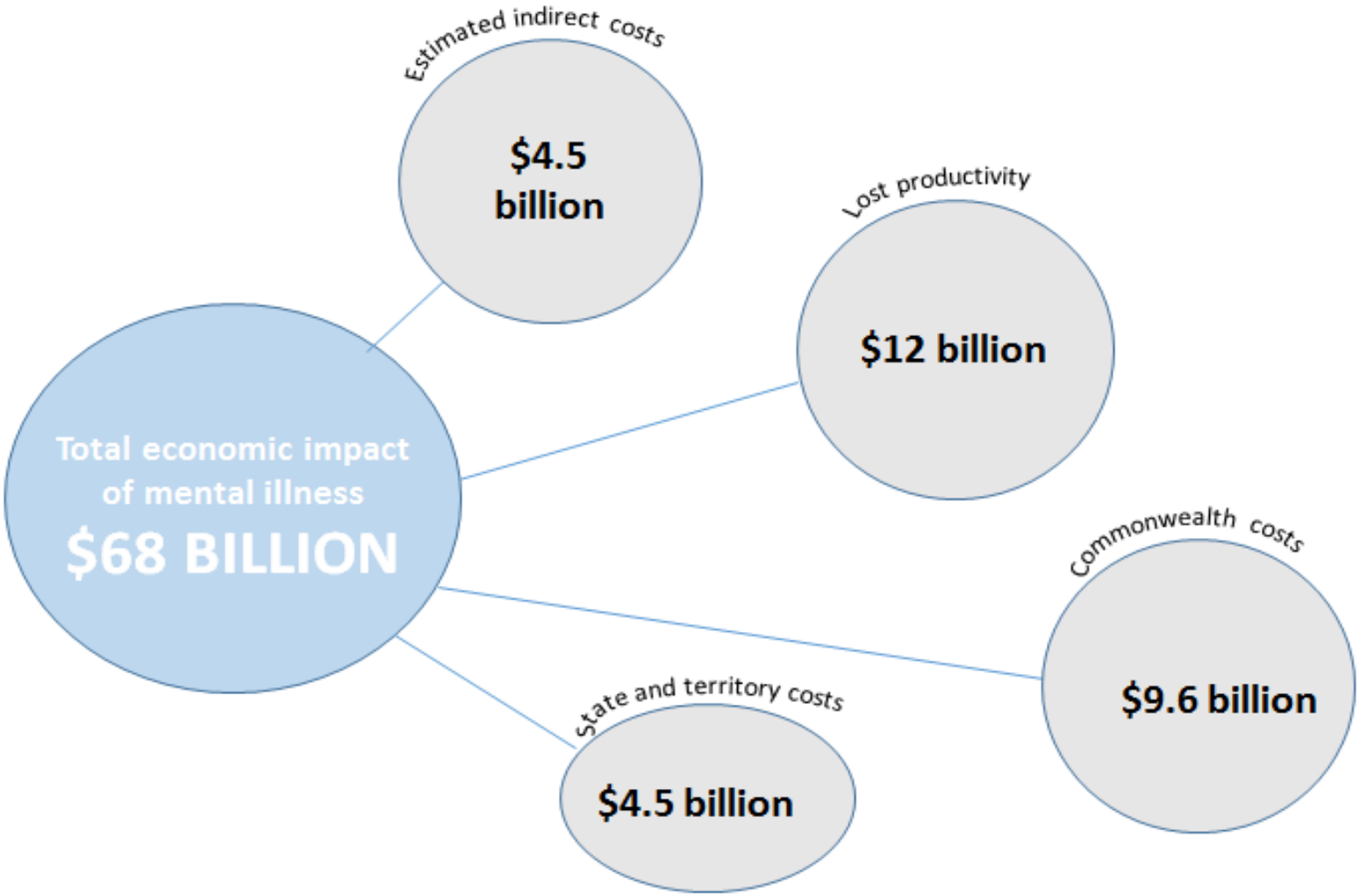
1 in 3 women

1 in 5 men

8

Australians die by suicide every day – 5 are men

Economic impacts



National Disability Insurance Scheme

The NDIS aims to provide:

- Choice and control for participants
- A lifetime commitment to supports and funding as required
- Increased independence and social and economic participation, including through social participation, education and employment
- Support for a partnership approach to connect to diverse supports as required

NDIS eligibility numbers differ

The Commission is concerned by the estimated number of people with mental illness and psychosocial disability who will not be eligible for support under the NDIS

- Data estimates there are around 700,000 people with severe mental illness in any given year.
- The initial estimate was that 64,000 people with *primary* psychosocial disability would qualify to receive Individually Funded Packages by 2019-2010.
- The ***National Mental Health Service Planning Framework*** believes it's more like 92,000 people (18-64 year olds) with severe and complex disorders.
- **The Planning Framework** estimates around 190,000 people with some level of psychosocial disability may be ineligible to receive support from the NDIS.

The Government responded to the Commission's concerns and made an $80 million funding commitment in the Federal Budget to help bridge this gap.

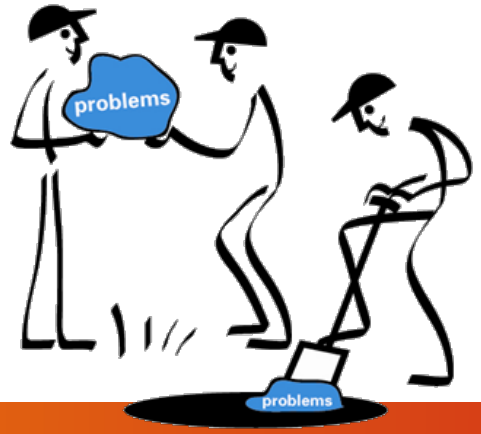
The Commission believes the $80 million is a good start, but it will not be sufficient to meet the need and it still needs to be matched by **states and territories** which in some instances appear to have been withdrawing funding for psychosocial disability services as part of the transition to the NDIS.

NDIS assessment process

The Commission has heard of problems with the NDIS assessment process for determining eligibility.

Concerns include:

- Many prospective participants are not able to collect the evidence required to complete NDIS access and review processes.
- People with severe mental illness are often unable or reluctant to engage with formal service systems or have no treating health professional
- There's a need for additional effort and outreach to help some people access, understand and provide the information necessary for them to participate
- Assessments have been inconsistent and unpredictable, and there is still no published eligibility criterion for people with psychosocial disability
- There are inconsistencies in the application of eligibility criteria and the planning process means that people with broadly similar circumstances receive different outcomes depending on where they get assessed.



Workforce & skill base inadequate

Productivity Commission Report

- The NDIS workforce needs to increase and become more diverse
- It is forecast the number of full-time positions needs to double over the transition period to around 70,000 additional disability support care workers (one in five new jobs over the transition period)
- In some regions, the workforce needs to triple in size to meet demand
- The workforce needs to be equipped to service around 475,000 Australians who are expected to receive individualised supports by 2019-20

Thank you

National NDIS Mental Health Conference

Australian Government
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