

Culture clash? Recovery in mental health under Australia's National Disability Insurance Scheme – a case study

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Key points

- The advent of the National Disability Insurance Scheme (NDIS) is having a seismic impact on Australia's fragile psychosocial service sector. So far, the nature of this impact has been largely anecdotal
- Using a case study, this paper aims to make more explicit how NDIS funding and policy settings are militating against holistic care and recovery-based approaches
- The National Disability Insurance Agency, and state/territory and national government departments responsible for mental health service funding, could use this example to drive continued improvements in relation to their roles in providing support to people with mental illness

Abstract

Objective: Using a case study, we aim to report on the compatibility of funding and policy settings under Australia's National Disability Insurance Scheme (NDIS) with the delivery of evidence based, recovery-oriented psychosocial services.

Type of program or service: We reflect on the impact of the NDIS on a psychosocial rehabilitation service run by Woden Community Service (WCS), one of the major service providers in the Australian Capital Territory, and specifically its Transition to Recovery (TRec) program.

Methods: We examine NDIS funding and policy settings and consider the recovery-oriented practices underpinning psychosocial programs like TRec. The construct of the program, its staffing and related issues are considered. The article draws on a formal evaluation of TRec conducted in 2015.

Results: The NDIS is having a seismic impact on Australia's psychosocial sector. Despite its positive evaluation, the future of the TRec program is problematic. Practically, service exit points have disappeared, reducing the program's capacity to properly transition clients between services and effectively increasing the likelihood of relapse. More generally, current NDIS policies are threatening the fidelity of WCS's approach to recovery practice.

Lessons learnt: This case study highlights tension between a new public insurance scheme primarily aimed at better managing consistent conditions and circumstances, and the recovery philosophy which has emerged in relation to episodic mental illness. This has implications for psychosocial services nationwide. The psychosocial rehabilitation sector has always been a peripheral element of Australia's mental health service mix. The advent of the NDIS offers hope that this may change. However, WCS's experience suggests that the NDIS must reconsider how best to foster recovery-oriented practice in mental health. This should be part of a more fundamental reconceptualisation of the role of psychosocial rehabilitation services in contemporary mental health care, not just for NDIS recipients. This work is urgent if Australia is to nurture its already rare psychosocial rehabilitation workforce and not see it dissipate.

Introduction

The Australian Capital Territory (ACT) has worked under the National Disability Insurance Scheme (NDIS) for longer than all other Australian jurisdictions, operating as a trial site from 1 July 2014.

Woden Community Service (WCS) is one of the ACT's major providers of psychosocial services. It previously ran both the Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMs) programs, before the funding for these programs was transferred by the Australian Government to the NDIS. Among the assumptions underpinning the NDIS was that many PIR and PHaMs clients would be transferred to the NDIS.¹ This does not appear to be happening, leaving people without services.

Beyond this immediate issue, this article explores the impact of the NDIS on WCS's capacity to continue to deliver recovery-oriented psychosocial care. Specific reference will be made to WCS's Transition to Recovery (TRec) program.

Issues with the National Disability Insurance Scheme (NDIS) and psychosocial disability

There is tension surrounding the inclusion of psychosocial disability as part of the NDIS. Former Australian of the Year Patrick McGorry suggested it was a mistake² and NDIS staff have been criticised for having limited understanding of psychosocial disability.³ The NDIS will support only about 64 000 people living with severe mental illness once the scheme is fully operational, far fewer than the estimated 230 000 Australians who are living with such illnesses.⁴ What happens to those not covered is unclear.

A recent report highlighted fundamental misalignment between the recovery focus of the psychosocial sector and the NDIS's aim to manage "permanent and lifelong disability".⁵ The National Disability Insurance Agency, which is responsible for implementing the NDIS, issued a strident rebuttal.⁶ These tensions are the subject of ongoing developmental work involving the NDIS and the mental health sector.^{7,8}

What is meant by recovery?

Recovery is a mainstream guiding principle for mental health workers and others.⁹ In general, psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination.^{10,11}

The extent to which the NDIS understands the concept of recovery is debatable. Nevertheless, on the ground, policy and funding approaches taken by the NDIS are having a critical and negative effect on recovery-focused practices.

About Woden Community Services's (WCS's) Transition to Recovery (TRec) program

TRec is an intensive community mental health outreach program that predated the NDIS. It is funded by the ACT Government, not the NDIS. Working with the ACT's public Adult Mental Health Service, TRec helps people transition to the community following discharge from acute care.

Trained TRec 'key workers' assist people to maximise their recovery and independence. They provide and arrange support in the community to manage subacute symptoms and prevent re-admission. This is critical work because of the pressure facing ACT mental health services, as in most Australian jurisdictions.¹² The TRec program runs for 12 weeks offering intensive support 7 days a week. TRec clients are typically people living with severe, enduring mental illness. Some TRec clients may have NDIS plans, some may not.

A 2015 evaluation of TRec found that participation in the program was associated with lower psychological distress, higher functioning in life skills, reduced relapse and reduced admission to hospital.¹³

The TRec evaluation demonstrated the benefits of applying a recovery approach to mental health service delivery, something the NDIS is struggling with, despite the overlap with core NDIS concepts such as empowerment and 'self-direction'.¹⁴

Psychosocial support has never been a significant part of Australia's mental health service landscape. (The TRec program arose during a short period of growth and development.) Psychosocial support services comprised 5.8% of total state and territory spending on mental health in 2005–06, rising to 7.5% in 2014–15.¹⁵ National spending rose also, particularly on programs such as PIR and PHaMs. Although the spending on these programs is now being transferred to the NDIS (note: TRec is an exception), not all WCS clients have made this transition.

The NDIS approach and its impact

NDIS packages of care have three components: capital support, capacity building and core support. The largest component of NDIS funding is directed towards core support. In December 2017, the scheme was providing \$7.6 billion worth of support to 130 455 clients Australia wide. Funding for core supports accounted for around 74% of total spending, with capacity building at just over 20% and the balance directed towards capital support.¹⁶ Core supports are typically aimed at maintaining the quality of a person's life, such as help with cleaning and shopping.

However, it is the other components of NDIS funding that are much more likely to fund services beyond mere maintenance that are consistent with recovery: development of communication skills; insight into mental illness; vocational, employment and housing

support; and so on. These are the focus of the TRec program. Yet it is these components that receive the smallest share of NDIS funding. WCS has been attempting to shoehorn its psychosocial services into increasingly tiny amounts of 'support coordination' funding provided to clients in their NDIS packages under the capacity building stream. However, many packages provide as little as 40 minutes of this support per week. Current NDIS policies have significantly reduced the funding needed to drive WCS's recovery practices.

This focus on core support has provoked concern about a dumbing down of the workforce, towards a role focusing more on attendant care (babysitting) rather than recovery.¹⁷ This would run counter to the Productivity Commission's recognition of the need to ensure the NDIS has access to a trained, recovery-focused workforce, able to draw on "more complex skills than those providing many forms of attendant care".¹⁸

The NDIS has affected workforce recruitment and retention. The NDIS rate of pay is lower than equivalent state and territory services. The NDIS is also using individual fundholding, where the clients each manage their own support funding. This replaces block-funding or contracts paid to the nongovernment organisations providing the care. These organisations are consequently struggling to offer long-term employment to staff. One thousand jobs may be lost from the psychosocial workforce.¹⁹

What does the TRec example demonstrate?

Key to the success of TRec is the dual role played by the key workers, providing both therapeutic psychosocial expertise and a coordination function with their clients, akin to the role previously played by WCS PHaMs recovery workers and PIR support facilitators. TRec key workers can no longer refer clients into either PHaMs or PIR because funding to these programs is ceasing. Current NDIS policy and funding settings have narrowed, not broadened, the support options open to people with severe mental illness in the ACT.

A further issue is that where a key worker identifies that their client needs additional care or services, these needs have sometimes been met by WCS itself. This could be seen as holistic care and good practice. Now, under the NDIS funding rules, this approach is viewed as a conflict of interest, with the provider able to generate more services for itself as well as the client.

Australia has the third-highest readmission rate for schizophrenia in Organisation for Economic Cooperation and Development countries, and the fourth-highest for bipolar disorder.²⁰ TRec-type services are critical to shifting this situation. WCS's experience, gained through its TRec, PHaMS and PIR services, is that, for these complex cases, having the support worker and coordination roles in the same team materially reduces the risk of clients disappearing between programs or services. Again, the NDIS would view this approach as a conflict of interest, inappropriately combining service provider and coordinator roles.

TRec highlights the value of intensive outreach recovery programs not available now under the NDIS. WCS's continued delivery of such programs depends on the NDIS providing the right mix of support coordination and capacity building funds. If this mix is right, the longer-term need for clients' core and other supports is likely to diminish as confidence and independence grows.

Conclusion

WCS's experience with TRec and its other programs offers salutary lessons about how to convert the opportunity of the NDIS into new ways of supporting durable psychosocial recovery. However, current NDIS funding and policy settings are hindering, not helping.

They appear to be geared towards services that perpetuate client maintenance and dependence rather than recovery and independence.

It is 30 years since the closure of Australia's mental health asylums and we still lack a network of community services designed to permit people to live well and with dignity in the community. The role of the NDIS in Australia's continued evolution towards recovery-oriented community services is unclear. There is doubt about who should be responsible for providing psychosocial support for complex cases. If mental health services are to continue to develop in Australia, we cannot permit the NDIS to simply be a place for a small number of people to go and rest between crises.

Peer review and provenance

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Competing interests

None declared.

Author contributions

SR wrote the article, assisted by CR, PB, PG and PR who are practitioners in the field, working within the new NDIS environment. All authors read and checked different versions of the paper as it was developed.

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