

About Psychosocial Disability and the NDIS, Introduction to the Concept of Holistic Psychosocial Disability Support

The need to integrate the principles of mental health recovery described in the National Recovery Framework, with the need to demonstrate that a person's psychosocial disability is, or is likely to be permanent in order to access individualised funding through the National Disability Insurance Scheme (NDIS), is well understood by the NDIA.

Following a national stakeholder workshop on Mental Health and the NDIS to explore this issue further with key representatives and stakeholders in the field, it was agreed that a concept paper be developed for further consideration, capturing the issues of the day and exploring the key concept of mental health recovery in the context of the NDIS and the need for a more holistic understanding of Psychosocial Disability Support.

Accordingly, Paul O'Halloran was commissioned to initially prepare a working document that could be further refined and developed through extensive consultation with the national stakeholder group, other contributors from the field and including a further consultation workshop with consumers and carers facilitated by the Mental Health Council of Australia (MHCA), now Mental Health Australia. The result is the following publication Psychosocial Disability and the NDIS, Introduction to the Concept of Holistic Psychosocial Disability Support.

About the author, Paul O'Halloran

Paul O'Halloran is a Senior Clinical Psychologist, and has worked and studied for over 30 years in the field of mental health. He has worked in Australia, the UK, Europe and the Middle East at all levels including direct clinical care, policy and practice development and service improvement. In Australia in the 1980s he worked with some of the early pioneering community home treatment teams in the Royal North Shore Hospital and

Community Mental Health Services. He also worked with the Richmond Implementation Unit / NSW Mental Health Branch to support rollout of a community based model of care across the State. As Senior Lecturer at the University of Wollongong, he developed the first Master-level degree programme in community mental health, which also entailed developing broadcast television programmes for nation-wide access.

In the UK, he had several key national, local and international roles including Director of Practice Development & Training at the Sainsbury Centre for Mental Health, Kings College London; Regional Director of Workforce & Service Development with the National Institute for Mental Health England, NIMHE; Head of Service Improvement & Practice Development within Hertfordshire Partnership Foundation NHS Trust. His work has also included consultancy with the World Health Organisation in Palestine (Gaza and the West Bank), Jordan, Bosnia and Herzegovina, Montenegro, Serbia, Sri Lanka and the Caribbean.

Currently, he is Director of MHINDS, (Mental Health International Network for Developing Services), a mental health consultancy organisation, and works part time with Western Sydney Local Health District as Senior Clinical Psychologist and Consultant in Assertive Community Treatment.

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PSYCHOSOCIAL DISABILITY AND THE NDIS

An Introduction to the Concept of Holistic Psychosocial Disability Support

By Paul O'Halloran

1. Orientation to the National Disability Insurance Scheme

The NDIS scheme was launched on the 1st July 2013. Initially there were four active trial sites based in South Australia, Tasmania, the Hunter in NSW and the Barwon area in Victoria. From July 2014 other sites have commenced, including in the ACT, Barkly area of the Northern Territory and Perth East Hills area in WA. Experience from the mental health early implementation sites has identified a need for clarity around psychosocial disability for people with mental illness. Specifically, there is a need for developing a more holistic understanding of mental health disability, which supports both a recovery orientation and evidenced-based practice and better allows for definition and differentiation of clinical and functional needs, thus supporting a more integrated approach to determining access, planning and implementation of necessary and reasonable supports.

2. Introduction and overview

Opportunities for recovery are maximised when consumers and families have choice about, and access to, whatever aspects of recovery supports are needed to optimise their personal efforts to cope with, adapt to, or overcome and feel more in control of, the impact of the illness.

The journey towards mental health recovery however, can be fraught with difficulties and navigating the often labyrinthine pathway to accessing needed mental health information and supports is complex. Coming to grips with the complexity of coping and adapting to the challenges of mental illness, and the need for embracing a personal recovery approach while engaging with the need for treatment and psychosocial disability support, while maintaining a sense of being in control, can be daunting for both individuals and their families. Recovery for many people entails the need for building on and enabling the power and wisdom of lived experience, recognising the importance of family

engagement and the social system, while realising the need for accessing a range of additional supports to help with coping and adapting to the impact of severe mental illness, including treatment and psychosocial disability support.

3. Aims of this paper

The general aim of this paper is to develop a more holistic understanding of psychosocial disability support and the NDIS. This will involve, from a personal perspective as a clinical psychologist, exploring the importance of the recovery approach as an integrative framework of values and actions, which help integrate the various domains of recovery supports including personal efforts at self-management, psychosocial disability services and clinical interventions.

4. Values and principles of a recovery approach

Effective treatment and psychosocial disability support to enable mental health recovery must rest on a firm foundation of recovery oriented principles and values. A good example of these, are the “Principles of recovery oriented mental health practice” as detailed in the Australian National Standards for Mental Health Services ¹. The 6 principles are:

i. Individual uniqueness: *Recovery oriented mental health practice:*

- Recognises that recovery is not necessarily about cure but is about achieving a meaningful and satisfying life.
- Accepts that recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life.
- Empowers individuals so they recognise that they are at the centre of the care they receive.

ii. Real Choices: *Recovery oriented mental health practice:*

- Supports and empowers people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.

¹ Commonwealth Government of Australia (2010). Principles of recovery oriented mental health practice. In National Standards for Mental Health Services. Canberra, ACT, Australia.

- Ensures that individuals can build on their strengths and take as much responsibility for their lives as they can at any given time.
- Ensures that there is a balance between duty of care and support for people to take positive risks and make the most of new opportunities.

iii. Attitudes and Rights: *Recovery oriented mental health practice:*

- Involves listening to, learning from and acting upon communications from the individual, their relatives and others about what is important to each person.
- Promotes and protects people's legal and citizenship rights.
- Supports people to maintain and develop meaningful social, recreational, occupational and vocational activities, which enhance mental wellbeing.

iv. Dignity and Respect: *Recovery oriented mental health practice:*

- Consists of being courteous, respectful and honest in all interactions.
- Involves sensitivity and respect for each individual's own values and culture.
- Challenges discrimination and stigma whether it exists within our own services or the broader community.

v. Partnership and Communication: *Recovery oriented mental health practice:*

- Acknowledges each person is an expert on their own life and that recovery involves working in partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.
- Values the importance of sharing appropriate information and the need to communicate clearly and effectively to enable effective engagement with services.
- Involves working in positive and realistic ways with individuals, their families and carers to help them realise their own hopes, goals and aspirations.

vi. Evaluating Recovery: *Recovery oriented mental health practice:*

Ensures and enables evaluation of recovery at several levels –

- individuals and their families can track their own progress;
- services are seen to use the individual’s experiences of care to inform quality improvement activities;
- there is a public reporting of key recovery indicators including (but not limited to) housing, employment and education outcomes, not merely health.

5. Recovery and severe and persisting mental illness.

The practicalities of recovering from severe and persisting mental illness frequently requires the integration of a range of supports to create choice and a sense of control, and to optimise personal self-management efforts. This can often entail the need to have access to clinical treatments, to assist in alleviating symptoms and managing the emotional distress and psychological aspects of the mental illness. Also, people frequently want support to be able to have a contributing life, and to manage the psychosocial disability aspects of severe and enduring mental illness, such as learning of new coping skills, assistance with day-to-day functioning and help to better participate economically and be included in their community.

Sometimes the varying language of clinical and disability support services can get in the way and create confusion or misunderstanding. Very often, this language does not reflect the understandings or language of lived experience, and the voice of the consumer movement more generally.

The NDIS uses the International Classification of Functioning, ICF, and the language of disability does not always readily translate into the mental health sphere. An example in point is the language of “permanency / or likelihood of permanency of impairment” which, while a core eligibility criteria for access to the NDIS, can on the surface at least, appear to conflict with a recovery approach, which is the international² and national³ guiding vision and value

² Antony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, **16**, 11-23.

base for contemporary practice in the mental health field.

Is it possible to reconcile the common language of recovery with the concept of “permanent / likely to be permanent” impairment? In some contemporary definitions, recovery is something only consumers can do, and it can’t be done for them. However services can be made more conducive and encouraging of recovery and may try to evaluate personal recovery and recovery orientation of services. While there can be no single definition, the recently published national mental health recovery framework⁴ identifies several common themes emerging from the published literature and the lived experience of consumers and their families. These include an understanding that recovery is:

- *“A unique and highly personalised experience;*
- *A journey that is individually defined and a process of personal growth and wellbeing;*
- *A non-linear process of ups and downs, growth as well as setbacks;*
- *Informed by individual strengths, preferences, needs and choices;*
- *Influenced and shaped by culture;*
- *Facilitated through social relationships including with family, friends, peers and practitioners;*
- *Fostered through hope, which can be a catalyst for beginning the journey”.*

The very individualised nature of various recovery definitions and the great heterogeneity in the outcomes for people with severe mental illness can at times contribute to confusion around recovery. For some people, following an episode of acute psychosis, there remain no observable signs or symptoms and no lasting impairments or functional disabilities associated with the diagnosis of severe mental illness. Some researchers, such as Professor Larry Davidson at the Yale Centre for Recovery, suggest that for all intents and purposes this can be considered as synonymous with a cure⁵. He describes this as “**recovery**

³ Australian Health Ministers Advisory Council. (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: Commonwealth of Australia.

⁴ Australian Health Ministers Advisory Council. (2013). A national framework for recovery-oriented mental health services: Policy and Theory. Canberra: Commonwealth of Australia.

⁵ Larry, D., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, August 2007 (Pg. 463); 16(4): 459 – 470.

from” severe mental illness and it applies to around 25% of people experiencing a severe mental illness such as a psychosis. For the remaining group of up to 75% of people who continue to experience symptoms and functional disabilities, Davidson argues that ongoing recovery is still relevant, but that rather than defining it in terms of having “*recovered from*”, it is more accurate and meaningful to describe the process as being “***in recovery***”. This “involves accepting for the near future that these conditions may not go away and focusing – in addition to treating the condition – on how the person can learn to live with it. This is the sense of being ***in recovery***” (Pg. 464).

Janet Meagher, a national leader with a personal lived experience perspective, clarifies further when she describes the terminology of “permanent/or likely to be permanent” and the language of 'recovery' as not being irreconcilable.

She asserts that there are many similarities and synchronicities between the core NDIS principles and the concept of recovery and further that people can still have a permanent or a persistent life-long mental illness but also continue efforts to maintain personal resilience and function within a recovery framework ⁶.

For this group of people with severe mental illness who are ‘in recovery’, a further clarification is provided by Slade ⁷, who distinguishes between ‘personal recovery’, and ‘clinical recovery’. Clinical recovery is concerned with treating impairments, ameliorating or eliminating symptoms of the illness and the rehabilitation of social functioning, with the purpose of supporting the personal strivings for a life worth living⁸. Whereas personal recovery is defined as ... “*a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows*

⁶ Janet Meagher (2014). Personal Communication, MH forum (31/01/14), NDIA.

⁷ Slade, M. (2009). A 100 Ways to Support Recovery. Rethink, UK.

⁸ Slade, M. (2012). Everyday Solutions for Everyday Problems: How Mental Health Systems Can Support Recovery. *Psychiatric Services* 63:702–704, 2012; doi:10.1176/appi.ps.201100521)

*beyond the catastrophic effects of mental illness'*⁹.

So recovery can be seen as a multi-dimensional and evolving construct that is continually being informed, challenged and expanded for example by the lived experience¹⁰, deeper understandings of the need for trauma informed care and practice¹¹, new developments in services and cultures¹² and the growing research literature¹³.

From the personal perspective it involves very individualised efforts at **feeling in control, of being able to make choices and of building new meaning and purpose in the face of the illness.** Simply put it is about getting one's life back. Clinically, recovery means engaging with treatment that optimises mental health and assists with symptom control to alleviate the associated suffering and distress of the illness. From a psychosocial disability perspective, recovery means learning or maintaining the skills to cope with the daily tasks of living, overcoming barriers to economic and community participation and accessing opportunities for greater social inclusion. Outcomes are optimised where consumers and families have choice about and access to whatever aspects of recovery are needed to support their efforts to cope with, adapt to, or overcome the impact of the illness.

This way of defining recovery includes the recognition that at the heart of personal recovery is a need for feeling in control and having choice. Moreover, while treatment of the illness may be crucial for many individuals, the disabling impact of the illness on the individual's recovery, is also essential to address. This conceptualisation of recovery is inclusive of the various thematic elements

⁹ Antony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, **16**, 11-23.

¹⁰ Dirk Corstens, Eleanor Longden, Simon McCarthy-Jones, Rachel Waddingham, and Neil Thomas. (2014). Emerging Perspectives From the Hearing Voices Movement: Implications for Research and Practice. *Schizophrenia Bulletin* vol. 40 suppl. no. 4 pp. doi:10.1093/schbul/sbu007

¹¹ Mental Health Coordinating Council (MHCC) 2013, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction*, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

¹² Jaakko Seikkula, Birgitta Alakare & Jukka Aaltonen (2011): The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care, *Psychosis: Psychological, Social and Integrative Approaches*, 3:3, 192-204.

¹³ The British Psychological Society and The Royal College of Psychiatrists (2010). *Core Interventions In The Treatment And Management Of Schizophrenia In Adults In Primary And Secondary Care (Updated Edition)*, National Clinical Guideline Number 82, National Collaborating Centre for Mental Health. National Institute for Health & Clinical Excellence, UK.

of the recovery paradigm and helpfully integrates several seemingly disparate components, including how:

- The personal, clinical and functional dimensions of recovery relate;
- The heterogeneity in outcomes, including cure, can be reconciled within definitions of recovery;
- Evidence-based practice effectively supports individual efforts towards recovery.

6. Evidence-based practice and recovery-oriented practice

Evidence-based practice is crucial to fostering recovery. There is a growing body of research that is helping to better articulate some of the more potent elements of the recovery approach ¹⁴. Some of the initial findings have confirmed the central importance of hopefulness and the maintaining of optimism about future prospects for coping with and managing the illness and associated psychosocial disability. This is strongly related to an internal sense of mastery over situations, of feeling empowered and in control and where there is choice available around key decisions involving treatment and psychosocial supports. Importantly, the power of personally meaningful activity, especially paid employment, was also highlighted as a key element of the recovery approach. Having supportive interpersonal relationships, including with family and carers, is also central to recovery.

7. Families and carers

Families and carers can often be the forgotten partners in recovery yet their involvement in ongoing support can be crucial elements that affect a person's long-term recovery. All families are of course different and while there are situations where some families may choose not to be involved and consumers may not want families to be involved, the evidence base very strongly supports the importance of engaging with families as allies in recovery, often through recognising that family members are in recovery themselves. Several randomised clinical trials¹⁵ have repeatedly demonstrated the benefits of family

¹⁴ Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist*; 34, 3-5.

¹⁵ Falloon, IRH. (2003). Family interventions for mental disorders: efficacy and effectiveness. *World Psychiatry*; 2(1): 20-28.

involvement. Families and carers also have their own needs to enable them in being effective partners in supporting recovery. Family interventions, which provide information, education, practical and emotional support to maintain hopefulness, coaching with communication and problem-solving, as well as crisis intervention, significantly reduce relapse rates for consumers. The training and supervision of staff is essential to implementation and quality improvement of effective family support programmes.¹⁶

8. People with severe and persistent mental illness in need of NDIS support.

The estimated percentage of the Australian adult population in need of NDIS individually funded supports as result of psychosocial disability related to mental illness is expected to be 0.4 %: that is 12% of people with severe and persistent mental illness¹⁷. This group of people will have impairment due to a severe and persistent mental illness, which may cause significant adverse and long-term effects on their abilities for community and economic participation and to carry out the necessary daily activities of living. While it is not possible to provide a definitive list of the specific impairments related to a mental illness that would fall into this category, they will certainly include such mental health conditions as schizophrenia and bipolar disorder and may also include severe and persistent presentations of depression, anxiety and obsessive-compulsive disorder or personality disorder, among others. This group of people, estimated by the Productivity Commission in their 2011 report of the inquiry in disability care and support to be about 57,000 nationally, experiences a combination of interacting and detrimental influences related to mental illness. These influences impact not only clinically on the person's wellbeing, but also have major damaging social and practical consequences in their lives, often leading to social exclusion and marginalisation from the very care, support and treatment necessary to have a decent life in the community.

Clinically, people in this group can experience a range of intense, disturbing symptoms. These may occur in the form of intrusive, threatening and

¹⁶ Kavanagh DJ, Piatkowska O, Clark D, O'Halloran, P., et al. (1993). Application of a cognitive-behavioural family intervention for schizophrenia in multi-disciplinary teams: What can the matter be? *Aust. Psychol*; 28:181–188.

¹⁷ Productivity Commission 2011 *Inquiry into Disability Care and Support Report*, Report No. 54, Canberra. Appendix M p. M.4

derogatory voices, or frightening suspicions that people are attempting to hurt them. Anxiety and fear can be so overwhelming at times that people just want to hide away. Sometimes people feel so helpless, hopeless and depressed that they contemplate or attempt suicide. These disturbing perceptions and emotions can be further compounded by profound loss in energy levels and ability to plan, concentrate or think clearly and communicate with others. On top of this, memories of trauma and abuse may lead to self-harming or a misusing of drugs or alcohol as a way of trying to cope.

While these experiences may vary and fluctuate in intensity over time, for the group of people **in recovery** from the effects of a severe and persistent mental illness, the impact can be long lasting and profound.

However, like most everyone else, people with a mental illness want a job, a decent place to live, a relationship, friends and family and a daily structure and purpose that makes life worthwhile¹⁸.

Unfortunately, psychosocial disability and social exclusion are a common secondary consequence of the clinical impact of the mental illness. The clinical impact of mental illness itself however prominent, is only one of several predisposing or precipitating factors which exacerbate recovery. Other factors include for example stigma, discrimination, social deprivation and co-occurring disorders such as substance misuse or poor physical health.

For this group, economic and community participation in the form of work or study is rare. Secure income through receipt of appropriate entitlements or benefits, along with access to stable and decent housing are often lacking and homelessness is not uncommon. The rate of severe physical health problems along with substance misuse is unacceptably high for this group. The life expectancy gap for people in this group is significant, estimated to be up to 30 years.¹⁹ Social and familial relations are often fractured in this context and many

¹⁸ Rose, D. (1996) Living in the community. The Sainsbury Centre for Mental Health.

¹⁹ Lawrence D, Holman CDJ, Jablensky AV. Duty to care: Physical illness in people with mental illness. Perth: University of Western Australia; 2001., cited in A Contributing Life: the 2013 National Report Card on Mental Health and Suicide, p 31

people frequently experience a disconnectedness from everyday life and a deep sense of social isolation and loneliness. Additionally, many people have lost or not had an opportunity to adequately develop the survival skills of daily living and so can often suffer a poor quality of life and community neglect. Stigma and discrimination associated with societal prejudice towards people with a mental illness further compound the clinical effects of the illness and the associated psychosocial disability.

This compounding of damaging effects is further exacerbated for many people who feel alienated and disengaged from treatment and support. Many people can feel their needs are not addressed by existing services, that there is little choice available and disagree with the views of staff about the nature of their difficulties and need for support and can often refuse help. However, as the Sainsbury Centre for Mental Health SCMH, commented in a similar exercise in the UK, directed at addressing the needs of this group of people, “The key to delivering the treatment and disability support for this group requires us to understand the underlying incompatibility of what people in need want and what the services offer.”²⁰

9. Recovery - Steps towards more effective coping and adaption

While recovery is always a very individualised journey, there are some commonalities in the tasks that many people need to undertake to effectively cope with and adapt to mental illness and psychosocial disability, and get their life back on track. These can include:

- **Maintaining Hope:** Maintain a sense of self-efficacy and hope, by learning from the experience & achieving a greater sense of control.
- **Finding Meaning:** Finding personal meaning in and comprehending the individual significance of the illness and disability.
- **Acceptance and learning:** Accept the reality of the illness and disability, learning to cope and respond effectively to the demands of the situation.

²⁰ Sainsbury Centre for Mental Health (1998). Keys to Engagement (pg. 26). Kings College London.

- **Social support:** Maintaining supportive relationships with family, close friends and social network.
- **Regaining emotional and psychological equilibrium:** Regain a sense of emotional equilibrium, to feel safe and more in control and to reduce anxiety and fear.
- **Community participation:** Developing personally valued roles in the community including paid employment.

10. How can services and supports help with these steps to improved recovery: Illness & psychosocial disability / Treatment and Psychosocial Rehabilitation.

Clinical treatment

Clinically, many people in this group affected by severe and persistent mental illness need access to evidence based and recovery oriented supports and services, available in their communities, in the least restrictive environment possible. The essential elements of an effective system of community treatment and support for people with severe and persistent mental illness, with complex and multi-agency needs, include:

- Easy access to support which is respectful, collaborative and engaging, as well as needs led and available on a 24/7 basis in their local communities;
- Early intervention, getting help quickly before problems become overwhelming;
- Help if in significant distress, to feel safe and to work through a crisis wherever possible in the home or familiar surroundings to reduce the need for hospitalisation;
- Access to effective, evidence-based medication therapies which ameliorate symptoms and alleviate associated suffering;
- Someone to talk to who can help with psychological and emotional supports;

- Access to information and help about recovery from someone with lived experience of mental illness/distress and disability such as peer support workers;
- Family interventions, which empower and support carers and recognises their own needs and their collaborative role in enabling recovery;
- Support for maintaining or improving good physical health and wellbeing;
- Practical help to coordinate, connect with and link up to the variety of supports and partnerships necessary to enable personal recovery;
- Outreaching and intensive supports for as long as needed, which are community centred and closer to where people live;
- Recovery support to create choices and explore opportunities to overcome barriers to economic and community participation and to learn new skills to better manage the illness/distress and disability.

While clinical treatment and support may be necessary to the recovery process for many consumers, it is not sufficient for most and a wider view of people's needs for psychosocial disability support is necessary if people are to overcome and more effectively manage the full impact of a severe and persistent mental illness.

Psychosocial disability support

Recovery, as previously mentioned, does not equate with cure and the elimination of impairment and disability. Rather, it is about "living a life of optimal wellbeing despite the impact of the illness"²¹.

The impact experienced by consumers due to impairments related to severe and persistent mental illness is referred to as Psychosocial Disability. This can include social exclusion in addition to the loss of or reduced ability to function

²¹ Unravelling Psychosocial Disability (2011). National Mental Health Consumer and Carer Forum, pg., 30 .

and participate in the community, as well as impairment of relationships such as having intimate, confiding and/or supportive others in your life. These impairments and also the related restrictions on participation include loss of or reduced abilities to function adaptively, concentrate and think clearly, experience good physical health and cope with the social and emotional challenges of daily living.

Psychosocial disability can be defined as “A mental health issue that affects people’s daily activities such as socialising or interacting with others in a social setting, learning or self-care, or their capacity to fully participate in society”. (based on the National Mental Health Consumer and Carer Forum and NDIS rules) ²².

The NDIS will especially offer psychosocial disability support where the impairment(s) results in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:

- a. Communication;
- b. Social interaction;
- c. Learning;
- d. Mobility;
- e. Self-care;
- f. Self-management; and
- g. Social and economic participation

The NDIS is about putting the person at the centre of the process of determining need, exercising choice and optimising a sense of individual control. From a person centred planning framework, the question becomes focused on what particular supports and assistance is required, in addition to self-management efforts, to pursue a better quality of life through greater community and economic participation ^{23 24}

²² People making choices about mental health treatment and care - Barwon pilot research project Annie Bruxner (University of Melbourne) Dr Lisa Brophy (University of Melbourne, Mind Aust.) Dr Erin Wilson (Deakin)

²³ Good Practice Guidelines for Person-Centred Planning and Goal Setting for People with Psychosocial Disability. A Project Report for Disability Care Australia. May, 2013

²⁴ Mental Health 2020: Making it personal and everybody’s business. The Mental Health Commission of WA.

11. Psychosocial disability supports & clinical Interventions (apart from independently self-managed processes) that address common elements of recovery

Recovery is a unique and personal journey for everyone affected by mental illness and disability. From a person-centred perspective, people need to have options and to be able to make choices about what their needs are in relation to the supports necessary to recover their lives and to make a contribution²⁵.

If we look hierarchically at the optimal mix of supports and services, the base or foundation of such a “pyramid of supports”, is self-management²⁶. However for many individuals who experience the intrusive clinical aspects of the illness, there may also be a need for additional support to assist their personal recovery such as symptom relief through both medical and psychological treatment. For others, it may be the disabling effects of the illness on their functioning and the need for psychosocial disability support. The multi-layered complexity of the recovery paradigm reveals the interrelationship of the personal, clinical and functional dimensions of recovery, providing a more effective way of understanding the great variation in recovery outcomes, as well as the importance of evidence-based practice for building quality recovery-oriented service provision

As explored earlier, outcomes are optimised where consumers and families have choice about, and access to, whatever aspects of recovery are needed and preferred, to support their efforts to cope with, adapt to or overcome the impact of the illness. Below are some useful examples of psychosocial disability supports and clinical treatments that have proved helpful in enabling people’s personal efforts with various aspects of recovery.

²⁵ National Mental Health Commission (2012). A Contributing Life: National Report Card. Australian Government, Canberra.

²⁶ World Health Organisation (2007). Service Organisation Pyramid for an Optimal Mix of Services. In Mental Health 2020: Making it personal and everybody’s business. The Mental Health Commission of WA.

Recovery needs ²⁷	NDIS Psychosocial Disability support (Examples)	Health Services Clinical Treatment Support (Examples)
Recovering hope	Education & information on Recovery Peer worker support & modelling Supporting community and economic participation through access to: <ul style="list-style-type: none"> • housing • work • relationship 	Motivational readiness intervention Psycho-education Therapeutic alliance
Redefining self & Reframing illness	Supporting access and enhancing opportunities for new roles (employee, volunteer, student, partner, etc.)	Psychological and social therapy Trauma informed intervention Early intervention Group therapy Psycho-education Psychological therapies including Cognitive Behaviour Therapy CBT & Dialectical Behaviour Therapy DBT
Meaningful activity	Support opportunities for work, study, leisure, hobbies Support to building social relationships and community connections	Individual Placement & Support IPS interventions for supporting access to employment & study. Mental Health services rehabilitation support programmes
Overcoming stigma	Advocacy Peer worker support Supporting access and enabling opportunities to mainstream community supports	Mental health promotion activities and anti-stigma campaigns

²⁷ (adapted from Davidson, L., et al. Pg. 18).

Recovery needs ²⁷	NDIS Psychosocial Disability support (Examples)	Health Services Clinical Treatment Support (Examples)
Assuming control	<p>Maximising choice</p> <p>Personal budgets</p> <p>Developing skills to support personal decision-making regarding medical & psychological treatment and other decisions for community living</p> <p>Supporting “the dignity of risk”</p> <p>Assistance to coordinate supports and assistance with daily personal activities – assistance for community (re) integration and day to day living including assistance with planning, decision-making, personal hygiene, household tasks, social relationships and financial management.</p> <p>Assistance with organising, planning and decision-making (e.g. help in moving into new home of one’s own)</p>	<p>Advance directives</p> <p>Supporting positive risk taking</p> <p>Recovery & wellbeing plans</p> <p>Collaboratively developed service plans incl. early warning signs & relapse signature</p> <p>Psychological and emotional support through Cognitive Behaviour Therapy CBT & Dialectical Behaviour Therapy, DBT.</p>
Empowerment & citizenship	<p>Development of daily living and life skills – to increase ability to live as autonomously as possible, including skills in daily life activities, communication and social skills, problem solving and managing funding of supports.</p>	<p>Collaborative treatment approaches maximising choice and self determination</p> <p>Minimising involuntary treatment within a recovery-oriented framework of duty of care and medico-legal requirements</p>

Recovery needs ²⁷	NDIS Psychosocial Disability support (Examples)	Health Services Clinical Treatment Support (Examples)
	To support better access to work, education, community participation, mobility & transport	
Managing symptoms & disability	Self management Peer support Social skills	Evidence-based therapy, treatment and rehabilitation including assessment and diagnosis, medication, pharmaceuticals, psychological therapy, cognitive remediation, crisis intervention, ensuring safety and risk assessment & management, stress management & relaxation training, relapse prevention, physical health care, Integrated treatment for substance misuse, psychosocial rehabilitation; Acute treatment (ambulatory or inpatient)
Being supported	Assistance with accommodation and tenancy obligations - to guide, prompt, or undertake activities to ensure the participant obtains/retains appropriate accommodation, including specialist tenancy support services where no other tenancy support option is available. Assistance with daily life tasks in a group or shared living arrangement (non-	Individual Care coordination (Case management), Assertive Outreach, Crisis intervention and acute home treatment, family interventions, supported accommodation (clinical)

Recovery needs ²⁷	NDIS Psychosocial Disability support (Examples)	Health Services Clinical Treatment Support (Examples)
	<p>clinical) – where accommodation is provided as an integral part of non-clinical care.</p> <p>Assistance with transport – specialist transport to and from health appointments required as a result of a participant’s disability (where no other transport option is appropriate and not substituting for parental responsibility).</p> <p>Development of daily living and life skills – to increase the participant’s ability to live as autonomously as possible, including skills in daily life activities, communication and social skills, problem solving and managing funding of supports.</p> <p>Assistance to coordinate supports and assistance with daily personal activities – assistance for community (re)integration and day to day living including assistance with planning, decision-making, personal hygiene, household tasks, social relationships and financial management</p>	

12. Summary & conclusion - Towards a more holistic & integrated approach to recovery and psychosocial disability support.

This paper is an initial resource to assist with the ongoing work to build the best possible system of support for people with psychosocial disability supported under the National Disability Insurance Scheme. It will be complemented by a range of planned projects to be undertaken by the agency, in collaboration with sector partners including people with psychosocial disability, their families and carers. These will initially include:

- A National Mental Health Sector Reference Group
- An operational review of access to the Scheme by people with a psychosocial disability
- A review of support clusters and pricing for supports related to psychosocial disability

It is expected that a range of new information will become available as the Scheme unfolds and refinements made to the material presented in this paper. It does, however, represent a starting point to facilitate discussion and shared understanding in the agency and sector and is a platform for further work.