NCOSS Conference Paper

Working Together for Mental Health

Case Management - Filling the Gap

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An NGO perspective on integrating approaches to coordinated care

In this presentation two case scenarios will be explored that demonstrate the difficulty the NGO sector and NSW Health case managers have in effectively dividing these roles and responsibilities . What happens when there is no case manager allocated? What is a reasonable response time?
I hope to explore these with you later and entice you to my way of thinking.

Qualitative research into NGO agencies, and particularly surveys of support workers within NGO support services has indicated that the sector is being relied on more and more to provide assertive case management to specific population groups that include homeless people, people living with dual disorders eg mental illness, and other conditions such as substance abuse, intellectual disability, challenging behaviours, people with co morbid illnesses and people with chronic illness.
The other interesting and revealing issue from these frontline workers were that they have seen a vast increase in the amount of people who have been diagnosed with personality disorders and psychotic disorders. Many carers and consumers themselves are also choosing the NGO's to provide assertive case management.

However, very few of these people are provided with case management from community mental health case management teams but are provided with episodic or crisis care. The majority of the case management is now provided by support workers in various settings, not only specialist mental health services, but neighbourhood centres, homeless refuges, job network providers and SAAP services. They are coordinating services for people with mental illness who do not have an allocated case manager from community health.
Another trend being observed by the NGO sector is of community mental health case managers discharging a person from case management when an NGO housing provider is involved. This has been attributed to case workers having very large number of people on their case loads and therefore needing to prioritise who they see. It has also been attributed to the fact that the community mental health case managers and the consumer have great respect and confidence in the case management role the frontline Ngo support workers can provide.
Later I will give some examples of case management that is being provided by my organisation.

So this trend of NGO"S providing more case management can be viewed as a positive direction, yet recent documents delineate case management or clinical rehabilitation and define the NGO sector's role as disability support. It has been my experience that the two are not so easily delineated nor defined as the documents suggest and that once a person's mental health crisis has been treated that clinical rehabilitation and case management is best achieved through truly community services.
Ten years ago, the NGO sector was seen as the "accommodation providers, support groups, leisure and recreation providers." I was often referred to as a "para-professional" and the majority of consumers had a NSW Health provided case manager, who would support this person and in some case for many years. The people on my team, the majority of who were residential support workers, would call the case manager in times of crisis or when clinical decisions were needed. Somewhere in the last ten years, policy seemed to shift and many consumers after acute episodes are only being supported for very short time frames by acute care or crisis teams, this can be for a period of three weeks and in extreme clinical need a possibility of three months.

As directions in providing mental health services have shifted from long term support and case management to episodic care, time framed rehabilitation options and increase focus on treatment; consumers have become more reliant on long term support from the NGO sector. This is especially evident for people with complex needs and who do not conform to specific treatment regimes or time frames. Many NGO's have now become the pseudo case managers for numerous consumers who have a high level of need and therefore require assertive case management or seamless service delivery. In fact the sector is **now filling the gap**. Many of us know that NGO's are not adequately funded to provide assertive case management but when our clients need to be linked into the community and have complex issues and when it's too difficult to get person back into a mental health case management system as they are not in crisis yet, we tend to do what is necessary.
A recent example of this is of one particular consumer who is living in our housing service and is not case managed by any service other than the NGO as he is deemed chronic. Ben is a very large forty year old man who lives alone but is employed within our supported employment program and due to the persecutory nature of his delusions, he is often absent. This is OK as it is a supported employment program, its ok to be off work if you are sick but if you are being paid you have to give 100%.: that;s another story.
Ben is supported by outreach workers who see him at least weekly but if the employment team who are not clinical staff are concerned they will ring the outreach team and they will make extra visits if that's OK with Ben.
On a recent occasion Ben stated he was very paranoid and the delusions he suffers were increasing despite remaining on his 900mg of Clozapine daily. The outreach worker called mental health for the Acute team to make an assessment and so they phoned Ben. They assessed he was OK over the phone due to the high volume of response issues they had. They advised that if we were still concerned that we take Ben to Accident and Emergency Department. Unfortunately it was a new worker who did not know Bens history

and Ben ended up becoming violent toward the doctor at Accident and Emergency when the outreach workers took him there. They were not allowed in to sit with Ben as they hospital wanted to wait for the Professionals to show up, the Acute team of course. He was then scheduled. Ben was admitted, stayed about a week and is released back into the NGO support services. This happens about every three years with Ben, when he asks for treatment he needs it urgently. He still is not "case managed" He is ashamed of his violence when he is unwell.
I suppose in this instance we do what is called disability support because taking someone to Accident and Emergency when they are ill is not clinical care. Yet how does the NGO sector only provide disability support and not assertive case management when supporting people with complex mental health needs.?.

For example Lets take Joe, a twenty year old Aboriginal male who has been discharged four weeks ago from the in-patient unit after his carer with whom he shared a caravan was found drowned in the nearby river. The NGO was asked by the inpatient unit to assess Joe's eligibility to Centre based rehabilitation services and activities. Not a big ask.
On interview by the NGO outreach worker, it was found that Joe was on Abstudy and not a disability support pension and was about to be breached by Centrelink for not attending to relevant conditions. We work urgently with the Psychiatrist, and Centrelink to get Joe on an appropriate benefit. He has been diagnosed for four years with Schizophrenia and was suspected of having secondary depression after the loss of his carer. Next disability support issue is-
He was now homeless and after his two week admission and his medication monitored and therefore all his clinical treatment needs are being addressed, he was deemed eligible for discharge and referred to the NGO for follow up with housing.
So we provide him with housing, initially hostel style accommodation. We link Joe in with Aboriginal mentoring program and he has an Aboriginal mentor come and take him to specific cultural or social events.

The NGO also applies through Commonwealth Respite agencies to have Joe's initial accommodation at the hostel paid for as he gave all his money away whilst in hospital to the various relatives and friends who visit him, we find through other family that this has been happening to Joe for years and he is left penniless on every pay day and relies on the Aboriginal community to feed and clothe him. We assist his mentor and family to look at the possibility of Guardianship Board application.
Next disability support issue-
Whilst staying at the hostel it is identified that Joe has alcohol and drug abuse issues, on returning from any unaccompanied outings Joe is in an extremely intoxicated state. He also has been smoking cannabis in his room. We ask Joe if he would see an alcohol and drug counsellor or attend a dual disorder group that is provided at our rehab centre by another NGO. Joe hasn't got there yet, but he saying that he would like to attend. The staff at the hostel is working through harm minimisation techniques with Joe so he stays as safe as possible. One of these was ensuring he had a ground floor bedroom as it

was feared Joe would have a fall in an intoxicated state as he often looks for the bathroom at night.
Another disability support issue is that the staff at the hostel have observed that Joe is very teary and isolates himself from other residents. After several discussions Joe reveals that he is terribly sad about the loss of his carer but also that he has been sad for years, and he keeps hearing the carers voice in his head.
An appointment with a psychiatrist is made and Joe's is prescribed new anti psychotic medication and an antidepressant. Joe will only see the psychiatrist with hostel staff as he states he does not trust many people and I suspect that a therapeutic relationship with his disability support workers has developed. Two weeks on and there are signs that things are looking up. Joe is smiling. He has been allocated a case manager and they will see him in about two weeks, They are pleased with his progress since his discharge from the in-patient unit and will get back to the us when Joe is case reviewed by the team about what case management will be provided to him. I am glad we can provide disability support.

To conclude
Providing a range of services within one organisation is not a new phenomenon and traditionally NGO accommodation support services had more of a co-case management role and the public sector would take on more clinical functions such as counselling, linking people with GP's and psychiatrists. Currently with less emphasis on long term support the NGO services are coordinating more varied activities and services to provide whole of life programs. Examples in metropolitan areas such as Compeer, Aftercare, Richmond Fellowship, B Miles, Chairmain Clift list goes on its a amazing what these disability support services can do.

The experience of NGO services in the North has been that positive health outcomes for consumers are achieved if not only are their basic needs addressed but further support is given to concentrate on more sophisticated needs. ie. A model of case management, it makes sense when you are providing the disability support to also coordinate other clinical activities, you don't have to necessarily be a clinician to coordinate them but a skilled, compassionate, dedicated "Para- professional" can also do the job. The NGO sector is providing them now, yet we need to be resourced, accepted as true partners and acknowledged as professionals.

Whilst policy documents state that NSW Health will provide clinical rehabilitation and the NGO sector will provide disability support it appears difficult to delineate these functions when assisting people recover from mental illness. It can be argued that a more cost effective, dignified and integrated case management approach is obtained when seamless service delivery is achieved. The Ngo sector is achieving this.

The Legislative Council's Select Committee Final Report on the Inquiry into Mental Health Services of NSW made many recommendations in Chapter 7 and chapter four and some observations in regard to case management.