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PRODUCTIVITY COMMISSION ISSUES PAPER

LONG-TERM DISABILITY CARE & SUPPORT

Preliminary proposal for developing an ACAT-type framework for people with developmental disabilities less than 65 years of age

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A. EXECUTIVE SUMMARY

The preliminary proposal considers the establishment of an ACAT-type framework for people with developmental disabilities less than 65 years of age.

The framework would consist of Disability Assessment Teams (DAT) that would provide assessments for eligibility for care and support under a new national scheme.

The benchmarks for funded packages under the scheme would need to be developed. The eligibility criteria for care and support and available funding under the national scheme would affect the capacity of the scheme to provide benefits and the number of people who could access it.

Services would be provided locally with full community participation of relevant stakeholders engaging principles of human rights, equity and fairness in the distribution of resources. Some examples of good practice models of comprehensive and networked services are presented.

It is recommended that the proposal be further considered and in particular, its linkages with the *NSW Health Service Framework for the health care of people with intellectual disabilities*.

B. BACKGROUND

The Inquiry by the Productivity Commission into the Disability Care and Support aims to improve the policies for the long-term care of people with disability.

The Inquiry mainly addresses people with disability aged less than 65 years, as there are good systems in place for the provision of aged care services. Younger people with disabilities tend to miss out as the current system for the coordination and provision of their care and services is inadequate and very fragmented.

The Issues Paper asks questions as to how a new national disability scheme could be designed, administered, financed and implemented. The terms of reference for the Inquiry indicate that the scheme is not intended to cover all degrees of disability. The scheme would appear to be intended for those in significant need of support, mainly those with severe or profound disability.

The new national disability scheme would need to:

- take into account the desired and potential outcomes for each person over a lifetime, with a focus on early intervention
- manage the costs of essential long-term care and community support, including a no-fault social insurance model and approaches used in other countries, and
- provide for a range of coordinated services, empower the person and carers to make informed decisions about their care and facilitate their participation in education, training and employment where possible.

C. THE ACAT AGED-CARE FRAMEWORK

There is a well established scheme for the care of persons with disability over 65 years of age. The scheme consists essentially of three components:

1. **Assessment:**
   Before a person can become a resident in an aged-care home they must have an assessment and approval from an Aged Care Assessment Team (ACAT). The team of specialists in aged care conducts standardised assessments to determine the person's eligibility for a high level (nursing home), low level (hostel) or a community care package. An ACAT assessment is usually valid for twelve months.

2. **Funding:**
   The Team is Commonwealth funded and administered by the State. The allocation of funding for nursing home beds and community places is capped and based on benchmarks according to the population. There may also be top-up funding from the State.

3. **Service Provision:**
   All residential care services are required to maintain standards and accreditation. The standards cover all aspects of residents' needs from health and personal care and safety to a range of lifestyle matters including independence, privacy and dignity. ACAT keep waiting lists and prioritise people for services. ACAT, the person and family and the service provider make the decision on placement.

D. PROPOSED ACAT-TYPE FRAMEWORK FOR YOUNGER PEOPLE WITH DISABILITY

The above aged-care model could be modified for people with disability less than 65 years of age. Such a model would need to take into account the different needs of preschool children, school-aged children, youth and adults. Within each of these groups, there will be different degrees of capacity and disability.

1. **Assessment:**
   NSW Health already funds a number of paediatric multidisciplinary Diagnostic and Assessment Teams that provide comprehensive diagnosis and assessment and management plans for preschool children with developmental delays/ disabilities. There are a few coordinated services which support adolescents with complex needs through their transitions from paediatric to adult health, disability and education services. There are limited specialist assessment services for adult with developmental disabilities.

   The *NSW Health Service Framework to improve the health care of persons with intellectual disabilities* (2009) is underpinned by the development and expansion of these multidisciplinary Specialist Health Teams.

   The above teams would be well placed to assess the overall care needs of people with disability, to assist them gain access to the most appropriate types of care services available and to access their eligibility for Commonwealth funded services under the new national disability scheme. The functional assessment tools used as part of determining eligibility and needs would be based on the policy goals of the scheme.

   These specialist health teams could be called Disability Assessment Teams (DAT).

2. Funding:

In line with the ACAT model, the Disability Assessment Teams would be Commonwealth funded and administered by the State. There may also be top-up funding from the State.

The eligibility criteria for care and support under the national scheme would affect the capacity of the scheme to provide benefits and the number of people who could access it.

The economic packages for accommodation, aids and appliances, respite, transport, day programs and community participation would be developed according to the eligibility criteria, fairness and cost. The benchmarks for economic forecasting according to assessed level of disability would also need to be developed from local and international data.

There would need to be clear definitions as to what services would be provided by the national disability scheme and what would be provided by the universal Medicare scheme. Will the national scheme provide narrow or wide coverage? Will the national scheme be for those with significant need of support, mainly those with severe and profound disability?

Key questions for the new national scheme are what is the extent of the unmet need and how much funding is required? The implementation of a Medicare levy, a no-fault scheme or other disability insurance scheme would determine the amount of funding available.

3. Service Provision:

Wherever possible, services should be provided at local level with full community participation of relevant stakeholders engaging principles of human rights, equity and fairness in the distribution of resources with a focus on early intervention, prevention and avoidance of crisis situations.

Coordinated packages of care would include accommodation support, aids and equipment, respite, transport and a range of community participation and day programs available for a person's lifetime. Benchmarks for service provision per population would need to be established as per the ACAT model.

The challenges of coordination are confounded by multiple agencies with different capabilities being involved in the delivery of services. A strong framework would be required to ensure clarity of the criterion of a service package, to streamline coordinated packages of care, and to achieve timely and consistent outcomes for clients and to avoid duplication of limited resources. People with complex needs require integrated services to address their needs in a comprehensive and holistic manner.

The scheme would be evaluated and adjusted as conditions change. Accreditation, regulation and oversight of service providers would be required.

The Disability Assessment Teams would have a role in improving the quality, range and consistency, accessibility and integration of services, and in promoting a broader understanding of the needs of people with disability, and their rights to effective services and care.

Some examples of good practice in the collaborative approach to care are illustrated below.

E. EXAMPLES OF BEST PRACTICE MODELS

The following are examples of best practice illustrating the benefits of Disability Assessment Teams in improving the provision of care and support to people with developmental disabilities.

- The Kogarah Model (SESIAHS Developmental Disability Network)
- School Therapy Physical Disability Team Model
- Transition Team Model

The Kogarah Model (SESIAHS Developmental Disability Network)

SESIAHS has established a Developmental Disability network across the area, based on the Kogarah model. The aims of the network are to promote the development of comprehensive multi-disciplinary teams integrated with primary, community health and acute hospital services as well as DADHC, DET and non-government agencies for children, adolescents and adults and their families/carers in their local communities. The network has encouraged consultants from various specialities (including psychiatrists, adult physicians and rehabilitation specialists) to develop an interest in developmental disability and this has facilitated the care of patients admitted to hospital.

With regards to acute hospitals, the network has piloted a Disability Consultancy Service of specialists and social work input at St George Hospital, particularly for adolescents and adults with challenging behaviours. The pilot has identified necessary improvements in services for patients, integrated admission and discharge planning, education of hospital staff and interagency co-operation. The Kogarah team has commenced sharing protocols with other Hospitals in the network. The pilot has also identified significant cost savings from decreasing the length of hospital stays for mental health and social problems. Close links with DADHC, DET and Community Mental Health are critical for this program to function.

School Therapy Physical Disability Team Model

School Therapy Teams for students with physical disabilities are an example of a best practice model. Students with developmental disabilities are likely to have a variety of educational, social and health needs during their school life. Students, families and teachers must often deal with a confusing array of professionals, therapy interventions and agencies to meet their needs. For students with complex problems an integrated multidisciplinary team approach, where the actions of diverse professionals are melded into a team, is likely to achieve better outcomes. Evidence shows that small multi-disciplinary health teams provide the highest net benefit and cost effective model to improve health care and therapy services for students with developmental disabilities.

The following table compares the potential or real impact of the Health Therapy Team to the scenario where such a team does not exist.

School Therapy Health Team	No School Therapy Health Team
• Evidence based • Integrated services provided in schools • Multidisciplinary assessment and management • Coordinated communication between therapists, school support staff, teachers, clients, families and carers • Training for all stakeholders improves outcomes for students • Linked to other health developmental services	• Therapists working in isolation at multiple locations operate as a barrier to access services • Not holistic approach • Discontinuous service • Communication is fragmented • Limited upskilling of therapists and school staff

Transition Team Model

The multidisciplinary health team that supports adolescents with complex needs in their transitions between health, disability and educational services is another example of a best practice model.

Youth with developmental disabilities are a disadvantaged group with complex health, educational and socio-economic needs that require services from a number of professionals and agencies. They are particularly vulnerable to the stresses of the transition period from paediatric to adult services. Youth with an intellectual disability and mental health problems present significant management difficulties when they attend hospital.

The integrated model of care provides opportunities for new innovative (often cost-neutral) services such as Transition Clinics in Special Schools. The aims of the transition team are:

- To improve access to quality health care for adolescents with developmental disabilities during the transition period from paediatric to adult services.
- To reduce preventable presentations to ED and prolonged hospital admissions for non-medical reasons with associated significant cost savings that can assist in funding preventative programs.
- To develop and establish policies and protocols for (a) access to hospital (b) specialist multidisciplinary health services and (c) for Disability Action Plans.
- To promote collocation/ conjoint clinics of paediatric and adult services for the transition group.
- To ensure interagency collaboration between DADHC, DET, Mental Health, Community Health, shared care with GP's, NGO's, Carers NSW, Police Department and Justice Health.
- To develop and establish ongoing programs for staff education and quality assurance/ research activities.

F. RECOMMENDATIONS

- That further consideration be given to developing the proposal for Disability Assessment Teams (DAT) for younger people with disabilities in line with the ACAT aged-care model

- That these teams should be aligned with specialised health teams in the *NSW Health Service Framework to improve the health care of persons with intellectual disabilities*

- That consideration be given to piloting the best practice models as part of the development of a national disability health scheme.

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