Community Mental Health Australia

Community Mental Health Australia Position Statement – Continuity of support

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

The organisations represented through CMHA are:

- Mental Health Coalition of South Australia
- Mental Health Community Coalition of the ACT
- Mental Health Coordinating Council NSW
- Mental Health Council of Tasmania
- Northern Territory Mental Health Coalition
- Mental Health Victoria
- Queensland Alliance for Mental Health Ltd
- Western Australian Association for Mental Health

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA advocates for and promotes evidence-based, good practice and capacity building for community based mental health services, and collaborates with consumers and carers through a lived experience partnership. CMHA does this at the national level, and at the state and local level.

This position statement articulates the community-managed mental health sector's position on what constitutes continuity of support for people receiving assistance from Federal Government mental health programs – Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs) and Day to Day Living (D2DL) – and are not eligible for the National Disability Insurance Scheme (NDIS).

How is continuity of support being described?

To date (beginning 2018), there has been no clear articulation by any Government Department or the National Disability Insurance Agency (NDIA) about what continuity of support actually looks like in practice, or what the provider of last resort would look like and who the provider/s would be.

The Department of Social Services (DSS) has stated the following on continuity of support:

> For existing Commonwealth clients who are assessed as not meeting the NDIS access criteria, the Commonwealth has committed to providing continuity of support. This will include assistance for PHaMs clients who are aged 65 or over when the NDIS begins in their areas, and/or clients who do not meet the residence requirements of the NDIS.

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> Continuity of support means clients who are found to not meet the access requirements of the NDIS will be supported to achieve similar outcomes, even if the arrangements for doing that change over time.
>
> In the short term, continuity of support will be provided through your existing programme funding. You will be notified once long-term arrangements for providing continuity of support have been finalised.[1]

The loss of services

A range of highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation and their disappearance means that people will no longer have access to these services that support them to reduce the disabling impacts of their mental condition.

The further significant issue is the gap in service provision that will be created with the transferring of funds for federally funded mental health programs from the Department of Health (DoH) and DSS for PIR, D2DL, PhaMs and Mental Health Carers: Respite Support service to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS. Figures from DSS for 2016-17 on PHaMs clients phasing into the NDIS were considerably lower than expected, with only around 35% of people phasing into the NDIS[2].

The federally funded mental health programs are designed to offer a range of flexible supports over short or longer time periods as required, and to engage intermittently in response to variations in acuity of mental health conditions that are episodic in nature. Based on the principle of recovery, these supports may be transitional, providing a supported journey towards greater independence, or intermittent and longer term, allowing participants to resume engagement as needed in response to variations in their health and wellbeing.

Unlike the NDIS and some other mental health services, the programs are accessible without a confirmed diagnosis and without the requirement for a condition to be permanent. All programs involve targeted and proactive strategies to engage individuals who may be homeless or transient or who for other reasons may not have engaged with any part of the mental health service system. The other important components of the programs and federal funding were:

- Case coordination – This relates most specifically to PIR, which aims to have services responding to needs in a more integrated and coordinated way. The intention was that PIR would work alongside PHaMs, D2DL and other initiatives in a complementary way, improving referral pathways across the system and delivering effective case coordination to achieve the best practice ideal of wraparound care.

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[1] Information for providers, Personal Helpers and Mentors Service, July 2016, Department of Social Services, Australian Government

[2] Question on notice no. 50, Portfolio question number: SQ17-000236, 2017-18 Supplementary budget estimates, Community Affairs Committee, Social Services Portfolio, https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/ca, Accessed 13 February 2018

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- Direct carer supports – The Mental Health Respite: Carer Support program was a dedicated carer support program. The NDIS model claims to provide equivalent, if indirect, supports to carers by supplying better-suited disability supports to NDIS participants themselves – thereby relieving the burden on families and carers. This concept however ignores many years of evidence and advocacy from a range of organisations noting that carers require separate support and that regardless of the supports consumers receive, carers will typically be the first person called upon for support. A report commissioned by Mind Australia on the economic value of mental health carers found that on average, mental health carers spent most of their time providing emotional support and psychosocial care, and that activities of daily living accounted for a very small proportion of their support time[3].
- Assertive outreach – CMHA has noted that assertive outreach components within the federally funded mental health programs are not replicated within the NDIS model. While the NDIA has developed a 'hard to reach' strategy, there is no dedicated funding in the NDIS for the delivery of mental health outreach to individuals or communities in need, particularly for Aboriginal and Torres Strait Islander communities. When the federally funded mental health programs cease, the dedicated outreach function also ceases for people outside of the service system, whether they meet NDIS eligibility criteria or not.

CMHA has recommended that the Federal Government continue to fund a low barrier to entry, flexible program for people living with a mental illness who will not be eligible for the NDIS. The Federal Budget 2017-18 announced $80 million funding over four years for community-based mental health, with the requirement that it be matched by each state and territory, to address the gap in services for people with a psychosocial created by the NDIS. However, there has been no sector-wide evaluation or calculation of the estimated number of people with psychosocial disability currently in federally funded programs who won't be eligible for the NDIS, nor consideration of the impact of defunding short term mental health support places to fund lifelong packages of disability support.

The transfer of state/territory and federal funding and the resulting gap in community support raises the fundamental question of how people (NDIS recipients or not) with serious mental conditions will have their psychosocial rehabilitation needs met in the future. The loss of psychosocial rehabilitation from the mental health support system will eventually impact on the wider system, including the NDIS to sustain quality services.

With the agreement between the Commonwealth and State and Territory Governments to provide continuity of support, there is considerable confusion and uncertainty about what this actually means in practice. The experience of the community managed sector is that it shifts the responsibility to provide support to the sector without any funding to do so. CMHA supports the recommendation of the Productivity Commission NDIS Costs inquiry that the NDIA should report on boundary issues and that there should also be mandatory reporting by all governments on the number of people covered by disability support programs pre- and post-NDIS.

The disability, clinical, forensic and broader health systems need to evolve and work together to best support people with a mental health condition. The gaps emerging as a result of the loss of the

[3] The University of Queensland School of Public Health (2016), The economic value of informal mental health caring in Australia: summary report. Mind Australia

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rehabilitation component, will place significant strain on the health system and the burden of these gaps ultimately falls on people living with a mental health condition and their families.

Provider of last resort

For both people eligible and ineligible for the NDIS, the provision of support is reliant on a healthy marketplace. CMHA believes that clarity around the arrangements for a provider of last resort need to be determined as a matter or priority between the Federal and State and Territory Governments. This is directly linked to the continuity of support provision – as services are withdrawn or transferred to the NDIS. For example, Victoria at full NDIS implementation will have removed all community mental health funding. Combined with the transfer of federally funded mental health programs to the NDIS, this will result in significant gaps across the spectrum of community mental health services for people both eligible and not eligible for the NDIS. The dual impacts of the loss of programs and funding with the potential withdrawal of services for people with psychosocial disability in the NDIS, is an issue that must be confronted and who will be the provider of services when those services may not be there.

CMHA supports the point made by the Productivity Commission in the NDIS Costs inquiry that the NDIS was not expected to fill all service gaps. There should also not be a situation where some people receive a high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not. The interface between the NDIS and mainstream services and the gaps that will be created for mental health in the transition to the NDIS are some of the most significant and concerning issues for the community-managed mental health sector.

In addition, the Federal Government has said that if Commonwealth mental health program clients 'choose' not to make an NDIS access request there will be no continuity of support and these people's needs will be the responsibility of state and territory governments. Where a person's 'choice' is linked to their psychosocial disability (i.e. cognitive behavioural impairments), this cost-shifting stance is of great concern and not consistent with Australia's obligations under the UN Convention on the Rights of Persons with Disability.

What should continuity of support look like?

It is the position of CMHA that continuity of support must adhere to the Federal Government's statement that clients found ineligible for the NDIS will be supported to achieve the same outcomes, even if arrangements change over time. This support will be provided through the NDIS; a low barrier to entry, flexible program funded by the Federal Government; and through state and territory governments continuing to fund community mental health services.

The following aspects will be incorporated:

- There needs to be links established between the NDIS and all parts of the mental health system recognising that people will need assistance, even if they have an NDIS package, from different parts of the system at different times.
- People accessing Federal Government funded programs – PhaMs, PIR and D2DL – will be assisted to test their eligibility for the NDIS where they elect to test their eligibility. This assistance will be funded through the NDIS and be provided by the PHaMs, PIR or D2DL service provider.

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- People not assessed as eligible or who do not test their eligibility, will receive assistance funded by the NDIS and provided for by either the PHaMs, PIR or D2DL service provider or by the NDIS Local Area Coordinator (LAC) to determine a plan of services which must not result in them receiving a lesser amount of service. The service provider or LAC will action the plan, and the person/client will be able to determine who assists them. The LACs will be resourced appropriately to have the capacity and expertise to undertake this process. The purpose of this process is to facilitate access to necessary and appropriate services. Part of the package or services available to these people, must include access to supported decision making, so that they can exercise choice and control and be supported through decision-making processes. State and territory governments must provide the funding to upskill the mental health workforce to offer this as a service. The peer workforce can be important in this context.
- If the person requires a period of support to coordinate their plan, this will be provided for through a federally funded low barrier to entry, flexible support program. This assistance may be short or longer term, depending on the person' needs as determined in the planning process by either the service provider or the LAC.
- As funding decreases for PHaMs, PIR and D2DL, people accessing the NDIS who are found not eligible, will be referred to the flexible, low barrier to entry program if they require ongoing support to coordinate services and in determining services they want and need. People must be able to enter and exit the program based on their need to access coordination support, that is they do not need to seek access to the program through the NDIS if they have already been through the NDIS access process and were given assistance via this process. This program needs to be funded by the Federal Government on an ongoing/recurrent basis and have the appropriate capacity to meet the needs of people ineligible for the NDIS.
- The range of services that a person may access will include:
  - state and territory funded services
  - services provided through the Primary Health Networks (PHNs)
  - the National Psychosocial Support Scheme (jointly funded by federal and state and territory governments)
- For individuals living with a mental health condition who are ineligible for the NDIS and are required to navigate Information, Linkages and Capacity Building (ILC) services either through an LAC or a service provider, it is vital that the system does not create a 'second class' of clients where the timeframes and referral processes for non-NDIS services and care coordination are lesser. An oversight mechanism should be built into the referral process, which includes quality and safeguard measures around referral and access timeframes that are comparable to people with an NDIS package.
- For continuity of support for families and carers there is a need for direct and indirect supports, including building supports into ILC and service provider processes.

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