Community Mental Health Australia Position Statement

National Disability Insurance Scheme and Psychosocial Disability

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
- Psychiatric Disability Services of Victoria (VICSERV)
- Queensland Alliance for Mental Health
- Western Australian Association for Mental Health

CMHA promotes the recovery of people living with a mental illness 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.

The state and territory peak bodies are involved in the implementation and roll-out of the National Disability Insurance Scheme (NDIS) and have a strong understanding of the impacts for service providers, consumers and carers through their members.

It is important that the key learnings and issues that emerge from the various reports and studies, particularly those from the community mental health sector – involved on the ground in delivering services as they transition – are incorporated and lead to changes which will ultimately affect the quality of service that is delivered to consumers.

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Responding to psycho-social disability

A key issue for CMHA with the NDIS overall is how the NDIS will respond to people with psycho-social disability to assist individuals to both reduce the disabling impacts of their illness (community-based rehabilitation including intervention, prevention and promotion) and to gain high quality disability support.

Community managed mental health service providers prioritise community-based rehabilitation to support individuals to recover, and the specific quality aspects take reference from the National Standards for Mental Health Services (or in some states specific psychosocial rehabilitation and support service standards). The community managed mental health sector has developed a workforce that is appropriately qualified and skilled to deliver these services and a culture that reflects the appropriate Standards.

A key question is how to provide an appropriate workforce base within the NDIS pricing and practice structure which references disability standards and is designed primarily to deliver disability support.

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact, with their seeming to be a misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support.

This creates a potential imbalance in the provision of mental health support which should represent a balanced system of clinical treatment, community-based rehabilitation and disability support.

A 2015 piece of work by Community Mental Health Australia (CMHA) led by the Mental Health Coordinating Council (MHCC) in New South Wales (NSW), on the impact of the NDIS on the mental health workforce, found that:

> an overall perspective from the study that many service providers consider the NDIS to be a 'challenging' environment, with pricing constraints and perceived rigidity in the Catalogue of Supports (now the National Disability Insurance Agency/NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner.[1] [2]

[1] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

[2] The report was commissioned and funded by the NDIS Sector Development Fund as part of an NDIS Capacity Building Project delivered by Mental Health Australia.

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The NDIS pricing does not officially set mental health sector workers' wages, however, it does have a significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders have noted that pricing was not sufficient to purchase a suitably skilled workforce that engaged in complex 'cognitive behavioural interventions' as well as direct personal care.[3]

A 2015 report by VICSERV on the NDIS Barwon trial concluded that the NDIS wasn't effectively delivering rehabilitation focused services and that these services and disability support services are both important parts of the continuum of care for people living with a mental illness. The federal and the state/territory governments should ensure both receive secure and ongoing funding.[4]

In order to maintain and support the community mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that the NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services. A model that includes community-based rehabilitation as a necessary part of a high functioning mental health system is essential. This should be developed in consultation and partnership with the community mental health sector.

A National Mental Health Workforce Strategy

A key piece of policy work that is required is an examination of the overall workforce in mental health, including the community managed mental health sector, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring. This needs to take into account the reforms to the mental health sector that are impacting the community-managed mental health workforce, such as the NDIS.

A National Mental Health Workforce Strategy produced by the Mental Health Workforce Advisory Committee was published in 2011 which identified a number of priority outcome areas including developing, supporting and securing the current workforce; and building the supply of the mental health workforce.[5] While this strategy was developed prior to the introduction of the NDIS, any future strategy should build on this work.

A workforce strategy should support both the mental health workforce and primary health workers, especially GPs, to prepare for mental health reforms, including the NDIS, in relation to mental health and their roles. The inclusion of the community managed mental health workforce is crucial.

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[3] Community Mental Health Australia (2015). Op cit.

[4] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

[5] National Mental Health Workforce Strategy (2011). Published by the Victorian Government Department of Health, Melbourne Victoria on behalf of the Mental Health Workforce Advisory Committee.

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A workforce strategy should provide particular assistance to the consumer and carer peer workforce (both paid and volunteer), including to prepare for the NDIS. This should build the capacity of this workforce to assist consumers and carers to access the scheme productively. Along with a strategy for peer workers, key areas of need such as the Aboriginal and Torres Strait Islander, rural and remote and early childhood workforce should be a focus and part of the strategy.

The lack of a comprehensive national mental health workforce strategy to develop, support and maintain the mental health workforce has been a significant policy gap and has meant that reforms in the sector which have a significant impact in the workforce, have no guiding policy to account for these issues.

Funding appropriate community managed mental health 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 help them to reduce the disabling impacts of their mental illness.

This has consequent issues in relation to the NDIS such as the potential for a growing level of disability and unmet need over time of people entering the scheme. Also the appropriateness of the pricing structure and its relationship to qualified mental health staffing being able to provide effective rehabilitation services, and therefore the level of funding provided to mental health NDIS packages.

Mental health and the crucial concept of psychosocial disability cannot be simply made to fit a system which is focused on disability support when psychosocial rehabilitation is a very different concept. We must ensure that mental health services are funded accurately through an appropriate mechanism. If this does not occur, it may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.

Recognising differences between the states and territories

As noted earlier, the 2015 report by VICSERV on the NDIS Barwon trial concluded that the NDIS wasn't effectively delivering rehabilitation focused services, and the federal and the state/territory governments should provide funding for these and disability support services.[6]

A key issue with the NDIS is the differences that are occurring between states and territories and the scheme being one of national consistency. There is a general guarantee in the bilateral agreements

[6] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

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between the Federal Government and the states and territories for continuity of support to people who are transitioning from existing services to the NDIS. However, this guarantee is being impacted at different levels with states and territories, and federally funded programs such as PIR, D2DL and PHaMs transitioning to the NDIS.

Some states are ceasing to fund some state-based and funded psychosocial services or services that assist people with psychosocial disability, such as psychosocial rehabilitation. This situation is also partly due to the timing of transitioning occurring at different stages and therefore people's access to the NDIS.

The real risks to consumers, carers and services providers are that some services may cease once the NDIS reaches full implementation, incomplete information for services and service recipients to plan; and uncertainty for workers regarding future demand for their skills and knowledge.

NDIS eligibility estimates in states and territories for people already in federally funded programs is as low as approximately 20% in some instances with obviously a high degree of ineligibility. This obviously creates significant gaps which states, territories and the federal government must take responsibility for and work together in genuine collaboration to ensure these people continue to receive services.

The central issue, as noted earlier, is that the NDIS is not a, and cannot replace the, mental health system and both disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness. CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital that governments work in partnership with community managed mental health service providers to develop solutions to concerns and issues that have emerged.

The experiences from the implementation of mental health within the NDIS in trial sites has demonstrated that support is required to transition the mental health sector, in particular the community managed mental health sector, to be ready and able to maintain services and support people within the NDIS. The 2015 report by VICSERV on the NDIS Barwon trial recommended that before full roll-out commenced there needed to be better communication with all stakeholders, and support for organisational readiness at 12 months prior and to shift to a new model of care.[7]

States and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements. There are regional variations in terms of the type of targeted support required, population

[7] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

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differences, and issues of distance for regional, rural and remote areas. Regionally based collective workforce development directions to identify innovations, in addition to national and/or state/territory-based approaches, are likely to derive a greater benefit from and also be more cost-effective.

A key issue is therefore facilitating transition for service providers and organisations. Communities of Practice (CoP) are an effective mechanism to deliver this, and have been successfully undertaken by CMHA member peaks in NSW and WA, and learnings from these can be used in the design of future CoPs. CMHA believes regional CoPs, which account for variations in regions, should be prioritised within Federal Government funding for work to support the community managed mental health sector in its pathway to the NDIS.

Options for funding services for people living with a mental illness who are ineligible for the NDIS

As PIR and D2DL funding is transferred to the NDIS it is evident that there will be a proportion of the client base who will move to the NDIS and a proportion who will be ineligible.

Consideration needs to be given to how people living with a mental illness who need to have collaborative and coordinated care continue to have this provided within a health framework, and developing a mechanism to fund this. A key factor in such a consideration is developing a mechanism which is workable for both the Government and the community mental health sector who would provide PIR and D2DL or like services, such as PHaMs.

A key issue will be developing options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access PIR and D2DL. CMHA contends that the Federal Government must continue to fund a flexible, low barrier to entry service (as per PIR, D2DL and PHaMs) that sits outside of the NDIS for people who need ongoing community and coordination support.

CMHA also contends that support for carers should be separate to the NDIS, in that carers should not have their access to services, such as respite, tied to the assessment of the person they care for. This is problematic in general, but particularly in mental health where a person may be unwell and not recognise the need for a carer or recognise that they have a carer.

Issues and actions

Below are issues and actions for CMHA, in order of priority. It is the position of CMHA that:

1. CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital that governments work in partnership with community managed mental health service providers to develop solutions to concerns and issues that have emerged.
2. The NDIS can't effectively deliver rehabilitation focused services and that these services and disability support services are both important parts of the continuum of care for people living with a mental illness. The commonwealth and the state/territory governments should ensure both receive secure and ongoing funding.

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3. NDIS eligibility estimates in states and territories for people already in federally funded programs show there will be a significant level of ineligibility. CMHA contends that the Federal Government must continue to fund a flexible, low barrier to entry service (as per PIR, D2DL and PHaMs) that sits outside of the NDIS for people who need ongoing community and coordination support.
4. Mental health cannot be simply made to fit a system which is focused on disability support when psychosocial rehabilitation is a very different concept and practice. Mental health services must be funded accurately through an appropriate mechanism. If this does not occur, it may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.
5. Community managed mental health services provide community-based rehabilitation to support individuals to recover, and has developed a workforce that is appropriately qualified and skilled to deliver these services.
6. A National Mental Health Workforce Strategy be undertaken to develop, support and maintain the mental health workforce. This should include the community managed mental health sector, the mental health peer workforce, and the primary health workforce.
7. The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports.
8. The NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services. A model that includes community-based rehabilitation as a necessary part of a high functioning mental health system is essential.
9. As states and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements. There are regional variations in terms of the type of targeted support required, population differences, and issues of distance for regional, rural and remote areas. Regionally based collective support and training, rather than national or state/territory-based, is an approach organisations are likely to derive a greater benefit from and also be more cost-effective.

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