2017

Joint Standing Committee on the NDIS – The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

COMMUNITY MENTAL HEALTH AUSTRALIA SUBMISSION

CONTENTS

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Introduction

CMHA would like to thank the Joint Standing Committee for conducting this inquiry and for providing CMHA with the opportunity to make a submission. CMHA would welcome the opportunity to address the Joint Committee when hearings are held as a part of the inquiry process.

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.

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 remains committed to the National Disability Insurance Scheme (NDIS) and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital to ensure that the recovery focus of community managed mental health services — which has come to inform the overall approach that is taken to addressing mental illness — is not lost. We also do not want to create 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.

CMHA has significant concerns that the NDIS is not being implemented as it was envisaged, in particular for people with psychosocial disabilities. These concerns include:

- The impact of the NDIS pricing structure and its relationship to qualified mental health staffing, with a seeming 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, while being unclear about its reach into more complex supports. Therefore, retaining a highly qualified mental health workforce for the NDIS is a concern.
- The transferring of funds for federally funded mental health programs from the Department of Health (DoH) and the Department of Social Services (DSS) - Partners in Recoovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PhaMs) - to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS.
- The Primary Health Networks (PHNs) being stated as a key means to address gaps outside of the NDIS when the PHNs are being directed by the Federal Government to not commission psychosocial services. This ignores the fact that funding for programs being transferred to the responsibility of the PHNs were routinely engaged in psychosocial service provision.
- Cost shifting occurring between the state and territory and federal governments. This includes the withdrawal of funding for state and territory funded mental health programs under the guise of this gap being addressed by the NDIS; inconsistency with state and territory governments not confirming future state and territory funding when they are or will be at full

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NDIS implementation; and the situation which occurred in the ACT with the 'estimate' for NDIS clients being reached but neither the ACT or Federal Government taking responsibility for the required funding shortfall.

- The lack of transparency in the bilateral agreements which provide no information on funding contributions or commitments by governments to both the NDIS or state and territory mental health programs and services. Having a stated guarantee of 'continuity of service' provides only assurances in word but not in actuallity.
- The National Disability Insurance Agency (NDIA) moving away from face-to-face assessment and planning for people applying for the NDIS which will have a significant impact on all people applying for the NDIS, but particularly people with any form of cognitive impairment or disability.
- The use or interpretation of the NDIS Act 2013 by the NDIA appears to be an area requiring examination. The December 2015 independent review of the NDIS legislation by Ernst and Young[1] stated as a key finding that while, at the time, the legislative framework was broadly enabling government to progress the NDIS Act, an important caveat was that the NDIS was at an early stage and evolving. That as the scheme moved into more locations and took on more people, a key recommendation was the government should conduct another review in 2 to 3 years to ensure the legislation was 'fit for purpose' for full scheme. Issues are occurring with requests for plan amendments triggering reviews of full plan, which are done centrally rather than regionally. Clients are also not permitted to see a plan before it is finalised, which anecdotally providers state is hindering clients understanding of their plan. The NDIA are stating verbally in meetings that the planning process is adhering to legislation. CMHA contends that a review of the legislation is required as its interpretation is leading to implementation problems and escalating administrative costs with the scheme.

Elizabeth Crowther, President CMHA wrote to all state and territory health or mental health ministers on 22 December 2016 requesting the following information by 31 January 2017:

- a total figure of the annual committed contribution to the NDIS from existing mental health funds;
- a total figure of the committed funding to community managed mental health services at the year of full transition of psychosocial disability to the NDIS in your jurisdiction; and
- a breakdown of the community managed mental health sector funding by service type (as per the NGOE Data Set Specifications or the nearest approximation).

At the time of finalising this submission, responses had been received from the Northern Territory, Tasmania and Western Australia. The responses did not directly address the information requested. The overall sense from the responses was that no work is being done as yet on contributions into the future for either the NDIS or their relevant jurisdictions. The other jurisdictions did not provide a response. The responses are included as a separate attachment to this submission.

[1] Ernst and Young, Independent review of the NDIS Act, December 2015, https://www.dss.gov.au/sites/default/files/documents/04_2016/independent_review_of_the_ndis_act.pdf

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CMHA's submission to this inquiry will address each of the Terms of Reference (TOR) for the inquiry and raise other related matters. CMHA undertook a consultation process with the states and territories to inform the responses to the TOR and information from this process is included in this submission. Summaries of the information provided by state and territory peaks are at Attachment A.

A number of the state and territory peaks will also be making their own submissions to this inquiry – ACT, NSW, NT, QLD, SA and Tas. CMHA supports these submissions and would urge the Joint Standing Committee to examine those submissions, which provide practical examples of how the NDIS is impacting mental health in each jurisdiction.

1. *That the joint committee inquire into and report on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, with particular reference to:*

    a. *the eligibility criteria for the NDIS for people with a psychosocial disability;*

CMHA supports the recommendation of the National Mental Health Commission (NMHC) Review of Programs and Services recommendation to 'urgently clarify the eligibility criteria for access to the NDIS for people with disability arising from mental illness and ensure the provision of current funding allows for a significant Tier 2 system of community supports.'[2]

The Mental Health Council of Tasmania (MHCT) have noted in their submission to this inquiry that the Independent Advisory Council (IAC) of the NDIA has stated that, "Ineligibility rates for applicants with a mental illness are significantly higher than those resulting from applications from people with physical, intellectual and sensory disabilities. The reasons for this are unclear and need further investigation."[3] MHCT believe that the lack of knowledge and understanding of psychosocial disability, enshrined in clear benchmarks, is likely to be a contributing factor to this discrepancy. They recommend investigating and adopting a consistent and standardised approach to the eligibility and planning processes for the NDIS, including ensuring that the tool used for assessment is specifically geared for psychosocial disability.

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. This was also a recommendation of the NMHC report.

Mental Health Carers Australia (MHCA) in their submission to the inquiry have highlighted their concern that due to NDIS eligibility criteria, many carers will not receive the care they need to continue in their caring role. This will occur if:

- The person with a mental illness is not eligible for the NDIS.

[2] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC

[3] Independent Advisory Council (IAC) (2015), IAC advice on implementing the NDIS for people with mental health issue, https://www.ndis.gov.au/about-us/governance/IAC/iac-advice-mental-health

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- The person with a mental illness chooses not to engage with the NDIS. Many people with mental health issues do not seek services so it is likely, in the absence of assertive outreach, that many people with severe mental ill health will not engage with the NDIS.
- The person with a mental illness is eligible but the caring role is not fully acknowledged.
- The support required by the carer is not accommodated by the activities funded through the NDIS.

MHCA note that there is a serious lack of clarity about what services will be available outside the NDIS for consumers and carers once funding from current services such as Mental Health Respite Carer Support, PHaMs and PIR transition into the NDIS. MHCA has recommended that plans to 'roll in' programs including Mental Health Respite Carer Support, PIR and PHaMs, which wholly or partly serve target groups ineligible for the NDIS, are immediately put on extended hold while the full implications for individuals and families both eligible and ineligible for the NDIS are assessed.

It goes to the issue, which CMHA has made in a number of submissions, that mental health cannot be simply made to fit a system, which is focused on disability support when psychosocial rehabilitation is a very different concept. A failure to recognise the complexities and issues particular to mental health may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.

This is why it is vital to address issues such as the eligibility criteria and quality assurance processes (which is addressed later in this submission) specifically regarding psychosocial supports and disability as a matter of urgency. Mental health in the NDIS is already at full transition in the ACT and implementation sites are expanding in and to other jurisdictions, and it is of a great disadvantage to the mental health sector that these aspects have not already been finalised for psychosocial disability, given the challenges that were envisaged and have eventuated.

b. the transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular;

i. whether these services will continue to be provided for people deemed ineligible for the NDIS;

CMHA has significant concerns with the gap in service provision that will be created with the transferring of funds for federally funded mental health programs from DoH and DSS for PIR, D2DL and PhaMs to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS.

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.

Consideration needs to be given to how people living with a mental health condition who need to have collaborative and coordinated care continue to receive this care within a health framework, and to develop mechanisms to fund this. A key factor in such a consideration is developing a mechanism, which

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is workable for both the Federal Government and the community mental health sector that currently provide PIR, D2DL or PHaMs services.

CMHA has proposed a project to develop options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access Federally funded programs, ensuring that their rehabilitation and support needs are met whether eligible or not. These options should be developed in partnership with and therefore supported by the community managed mental health sector, providers, consumers and carers. They will provide the Government with a clear set of options that are suitable, and provide direction on how services could be funded. It is estimated that the cost for undertaking this work would be approximately $70,000.

The September 2016 Intermediate Report of the Evaluation of the NDIS by the National Institute of Labour Studies, Flinders University concluded that the examination of available qualitative data had shown concerns on the impact of the NDIS on people who would not be eligible, with some non-NDIS participants reporting they were receiving fewer services or falling through service gaps and receiving no supports.[4]

There has been no sector-wide evaluation of the estimated number of people with psychosocial disability currently in federally funded programs who won't be eligible for the NDIS. Anecdotal NDIS eligibility estimates in states and territories for people already in federally funded programs is generally between 20-40%. There is a general lack of access to data outside of and/or across state and Commonwealth government departments to help manage change occurring through NDIS implementation and other mental health sector reforms being implemented through the PHNs.

NSW has noted that some organisations delivering these federally funded programs have audited their client caseload and report that only 30% may access NDIS. While the Hunter NDIS trial site experience demonstrates that this seems to be growing with time, experience and a growing understanding of the evidence required to support access. In the ACT, where NDIS roll-out for mental health is the most progressed, it is expected that there will be approximately 63 people who are currently in PIR who won't have an NDIS package by the time the service is scheduled to close on 30 June 2017.

A significant issue that has been raised in relation to the overall transition process of the NDIS is that it is transferring risk to providers – with service providers consequently transferring the risk to consumers – for services to be financially viable. This goes against the value system of service providers. For example any delays to putting in place plans or reviewing plans which leads to consumers and then providers not receiving payment, leaves providers in a position of having to make a decision to provide services and not be paid. There is also a risk that providers may choose not to support more complex clients if there are out-of-pocket costs associated.

An example of problems occurring with the planning process from the ACT stated that a male in his early 50s had a plan for $58,000 per annum and through a review this was reduced to $19,000 per annum. A

[4] Mavromaras, K., Moskos, M. and Mahuteau, S. (2016) Evaluation of the NDIS, Intermediate Report, September 2016. Adelaide: National Institute of Labour Studies, Flinders University.

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review process was put in place taking 2 months, at the non-government provider's expense, and the result was an increase back to $58,000.

Providers have suggested that having pre-planning assistance for consumers and allowing consumers to view their plan before it is finalised would be steps to address some of the problems occurring.

c. the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;

i. whether these services will continue to be provided for people deemed ineligible for the NDIS;

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 over time of people entering the scheme, as well as 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.

It is vital to 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.

A central 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 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 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. This situation is also partly due to the timing of transitioning occurring at different stages and therefore people's access to the NDIS.

Jurisdictional issues

Victoria has seen a substantial withdrawal of funding for community managed mental health services, with funding for the community-managed mental health workforce not being continued – i.e. the community mental health workforce will no longer exist, instead a disability support workforce will be in place. This contrasts to the NSW Government, which is continuing to fund mental health programs delivered by the community sector and, at present, appears unlikely to withdraw the funding as the NDIS rolls out.

The NSW Government intends to rationalise and grow community sector delivered programs over time, however NSW is approaching this from a basis of being one of the least funded non-government sectors across jurisdictions. Services in the Northern Territory (NT) have provided anecdotal feedback that they

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are most likely to be able to continue to access funding streams for clinical mental health services and to a less extent for community based mental health services.

The situation in Western Australia with the state government announcing they will have a state-run model of the NDIS adds a further complication to the issues of state and federal funding for services in that jurisdiction. Limited detail is available about how this will work in practice, including funding mechanisms, and immediately creates a situation where there will not be a nationally consistent scheme. At the time of developing this submission, no details were available about whether existing state mental health and disability service funding will contribute to the funding of the WA NDIS. Further, there is a lack of clarity about how the WA NDIS will interact with state service systems including how funding transfers will work in practice and which state funded mental health programs will be affected.

There is significant concern that people currently receiving support will no longer have access to these supports despite the principle of no disadvantage. There is no information about what effect the WA NDIS agreement may have on state funded carer/family support services. This uncertainty itself is a cause for concern.

Concerns have been raised in Queensland about outcomes for people with mental health issues currently supported through the Queensland Health funded Housing and Support Program (HASP) which has been identified as a defined program by the NDIA. Issues around the transfer of data to the NDIA has meant that approximately half of these clients are required to go through the application process as if they were a new participant. Many of the community mental health organisations that receive HASP funding and currently support these clients were only made aware of this issue in recent weeks. In addition, concerns have been raised by community mental health organisations on behalf of HASP clients reporting that NDIA assessors have not recognised HASP as a defined program and requested evidence of disability to support their applications. This has resulted in many of these clients receiving a reduction in support. A number of appeals against this outcome are being currently lodged.

In Tasmania, both levels of government have made a commitment to the 'principle of no disadvantage' through the bilateral agreement between the Commonwealth and Tasmanian Governments this commitment is to making sure that 'no one will be worse off' under the scheme. Where the NDIS does not fund a support previously received by a participant, or if a prospective participant is not eligible for the NDIS, the NDIA will identify alternative supports or refer the participant to other systems to ensure each person will achieve the 'same outcomes as a participant under the NDIS'. However, the experience in Tasmania has been that that people are already falling through the cracks as exiting services transition to the NDIS. Many services at both federal and state levels are being restricted to existing clients and closing down in stages during the transitioning period. Government guidelines direct services to concentrate their efforts on transitioning clients, which further restricts the diminishing resources needed to provide services.

In South Australia there are significant concerns about the large number of people experiencing mental illness who may not be eligible for NDIS support, as well as an unseen cohort of people who do not currently utilise existing mental health services. There are concerns about the ongoing availability of community-based psychosocial support services in SA where there is currently a lack of clarity about the ongoing funding post-NDIS implementation. If these community-based services are ceased, it is the

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belief that there is likely to be a significant increase in the level of severe and complex mental illness, people experiencing a mental health crisis and, in turn, presentations at emergency departments. A survey of Mental Health Coalition of SA (MHCSA) members showed that jurisdictions need to continue to fund existing mental health services at or around 98%, to avoid significant service gaps between mental health and disability over the long term. Further information on these issues is presented in a discussion paper by the MHCSA on community-based psychosocial rehabilitation, which is at Attachment B for the information of the Joint Standing Committee.

d. the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework;

Given the limited amount of funding available under the Information, Linkages and Capacity (ILC) building framework, and the fact that there is no quarantining for psychosocial disability and/or mental health, access to this funding will be highly competitive. Overall, ILC doesn't have the capacity to provide for the scope of what existing services deliver, and respond to the needs of people who won't be eligible for the NDIS.

It is likely that large organisations providing services to people with mental health conditions are considering tendering through building upon and/or establishing an evidence base for programs that they already run. The 'ineligible activity' guidance in the Program Guidelines for 'peak body activities, such as policy advice, advocacy or operational costs' requires clarification, as it is unclear if peak bodies, including but not limited to consumer and/or carer organisations, are able to apply.

The situation for understanding where mental health prevention, promotion and early intervention practice sits in an NDIS environment with parallel mental health sector reforms through PHNs is particularly complicated. The NDIS 'Applied Principles' state that rehabilitation is a health/mental health mainstream responsibility, however, psychosocial services and supports that build individual and/or community mental health and prevent psychosocial disability arising are known evidence based practice.[5]

As CMHA has stated in other parts of this submission, it is vital that states and territories continue to provide a well funded state or territory based mental health system for people with psychosocial disability regardless of the other reforms occurring.

e. the planning process for people with a psychosocial disability, and the role of primary health networks in that process;

As noted earlier, CMHA is concerned that the NDIA is moving away from face-to-face assessment and planning for people applying for the NDIS. This will have a significant impact on all people applying for the NDIS, but particularly people with any form of mental illness or cognitive impairment or disability, as it creates significant difficulties for communicating or assessing their level of need. Further for mental

[5] MIND and the University of Melbourne (2016). *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery:*

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health, which is typically episodic, having non-face-to-face assessment and planning creates difficulties in adequately assessing need and the person's circumstances.

Providers have suggested that having pre-planning assistance for consumers and allowing consumers to view their plan before it is finalised would be steps to address some of the problems occurring. The pre-planning phase is viewed as vital, and it is important that people receive information to help in the pre-planning phase, as many people are going to planning sessions unprepared and individuals don't always know what they can ask for or how to articulate their disability. The required information would include:

- What documentation is needed to support the assessment process?
- Guidance on how people can be thinking about goals and how their needs may change in future.
- Guidance on the types of services that are available.
- What services do they currently as compared to what is actually available?

The NDIA must play a role in ensuring such information is provided, but currently this is not occurring.

The following quote from a provider in the NT exemplifies the issues occurring with the planning process:

> The main issue affecting the majority of our clients is their failure to participate fully in discussions regarding transition to the NDIS as many struggle to fully understand the scheme. It is challenging to communicate all the aspects of the NDIS and build the understanding of clients regarding the assessment process, how they will access services and how they may be affected if deemed ineligible. To overcome these issues there is continuous engagement with the client with the support of their family members, however this can be a long and resource intensive process. Another issue is that our clients are very transient and some, despite all efforts, cannot be contacted.

A further raised has been planners being adequately experienced in mental distress. In order to be effective, planners need to have an understanding of psychosocial disability and mental illness, and the impact these have on the entire planning process and future needs of the consumers/ participants. This includes adopting a recovery framework to developing a plan and assessing people's needs. A provider of an Aboriginal and Torres Strait Islander service in the NT has also made the point that many of their clients have elements of post-traumatic stress disorder (PTSD) due to their cultural background, therefore an understanding of not just mental health but culturally relevant factors needs be a significant consideration.

As raised earlier, the plan review function is an important part of the overall planning process and must be sustainable now and into the future. Requests for amendments to plans triggering reviews which are done nationally and clients not being allowed to view plans before they are finalised, is creating inflexible processes and escalating administrative costs of the scheme.

The situation in WA is also creating uncertainty around the planning process. To date, no knowledge is available about which of the WA trial planning processes will apply to the WA NDIS roll out. The bilateral

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agreement indicates that a NDIS in WA will build on the lessons learned in NDIS trials[6] across the country, and that the Disability Services Commission (DSC) has been adamant about the purported benefits of its model, despite the evaluation of the two WA trials not being publicly released. Therefore it is important that the evaluation results of the WA trials be promptly released publicly to address concerns and fears arising from the uncertainty over the selection of a beneficial system; and that the lessons learned through the deliberate, proactive engagement and supported access and planning processes of the Perth Hills NDIS Psychiatric Hostels Project are actively applied in a WA NDIS.

The role of PHNs in planning, or indeed providing services as a part of the NDIS, will be significantly impacted by the types of services they are enabled to commission. The guidance documents developed to assist the PHNs includes the directive that PHNs cannot commission psychosocial services. It states they can promote links to broader services, recognising these services are vital, but they are not within their scope.[7]

The community-managed mental health sector will only have a role in the future of the PHNs if the PHNs are able to commission psychosocial services; and if they are able to be truly flexible; work with state, territory or local area health services; and act on the gaps that are shown through their planning processes.

f. whether spending on services for people with a psychosocial disability is in line with projections;

As noted earlier in this submission, CMHA has significant concerns with the overall transparency of how funding is being provided by governments at the federal, state and territory level to both the NDIS and state and territory community managed mental health services, including the general lack of information being made available by governments. This is creating difficulties in determining if spending for people with psychosocial disability is keeping in line with projections.

Cost shifting is occurring between the state and territory and federal governments. This includes the withdrawal of funding for state and territory funded mental health programs under the guise of this gap being addressed by the NDIS; inconsistency with state and territory governments not confirming future state and territory funding when they are or will be at full NDIS implementation; and the situation which occurred in the ACT with the 'estimate' for NDIS clients being reached but neither the ACT or Federal Government taking responsibility for the required funding shortfall.

There is particular lack of transparency in the bilateral agreements which provides no information on funding contributions or commitments by governments to both the NDIS and state or territory mental health programs and services. Having a stated guaranty of 'continuity of service' provides only assurances in word but not in actuality.

The lack of transparency in the bilateral agreements is exemplified by the situation in WA. There is a concern that in the context of increased financial risk to the WA government, as specified in the bilateral agreement, there will be an incentive to limit both the numbers of WA participants and total amount of

[6] Part 1, section 7

[7] Primary Mental Health Care Services for People with Severe Mental Illness. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Department of Health Australian Government.

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funded supports in WA NDIS plans. There is a risk that this will particularly affect people with psychosocial disability because of the challenges in meeting eligibility documentation requirements, and because many of those with the highest need will not be currently engaging with the service system and will likely remain so.

g. the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability; and

There is currently no outreach component in the NDIS and providers are concerned about how consumers who may be eligible for a plan will be engaged and supported to access NDIS. This is particularly concerning for the most vulnerable and disengaged people, such as from Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) communities and homeless groups.

Many people require considerable hours of outreach, engagement and functional assessment activities over an extended period of time to consider and make an NDIS access request. People with mental health conditions can be overwhelmed and/or distressed by the level of complexity that can sometimes accompany making an access request and therefore 'choose not to apply' or 'withdrew their access request'.

The systemic outreach process under the NDIS is not working for the following reasons:

- People can sometimes be difficult to reach and connect with.
- Phone calls can be an issue – consumers get a phone call from the NDIS, and because it's the NDIS the individuals say they aren't interested (don't realise it is part of the planning process or they don't answer their phone).
- Service providers can't be in contact with the individuals until the plan has been approved.
- Clinical services do not have the time to follow through and support consumers to access the NDIS.

Under the NDIS, there is no incentive for an organisation to persist with a client (if they are not at home or don't answer the phone) because work is not funded until they are engaged and in order to stay financially viable, service providers have to take this into consideration**.** There needs to be a strong recognition that there is sometimes a need for assertive and active outreach.

As discussed above, WA adopted assertive outreach in the two projects to engage people living in psychiatric hostels in the Perth Hills trial site. These proactive outreach projects have identified people with psychosocial disability likely to be eligible and supported them through trial processes to gain access to funded supports. The success of this project can be attributed to a sustained focus, proactive outreach model, staff skilled in understanding and engaging people with psychosocial disability, and collaborative engaged stakeholders.

Outreach will be a significant consideration in addressing the challenges in engaging Aboriginal people with psychosocial disability. Significant challenges exist in engaging Aboriginal people in disability services, particularly in remote areas, and there is a need for the NDIS to have a higher proportion of skilled Aboriginal workers.

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There is concern about engagement with and access to the NDIS for those people who experience social and geographic isolation in rural and remote regions of Queensland. Feedback from community mental health organisations is that these people are often hard to reach and generally not engaged with services due to lack of knowledge of the availability of services and supports. For many of these people experiencing mental health issues, access to appropriate and understandable information is challenging. In some rural and remote regions in Queensland, there are also concerns that there won't be adequate NDIS registered services available for people to purchase the supports and services that they need.

Experiences of the NDIS rollout on Palm Island and in some other Aboriginal and Torres Strait Islander communities have uncovered the importance of working with a community to identify tailored ways in which to support the transition utilising an outreach model. Identifying activities appropriate to the community, ensuring appropriate methods for measuring outcomes are employed, appropriately resourcing and acknowledging the importance of family supports are all important aspects of outreach that should be considered for many communities. Further, issues have been raised in the NT about using culturally appropriate and safe tools, planning and assessment for Aboriginal and Torres Strait Islander people, particularly addressing cultural and language differences so that people are not disadvantaged. This also applies to CALD communities.

The one size fits all approach to the delivery of NDIS information has not been particularly effective in terms of assisting the NDIA to reach their targets. A more tailored, thoughtful and patient approach, working with each community and drawing on their own strengths could have proved to me more effective in supporting people to engage with the NDIS.

h. the provision, and continuation of services for NDIS participants in receipt of forensic disability services;

There are currently no guidelines on when people who have been incarcerated or held in 24-hour facilities can or cannot be supported under the NDIS. Service providers are not funded under the NDIS to undertake visits, which is sometimes what people need, as consumers may have built up a strong relationship with their worker who cannot visit them in a facility.

i. any related matter.

- Develop 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 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.

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

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occurring in mental health is having an impact on the workforce in community-managed mental health sector including the pricing structures of the NDIS and the impacts on qualified staff.[8]

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.

- Develop quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact, with there seeming to be a misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. A model that includes community-based rehabilitation as a necessary part of a high functioning mental health system is essential. 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.

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.[9]

The VICSERV report 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.[10]

The September 2016 Intermediate Report of the Evaluation of the NDIS by the National Institute of Labour Studies, Flinders University found that in examining the available quantitative and qualitative data that while overall the NDIS trials had led to increased supports and improved outcomes, not all groups where seeing this improvement. Qualitative reports showed that a particular group of people experiencing poorer outcomes and lower levels of service were people unable to advocate for themselves, specifically people with psychosocial disability. Both the qualitative and quantitative data showed that people with mental health and psychosocial disability were more likely to report less control and choice since becoming NDIS participants.[11]

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[8] 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.

[9] 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.

[10] 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.

[11] Mavromaras, K., Moskos, M. and Mahuteau, S. (2016) Evaluation of the NDIS, Intermediate Report, September 2016. Adelaide: National Institute of Labour Studies, Flinders University.

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The Flinders University report also collected quantitative information on three measures of wellbeing: (1) psychological wellbeing; (2) Personal Wellbeing Index; and (3) sense of social connection. On all three measures NDIS participants with a mental illness or psychosocial disability recorded a mean measure of wellbeing significantly lower that for other disability groups.[12]

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 NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services. The initial findings of reports for psychosocial disability in terms of the services they are receiving and the impact this is having on their life are a cause for concern and issues around quality are a central aspect of this which must be addressed.

Summary Recommendations and Conclusion

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health illness. However, it is vital to ensure that the recovery focus of community managed mental health services continues, and that we don't create a situation where some people receive a high level of support and others do not. People living with a mental illness must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not.

There are a number of issues for CMHA that must be addressed by Government as a matter of urgency, as if not addressed the NDIS will continue to transition for mental health across the country, and they will become greater problems and lead to people living with a mental illness missing out on or losing services.

The key issues and recommendations for CMHA are:

- Implementing the recommendations of the NMHC to clarify the eligibility criteria for access to the NDIS for people with psychosocial disability, and for support for carers to be separate to the NDIS, not tied to the person they care for.
- CMHA has significant concerns with the gap in service provision that will be created with the transferring of funds for federally funded mental health programs from DoH and DSS for PIR, D2DL and PhaMs to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS. The Federal Government must continue to fund a flexible, low barrier to entry service that sits outside of the NDIS for people who need ongoing community and coordination support, and State, Territory and Federal Governments must take responsibility for and work together in genuine collaboration to ensure these people continue to receive 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. It is vital to ensure that mental health services are funded accurately through an appropriate mechanism. A central issue with the NDIS is the differences that are occurring between states and territories and the scheme being one of national consistency. The general guarantee in the bilateral agreements for continuity of support to people who are transitioning from existing services to the NDIS is being

[12] Ibid

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impacted at different levels with states and territories, and federally funded programs being removed or transitioning to the NDIS.

- 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. 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 limited amount of funding under the ILC building framework means that access to this funding will be highly competitive. The ILC doesn't have the capacity to provide for the scope of what existing services deliver, and respond to the needs of people who won't be eligible for the NDIS.
- Concerns that the NDIA is moving away from face-to-face assessment and planning for people applying for the NDIS, which will have a significant impact on all people applying for the NDIS, but particularly people with any form of cognitive impairment or disability. Further for mental health, which is typically episodic, having non-face-to-face assessment and planning creates difficulties in adequately assessing need and the person's circumstances.
- There must be pre-planning assistance for consumers; allowing consumers to view their plan before it is finalised; and having planners with an understanding of psychosocial disability undertaking planning for people with a mental health condition.
- That the evaluation results of the WA trials are released publicly to address concerns arising from the uncertainty over the selection of a beneficial system; and that the lessons learned through the proactive engagement and supported access and planning processes of the Perth Hills NDIS Psychiatric Hostels Project are actively applied in a WA NDIS.
- The role of PHNs in planning or indeed providing services as a part of the NDIS will be significantly impacted by the types of services they are enabled to commission. The community-managed mental health sector will only have a role in the future of the PHNs if the PHNs are able to commission psychosocial services; and if they are able to be truly flexible; work with state, territory or local area health services; and act on the gaps that are shown through their planning processes.
- The use or interpretation of the NDIS Act 2013 by the NDIA appears to be an area requiring examination. A review of the legislation is required as its interpretation is leading to implementation problems and escalating administrative costs with the scheme.
- Significant concerns with the transparency of how funding is being provided by governments at the federal, state and territory level to both the NDIS and state and territory community managed mental health services. This is creating difficulties in determining if spending for people with psychosocial disability is keeping in line with projections.
- There is currently no outreach component in the NDIS and providers are concerned about how consumers who may be eligible for a plan will be engaged and supported to access NDIS. There needs to be a strong recognition that there is sometimes a need for assertive and active outreach.
- WA adopted assertive outreach in two projects to engage people living in psychiatric hostels in the Perth Hills trial site. The success of this project can be attributed to a sustained focus,

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proactive outreach model, staff skilled in understanding and engaging people with psychosocial disability, and collaborative engaged stakeholders.

- Outreach will be a significant consideration in addressing the challenges in engaging Aboriginal people with psychosocial disability. Significant challenges exist in engaging Aboriginal people in disability services in remote areas in particular, and there is a need for the NDIS to have a higher proportion of skilled Aboriginal workers.
- The NDIA must identify tailored ways in which to support the transition of the NDIS utilising an outreach model, in particular for Aboriginal and Torres Strait Islander and CALD communities. Identifying activities appropriate to the community, ensuring appropriate methods for measuring outcomes are employed, appropriately resourcing and acknowledging the importance of family supports are all important aspects of outreach that should be considered for many communities.
- There are currently no guidelines on when people who have been incarcerated or held in 24-hour facilities can or cannot be supported under the NDIS.
- A key piece of policy work that is required is an examination of the overall workforce in mental health, including the community mental health sector. 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.
- The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact. 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 NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services.

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Attachment A – Summary information provided by state and territory peaks

Mental Health Community Coalition (MHCC) ACT

Update on Partners in Recovery (PIR) in the ACT is an expected 63 people who won't have an NDIS package by the time the service is scheduled to close on 30 June.

Some of the MHCC key concerns include:

- Access processes which are very bureaucratic and causing people to give up.
- Difficulty of collecting evidence of disability.
- Actual wait for access decisions for people with psychosocial disability (PSD) commonly up to 180 days.
- No consistency in plans for people with PSD, either in terms of dollar size or supports.
- Inability to amend plans without a full review, even if the issue is clearly a mistake.
- Lack of clarity about which supports are NDIS funded and which are considered Health services. This appears to be a factor in the inconsistency in plans.
- Lack of capacity to deliver sound psychosocial rehabilitation and recovery-focussed supports within the NDIS framework. The focus on core supports in plans appears to be driven by price. People with PSD have a higher need for support coordination and capacity-building supports.
- Lack of contingency in plans for crisis situations or rapid escalation of support needs due to a mental health episode.
- Lack of supports for carers in plans.
- Limited access to respite under NDIS leading to stress for participants and pressure on carers.
- Inability to sustain a skilled and qualified workforce on the current NDIS Pricing Framework.
- Lack of consideration for back office costs, training and development, supervision, etc. in NDIS pricing framework.
- Providers cross-subsidising NDIS services from block-funded services.
- Risk of market failure in coming months due to providers withdrawing from NDIS service delivery in part or full, or withdrawing from providing services to agency management participants.
- Portal problems causing providers and participants to not be paid for services delivered, incurring debts and losses.
- Constantly changing rules, processes and advice leading to difficulty in planning and delivering services.
- Extremely poor communication from NDIA leading to uncertainty and opportunity costs.

Mental Health Coordinating Council NSW

- If you currently provide a Partners in Recovery (PIR), Day to Day Living (D2DL) or Personal Helpers and Mentors Service (PHaMS) funded service, what is your estimated number of people with psychosocial disability currently in these programs who won't be eligible for the NDIS?

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There has been no sector wide evaluation of this in NSW due to the very large numbers of Commonwealth mental health program clients. Some organisations delivering these programs have audited their client case load and report that only 30% may access NDIS. While Hunter NDIS trial site experience demonstrates that this seems to be growing with time, experience and a growing understanding of the evidence required to support access.

In total, MHCC estimates that we are looking at a minimum of 6,000 people with mental health conditions in NSW being potentially disadvantaged through NDIS implementation. Some further background information used to cautiously calculate this figure is below:

- 6,000 estimate allows for 80% of PIR clients and 30% of PHaMS clients accessing the NDIS and is believed to be an underestimate.
- PIR (NSW capacity of about 7,000 clients in 15 catchments across three years) – NDIS access rates for the Hunter trial site PIR were initially very low at just 20-30%. Over time, these have reportedly increased to about 80%. This required a lot of functional assessment activity by both PIR and the Hunter New England Mental Health Service to gather sufficient evidence to support NDIS access (40 to 60 hours per person). PIR in Western Sydney also report early success with NDIS access and this has required using brokerage funding to engage private occupational therapists to undertake functional assessments across an average of 120 hours of combined functional assessment work. If 80% of all NSW PIR clients do access NDIS funded support this would leave around 1,400 people in need of another service (this target is likely ambitious.
- D2DL (capacity unknown; although understood that some capacity indicators were added into recent contracts) – NDIS access rates consistently reported at about 20-30% with this figure growing as people learn about sufficiency of evidence required.
- PHaMS (capacity of about 6,000 per annum as per the 'Community Mental Health Program – Summary Data 2014-15' available on the DSS website: https://www.dss.gov.au/our-responsibilities/mental-health/publications-articles) - access consistently reported at around just 20-30%. If 30% of all NSW PHaMS clients do access NDIS funded support this would leave around 4,200 people in need of another service.
- DSS's Community Mental Health Program Data 2014/15 also informs us that about 8,000 people in NSW benefit from the Commonwealth funded Mental Health Respite: Carer Support (MHR: CS) program which is also in-scope for the NDIS. Whether this is families/carers and/or clients is unclear to MHCC. NDIS impacts on this program in the trial site have been difficult to ascertain due to a late commencement of this program site.

An issue related to the above regards the lack of access to data outside of and/or across state and Commonwealth government departments to help manage change occurring through NDIS implementation and other mental health sector reforms being implemented through Primary Health Networks.

MHCC wrote to the National Disability Insurance Agency (NDIA) CEO about our concerns in October 2016 and this correspondence included a request access to data: http://www.mhcc.org.au/media/85835/bowen_ndia_ndis_nsw_letter_20161024.pdf. The NDIA has since replied seeking permission to table our letter for discussion with DSS, the Commonwealth

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Department of Health and the NDIS Actuary as the issues described are broader than just the NDIA. MHCC has agreed to this occurring there and elsewhere, as required.

Furthermore, there appear to be issues related to how the NDIA and/or DSS are measuring access. 'Key Data on Psychosocial Disability and the NDIS as at 30 June 2016' reports that 78% of participants with a psychosocial disability submitting an access request have been found to meet the access requirements for the scheme: https://www.ndis.gov.au/NMHSRG-October-2016.html If Commonwealth mental health program clients - and other vulnerable and marginalised people who have difficulty navigating sometimes complex NDIS access processes – were deemed ineligible as they 'choose not to apply' or 'withdrew their access request' then we believe the access statistics would be much lower and more insightful about the experiences that people with mental health conditions are having.

- Do you currently receive state or territory government mental health funding? If so, will you still receive this after the NDIS reaches full scheme in your area? Will you still be able to provide services to people with psychosocial disability ineligible for the NDIS through state or territory funding?

Yes. The NSW Ministry of Health continues to fund mental health programs delivered by the community sector. This is a mixture of discrete program streams introduced from around 2000 onwards, 'ad-hoc' grants and Ministerial Grants. This is a complex set of arrangements that are currently undergoing reform through the 'Partnerships for Health' initiative (including the introduction of contestable tendering). The state government intends to rationalise and grow community sector delivered programs over time although NSW is approaching this from a basis of being one of the least funded non-government sectors across jurisdictions.

Current NSW Ministry of Health programs are:

- The Housing and Accommodation Support Initiative (HASI)
- Recovery and Resource Services Program (RRSP; being subsumed through HASI retendering with a shift to more flexible individualised 'care packages')
- Family and Carer Mental Health Support Program.

The NSW Ministry of Health is establishing the following new programs:

- Enhanced Adults Community Living Supports - increase the level of community living supports to help a further 500 adults across NSW recover and transition to a quality life in the community (HASI enhancement in the direction of individual and flexible funding approaches)
- Pathways to Community Living Initiative – this is a coordinated state-wide approach to supporting 430 people with enduring and serious mental illness who have been in hospital for more than twelve months to, wherever possible, re-establish their lives in the community. The initiative is part of the NSW government's commitment to strengthen mental health care in NSW by developing effective community-based residential care and support options for people experiencing long stays in mental health inpatient units.

NSW will not likely withdraw these programs as the NDIS scales up but they will not be sufficient to address unmet population mental health need for people ineligible for an NDIS individual funded

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package. Furthermore, it seems that the NSW Ministry of Health program focus will be increasingly aligned to people most at risk for psychiatric hospitalisation.

- Do you intend to apply for funding under the NDIS Information, Linkages and Capacity Building framework? If so, what types of programs will you apply to receive funding for?

MHCC will not be applying for funding to deliver Community Inclusion and Capacity Development (CICD) programs toward implementing Information, Linkages and Capacity Building (ILC) through the National ILC Sector Readiness Grants currently at tender. Most large organisations that provide service delivery to people with mental health conditions indicate that they are considering tendering for CICD/ILC through building upon and/or establishing an evidence base for programs that they already run. From a mental health perspective there appear to be opportunities as these relate to:

- Consumer run services and programs (i.e., including but also moving beyond peer work).
- Prevention, promotion and early intervention.

The situation for understanding where mental health prevention, promotion and early intervention practice sits in an NDIS environment with parallel mental health sector reforms through PHNs is particularly complicated. This is because the NDIS 'Applied Principles' state that rehabilitation is a health/mental health mainstream responsibility, however, psychosocial services and supports that build individual and/or community mental health and prevent psychosocial disability arising are known evidence based practice.[13]

At a 9 February MHCC Member Meet Up Forum where we consulted on this NDIS submission we were reminded that many frontline workers are still striving to understand what an NDIS individual funded package is let alone the ILC which is still in a developmental place.

Furthermore, the 'ineligible activity' guidance in the CICD/ILC Program Guidelines for 'peak body activities, such as policy advice, advocacy or operational costs' require clarification. Does this mean that peak bodies, including but not limited to consumer and/or carer organisations, are unable to apply? Given the limited amount of funding available and the fact that there is no quarantining of the psychosocial disability and/or mental health spend this will be an intensely competitive ILC field.

- Have you had to actively seek out clients with psychosocial disability to apply for the NDIS?

No. However, many require considerable hours of outreach, engagement and functional assessment activities over an extended period of time to consider and make an NDIS access request. People with mental health conditions can be overwhelmed and/or distressed by the level of complexity that can sometimes accompany making an access request and thus 'choose not to apply' or 'withdrew their access request'.

- Have you had involvement with clients with psychosocial disability undergoing the planning process for the NDIS? If so, what has been your experience of this process?

[13] MIND and the University of Melbourne (2016). *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery:*

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Yes. People with mental health conditions usually require considerable pre-planning activity and /or a supporter to negotiate the planning and review process. As with access people with mental health conditions can be overwhelmed and/or distressed by the planning and review processes. Telephone based planning does not work in supporting people with mental health conditions and several face-to-face meetings may be required to complete a plan. The 'My First Plan' approach disadvantages NDIS eligible Commonwealth mental health program clients who are typically inadequately funded against their needs in comparison to NSW Family and Community Services (FaCS) Ageing, Disability and Homecare (ADHC) clients who are a priority in NSW transition. MHCC member advise is that the Local Area Coordinator planning roles (through SVDP and Uniting) are not well skilled for mental health/psychosocial disability practice and that acquiring this skill set has been challenged by the ambitious transition targets that they are being asked to meet.

NT Mental Health Coalition

Northern Territory Context

Health services in the Northern Territory are provided in the context of unique geographic and demographic factors. The Northern Territory Department of Health has described some of the challenges these factors present to the delivery of services; including:

- The NT Department of Health covers 1.35 million square kilometers, much of which is sparsely populated and has a high portion of Aboriginal people.
- The NT population is ageing and experiences high levels of chronic disease and co-morbidities, especially in the Aboriginal population.
- Over 43% of the NT population reside in remote or very remote areas. There are over 600 communities and remote outstations in the NT, all with varying degrees of people and families' numbers with limited access to services.
- Social and economic disadvantage has particular links to remoteness and the lack of services.
- In 2015 – 16, NT hospitals received 3,282 admissions with mental health diagnosis.
- Coalition members report that the lack of a uniform electronic patient information system across the Northern Territory health system contributes to a 'clunky' coordination of care.
- While Indigenous people constitute 30% of the NT's population, Indigenous people represent 43% of all consumers assisted by community-based (non-inpatient) mental health services and 52% of admissions to mental health inpatient facilities.
- The NT recorded the highest imprisonment rate in Australia, at 958.1 prisoners per 100,000 adult population in the March Quarter 2016. This is 4.7 times the national rate of 204.7 prisoners per 100,000 adult population.
- During the March Quarter 2016, the Northern Territory Aboriginal and Torres Strait Islander imprisonment rate was 3,025.2 per 100,000 adult Aboriginal and Torres Strait Islander population. This is 29.4% higher than the national Aboriginal and Torres Strait Islander imprisonment rate of 2,337.6 prisoners per 100,000 adult Aboriginal and Torres Strait Islander population.

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Members Perspectives

Uncertainty and a lack of detailed information around the rollout of the NDIS were common themes to emerge from surveys and interviews with the Coalition's members.

Coalition member organisations that work within a recovery and rehabilitation model contend that the Federal Government must continue to fund a flexible, low-barrier-to-entry service, such as PIR, D2DL and PHaMS. These services are effective in supporting people who need ongoing community-based care and coordination support. The flexibility of these programs has ensured that consumers and their carers have a wrap-around service that is suitable for their families and communities.

Coalition members are also adamant that the provision of services under the NDIS for people with psychosocial disabilities align with the principles of the current policy and practice frameworks:

a. A National framework for recovery-oriented mental health services: guide for practitioners and providers
b. Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014
c. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice
d. United Nations Declaration on the Rights of Indigenous Peoples
e. Principles of Aboriginal Community Control Health Organisations
f. Primary Mental Health Care model

Many Coalition members have raised concerns about the financial sustainability of service delivery within NDIA's current pricing model. This is of particular relevance for organisations that deliver services in regional, remote and very remote areas, where service costs are significantly higher.

Members report that NDIS is posing significant strain on small to medium services that do not have resources to redevelop organisational systems and structures to operate sustainably within a market-based service economy. There is a concern that this will result in organisation closures and lead to a market of larger, one-size-fits-all service organisations, reducing quality of services and limiting choice for consumers - especially those living in very remote communities.

The Bilateral Agreement between the Commonwealth and Northern Territory for the transition to an NDIS recognises the risk of service failure in remote communities, where there are thin or non-existent markets, including limited supply and very low demand for services. The agreement also states that the NDIA is responsible for ensuring provider of last resort services are in place for all participants in the NT, where other services are not operational. Member organisations report a lack of detailed information around what 'provider of last resort' options might look like in practice, causing angst throughout the sector.

The Coalition and its members are working with the Northern Territory Primary Health Network (NT PHN) to ensure equity and continuity of services and programs continue for consumers. PHNs across Australia have been directed by the Federal Government not to commission psychosocial services, however programs transferred to the NT PHN routinely involve psychosocial services. The inability of

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PHN's to fund psychosocial services will thus produce a gap in servicing the support needs of NT communities.

The Coalition members are concerned that the National Disability Insurance Agency (NDIA) is moving away from face to face assessment and is excluding carers and interpreters for clients applying for the NDIS. This has a significant impact on people living with psychosocial disability. In some cases, the NDIA Planners are reported to have inadequate understanding of psychosocial disability and have underestimated or overlooked key areas of support required by the clients.

In the Northern Territory, member organisations and carers report that consumers are having difficulties in effectively articulating their ongoing needs during the assessment process. NDIA assessors have reportedly had difficulty in understand people with psychosocial disability, particularly in the areas of;

a. Understanding episodic or chronic psychosocial disability
b. Understanding of services/programs before the NDIS commenced
c. Understanding of carers roles and the value-add that carers provide

The NDIS has highlighted that the scheme is for people living with a psychiatric condition, who have significant and permanent functional impairment. Those at greatest risk of being ineligible for a NDIS package are people living with the most common psychosocial disabilities including post-traumatic stress disorder, anxiety, depression and intergenerational trauma.

Under the National Disability Insurance Agency (NDIA) clients are required to provide evidence of a diagnosis of their psychosocial disability from a professional clinician i.e. Psychologist. This type of specialist service is not readily available in most remote areas, with significant waiting periods existing for most consumers within the public health system.

Indigenous people are significantly over-represented both in the NT prison system, and in accessing community mental health services. Coalition members are concerned by this correlation and by existing restrictions on access to non-inpatient mental health services for prisoners in the NT.

VICSERV – Consultation on Joint Standing Committee on the NDIS mental health inquiry

Transition to the NDIS

Funding

- The Federal Government is pushing risk to the service providers, forcing service providers to shift the risk to consumers just to remain financially viable. This goes completely against the value system of the service providers
- Continuity of service to consumers is a concern to providers. The date when an individual has their plan approved is the date from which funding will be removed – if a client refuses to acknowledge continuity of service or confirm that they would like to continue with the same service provider – claims to the NDIA for services won't be paid, leaving service providers out of pocket.

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Types of services

- During transition, organisations are unable to provide the same breadth and quantity of services that they were previously offering (e.g. groups) and it is uncertain whether they will be able to continue to offer them under the NDIS. All funding dependent.

Engagement pre-planning

- There are people who we have dealt with in the past who are eligible for the NDIS but we can no longer make contact with them as we no longer have funding to put resources in to engaging with them.
- There is no outreach component in the NDIS and providers are concerned about how consumers who may be eligible for a plan will be engaged and supported to access NDIS. This is particularly concerning for the most vulnerable and dis-engaged people, such as from indigenous, CALD and homeless groups.
- One provider estimated that one third of those who could be eligible will not access ongoing supports. One service provider gave an example of trying to support one of their clients who was incarcerated and needed to be assessed. It took them 20 hours (unfunded) before they could gain access.
- The risk is that providers may turn away 'complex' clients if there are out-of-pocket costs associated.
- During the trial period for the NDIS in the ACT – the ACT government put funding towards pre-planning but it was just a one-off payment - these type of pre-engagement activities proved successful in supporting access to the scheme.

Service Gaps

Service gaps have been identified for the following groups:

- Families and carers: currently a lack of a defined role – no recognition about how they are a valuable part of the process
- Clients over 65 – not clear yet about how can they be supported
- Refugees and people on restrictive visas
- CALD communities - VCOSS commissioned research with the CALD communities to understand how they are experiencing the NDIS – the overwhelming response was that they don't understand the system and that advocacy and support services during the planning process can be really beneficial
- Outreach services with Aboriginal and homelessness groups shows success usually only when there is an LACs with particular engagement skills or specific background.
- Peer support workers – currently not recognised in the scheme – although the peer worker workforce is of great value, and is growing
- Independent advocates for compulsory treatment:
    - Advocates are needed for people who don't have a key worker at the moment and who can attend the planning sessions with them
    - There is an obligation under the Convention on the Rights of Persons with Disabilities that there is properly funded advocacy

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Scope and level of funding for mental health services under the ILC framework

- LAC / ILC will not have the resources or capacity to deliver what existing services do
- Mental health continues to be overlooked particularly in relation to the ILC funding
- There is currently no real benefit to mental health services from ILC because the funding is so minimal - there are insufficient funds for providers to be able to deliver adequate services to respond to the needs of people with mental health issues who are not eligible for NDIS. The consultation group agreed that the responsibility for providing services to those not eligible for NDIS should rest with the State Govt.

Planning process for people with a psychosocial disability, and the role of primary health networks in the process

Systematic process needs to be developed to ensure effective planning

- Assessment and Planning meetings should be held face-to –face not over the phone
- It is important that people get information to help in the pre-planning phase because currently a lot of people are going to sessions unprepared and individuals don't always know what they can ask for or how to articulate their disability
- This kind of information includes:
  - What documentation is needed to support the assessment process
  - Guidance on how people can be thinking about goals and how their needs may change in future
  - Guidance on the types of services available
  - What services do they currently get versus what is actually available?
- There is an NDIA role in letting people know what to think about before a planning session –this isn't happening at the moment
- The review function is important to ensure that it will be reasonable and sustainable into the future
  - There are incidents where people don't know what they are going to get until the plan is submitted – and there is currently no opportunity to take time to consider the plan before it is finalised. Then, if it turns out that the plan is not working for them they need to go through a lengthy appeal process
  - A suggested solution for better management of assessment and planning for people needing psychosocial disability supports was to establish a LAC with specialist Mental Health focus.

Need for planners to understand psychosocial disability and mental illness

- In order to be effective, planners need to have an understanding of psychosocial disability and mental illness, and the impact these have on the entire planning process and future needs of the consumers/ participants.
- NDIA indicates that this is an issue that can be dealt with further down the track but if a planner doesn't know what is needed or really understand the depths of a person's disability the package developed won't suit

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Consideration of the recovery framework

- Consumers realise that they will have to be thinking about their worst day when they are in a planning meeting. But if they are having a good day – they may not realise what they need in a couple of weeks when they actually do need something.
- Planning and decision – episodic reliance on carers and supports
    - Factor this in when planning is being undertaken
    - Carers and supports may want to go through that process separately because of the dynamic or stigma that exists in the relationship
- There is also some concern that people are rejecting the money they are being offered because they don't they don't relate to the term *permanent disability* and so believe the NDIS is not what they need – this language of disability confuses consumers who are used to 'recovery' language. The community mental health sector has worked hard to promote a recovery-oriented emphasis, and the concept of 'permanent disability' counteracts this.

What role will PHN's play?

- Currently, no flexibility in what they can commission
- NDIS mental health guidelines need to change to enable them to commission PHNs for psychosocial disability
- Good communication between the Commonwealth and the PHN's is not happening currently

The role and extent of outreach services to identify potential NDIS participants with a psychosocial disability

- The systemic outreach process under the NDIS is not working:
    - People can sometimes be difficult to reach and connect with
    - Phone calls can be an issue – consumers get a phone call from the NIDS, and because it's the NDIS the individuals say they aren't interested (don't realise it is part of the planning process or they don't answer their phone).
    - Service providers can't be in contact with the individuals until the plan has been approved
    - Clinical services do not have the time to follow through and support consumers to access the NDIS
- Under the NDIS, there is no incentive for an organisation to persist with a client (if they are not at home or don't answer the phone) because work is not funded until they are engaged and in order to stay financially viable service providers have to take this into consideration
- There needs to be recognition about the fact that there is sometimes a need for assertive and active outreach
- Support coordination
    - Pays at a slightly better rate
    - Some organisations are appointing finance managers to meet with clients in the initial stages of engagement -until they have the package in place and they can pay for the time with the support-co-ordinator.
    - There have been some issues with client / carer control – one individual hasn't had a full service for 6 months because of challenges in working through the carer.

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- Needs to be ongoing service because it gives carers and families a break from the tasks they may otherwise have to do.
- Families and carers should have the flexibility to take on a greater support role when they can
- Scheme design needs to include consideration of what families and carers need

- Individuals who are in out of home care
  - Navigating a system on their own with no other support resource available to them

The provision and continuation of services for NDIS participants in receipt of forensic disability services

- Individuals that are incarcerated in 24 hour facilities:
  - Service providers not funded under the NDIS to undertake visits, which is sometimes what people need – consumers may have built up a strong relationship with their worker who cannot visit them in the correctional facility.
  - People in prison who may not receive any visitors need that relationship to continue as part of their recovery
  - People who are being released need support during and after the transition

- There are currently no guidelines on when people who have been incarcerated can / cannot be supported under the NDIS
  - Need a clear process acknowledging individuals who have a mental health issue / need medication / support services who are going into incarceration

Workforce

- Victoria is unique as the funding for community mental health workforce is not being continued – i.e. the community mental health workforce will no longer exist, instead a disability support workforce will be in place.
- Support coordination / or taking people out to activities – needs a level of trust that is built up over time
- The system doesn't allow for that trust to be built up due to a more casualised, contract workforce and changing staff.
  - The system now supports rotating support workers where rosters change and different people are assigned
  - Overlooking what recovery requires – which is heavily based on relational work
- Families and carers will end up playing a role that is currently played by support workers – which is unpaid
- Workers safety
  - Clients previously seen by 2 staff (for safety reasons) are now only being seen by one - to manage costs
  - This increases level of risk for staff and risk of WorkCover claims for organisations
- There needs to be the inclusion of an appropriate assessment framework within the NDIS
  - Insurance model risk framework is currently being used which doesn't suit the psychosocial disability support service

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- Hourly rates in the pricing structure demonstrates the lack of understanding of the level of workers' skill and expertise to deliver psychosocial disability supports
- Functional impairment assessment process should be developed to drill down into what is required with the supports and then provide a support worker with the associated qualification level
- Behavioural assessment needs to be done before support coordination can be provided to ensure the right supports are provided

- Service providers need to take a big leap into an unknown – take commercial risks:
  - how much do you invest in employing full time staff
  - bigger organisations will be able to manage the risk more than the smaller organisations that provide more specialised services
  - Even if the workforce is there, the organisations still need to be financially sustainable to support that workforce
  - Specialist capabilities will be lost when the lever of price controls what services will be required and can be provided over a long period of time

Roles of carers

- Some Carers are struggling to cope with the new system:
  To understand the new system
  To understand the new language of disability and of the NDIS
  To mediate between the different players in the system
- There have been instances where participants have not received their full entitlement of supports because planners have made assumptions based on what supports carers and families are already providing. They have not offered for these supports to be funded even if it would have been the preference of the participant
- Some carers are feeling like they are receiving more – but their loved one is actually purchasing a different type of support, that is cheaper
- Some individuals are experiencing knock backs from their usual service providers because they are not in a position to provide the services as the workforce is not ready yet – because the services are quite different to what was originally provided
- Some carers are stepping in to "self-manage" because they feel that is the only option
  - Some carers are skilled and knowledgeable but others don't understand the award rates / costs etc.
  - However, also there have been carers taking on the package who decide after a period of time that it was too much and too challenging (for example, accessing the portal is difficult)
  - Even people who have experience in running their own business have found it difficult to deal with the NDIA
- Some carers have identified that their biggest anxieties are around plans that exist but aren't being accessed because of misunderstanding about what the plan is
  - This then falls back on the carers who have to play the mediator between the planner / service provider and the individual – but they are still not recognised through the NDIS

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EXAMPLES

Transition to the NDIS

Example 1

NDIS people with psychosocial disability will begin roll-out next year in Moreland – current thoughts and concerns that are arising:

- Engagement with consumers raises concerns about those who are not eligible and/or choose not to be eligible – what will happen for them / how can they be supported
- Evolution of the organisation fitting in with the NDIS – how do we see it working: potentially active day programs with groups, given the previous success and popularity of the group programs
- Need to take a risk with selecting what group the organisation thinks participants want and then put it out into the competitive market
- Needing to work out how many people are needed to make a group financially viable under the NDIS pricing structure, then decide that it's what people want and take that risk, competing in the market that is evolving

Example 2

- NDIA doesn't have the right processes or people in place to allow the transition to adequately fit with the pre-engagement activities that had been implemented
- DHHS has funded an organisation in NEMA to provide preplanning engagement – the organisation has found that the engagement activities sometimes have the effect of raising the clients hopes and expectations that then falls down when the client crosses over to work with NDIA during the planning process

Example 3

- A trial in Barwon assisting people with early transition has found that the NDIS has been really good with their marketing, providing a broad stroke picture of the scheme
- However, how that is translating to families and individuals – they have positive expectations built up through the marketing but the service providers find that its then up to them to explain the actual details of the packages that have been received
- The NDIA are good at reframing how the NDIS impacts groups of people but, at the individual level, it's been difficult to engage NDIA or for the carer to follow up and get package details

Example 4

- There is now very little continuity with the services being provided - new services are being created and the old ones ended
- The date when an individual has their plan approved is the date funding is stopped to the services that they were receiving – if a client refuses to acknowledge continuity of service or confirm that they would like to continue with the same service provider – claims to the NDIA for services won't be paid leaving service providers out of pocket

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- It is estimated that the transition arrangements for 600 MHCSS consumers will leave one organisation $800,000 out of pocket

Example 5

Peer worker service gaps:

- There is currently no specific line item for peer work which leaves a big gap for workers and participants
- In the NEMA region, consumer participation has been valuable and important – including the participation of consumers on committees etc. – it is difficult to see how this can continue to work under the NDIS meaning that a valuable input will be lost
- Need more opportunities to include this

Scope and level of funding for mental health services under the ILC framework

- Experience with the LACs is very variable and comes down to the individual
- Some staff in the LACs have been proactive in assisting people, making efforts to follow up and do outreach, but some other under the same LAC do not make the same effort
- Many in the consultation supported the idea that even though Psychosocial disability falls under the NDIS, there is still a need for a separate state mental health community rehabilitation service in Victoria

Planning process for people with a psychosocial disability, and the role of primary health networks in the process

Example:

- There have been incidences where individuals are being referred from disability services because they have a mental health need
- However, a lot of them have had the planning discussion with NDIA over the phone – by the time they come in they are confused and have no idea what the planning document is about
- Some are then protective of their plans and do not want to discuss it with the service providers

Workforce

- Mind's Consumer choice and control project results indicate that choice and control is being constrained:
    - Example: an individual said she was too anxious to change providers and didn't do so until she built enough confidence - which was after 3 years
- Consumers that understand the quality of service and constraints of the system ensure that control and choice is there, but the consumers often don't have the understanding, resulting in huge levels of stress for individuals

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Western Australian Association for Mental Health (WAAMH)

WAAMH's contribution focuses on the differences of the WA NDIS arrangements and the issues and concerns that have arisen in WA trials. It does not address Commonwealth matters such as eligibility and transition of Commonwealth funding programs.

1. **Term of Reference C: the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;**
    i. **whether these services will continue to be provided for people deemed ineligible for the NDIS;**

To date, no details are available about whether existing state mental health and disability service funding will contribute to the funding of the WA NDIS.

Further, there is a lack of clarity about how the WA NDIS will interact with state service systems including how funding transfers will work in practice and which state funded mental health programs will be affected.

There is significant concern that people currently receiving support will no longer have access to these supports despite the principle of no disadvantage. The bilateral notes in Schedule E state that:

> 4. The Parties agree that continuity of support will apply for people resident in an area or cohort that is transitioning to the NDIS if:
> a. they receive support but do not meet the NDIS access requirements set out in the State legislation, or are receiving supports that do not meet the definition of reasonable and necessary support in the State legislation; and
> b. the funding for this support is attributed to a program/service that will cease when the NDIS in WA is introduced.

We also do not yet know what effect the WA NDIS agreement may have on state funded carer/family support services. This uncertainty itself is a cause for concern.

2. **Term of Reference E: the planning process for people with a psychosocial disability;**

To date, no knowledge is available about which of the WA trial planning processes will apply to the WA NDIS roll out.

We note that the bilateral agreement indicates that a NDIS in WA will build on the lessons learned in NDIS trials[14] across the country, and that the Disability Services Commission (DSC) has been adamant about the purported benefits of its model, despite the evaluation of the two WA trial not being publicly released.

<u>Recommendations:</u>

- That the evaluation results of the WA trials be promptly released publicly to address concerns and fears arising from the uncertainty over the selection of a beneficial system.

[14] Part 1, section 7

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- That the lessons learned through the deliberate, proactive engagement and supported access and planning processes of the Perth Hills NDIS Psychiatric Hostels Project, which have resulted in funded plans for 110 people with psychosocial disability living in psychiatric hostels, are actively applied in a WA NDIS.

3. **Term of Reference F: whether spending on services for people with a psychosocial disability is in line with projections;**

At 30 June 2106 11% of NDIS participants in the WANDIS had psychosocial disability listed as their primary disability,[15] and it was the second most common primary disability for new individuals entering the scheme in the previous quarter (23%).[16] Based on data from the Commonwealth trial sites nationally 37% of participants with a primary or secondary psychosocial disability have more than one disability listed.[17]

The Productivity Commission estimates that when fully rolled out 14% of participants with psychosocial disability will benefit from the scheme nationally.[18]

The compiled table below compares WA NDIS figures with those for Commonwealth trials. Figures as at 30 June 2016.[19]

	Total number of participants	Number of participants with psychosocial disability as **primary** disability	% of participants with psychosocial disability as **primary** disability	% of total number of participants who identify as ATSI
WA NDIS	2399	264	11%	4%
Commonwealth trial in WA	2494	175	7%	5%

[15] Disability Services Commission. (31 Jul 2016, p.5). Quarterly Report to the Commonwealth Government June 2016. Government of Western Australia.
[16] Disability Services Commission. (31 Jul 2016, p.14). Quarterly Report to the Commonwealth Government June 2016. Government of Western Australia.
[17] National Mental Health Sector Reference Group. (Oct, 2016). National Mental Health Sector Reference Group Sector Communiqué – October 2016. Attachment A - Key Data on Psychosocial Disability and the NDIS as at 30 June 2016. Australian Department of Human Services.
[18] National Disability Insurance Agency. (10 Oct 2014). Nearly 700 people with psychosocial disability are part of the NDIS. Media release. Australian Government.
[19] Commonwealth trial figures from National Disability Insurance Agency. (Jun 2016, p.34). Quarterly Report to COAG Disability Reform Council 30 June 2016. WA NDIS trial figures from Disability Services Commission. (31 Jul 2016). Quarterly Report to the Commonwealth Government June 2016. Government of Western Australia.

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Commonwealth trial NSW (Hunter)	7805	859	11%	7%
Victoria	5284	740	14%	2.6%
Commonwealth trials all Australia	30,281	2,120	7%	6%

Note: these figures are not strictly comparable: WA NDIS figures are for all individuals who are accessing WA NDIS with a current approved plan, plus individuals found eligible who do not yet have an approved plan. Commonwealth figures are for individuals with approved plans only.[20]

Although the 11% in the above table represents progress, WAAMH remains concerned that due to the demanding targets for scheme access during the trials, combined with insufficient targeted outreach, these figures are likely to mainly include those people with psychosocial disability that are already accessing services.

At 30 June 2016, only 439 people with psychosocial disability had accessed the NDIS in WA. Without genuine targeted engagement, those consumers experiencing the most disadvantage, such as transitory people with a history of chronic under servicing, will have substantial difficulties accessing the scheme.

WAAMH has received varying feedback from stakeholders about the consistency and adequacy of funded supports for people with psychosocial disability both within and across the two Western Australian trials.

Feedback from providers, consumers and carers has emphasised the difference that supported access and planning processes, and in many cases family or independent advocacy, makes to whether someone is found eligible for the scheme. The feedback also reports the difference supported access and planning processes (or lack thereof) makes to the type and amounts of funded supports in plans that are approved.

WAAMH is concerned that in the context of increased financial risk to the WA government, as specified in the bilateral agreement, there will be an incentive to limit both the numbers of WA participants and total amount of funded supports in WA NDIS plans. There is a risk that this will particularly affect people with psychosocial disability because of the challenges in meeting eligibility documentation requirements, and because many of those with the highest need will not be currently engaging with the service system and will likely remain so.

Recommendations:

- WA NDIS establishes a target of 6,000 people with psychosocial disability accessing the scheme, to include a specific focus on those people with limited access to existing supports.

[20] Disability Services Commission. (31 Jul 2016, p.5). Quarterly Report to the Commonwealth Government June 2016. Government of Western Australia.

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- WA NDIS establishes specific processes, staffing and practices to best engage people with psychosocial disability, including peer workers, specific funded projects, and capacity building of consumers and carers.

4. Term of Reference G: the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability;

The Productivity Commission estimated that 6,000 people with psychosocial disability would access NDIS funding in WA. In Western Australia, WAAMH and its members remain concerned that this target of 6,000 will not be met.

In particular, WAAMH and its members are concerned that the most disadvantaged people with psychosocial disability will remain without supports. This includes those people that have been historically chronically under-supported, in receipt of very limited or inappropriate services, and/or had challenges in engaging with the service system. Many of these consumers need supports the most, yet are the hardest to engage, increasing the likelihood that they will remain without access. Details about how the WA NDIS will engage these people have not yet emerged.

WAAMH has received feedback indicating concerns held by many mental health consumers, carers/families and community managed mental health organisations about DSC's capacity to understand and respond effectively to people with psychosocial disability, and its openness and commitment to developing this knowledge and skill set within the organisation and its staff.

WAAMH and its members have noted limited and inconsistent engagement between the WA trials and the Mental Health Commission, the Department of Health and its services, and other health agencies. This has been a barrier to the program's implementation including to engaging some potential participants with psychosocial disability.

A notable exception has been the two projects to engage people living in psychiatric hostels in the Perth Hills trial site. These proactive outreach projects have identified people with psychosocial disability likely to be eligible and supported them through trial processes to gain access to funded supports. The NDIS psychiatric hostels project has achieved high rates of eligibility, with funded plans for 110 of 180 hostel residents. The success of this project can be attributed to a sustained focus, proactive outreach model, staff skilled in understanding and engaging people with psychosocial disability, and collaborative engaged stakeholders.

Challenges in engaging Aboriginal people with psychosocial disability are even more pressing. The WA NDIS roll out will commence in the Kimberley and Pilbara in July 2017, with Goldfields commencing in July 2018. These areas have WA's largest Aboriginal populations and some of its most remote communities. Significant challenges exist in engaging Aboriginal people in disability services in these areas; there is a need for a WA NDIS to have a higher proportion of skilled Aboriginal workers than DSC currently has. Due to the late announcement however, engagement has not yet begun, nor has the community managed organisational readiness required to ensure service availability and suitability, and the meeting of NDIS objectives of choice and control.

<u>Recommendations:</u>

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- The WA NDIS pursues improved integration, collaboration and coordination across the WA NDIS and WA health, mental health, disability, housing and justice systems. This should include proactive engagement between these agencies to ensure those at most disadvantage access the scheme.
- Specific outreach projects to engage people with psychosocial disability in the scheme to assist in meeting the targets are funded and implemented; these should build on successful NDIS engagement of people living in psychiatric hostels in the Perth Hills, utilise peer models and be co-produced with people with psychosocial disability.
- An increased Aboriginal workforce and funded, outreach projects to engage Aboriginal people with psychosocial disability; these should incorporate Aboriginal community, Elder and organisational co-design, and culturally secure implementation.

5. Term of Reference I: any related matter.

ii. WA Bilateral arrangements

On 1 Feb 2017, the Commonwealth and Western Australian Governments signed a bilateral agreement for a nationally consistent but state-run NDIS with the transition to begin on 1 July 2017. This scheme is referred to as WA NDIS.

The scheme will be delivered by a new WA NDIS authority and will be governed by a seven-member independent WA Board. The WA Board and authority's responsibilities will be set out in state legislation which will mirror the national legislation. People will enter the scheme between 1 Jul 2017 and 30 June 2020 based on a geographic roll out.[21]

The bilateral agreement and WA roll-out map is available at: http://www.disability.wa.gov.au/wa-ndis-my-way/wa-ndis-my-way/

The Bilateral and associated announcements provide little to no details about how the WA NDIS will engage people with psychosocial disability. There is an immediate need for close collaboration with stakeholders that have expertise in psychosocial disability, including consumers, carers/families and community managed organisations, at all levels from on the ground to governance.

Recommendations:

- The WA NDIS Board includes a member with expertise in psychosocial disability.
- The WA NDIS integrate consultation and genuine co-design mechanisms with people with psychosocial disability.

iii. Scheme costs

To date, no details are available about whether existing state mental health and disability services will contribute to the funding of the WA NDIS.

[21] Barnett, Hon, C. & Faragher, Hon, D. (1 Feb 2017). Joint media statement - Governments sign bilateral agreement on local delivery of NDIS in WA. Government of Western Australia.

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The WA-Commonwealth bilateral agreements set out cost arrangements unique to Western Australia. These include:

a. WA contributing 59.4 per cent of care and support package costs for an agreed number of eligible participants each year for the transition period. The Commonwealth would contribute the remaining 40.6 per cent for care and support package costs.
    - Comment: this is in keeping with other state and territory agreements

b. WA and the Commonwealth would equally share the cost of all non-package related costs for information, linkages and capacity building supports and local area co-ordination.
    - Comment: this is in keeping with other state and territory agreements

c. WA funding 100 per cent of the administration and operating costs of the agency and any Board or Advisory Council established under WA legislation.
    - Comment: in all other jurisdictions the Commonwealth funds all administration costs

d. WA funding 59.4 per cent of care and support package costs for non-Indigenous participants who turn 65 and Indigenous participants who turn 50, and choose to remain in the scheme, until such time that WA agrees to implement changes to roles and responsibilities in line with the National Health Reform Agreement 2011, including arrangements for cross-billing, budget neutrality and administration responsibility for over 65's in aged care and disability services transferring to the Commonwealth
    - Comment: this is different to other jurisdictional agreements. For example, in the NSW Heads of Agreement point 34 "the Commonwealth bears full funding responsibility for non-Indigenous people over 65 and Indigenous people over 50 who choose to stay in the Scheme as per the National Health Reform Agreement [rather than moving to the aged care system]".[22]

e. The Commonwealth funding a maximum of 25 per cent of the risk of any increase in costs associated with higher than expected participant numbers or higher package costs, with WA funding the remaining 75% risk.
    - Comment: in all other jurisdictions, the Commonwealth will fund cost overruns at a higher rate. For example, in NSW Commonwealth is committed to always assuming a minimum of 75% of risk, and conversely NSW is committed to assuming no more than 25% of risk for client support costs [23]

f. WA being responsible for managing the upfront cash flow risks of the agency in delivery of the WA delivered NDIS model.

[22] Commonwealth of Australia & the State Government of New South Wales. (6 Dec 2012). Heads of Agreement between the Commonwealth and NSW Governments on the National Disability Insurance Scheme.
[23] Commonwealth of Australia & the State Government of New South Wales. (6 Dec 2012). Heads of Agreement between the Commonwealth and NSW Governments on the National Disability Insurance Scheme.

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g. The Commonwealth and WA equally sharing any savings due to lower than expected participant numbers and/or lower package costs. This will occur through a reversal of the funding mechanism available in other states, in that the Commonwealth will provide funding in arrears based on actual participants that have transitioned.

WAAMH is concerned that the higher burden of risk to WA associated with higher than expected scheme costs provides an incentive to a WA NDIS to keep scheme costs down through reduced new entrants to the scheme and tighter plan costs. We are further concerned that people with psychosocial disability who are not accessing services, are transitory, or challenging to engage will be most vulnerable to these cost pressures.

iv. Scheme readiness

WAAMH is aware that across the state there is significant variation in scheme readiness for community managed mental health services especially, but not limited to, those in rural and remote regions.

The challenges in scheme readiness have been compounded by the late announcement of the WA NDIS arrangements, resulting in extremely limited lead time in many areas. The tight timeframes for scheme roll out and high targets for scheme access are problematic in the context of WA's geography, limited services in remote areas, and diverse populations.

The lack of readiness could result in limited services options, especially in rural and remote areas and those in regions due for 2017-2018 roll out.

Recent consultation with WAAMH members in rural WA identified major concerns about the implications of the NDIS for the community mental health workforce in rural and remote areas. Concerns include the lack of preparedness and readiness for the NDIS, uncertainty associated with the implementation of the NDIS for clients and agency funding, the impact of the NDIS upon staff and agencies and concerns about the role of Disability Services Commission and the DSC Local Coordinators who are seen to lack understanding and insight into psychosocial disabilities.

Agency managers and coordinators see that the NDIS will demand different types of work and require new skills and capabilities from the workforce, however they are concerned that there has not yet been any substantial investment in training and workforce development for the community mental health sector, particularly in non-trial sites and in rural and remote areas where access to training and workforce development opportunities is already limited.

From its involvement in the NDIS Workforce Development Project[24], WAAMH is also aware of concern about the impact of the NDIS pricing structures upon the workforce. Concerns identified in the Report include that funding and pricing structures do not make allowance for induction, training, and workforce development; that agencies may have to back away from minimum workforce qualifications because they can't afford to pay salaries to attract and retain that level of worker; there is little margin for non-direct

[24] Mental Health Australia, Community Mental Health Australia and NDIS (2015) *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project,* October 2015.

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service work in pricing structures and the difficulty of remaining faithful to the recovery model while deploying staff within the pricing structures.

v. The inclusion of lived experience and mental health specific expertise in design, implementation and governance

Members have experienced limited knowledge and understanding of psychosocial disability amongst DSC and its staff. In this context, WAAMH is concerned about the lack of consultation with people with psychosocial disability and their carers/families about the governance model.

Given the critical differences in how people with psychosocial disability and the community managed mental health sector engage with the NDIS there is a need for greater involvement of their expertise in the governance, design and implementation of a WA NDIS.

vi. A separate state-delivered scheme

Without publicly available information, such as the evaluation of the WA trials, to substantiate its benefits, our stakeholders have some concerns about a state-delivered model. These include the inherent inconsistency in WA having a state-run scheme which, in addition to the matters already raised, increases the complexity of future reviews and adjustments to the NDIS Australia wide; and the risk to a state-based scheme should there be any change in priorities of a WA government.

Attachment B

Discussion Paper:
Community-based Psychosocial Rehabilitation: A Casualty of the National Disability Insurance Scheme?

Executive Summary

The Mental Health Coalition of South Australia has, and will continue to advocate for holistic support for those experiencing mental illness. This support should encompass services that provide clinical treatment, community psychosocial rehabilitation services and disabilities support. The National Disability Insurance scheme provides opportunity to enhance support in the disabilities services sector, an area often under serviced for those experiences severe and complex mental illness that results in disability. However, There is documented concern about the large number of people experiencing mental illness who may not be eligible for NDIS support, as well as an unseen cohort of people who do not currently utilise existing mental health services. Furthermore, concerns exist as to the ongoing availability of community psychosocial support services in South Australia where currently a lack of clarity about the ongoing funding upon NDIS implementation exists. If these services are ceased it can be proposed we will see a significant increase in the level of severe and complex mental illness, people experiencing mental health crisis and in turn presentation at emergency departments. The following discussion paper outlines the key concerns for the Mental Health Coalition of South Australia surrounding the transition and roll out of the NDIS and provides the following recommendations to ensure the South Australian Government upholds its commitment as outlined in the bilateral agreement to continuity of service:

1. Recognising the need to ensure balanced investment in a three-part system for mental health services and disability support for people with severe mental illness through clinical treatment, psychosocial rehabilitation and disability support.
2. Continuing to retain on-going funding at the same level in community-based rehabilitation regardless of the percentage of consumers who get access to NDIS. This will maintain continuity of access for people with mental illness to this important part of the mental health system.
3. Working with consumers, carers and NGO service providers to establish a comprehensive and timely transition planning process for the mental health component of NDIS.
4. Advocating to the Commonwealth to continue providing rehabilitation services (such as PHaMS, Mental Health Respite: Carer Support, Day to Day Living etc) regardless of how many people gain access to NDIS. Reduced funding of these services will result in poorer mental health for people with severe illness and increased need for crisis and acute care services provided by the State.
5. Advocating for support for consumers to access NDIS beyond the transition period.
6. Increasing investment in psychosocial rehabilitation programs if the Commonwealth withdraws funding to current programs in the transition to NDIS.

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Discussion

In Australia it is estimated that 1 in 5 people will experience some form of mental ill health each year (Australian Institute Health & Welfare (AIHW) 2016). In 2014–2015 approximately 18.3% of the South Australian population reported experiencing a long-term mental health or behavioural problem (ABS, 2015).

The Mental Health Coalition of South Australia is committed to advocating for a holistic approach to mental wellness in South Australia. This commitment includes a desire for those experiencing persistent and severe mental illness to have access to appropriate mental health treatment, community based rehabilitation and disability support to achieve recovery in ways that are meaningful to the individual.

The National Disability Insurance Scheme (NDIS), at full implementation is designed to have capacity to support 12% of those experiencing severe mental illness (O'Halloran, 2016). The National Mental Health Commission (NMHC) has defined severe mental illness as 'a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning' (NMHC 2014). Those experiencing this level of mental ill health have been characterised by three sub groups:

- **Severe episodic**: individuals who have discrete episodes, interspersed with periods of remission (about two-thirds of the overall severe population).

- **Severe and persistent illness**: individuals with chronic mental illness that causes major limitations on functioning (i.e. very disabling) and is chronic without remission over long periods. This group represents about one-third of the overall severe population.

- **Severe and persistent illness with complex multiagency needs**: this group represents those with the greatest disability among the severe population and who require significant clinical care (including hospitalisation), along with support to manage most of the day-to-day living roles (e.g. housing support, personal support worker domiciliary visits, day program attendance) (NMHC, 2014).

Those who do not fit these subgroups and are experiencing episodic or chronic (persistent) conditions, not confined to specific diagnostic categories with both severe disability and those who have complexities that are not disability-related (e.g. chronic physical illness, high suicide risk, require coordinated care etc.) are considered to be experiencing severe and complex mental illness (NMHC, 2014). Severe mental illness may result in either, or both psychiatric disability (impairment in one or more areas of functioning, such as occupational, academic and social) and psychosocial disability (effects that impair or restrict functioning, capacity think clearly, physical health and social emotional activities and relationships). (Hayes et. al. 2016; National Mental Health Consumer & Carer Forum 2011; Stein et al. 2010).

For those experiencing mental illness WHO recommends the implementation of:
'… community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; the continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers and the promotion of self-care, for instance, through the use of electronic and mobile health technologies' (WHO, 2013, p.14).

The concept of a sector built primarily on community mental health services is reflected in the current National Mental Health Policy (2008) which aims to ensure consumers are supported via a variety of connected services ranging from primary health care and acute mental health services through to

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community mental health services delivered by both the government and non-government sectors (FNMHP, 2009-2014; NMHP, 2008; Whiteford & Buckingham, 2005). With clients' needs being the focus of service delivery, the national goal is 'for people with mental health problems and mental illness to have access to the right care at the right time', and for services to be provided in a manner that places prevention and early intervention as a priority for sustainable recovery outcomes (FNMHP, 2009-2014; NMHP, 2008). This was based on people having access to an inter-connected sector including acute, clinical, and community services. This was evaluated against a downward spend trend in stand-alone psychiatric institutions and increased funding to general hospital mental health beds, community mental health services and non government mental health services. Reports show that in South Australia this transition was slow, with only approximately $2m or 1.7% of South Australian Mental health funding allocated to NGO delivered community based services in 1992-1993 rising to $3m in 2002-3 (National Mental Health Report, 2013). To the credit of the SA Government this increased to 9.5% in 2007-2008 and 11.5% in 2012-13. In the last two years this has declined alarmingly with the defunding of programs such as Intensive Home Based Support and Crisis Respite (Mackay & Goodwin-Smith, 2016; National Mental Health Report, 2013). This is in contrast to the literature that shows that consumers supported by systems built on collaborative, integrated community services, with rehabilitation elements have notably better recovery outcomes and quality of life than those treated in institutional care (Anderson et al. 2000; Carter, Burke & Moore, 2008; England & Lester, 2005). Evidence has also shown the importance and value of good quality acute and clinical based care where required (Mansell, 2005). We would argue that this demonstrates that effective mental health support must address three core areas - clinical treatment, community based rehabilitation and disability support - and that these areas must be linked to the mainstream health, mental health, housing and other social health services people need (Mackay & Goodwin-Smith, 2016).

The Productivity Commission estimates that under the proposed NDIS model, only 60,000 of the 489,000 people identified as experiencing a serious mental illness will qualify for a NDIS package of support based on the proposed criteria requiring to prove a 'permanent impairment', or more specifically in the mental health context, a 'serious and persistent mental illness with complex interagency needs' (Mental Health Council of Australia, 2013, p.01; Productivity Commission, 2011).

The Mental Health Council of Australia (MHCA) have proposed that, while not all 489,000 people estimated to be experiencing mental illness will require a package, the qualification criteria is confusing and will result in a large number of people who require support being excluded from accessing individualised packages (2013). Furthermore, the Productivity Commission's (2011) estimate that only 10% of those who qualify will require the most intensive levels of support has been noted by MHCA to underestimate the level of need for support and the complexity of mental health issues (MCHA, 2013). Concern has also been raised with regard to consumers who will not qualify for individual funding and their continued access to existing services and supports (which have been noted to already be insufficiently coping with demand), given the expected reduction in service funding to accommodate expenditure for the NDIS model (MCHA, 2013).

To underline the complexity, note must also be made of a potential 'unseen' cohort of people who may require access to mental health services, the NDIS and psychosocial rehabilitation programs. Eddie Bartnik (2016) noted that at existing roll out sites the NDIA have found that a reasonable proportion of people (an estimated 50%) entering the NDIS with a psychosocial disability are "new", that is, not currently known to the mental health system. Given that of the estimated 7.3 million Australians aged 16 to 85 experiencing mental illness less than half will access specific mental health treatment (Morgan, et. al. 2011), this is not surprising, and suggests the Productivity Commission's target of 60,000 people with severe mental illness to qualify for an NDIS package may be a significant underestimate of need. If service options are decreased to fund the Scheme and the Scheme is unable to provide packages to these people, we will see increased crisis, and detrimental effects to people's lives.

In 2010 three in ten people with a psychotic illness were recipients of a non-government mental health

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service and 6,200 people were engaged solely with a non-government organisation (NGO) (Morgan et. al. 2011). These organisations are the primary providers for community-based rehabilitation programs in the mental health sector. Unlike disability focused services which aim to reduce impairment, activity restrictions and participation limitations through assisting with daily living, community inclusion and other social and physical requirements (Department for Communities and Social Inclusion (DCSI) 2016), rehabilitation programs are aimed at 'recovery, improving independent functioning and reducing disability through education, support and individual recovery plans' (Morgan et. al. 2011). Almost a quarter of people with a psychotic illness in 2010 had utilised an NGO group rehabilitation program and one third of people had participated in community rehabilitation programs, with a majority of these reporting the programs as beneficial to their recovery journey (Morgan et. al. 2011).

The NDIS model, underpinned by consumer directed care, provides those with disabilities with an annual individual funding sum from a central government agency to 'purchase' a variety of government and non-government specialist services of their choice (Davis & Gray, 2015; MHCA, 2014). The scheme is based on the World Health Organisation International Classification of Functioning, which defines disability as 'a consequence of a health condition or changes to bodily structures that lead to impairment, activity restrictions and participation limitations' (Hayes et. al. 2016; O'Halloran, 2016). Available policy and literature states that the scheme will offer psychosocial disability support only where impairment impacts on functioning in communication, social interaction, learning, mobility, self-care/management and economic participation (Hayes et. al. 2016, O'Halloran, 2016). This suggests the NDIS will be focused on reducing restrictions to activity, via supports with daily living, community inclusion and other social and physical requirements not on rehabilitation to reduce impairment (Hayes et. al. 2016, O'Halloran, 2016). Thus the Mental Health Coalition of South Australia argues that based on available literature the NDIS will clearly provide a disability support focus. This is of significant concern, not only for those that will be ineligible for any NDIS support but for those that require psychosocial rehabilitation in addition to disability services to achieve their recovery goals and maintain meaningful mental wellness.

The Mental Health Coalition of South Australia consistently advocated that people experiencing mental ill health may also require coordinated support for their social health needs. In addition to this mainstream support, as people with severe mental illness gain and maintain a higher levels of wellness they can get their needs met through primary health and mental health care services (general practitioners, psychiatrists, psychologists, nurses, allied health professionals, pharmacists, Aboriginal health workers, etc). There is, however, an undeniable percentage of people that are able to get their health and mental health care needs met in primary care settings but also require community based rehabilitation and/or disability support. Unless the Commonwealth changes its approach there will be a decline in access to community based psychosocial rehabilitation support as part of the transition to the NDIS and consequently we would predict increasing frequency of crisis and mental ill health for individuals and their families. In addition there is likely to be an increase in complex presentations in other community services such as housing, employment and education. It is not clear what the SA Government response will be to this impending crisis.

The South Australian mental health sector has historically provided support through two of the three key elements required for an effective mental health system, clinical treatment and community psychosocial rehabilitation services. The Mental Health Coalition of South Australia supports and applauds the Commonwealth and South Australian Governments for their intent to improve disability support for people with a long-term disability as a result of severe and persistent mental illness. This is an area that has traditionally been poorly serviced in South Australia (Mackay & Goodwin-Smith, 2016). People with mental illness as the primary diagnosis have historically had little support for their disability needs from both disability services and the mental health system. The NDIS will reduce this need in relation to restrictions impeding activity and participation. Despite the stated intent for the NDIS to work in partnership with clinical treatment and psychosocial rehabilitation, however, it is evident that the transition in both funding and policy is shifting the core system elements from a clinical treatment, community rehabilitation focus to a clinical

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treatment and disability support focus. This loss of psychosocial rehabilitation and gain in disability support will again result in ineffective, unbalanced system and the increasing risk of increasing mental ill health within our community (Mackay & Goodwin-Smith, 2016). This will also be compounded by decreased funding and access to early intervention and prevention focused programs.

It would appear that neither the Commonwealth nor the South Australian Government intended to reduce the availability of community based psychosocial rehabilitation services to fund the full implementation of the NDIS. Yet, with the agreements to transition mental health program funding to provide NDIS packages it has become evident that, unless there is a significant change in approach, governments will dramatically reduce access to rehabilitation support in the community resulting in loss of service, especially for those who don't meet the NDIS eligibility criteria. Notably, Commonwealth programs such as Personal Helpers and Mentors Service (PHaMs) and Partners in Recovery (PIR) appear destined to no longer be available, and the future of South Australian services including Individual Psychosocial Rehabilitation and Support Services (IPRSS) and a range of other programs remains unclear. The Primary Health Networks have been charged with the local planning and commissioning of services however the Commonwealth Department of Health guidance appears to specifically exclude community-based psychosocial rehabilitation programs. Unfortunately, therefore, the NDIS will, in improving disability support needs, do so at the expense of community-based rehabilitation.

This approach to funding NDIS is particularly disappointing given the strong evidence base for community-based rehabilitation, in partnership with treatment services, being effective and efficient in assisting people with severe and persistent illness reduce the disabling impacts of mental illness. Research undertaken by Mackay & Goodwin Smith (2016) in South Australia consolidated concerns that the NDIS will not accommodate all people experiencing mental ill health, in particular concerns for those that will not be eligible for a package. The Department of Social Services (DSS) and the NDIA have stated they believe access criteria for NDIS and PHaMS in particular are similar (Invitational Round Table on Mental Health and the NDIS 2016; NDIS Access Workshop 2016) and therefore concerns about eligibility are unfounded. Evidence in trial sites clearly shows a range of access from very few to many. This reflects unease within South Australia about the lack of clarity around if or how psychosocial services for those outside of NDIS will be funded, as well as growing concern about availability for rehabilitation style support services for those that do receive NDIS funding (Mackay & Goodwin-Smith, 2016).

Some jurisdictions have agreed to the complete defunding of all psychosocial rehabilitation programs. Some jurisdictions have alternatively proposed that dollars should follow people. That is, if for example, 25% of people currently engaged in a mental health funded program are eligible for NDIS then 25% of funding should be transitioned to the NDIS. Whilst the second approach is clearly better, both approaches will create a significant gap in continuity of care for those experiencing mental ill health, via reduced availability of community psychosocial rehabilitation support to those who become unwell in the future. Analysis of data collected by the MHCSA in 2016 gives insights into the scale and growth of the gap in services, if jurisdictions proceed with either of the aforementioned funding transition scenarios**.** The MHCSA survey asked NGO mental health service providers to state the number of participants in their programs during the 2015/2016 financial years and to estimate the number of those who would be likely to be eligible for NDIS using the definition of "a life-long disability caused by a mental illness". Responses were received from 11 organisations over 15 programs meaning that the numbers derived from the survey underestimate total numbers and any projections can therefore be considered conservative. Although likely eligibility for NDIS is estimated, there is a concerning reality that a significant number of people may no longer receive, or have access in the future to community based psychosocial rehabilitation services upon full implementation of the NDIS.

Responses for State funded programs reported a total of 2,985 participants with 606 or (20%) estimated as potentially eligible for NDIS, thus, 2,379 people estimated to be ineligible.

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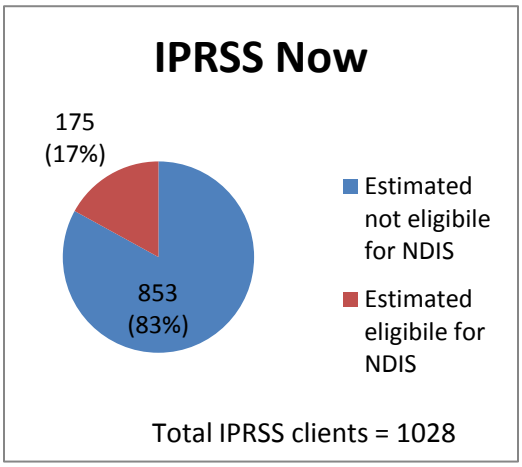
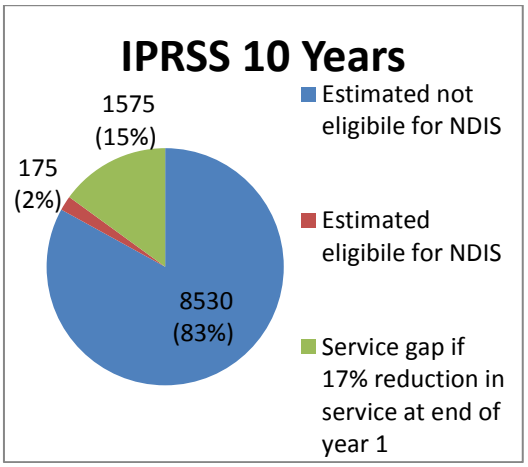
Responses for Commonwealth funded programs reported a total of 4,012 participants with an estimated 967 or 24% likely to be eligible for, leaving an estimated 3,045 people ineligible for NDIS.

If both state and Commonwealth funded psychosocial services cease, this could result in a total of 5,424 people without access to services, and 1,573 NDIS participants without access to rehabilitation type support options. Projections over time further compound the detrimental impacts of this for people with severe mental illness.

For example: If the IPRSS program continues at the current level of funding it will deliver community-based rehabilitation to 10,280 people over 10 years (assuming 12 months average length of service). If IPRSS funding is reduced by 17% (equivalent to estimated access rates to NDIS), this looks like a reasonable approach in the first year. NDIS numbers, however, are not projected to grow except in line with population growth. This means that over every subsequent year there is a gap of 173 people per annum that will no longer have access to the reduced IPRSS service or to NDIS. Reducing total funding by 17% would result in a gap over 10 years of *1,557 people who will receive neither IPRSS services nor NDIS.*





The impact of the loss of Commonwealth funded programs upon full implementation will similarly result in major loss of access to service for many people with severe mental illness. As with State mental health programs, the Commonwealth programs are designed as relatively short term interventions and so the projections demonstrate an increasing gap over time of people who will lose access to service. Based on our sample, if Commonwealth programs are completely defunded from services available in South Australia, in the first year 3,045 people will be looking to the State Government for services, and this will grow annually.

Although we have been unable to source reliable throughput data for Commonwealth programs, it is our understanding that a reasonable estimate for PHaMS program is that participants on average receive support for 12 months. Using this estimate, over a ten year period the PHaMs program would support 17,000 people. Therefore, defunding of this service over a 10 year period means creating a gap 17,000 people who will not be able to access an effective self-referral psychosocial rehabilitation service.

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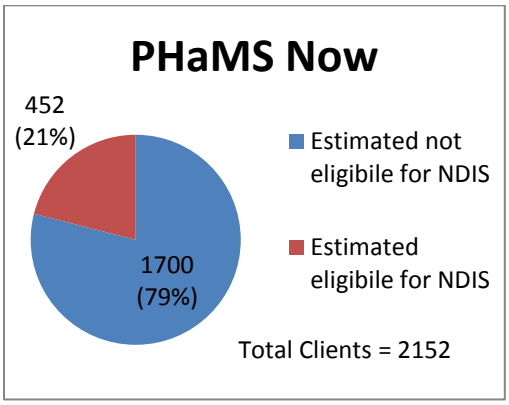

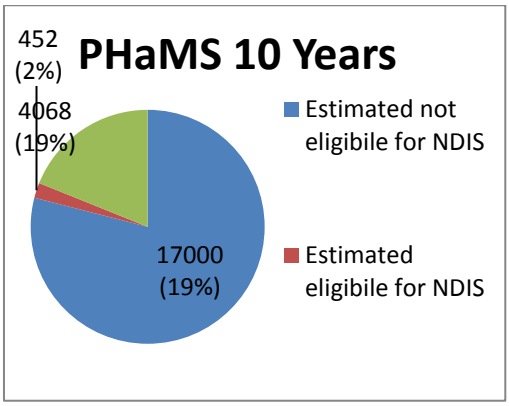

Given that funding guidelines for PHaMs, Mental Health Respite: Carer Support and PIR have all been changed to require programs participants to be potentially NDIS eligible, these programs have become transition vehicles for NDIS rather than providing services to the population originally intended. There is an urgent need to review this imminent gap in service. It can only be assumed, that without both Commonwealth and State funded psychosocial programs we will only see an increase in the levels of mental ill health and crisis experienced by individuals and in turn, increased pressure on remaining NGO programs and other parts of the mental health system including acute care and emergency departments. This cohort of people without a service will begin on 1st July 2017.

The Commonwealth has stated that they will support people with mental illness through the transition. The value of this guarantee however is tempered by the change in criteria of Commonwealth mental health programs such as Personal Helpers and Mentors (PHaMS) and Partners in Recovery (PIR) to target people who are likely to meet the criteria for entry and to support clients into the NDIS. Whilst there are valid reasons for this change, it will also mask the extent of the service gap that will open up as these programs are defunded as we move to full transition to NDIS.

The Mental Health Coalition of South Australia applaud the SA Government's intention to continue to care and support those people requiring mental health services who will not be eligible for NDIS (Minister Snelling, 2015; Bi-lateral Agreement).

There remains however ongoing concern about the lack of clarity on how these assurances will be implemented in practice.

There is a risk that vital mental health services may be defunded, wholly or in part, thereby reducing access for people experiencing mental ill health to psychosocial rehabilitation services.

Recommendations

It is evident that if funding to psychosocial rehabilitation services during the transition to NDIS is reduced, this will adversely affect the ability of thousands of South Australians with severe mental illness to manage their illness. This will result in poorer quality of life for individuals and increasing reliance on acute and crisis services. This will also impact on other community services and families to provide additional supports.

Both the SA and the Commonwealth Governments have given assurances that people will not be disadvantaged by the transition to NDIS.

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Giving effect to these assurances needs urgent attention as from 1 January 2017 people in SA will start to be able to test their eligibility for NDIS. South Australians with severe mental illness and their families need assurances that they will continue to have access to high quality community-based rehabilitation services whether eligible for NDIS or not.

These recommendations were developed with input from mental health stakeholders at our Mental Health Leaders Forum on November 24 2016.

The Mental Health Coalition of South Australia therefore recommends that:

The South Australian Government upholds its commitment as outlined in the bilateral agreement to continuity of service by undertaking the following:

1. Recognising the need to ensure balanced investment in a three-part system for mental health services and disability support for people with severe mental illness through clinical treatment, psychosocial rehabilitation and disability support.
2. Continuing to retain on-going funding at the same level in community-based rehabilitation regardless of the percentage of consumers who get access to NDIS. This will maintain continuity of access for people with mental illness to this important part of the mental health system.
3. Working with consumers, carers and NGO service providers to establish a comprehensive and timely transition planning process for the mental health component of NDIS.
4. Advocating to the Commonwealth to continue providing rehabilitation services (such as PHaMS, Mental Health Respite: Carer Support, Day to Day Living etc) regardless of how many people gain access to NDIS. Reduced funding of these services will result in poorer mental health for people with severe illness and increased need for crisis and acute care services provided by the State.
5. Advocating for support for consumers to access NDIS beyond the transition period.
6. Increasing investment in psychosocial rehabilitation programs if the Commonwealth withdraws funding to current programs in the transition to NDIS.

References

Anderson, J, Dayson, D, Wills, W, Gooch, C, Margolius, O, O'Driscoll, C & Leff, J 1993, The TAPS Project, Clinical and social outcomes of long-stay psychiatric patients after one year in the community, *British Journal of Psychiatry*, 162, Supp. 19, 45-56

Australian Bureau of Statistics (ABS) 2015, *National health survey: First results, 2014-15*, ABS cat. no. 4364.0.55.00, Canberra

Australian Institute of Health and Welfare (AIHW) 2014, *Mental health services in brief 2014,* cat. no. HSE 154. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW) 2016. *Mental health services in brief 2016*, Cat. no. HSE 180 Canberra: AIHW

Bartnik, E 2016, Invitational Roundtable on Mental Health and the NDIS, 12th October, Adelaide

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Carter, M, Burke, T & Moore, S 2008, C*ase studies in deinstitutionalisation: Implementing supported housing programs in two Australian states,* Institute for Social Research, Swinburne University of Technology, Victoria

Commonwealth of Australia*, Bilateral Agreement between the Commonwealth* and South Australia for the transition to an NDIS*,* Commonwealth of Australia*,* Canberra

Davies, K & Gray, M 2015, '*Mental health service users' aspirations for recovery: examining the gaps between what policy promises and practice delivers'*, British Journal of Social Work, Vol. 45, No.01, pp.45-61

Department for Communities and Social Inclusion (DCSI) 2016), *Disability Services Officers (Support Workers*), DCSI, Government of South Australia, South Australia, http://www.dcsi.sa.gov.au/careers/recruitment-programs/disability-services-officers-support-workers

Department of Health and Ageing 2013, *National mental health report 2013: tracking progress of mental health reform in Australia 1993-2011,* Commonwealth of Australia, Canberra

Department of Health, *Fourth national mental health plan 2009-2014*, Commonwealth of Australia, Canberra

Department of Health, *National mental health policy 2008*, Commonwealth of Australia, Canberra

Department of Social Services (DSS) 2016, Invitational Roundtable on Mental Health and the NDIS, 12th October, Adelaide

Department of Social Services (DSS) 2016, NDIS Access Workshop, 30th November, Melbourne

England, E & Lester, H 2005, 'Integrated mental health services in England: a policy paradox', *International Journal of Integrated Care*, Vol.5, No.04, pp.1-8

Hayes, L, Brophy, L, Harvey, C, Herrman, H, Killackey, E and Tellez, J 2016, *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery*, The Centre for Mental Health, Melbourne School of Population and Global Health, Victoria

Mackay, T & Goodwin-Smith, I 2016*, Mental Health: Exploring Collaborative Community Reform in South Australia,* Australian Centre for Community Services Research*,* Flinders University*,* South Australia

Mental Health Council of Australia (MHCA) 2013, *Mental Health and the National Disability Insurance Scheme position paper*, Mental Health Council of Australia, Canberra

Morgan V, Waterreus A, Jablensky A, Mackinnon A, McGrath J, Carr V, Bush R, Castle D, Cohen M, Harvey C, Galletly C, Stain H, Neil A, McGorry P, Hocking B, Shah S & Saw S 2011, *People Living with Psychotic Illness*, Commonwealth of Australia, Canberra

National Mental Health Commission, 2014, *Contributing Lives, Thriving Communities, The* National Review of Mental Health Programmes and Services, Sydney

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National Mental Health Consumer & Carer Forum 2011, *National Mental Health Consumer and Carer Forum Position Statement on Psychosocial Disabilities Associated with Mental Health Conditions*, National Mental Health Consumer and Carer Forum (NMHCCF) Steering Committee on Psychosocial Disability, Canberra.

O'Halloran, P 2016, *About Psychosocial Disability and the NDIS, Introduction to the Concept of Holistic Psychosocial Disability Support,* Mental Health Australia

Productivity Commission 2011, *Disability care and support,* Report no. 54, Commonwealth of Australia, Canberra

Snelling, J 2015 (Minister for Health, Minister for Mental Health & Substance Abuse, Minister for the Arts, Minister for Health Industries), *Letter to the Mental Health Coalition of South Australia*, 10th December 2015, Parliament House South Australia

Stein J, Phillips A, Bolton D, Fulford K, Sadler Z & Kendler K S 2010, 'What is a mental/psychiatric disorder?' *Psychological Medicine*, vol. 40, p.1759–65.

Whiteford, H & Buckingham, W 2005, 'Ten years of mental health service reform in Australia: are we getting it right?', *Medical Journal of Australia*, Vol.182, No.08, pp.396-400

World Health Organisation (WHO) 2013, *Mental health action plan 2013-2020,* World Health Organization Geneva

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