Psychiatric Disability Services
of Victoria (VICSERV)

Submission on

Transitional arrangements for the NDIS

Joint Standing Committee on the NDIS

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Introduction

VICSERV is the peak body representing mental health organisations in Victoria.

Our vision is a society where everyone has access to high quality awareness, prevention, and recovery-orientated mental health and suicide prevention services when they need it. VICSERV collaborates with consumer and carer peak bodies within Victoria and national peak bodies including Community Mental Health Australia (CMHA).

The services provided by VICSERV members include programs funded through the Victorian Government's Mental Health Community Support Services (MHCSS), and Commonwealth mental health programs such as Personal Helpers and Mentors (PHaMS) and Partners in Recovery (PIR).

VICSERV supports the NDIS and acknowledges the positive benefits that it will bring for many people living with psychosocial disability, but there are a number of concerns that continue to distress individuals and families, and create issues for organisations as they transition to the scheme across Victoria.

Our concerns include:

Concerns	Proposed solutions
1. The engagement, planning and review process for the NDIS does not adequately acknowledge the particular needs of people with psychosocial disability	The NDIA improve current planning processes and protocols and initiate training for NDIA planners and LACs to improve their knowledge of psychosocial disability and principles of recovery.
2. The lack of knowledge and expertise of NDIA planners and the Local Area Coordinators (LAC) in mental health means they cannot provide an appropriate plan for someone with psychosocial disability.	
3. Hard to reach individuals and those not engaged with the mental health system are at risk of missing out on the valuable supports NDIS can provide, as it does not fund or provide assertive and active outreach to engage these groups.	Allocate resources for workers skilled in working with hard to reach groups, including people with mental health issues, to support potential participants in their understanding of, access to, and preparation for the NDIS. This should include active outreach for people at risk of disengaging from services and people from Indigenous and culturally and linguistically diverse communities.
4. The level of funding being provided under the ILC framework doesn't have the capacity to provide for the scope of what existing services deliver, whilst also responding to the needs of people who won't be eligible for the NDIS.	Increase funding to the ILC framework to ensure it is able to effectively meet its functions.

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<td>5. Current NDIS prices do not align with the cost of providing mental health support which will likely lead to an ‘exiting’ of highly skilled workers from the sector and a ‘de-skilling’ of the mental health support workforce</td>
<td rowspan="2">Development of a workforce strategy which includes:
- specific assistance to the peer workforce;
- focus on key areas of need such as the Aboriginal and Torres Strait Islander and rural and remote;
- consideration of constraints and identification of costs for service providers in providing pre-vocational training and ongoing upskilling; and
- monitoring and reporting processes to ensure continuous reassessment of the workforces capacity to support the NDIS and mainstream services.</td>
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<td>6. The misalignment of the NDIS pricing schedule with the capacity for service providers to provide effective mental health care, including the ability to activate expert intervention at times of high risk.</td>
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These concerns are compounded in Victoria by the loss of State government funded psychosocial rehabilitation provided by community based organisations.

In addition to raising a number of Victorian issues, we endorse the submission of national peak body, Community Mental Health Australia (CMHA), which is a coalition of the eight state and territory peak mental health organisations, including VICSERV. CMHA, through the state and territory bodies, has a direct link and contact to mental health organisations delivering services at the coalface across Australia.

Boundaries and interface of NDIS service provision, and other non-NDIS service provision with particular reference to health, education and transport services

For those people with impairment/s in their psychosocial functioning not eligible for an individualised package under the NDIS, it is intended that mainstream or other disability supports will assist them, however the issues associated with available supports outside of the NDIS are significant for people with mental illness and particularly in Victoria.

From 01 July 2016, the Victorian Government began a progressive transfer of state funding for community mental health into the NDIS to fund disability supports. With the exception of Youth Residential Rehabilitation and Mutual Support and Self Help, there will be almost no state-funded community based services available for people with functional impairment associated with severe mental illness. This is the situation now in Barwon, which as Victoria's trial site, is now operating under full scheme.

The Federally funded programs of PHaMS and PIR are also flagged to progressively lose funding over the next few years, significantly reducing options for people seeking mental health supports and placing greater demand on community services and hospital emergency departments.

Loss of Psychosocial Rehabilitation

The legislative framework, and bilateral agreements, clearly stipulates that the NDIS is not a replacement for psychosocial rehabilitation, and that 'rehabilitation, recovery and early intervention supports' are considered the responsibility of the mental health system, as per the COAG Agreed Principles and Tables of Support.

However, the transfer of Victoria's MHCSS funding to the NDIS and the resulting gap in community support raises the fundamental question of: *how will people (NDIS recipients or not) with severe mental illness in Victoria have their psychosocial rehabilitation needs met in the future?*

The loss of psychosocial rehabilitation from the mental health system will eventually impact on the wider system, including the NDIS.

Recent State Government funding allocations have provided some hope that people ineligible for disability supports will get some form of community mental health care. In the 2017 / 2018 State budget, the Victorian Government announced "75,000 hours of community care" to reduce the demand on clinical mental health services, followed with a further investment of $20 million for community mental health in June 2017. We are yet to learn more about how this funding will be allocated and the support service offering it will provide.

We are encouraged by Minister Hunt's recent announcement at the COAG meeting on 4 August, regarding establishment of a time-limited Mental Health Expert Advisory Group. It is expected that the group provide advice on broader mental health policy

issues including cross-portfolio consideration of issues that may arise from the implementation of mental health reforms and the NDIS for people with severe and complex mental illness. We are looking forward to the outcomes of this group and note that they will need to work quickly to address the escalating problems in Victoria.

As more information comes to light about State and Federal priorities in the mental health space, it is apparent that the disability system, clinical system, forensic and broader health system, as well as other service systems including the housing and homelessness and Alcohol and Other Drug support service systems, will need to evolve and work together to best support people with mental illness.

In the recently released Productivity Commission (the Commission) Position Paper into the review of NDIS costs, the Commission recognised that there are issues emerging with how the NDIS works alongside mainstream services, including mental health services.

The Commission recommended that the Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people; and that the NDIA should also report on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

We fully support these recommendations put forward by the Commission and want to emphasise the urgency with which these matters must be addressed.

The gaps emerging as a result of the loss of the rehabilitation component from the previously integrated mental health service offering will place significant strain on the health system. Effective discharge planning from acute services relies upon an integrated plan between clinical providers and community support services – under the current structure of the NDIS this is not possible. Mental health services in Victoria have reported that, even when support coordination is included in a plan there have been instances when staff have not always been funded to talk to hospitals about the changing needs of an individual.

The burden of these gaps ultimately falls on people living with a mental illness and their families.

Support for chronic illness

The Bill to establish the NDIS Quality and Safeguards Commission, which is currently the subject of a Senate Inquiry, raises a number of concerns regarding co-morbidity and the inter-relationship between mental health and chronic illness.

The review has proposed that the following words be inserted into the legislation (as per the Bill’s Explanatory Statement, this relates primarily to chronic illness): *'support that a person is likely to require must be appropriately funded or provided through the NDIS and not more appropriately funded or provided through other mainstream general systems of service delivery or supports such as health or education'*.

It is understood that the intent of these words is to ensure that a disability and chronic illness or condition be considered as part of the disability; and subsequently that support would be provided to a person with psychosocial disability and a chronic illness where the mental illness impacted their ability to manage the chronic illness.

We are concerned however that there is a lack of clarity around how co-morbidity fits within the NDIS, particularly with the word changes being proposed through the Bill.

We draw your attention to CMHA's submission, which includes case studies that illustrate how interpretation of this clause in the Act may vary and create unacceptable outcomes for participants with chronic illness.

One of the case studies includes a person with complex mental illness and chronic diabetes who, under the previously funded state-based system, received support to manage the diabetes and administer insulin. The funding for this support was transferred to the NDIS. The person was found eligible for the NDIS but was informed they would need to access support for the diabetes through state health services, despite the fact that the support they were receiving previously was now the responsibility of the NDIS.

However, the person's impaired functioning as a result of their mental illness means they cannot look after their diabetes, therefore making it a disability support issue.

These concerns highlight why considerable examination is required, including understanding where supports are accessed and what funding states and territories have transferred to the NDIS that provided chronic disease support for people with disability.

We endorse CMHA's position that there must be ways of providing coordinated support to people with psychosocial disability and co-morbidity, such as chronic illness, who are NDIS participants without them having to go to more than one service system.

Coordinated, wrap-around support – regardless of what the support needs are – is the crucial part of a psychosocial approach to addressing mental illness and this will be at risk if people are required to seek help in more than one service system, many of whom may not be able to do this. The Federal Government and the State and Territory Governments must be able to determine with confidence where there is service crossover, and come to payment arrangements where that is required, so that NDIS participants receive the support they need through one package.

Consistency of NDIS plans and delivery of NDIS and other services for people with disabilities across Australia

Skills, training and knowledge of psychosocial disability

To develop an appropriate plan for someone with psychosocial disability, an understanding of mental illness, the functional impact this can have on a consumer and the broader impact on their carer or family network is required. It is therefore

essential that planning be conducted by people with experience in and an understanding of psychosocial disability.

An understanding of what a mental health support worker does is also important in order for a planner to have insight into a person's current supports. Many service providers have raised concerns that consumers were not able to articulate the 'behind the scenes' work that their support worker engaged in or the nature of the supports they were receiving under an MHCSS service (the Victorian Government-funded program prior to the NDIS) - and that this may be overlooked in their NDIS plan.

Service providers in Victoria have found that this is particularly the case with 'capacity building supports'. An early finding of a research project being delivered by Mind Australia on choice and choice-making in the context of the NDIS found that with capacity building supports, an understanding of the impact of illness and appropriate supports comes into play more than with core supports.

This project highlighted that to identify requirements for assistance with personal care or with shopping is quite different to understanding the supports that might be needed to put together a more independent life.

In addition, consumers have reported that they receive better outcomes both from their NDIS plan and in their engagement with the associated supports when a support person attends their planning or plan review meetings. In particular, PHaMs programs in Barwon were provided with extended State funding until September 2016 to assist those consumers to transition into the NDIS. Many consumers credited their PHaMs worker with getting them into the Scheme, saying that without their worker organising the paperwork and giving them a stronger voice during the planning stage, they doubt they could have secured eligibility or a funding package on their own. The importance of having this support person present was echoed by mental health services who noted a significant improvement in the quality of plans when a support person attended the planning meeting.

There is a direct relationship between how much time and resources are dedicated to preparing a client (including sourcing and compiling paperwork and reports) and how likely they are to be deemed eligible for a funding package – and the quality of the subsequent supports in their plan. One organisation reported that this pre-engagement support was attributable to 20 hours of work per client.

Many consumers with psychosocial disability require workers with the skills, experience and persistence to motivate and empower them to engage with supports and activities. With such a significant reform as the NDIS, it is vital that consumers receive consistent and supportive help from someone they know and trust in order to understand the changes and challenges it represents. More importantly, this engagement support is needed not only from the very beginning of the NDIS process, but also the application, planning and implementation stages.

During the trial roll-out in Victoria's Barwon region, it was noted that the NDIA actively discouraged support workers participating in the planning process, suggesting their presence was a potential conflict of interest. Over time the NDIA has acknowledged the value of having a support worker in this planning meeting to help articulate a

participant's needs. This has been welcomed by consumers and carers, who note the importance of having ‘someone who understands’ in the room.

VICSERV is pleased that we have been able to negotiate the delivery of training to a selection of Local Area Coordinator's (LAC) and NDIA Planners in the Loddon region in September. This training aims to give the people who have a key role in the planning process a better understanding of psychosocial disability (and the associated functional implications), as well as inform them of considerations for appropriate planning and plan development for people with serious mental illness.

This is a significant step towards ensuring that people with psychosocial disability will receive the best possible plans and supports in the implementation process. VICSERV hopes that this training will result in other regions taking up this opportunity to improve the planning process and outcomes for people with psychosocial disability and their families and carers.

Planning meetings

There continues to be concerns on the ‘quality’ of planning meetings and resulting plans.

While some consumers and organisations have spoken very positively about their planner, the meeting and the plan they received, others were critical of this process, believing the planner did not have a good understanding of mental illness. VICSERV noted a strong relationship between a consumer’s impression of their communication with the planner and the quality of the plan that was developed.

Consumers in the Barwon region expressed how difficult they found the process of painting themselves in the “worst light” for their NDIS planning session in order to receive appropriate supports, and how this was in conflict with their desire to build self-esteem and confidence.

Planning for recovery-oriented supports requires an understanding of recovery-oriented practice and the ethos behind it. Developing an appropriate plan for someone with psychosocial disability also requires an understanding of mental illness, the functional impact this can have on a consumer and the broader impact on their carer or family network.

Service providers have reported on the value of being able to engage with the carer and family network through the development of a Plan: *“Typically, an effective plan is developed over a period of 6-8 weeks in concert with the development of a trusting relationship with their worker”* (support worker from a community managed mental health organisation).

Outreach for people with complex needs

Issues around engaging with the NDIS are of particular concern for vulnerable and dis-engaged people, including indigenous, culturally and linguistically diverse (CALD) and people experiencing homelessness. The mechanics of the NDIS provide no

incentive or support for community mental health organisations to persist with hard-to-reach clients as this work remains unfunded.

Resources need to be allocated for workers skilled in working with hard to reach groups, including people with mental health issues, to support potential participants in their understanding of, access to, and preparation for the NDIS. This should include active outreach for people at risk of disengaging from services and people from Indigenous and culturally and linguistically diverse communities.

Rollout of the Information, Linkages and Capacity Building Program

In November 2016, the NDIA released its Information, Linkages and Capacity-Building (ILC) Commissioning Framework. The Framework outlined that funding grants would be awarded to organizations to deliver services that empower people with a disability, improve access to mainstream services and build community inclusivity. It identified support for carers, and for ineligible people with a disability as priorities. In February 2017, the NDIA opened the first funding round of the ILC National Readiness Grants.

Throughout the trial and current implementation of the NDIS in Victoria, the premise of the ILC is at risk of failure. Service providers comment that ILC grants are not even "on the radar" as the funding provided through the framework is so minimal and doesn't have the capacity to provide for the scope of what services were delivering under state funding, or what people ineligible for the Scheme need.

In May 2017 the NDIA announced the successful applicants of the first round of ILC grants, awarding $14 million nationally across 36 organisations with Wellways Australia the only organisation awarded funding under 'community awareness and capacity building' focussing on psychosocial disability. A second round of funding for ILC grants will be held in the second half of 2017.

Any other related matters

Workforce readiness

The NDIS offers disability supports with the aim of building skills and capabilities around community participation and employment - and is funded accordingly. This is a completely different service offering to the psychosocial rehabilitation that people with severe mental illness in Victoria have been accessing under the state-funded MHCSS program.

Some organisations are relying on other funding streams to cross-subsidise and retain their qualified mental health workforce, others have had to re-classify job roles and offer roles at a lower rate of pay. Providers noted that these measures are not sustainable and losing qualified workers seems inevitable in the long-term.

Further, the risk that this 'deskilling' of the workforce places not only on the consumer, but also on the workers is significant. Good quality disability support should not come at the expense of the workers safety and rights.

The following case study and supporting information articulates these concerns.

Complex Client Case Study

NDIS Client with a history of violence, assault and drug use and known to forensic services.

The client had moved to another region of Victoria – NDIS plan contained core supports around social skills, accessing a psychologist and some background information on diagnosis.

Limited direction was initially included in the plan to the service provider to highlight the risk or history of the client – this would become available later after the service provider put in time to chase up reports (time not funded by NDIS).

Experienced worker from a service provider (a qualified clinical nurse) reviewed history of client and could recognise diagnosis and convened an internal meeting to discuss next steps. At the organisations own cost ("only able to do it because we still have MHCSS funds") they allocated a degree-qualified worker with "decades of experience in mental health" to the client.

The worker was driving the client from an appointment and the client became aggressive and attacked the worker. The client later reported she had taken ICE prior to the appointment.

The worker was able to remove herself from the situation, escaping with minor injuries. She was then able to call the police and managed the situation as appropriately as possible based on her skill and experience in working with clients with complex mental health presentations.

The provider recommended that this client receive supported accommodation due to her high needs and dual disability, but this did not end up in her NDIS plan. This client had been transient for many months, her history revealed that in her past she had been given a substantial Multiple and Complex Needs Initiative package, at one time resided in a CCU, and at another time had been incarcerated. The client's history showed she had been receiving services as a child from three years of age.

The complexity and risk of this client was only identified as the plan was viewed through a "clinical lens" from experienced staff – the plan itself did not highlight this information or make it obvious for the service provider or worker.

The service provider allocated an experienced support worker at their own cost. The service provider could have allocated a disability support worker with no experience or skill in working with people with complex needs and the outcome could have been much worse – severe injury to the worker, a more severe sentence for the client, huge work-cover costs to the provider, potential media coverage of the incident.

This example also highlights potential implications for complex clients and their access to supports – providers in the future may choose not to accept clients with high needs due to the risks; increasing the risk to these participants.

Case management has previously been an important aspect of many consumers with complex issues, allowing full disclosure of their history and support needs, but **Support Coordination under the NDIS does not fill this role**.

The case study noted above is not an isolated incident - there are more examples emerging of providers getting no background on clients. Disability support workers are visiting the homes of clients that even clinical service workers deem too unsafe to visit.

The move to employing staff on short-term or casual contracts was also noted by service providers across Victoria who said that the future was too uncertain to provide ongoing positions.

A workforce strategy should be developed to support both the mental health workforce and primary health workers, especially GPs, to prepare for mental health reforms, including the NDIS, in relation to mental health and their roles.

The workforce strategies that have been developed in the past have not addressed the community managed psychosocial rehabilitation sector and has meant that reforms which have a significant impact have no guiding policy. The consideration and inclusion of the community mental health workforce is crucial if we are to achieve an effective mental health system.

The following should be considered in the development of any workforce strategy:

- Inclusion of specific assistance to the peer workforce, including to consumers and carers (both paid and volunteer), including to prepare for the NDIS
- A focus on key areas of need such as the Aboriginal and Torres Strait Islander, rural and remote and early childhood workforce
- Identify constraints for service providers in providing pre-vocational training and ongoing upskilling of the NDIS workforce and identify how these constraints can be overcome, which must include the allocation by governments of monetary resources through a funding stream that sits outside of the NDIS pricing structure
- Similarly identity costs associated with providing ongoing professional development and training for the NDIS workforce to ensure quality of supports is maintained moving forward
- Inclusion of monitoring and reporting processes to ensure continuous reassessment of the workforces capacity to support the NDIS and mainstream services.