Further Unravelling Psychosocial Disability

Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis

A NSW NDIS and Mental Health Analysis Partnership Project of the
Mental Health Coordinating Council and Mental Health Commission of NSW

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MHCC respects and promote people's fundamental human rights. We acknowledge the traditional custodians of the land and value the lived experience of people recovering from mental health related conditions – both past and present.

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The activity described in this report was undertaken in partnership with the Mental Health Commission of NSW.

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EXECUTIVE SUMMARY

The development and introduction of the National Disability Insurance Scheme (NDIS) is acknowledged as the most important human service and economic/productivity reform that Australia has seen since the introduction of Medicare 30 years ago. The NDIS is a 'social insurance' model for funding and delivering long-term disability care and support for people with significant disability.

It will take several years for the NDIS Board and the National Disability Insurance Agency (NDIA) to implement, operationalise and fine tune the NDIS so that it is economically viable, as well as to establish and develop the cross sectoral relationships required to sustain it. This is especially pertinent given the history of structural siloing of the health and disability/social care sectors in most states and territories over the last 20 years, as well as at the Commonwealth level, and between the Commonwealth and states and territories governments.

In the words of a person with lived experience of health/mental health problems and psychosocial disability, the experience at the NSW Hunter trial site during the first year of NDIS implementation has, from a mental health sector point of view, "*been at times challenging, mostly positive and at times, quite breathtaking"*.[1]

It is widely acknowledged that all people potentially affected by NDIS implementation namely participants, their families and carers, and service providers across a range of community sector, public, private and primary healthcare and disability settings, are very much in a 'participatory action' learning space. It is also acknowledged that the NDIS trial sites have involved a lot of experiential learning about the situation and impacts of the NDIS on people affected by mental illness/psychosocial disability, and that much of this learning has occurred in the NSW Hunter trial site. One important aspect of this learning has been the interface of the innovative Hunter Partners in Recovery (PIR) initiative with the NDIS.

The Mental Health Coordinating Council (MHCC) has been working in partnership with the NSW Mental Health Commission since June 2013 to undertake a project focused on the Hunter NDIS trial site that seeks to better understand opportunities that present for people affected by mental health conditions.[2]

The outcomes of the NSW *NDIS Mental Health Analysis Partnership Project* trial site activity set out to better understand and make recommendations regarding:

- how psychosocial disability should be understood and included under the NDIS in terms of:
    - access (eligibility)
    - existing mental health community sector and public mental health programs
    - equity, monitoring and safeguard mechanisms
    - workforce appropriateness
- the wider NDIS and health services interface, especially as this relates to the unmet physical health needs and high prevalence of substance use by people living with mental illness
- people presenting with multiple co-existing difficulties in addition to psychosocial disability, such as acquired brain injury (ABI), intellectual disability (ID) and other cognitive impairment/s as well as physical disability
- the suitability of the NDIA access and planning process developed for people with psychosocial disability

[1] D Hamilton, 'Breathtaking in More Ways than One: A much needed consumer perspective on the NDIS', *View from the Peak*, Mental Health Coordinating Council (MHCC) Quarterly Newsletter, p. 12, Sydney, June 2014.

[2] In this report we mostly use the term 'mental health condition' to denote mental illness/disorders, mental/psychological/ emotional distress, and psychiatric/psychosocial disabilities, etc. although the language used changes depending on the context of the usage.

- the national discourse regarding the situating of psychosocial disability within the NDIS.

This project has contributed to development of the NSW Mental Health Commission's inaugural Strategic Plan. The challenges associated with forward planning around the opportunities presenting through the NDIS were considerable given the dynamic and changing human services policy and funding environment.[3] This project has also contributed to work undertaken by Mental Health Australia (MHA - formerly the Mental Health Council of Australia) through their *NDIS Capacity Building Project*.[4]

The NDIA has not reported on the total number of NDIS participants with a primary psychosocial disability nationally, as at the end of June 2015. However, there were 1090 NDIS participants with a primary psychosocial disability and an approved plan.[5] These figures at the end of March 2015 were 1039 in total and 866 with an approved plan respectively.[6] At the end of March 2015, the NDIA also reported 534 participants with a secondary condition of a psychosocial nature. At the end of June 2015, there were 401 NDIS participants with a primary psychosocial disability and a plan in NSW (37%). This represents an increase from 170/420 at the end of June 2014 and 269/1039 at the end of March 2015.[7,8]

The NDIA (Hunter) advise that the increase of 132 people with psychosocial disability and NDIS plans in the last quarter of 2015 is primarily a result of PIR clients phasing in to the NDIS. At the end of December 2014 Hunter PIR reported that there were 50 joint NDIS consumers from a total of 229 Hunter PIR clients from the three LGAs that make up the Hunter NDIS trial site.[9]

While monitoring access and planning rates and processes is important, the greatest achievement of the NSW *NDIS Mental Health Analysis Partnership Project* has been establishment of the Hunter NDIS and Mental Health 'Community of Practice' (COP) Forum (pictured). The forum was established to facilitate and share learning occurring both within and outside the Hunter trial site. The forum met seven times between June 2013 and 2015 and has had a total of 317 participants across all events, with about 70 people attending on each occasion.

Top - Tina Smith, Mental health Coordinating Council
Centre – Sage Green, Mental Health Commission of NSW
Bottom – Eddie Bartnik, National Disability Insurance Agency at the December 2014 Hunter NDIS and Mental Health Community of Practice

[3] Mental Health Commission of NSW, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024,*,NSW Mental Health Commission, Sydney, 2014a.
[4] Mental Health Australia, *Mental Health Sector Needs Analysis: Building the capacity of the mental health sector to engage with the National Disability Insurance Scheme - Report prepared for the NDIA* (draft), Canberra, (2014).
[5] National Disability Insurance Agency, *Quarterly Report to COAG Disability Reform Council - 30 June 2015,* Council of Australian Governments (COAG) Disability Reform Council, 2015a.
[6] National Disability Insurance Agency, *Quarterly Report to COAG Disability Reform Council - 30 March 2015,* Council of Australian Governments (COAG) Disability Reform Council, 2015b.
[7] National Disability Insurance Agency, *Quarterly Report to COAG Disability Reform Council - 30 June 2014*, Council of Australian Governments (COAG) Disability Reform Council, 2014a.
[8] National Disability Insurance Agency, op. cit. 2015b.
[9] Hunter Partners in Recovery (PIR), *Hunter PIR and the NDIS: Building a stronger partnership,* Newcastle, 2015.

Establishment of the COP Forum and the learning that has occurred through it and other project activities was made possible by the resourcing of a designated Project Officer/NDIS Mental Health Analyst position, based at *MHCC*, and working within the Hunter trial site.

Further information about the project and forum are available on the MHCC website: http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx (or Google 'MHCC NDIS').

This report has been developed by *MHCC* to capture Hunter trial site experiences from a mental health perspective through to the end of June 2015. Whilst it has been primarily written for a NSW audience, it will also provide helpful information to other state, territory and Commonwealth stakeholders as the complex process of NDIS implementation continues over the next three years and beyond.

This report provides:

- a background to the context in which the project is undertaken - **Introduction and Overview**
- a summary of the main findings of the project - **Project Outcomes and Recommendations**
- a reflection that considers the experiences and provides suggestions for this learning to both continue and accelerate - **Discussion and Priority Actions**

Throughout this report additional information relevant to people thinking about the NDIS and mental health/psychosocial disability is provided in the form of stories of the lived experience of NDIS in the Hunter trial site. There is further information in the report's appendices.

The **priority actions** arising from the initial 2013/14 project findings, outcomes and recommendations are:

- **Action 1:** Advocacy and action to ensure the effective representation and participation of consumers, carers and mental health service providers (i.e. community sector, public and private-for-profit) in implementation and evaluation of the NDIS and the emerging health/disability interface

- **Action 2:** Implement Hunter NDIS and Mental Health 'COP' Forums and other activities to increase the recognition and understanding of the needs of people living with psychosocial disability

- **Action 3:** Pursue the development of collaborative, recovery-oriented and trauma-informed health and wellbeing approaches to strengthen assessment and care planning/review processes both for people eligible and not eligible for NDIS Tier 3 supports

- **Action 4:** Pursue a research and development direction including use of psychometrically sound tools that allow for detailed analysis of trial site experiences, including collection of comprehensive data to establish eligibility and access benchmarks, and service delivery resulting in effective and valued client outcomes

- **Action 5:** Participation in development of strategic directions for NDIS psychosocial disability and recovery support workforce recognition and development including, but not limited to, directions for peer workforce development and the skills required for complex care coordination practice

- **Action 6:** Influence the development of the NSW and national framework for development of NDIS quality and safeguards processes inclusive of mechanisms to encourage the adoption of approaches to involuntary mental health treatment consistent with the human rights aspirations of the UNCRPD

- **Action 7:** Continue to contribute to the national discourse regarding the NDIS, psychosocial disability and mental health including, but not limited to, ongoing collaboration with the MHA NDIS Capacity Building Project.

These priority actions subsequently informed the *MHCC* and NSW Mental Health Commission 2014/15 *NDIS and Mental Health Analysis Partnership Project* directions (see over page). Our current focus, as identified in the 2014/15 project objectives, is on facilitating consumer, carer and community co-design of the NDIS.

Early experience at the NSW Hunter NDIS trial site has been a very stimulating time, full of possible opportunities to improve the lives of people with high levels of psychosocial disability related to mental health issues.

Some additional highlights of the *NDIS and Mental Health Analysis Partnership Project* that are further described in this report are:

- attendance at Hunter based inter-governmental NDIS implementation meetings during 2013 (there has subsequently been no systemic mental health consumer, carer or community sector representation to formal NSW implementation meetings)
- sharing learning about the positioning of health and wellbeing within the NDIS, including the positioning of mental health and psychosocial disability
- witnessing the return to community living of a number of people who had been inappropriately residing in psychiatric hospitals in the Hunter due to lack of appropriate and accessible community based services
- observing and influencing development of the very important emerging interface between the new PIR initiative and the NDIS/NDIA
- contributing to directions for strengthening the interface between the NDIA, the NSW Department of Family and Community Services (FaCS, and especially the Ageing, Disability and Homecare/ADHC service) and NSW Health (especially the HNELHD)
- contributing to the work of the NSW Ombudsman's Office in implementing their new roles and functions arising from the 2014 Disability Inclusion Act[10]
- forward thinking about the potential impacts and opportunities presenting through the forthcoming 'Partnerships for Health'/Grants Management Improvement Program reforms for NSW Health funded non-government community managed organisations (NGOs/CMOs)
- development of six-monthly e-newsletters describing the Hunter experience
- regular updates in the *MHCC View from the Peak* quarterly newsletter
- numerous presentations at state and national conferences and other gatherings
- continuing advocacy for consumer, carer and community representation and participation across all levels of NDIS implementation and evaluation.

[10] NSW Government, *Disability Inclusion Act, 2014 (NSW),* 2014a.

NDIS and Mental Health Analysis Partnership Project Alignment with the NSW Mental Health Strategic Plan 2014/24

The *NDIS and Mental Health Analysis Partnership Project* now aligns with the NSW Government's *Mental Health Strategic Plan* as follows:

- **8.3 Supporting Reform: Developing the community-managed sector**
- **10. Broader Context of Reforms - NDIS**[11]

In 2014/15, the project had the following objectives that support the core functions of the NSW Mental Health Commission in monitoring implementation of the strategic plan.

NSW Mental Health Commission core function 1: Promote and facilitate the sharing of knowledge and ideas about mental health issues.

Objective 1.1: Advocate for the importance of individual and systemic consumer, carer and community sector participation in NDIS planning, implementation and evaluation

Objective 1.2: Provide consumers, carers and the community sector with the opportunity to attend and learn about current issues and opportunities presented through the NDIS for people with a mental health issue and those that provide services to them

NSW Mental Health Commission core function 2: Undertake and commission research, innovation and policy development in relation to mental health issues.

Objective 2.1: Influence policy decisions relating to mental health and the NDIS

Objective 2.2: Ensure that any research undertaken in relation to NDIS is informed by the experiences of the Hunter trial site

Regular NDIS updates in *View From the Peak* and *Hunter NDIS 6 monthly* newsletters.

[11] Mental Health Commission of NSW, op. cit.

Early learning from the Hunter and other NDIS trial sites has contributed to enhanced national directions for the inclusion of people with mental health conditions within the NDIS, and for consideration of impacts elsewhere in the range of disability-specific and mainstream services and supports available for people with mental health conditions. It is now evident that this learning and its influence on the shape and impacts of the NDIS will continue for many years to come, and a relevant body of literature is beginning to appear. [12], [13], [14] The establishment of a Mental Health Sector Reference Group by the NDIA along with its related work program is a much-welcomed development.

In 2013 the World Health Organization (WHO) agreed upon an action plan to provide comprehensive, integrated and responsive mental health and social care services in community based settings.[15] The environment of human service delivery change within the Hunter NDIS trial site is profound and will continue to gather momentum as implementation work extends beyond the trial sites. Therefore we must remain vigilant. There are considerable opportunities presenting to achieve better coordinated and integrated health and social care for people who are most in need of this help, and to prevent disability from arising. People living with mental health conditions have been systemically discriminated against for over 30 years in regard to their health and social service access. Structured and strategic learning about the positioning of mental health/psychosocial disability with the NDIS needs to continue in order that opportunities be maximised for people affected by mental health conditions, and their families and carers.

There are substantial challenges in moving from a disability services system that is fragmented between states and territories and reliant on ad hoc funding streams, to a national scheme based on individual choice and flexibility, and from block funded to fee-for-service arrangements. Parallel reforms in mental health, aged care and primary health care add to the complexities of NDIS implementation. As a result of the *NSW NDIS and Mental Health Analysis Partnership Project* activity being undertaken by *MHCC* in partnership with the NSW Mental Health Commission, NSW is well prepared to embrace these challenges as it relates to better understanding and further unravelling the needs of people with psychosocial disability.

[12] P O'Halloran, *Psychosocial Disability and the NDIS: An Introduction to the Concept of Holistic Psychosocial Disability Support*, NDIS/DSS, Canberra, 2015.
[13] MIND, *Mental Health and the NDIS: A Literature Review, NDIS/DSS, Canberra, 2015.*
[14] VICSERV, *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 service system*, Victoria, 2015.
[15] World Health Organisation (WHO), *WHO Comprehensive Mental Health Action Plan 2013/2020*, Sixty-sixth World Health Assembly, Resolution WHA66/8, 2013.

Overview of Process Used To Identify Current Project Objectives

2013/14 Objectives	2013/14 Outcomes	2013/14 Recommendation/s	2013/14 Priority Action/s	2014/15 Objectives
How psychosocial disability should be understood and included under the NDIS in terms of:				
• access and eligibility	1. 170 adults with high levels of psychosocial disability related to mental illness have been found eligible for Tier 3 NDIS services in Hunter trial site. However, the number of people with either a primary or secondary psychosocial disability accessing the Scheme needs to be closely monitored, including those deemed ineligible, and clear benchmarks for eligibility and access need to be established.	1. Identify structures to provide iterative guidance regarding PSD and recovery support services access and NDIS eligibility (who is in and who is out). 2. Obtain greater clarity regarding service user needs, service availability and access for people deemed ineligible for a Tier 3 funded support package.	**Action 1:** Advocacy and action to ensure the **effective representation and participation of consumers, carers and mental health service providers** (i.e. community sector, public and private-for-profit) in implementation and evaluation of the NDIS and the emerging health/disability interface.	**Objective 1.1: Advocate for the importance of individual and systemic consumer, carer and community sector participation in NDIS planning, implementation and evaluation**
• existing mental health community sector and public mental health programs	2. There is a high impact on existing community sector and public mental health programs resulting from NDIS implementation.	3. Engage with activities to map and rationalise acute, sub-acute and non-acute psychosocial disability and recovery support programs in mental health programs (i.e. both community sector and government programs in NSW). 4. Engage with national policy recommendations to increase psychosocial disability and recovery support funding levels in NSW from 6/8% to 30% by 2024.	**Action 2:** Implement Hunter NDIS and Mental Health 'COP' Forum and other activities to **increase the recognition and understanding of the needs of people living with psychosocial disability** **Action 3:** Pursue the development of collaborative, recovery-oriented and trauma-informed health and wellbeing approaches **to strengthen assessment and care planning/review processes** both for people eligible and not eligible for NDIS Tier 3 supports.	**Objective 1.2: Provide consumers, carers and the community sector with the opportunity to attend and learn about current issues and opportunities presented through the NDIS for people with a mental health issue and those that provide services to them** **Objective 2.1: Influence policy decisions relating to mental health and the NDIS**
• equity, monitoring and safeguard mechanisms, and	3. Considerably more legislative reform work to make increased use of supported decision making needs to be undertaken to ensure development of a national framework for quality and safety associated with NDIS implementation.	5. Provide monitoring and safeguard mechanisms that provide oversight and accountability across mental health community managed and for-profit providers both in terms of safety, best practice and consumer and care. 6. Provide complaint mechanisms that support people to initiate and follow through with appeals and complaints, and provide supported decision making opportunities for people who require assistance in advocating for themselves.		

2013/14 Objectives	2013/14 Outcomes	2013/14 Recommendation/s	2013/14 Priority Action/s	2014/15 Objectives
• workforce appropriateness.	4. NDIS workforce development directions need to include consideration of the complex skills required for working with people with psychosocial disability, in both peer and non-peer work roles, and the qualifications and professional development pathways associated with these.	7. Pursue directions to establish the peer workforce within both government and non-government organisations involved in the provision of services under the NDIS. 8. Undertake activities to promote the complexity of skills required in PSD and recovery support work, including the skills required for complex care coordination.	**Action 4:** Pursue a research and development direction including use of psychometrically sound tools that allows for detailed **analysis of trial site experiences including the collection of comprehensive data** to establish eligibility and access benchmarks and service delivery resulting in effective and valued client outcomes. **Action 5:** Participation in **development of strategic directions for NDIS psychosocial disability and recovery support workforce** recognition and development including, but not limited to, directions for peer workforce development and the skills required for complex care coordination practice. **Action 6:** Influence the development of the NSW and national **framework for development of NDIS quality and safeguards processes** inclusive of mechanisms to encourage the adoption of approaches to involuntary mental health treatment consistent with the human rights aspirations of the UNCRPD. **Action 7:** Continue to **contribute to the national discourse regarding the NDIS, psychosocial disability and mental health** including, but not limited to, ongoing collaboration with the MHA NDIS Capacity Building Project.	**Objective 2.2: Ensure that any research undertaken in relation to NDIS is informed by the experiences of the Hunter trial site**
The wider NDIS and health services interface, especially as this relates to the unmet physical health needs and high prevalence of substance use by people living with mental illness.	5. Role delineations between the NDIS and Health need to be better understood and operationalised, especially as this relates to understanding what a 'clinical' and/or 'non-clinical' treatment, rehabilitation and/or support service is, what work settings these occur in, and which health and community service workers provide them.	9. Ensure that people's care plans extend beyond arrangements for the treatment of mental illness and consistently include items related to supporting self-directed health and wellbeing and meeting the personal goals of the individual. 10. Ensure that assessment and care planning processes make routine use of psychometrically sound tools for screening substance use issues.		
People presenting with multiple co-existing difficulties in addition to psychosocial disability, such as acquired brain injury (ABI), intellectual disability (ID) and other cognitive impairment/s as well as physical disability will also be explored.	6. NSW Health needs to work closely with ADHC as this relates to the closure of their large residential institutions and exits to community living for people with stable mental illness no longer needing hospital-based psychiatric services. These transitions should be both recovery oriented and trauma informed.	11. Advocate for the needs of people with co-existing difficulties to be provided with services consistent with the International Classification of Functioning, Disability and Health approaches. 12. Ensure assessment for specific decision making capacity and provide services that ensure supported decision making, as well as support and information for families and carers.		
The suitability of the NDIA assessment tool/s developed for people with psychosocial disability.	7. Continued advocacy is required for assessment tools and processes more suited to the needs of people with mental illness/psychosocial disability.	13. Advocacy for use of a more suitable assessment tool that is psychometrically sound for a wide range of impairments/disabilities. 14. Mandated use of tools that explore consumer and carer satisfaction.		
The national discourse regarding the situating of psychosocial disability within the NDIS.	8. The *NDIS Mental Health Analyst Partnership Project* has positioned both the NSW Mental Health Commission and *MHCC* to contribute to the national discourse regarding the positioning of psychosocial disability within the NDIS.	15. Strengthen mechanisms for sharing the learning from the Hunter NDIS trial site both across NSW and nationally. 16. Continue to engage with national projects and initiatives exploring the situation of mental health/psychosocial disability within the context of NDIS (e.g. MHA, DSS, NDIA Mental Health Sector Working Group etc.).		

INTRODUCTION AND OVERVIEW

Australia's National Disability Insurance Scheme (NDIS - the Scheme) was established through an Act of Parliament (the *NDIS Act, 2013*)[16] and introduced from July 1st 2013, The NDIS is a social insurance model for funding and delivering long-term disability services and support to people with severe or profound disabilities. It is based on the premise that all citizens have a right to good health and social support regardless of their economic circumstances. Implementation occurs through the NDIS Board and the National Disability Insurance Agency (NDIA - the Agency).

The scope of this paper does not lend itself to a full history of the origins and potential implications of this ground breaking legislation or its governance, management or operational implications. Nevertheless, it will provide some introductory comments regarding the context in which the NSW *NDIS and Mental Health Analysis Project* is undertaken, as well as an overview of the 'how and why' of the project.

The project was undertaken by the Mental Health Coordinating Council (MHCC) and NSW Mental Health Commission at the NDIS trial site in the Hunter region of NSW (Newcastle, Lake Macquarie and Maitland Local Government Areas). The project's aim was to explore the position of mental health within the NDIS and further unravel our understanding of the needs of people affected by or at risk of developing psychosocial disability related to mental health problems, the needs of their families and carers and those of the organisations that support them.

A participant's view of the NDIS

"It is 'breath taking' being at the forefront of the roll out of the NDIS in Australia. Although reform of the disability sector promises much philosophically, implementation of the Scheme will not automatically lead to good outcomes. It won't necessarily lead to evidence based practice or be in the best interest of all (mental health) consumers. Therefore, we need to be vigilant."

"Unfortunately a tension still exists between the (long and hard fought for) recovery oriented approach adopted in response to consumer voices in the community sector, and 'clinical'/medical model perspectives which predominate elsewhere."

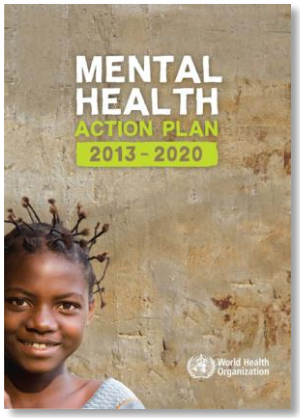
"…the NDIA must truly understand and acknowledge the complex nature of psychosocial disability so that the NDIS can meet the needs it was established to address." [17]

[16] Commonwealth of Australia, *National Disability Insurance Scheme Act 2013.* 2013a
[17] D Hamilton, op. cit.

The Context of the Project

Mental Illness and Psychosocial Disability

The World Health Organisation (WHO) *Comprehensive Global Mental Health Action Plan 2013/20* (pictured) observes that people with mental disorders experience disproportionately higher levels of both disability and mortality.[18] Australians living with mental health conditions and/or psychosocial disability are among the most disadvantaged people in our community.[19] Experiences of people living with psychosocial disability related to a mental health condition are described by the National Mental Health Consumer and Carer Forum (NMHCCF). The NMHCCF make 32 recommendations for improving the health and social circumstances of people affected by psychosocial disability (see Appendix 1). Very few of these recommendations have been progressed, and the NDIS provides an important opportunity to do so.



Mental health conditions are the main source of disability burden worldwide, and their impact begins early in life.[20] In 2003, mental illness accounted for 13% of the total burden of disease in Australia, and ranked third for morbidity and mortality after cancer and cardiovascular diseases.[21] With a contribution of 24%, mental illness is the leading cause of the non-fatal burden of disease. The Australian government estimates that around 600,000 Australians experience severe mental illness and some 60,000 have enduring and disabling symptoms and high levels of psychosocial disability.[22] Many others have low to moderate levels of psychosocial disability complicated through co-existing health and/or social issues. According to the 2010 *Survey of High Impact Psychosis*, people with psychotic illness also frequently experience poor physical health outcomes.[23] For example, 26.8% of survey participants had heart or circulatory conditions, and 20.5% had diabetes, a rate more than three times that seen in the general population.

The lived experience of people with, or at risk of developing psychosocial disability needs to be much better understood, as it arises from complex interactions between limitations in activity and the environment in which people live.[24] Psychosocial disability is conceptualised by the WHO *International Classification of Functioning, Disability and Health* (ICF) as impairments of mental functions, activity limitations and participation often associated with, but not limited to, mental ill health.[25] More simply put, the experience of psychosocial disability is as much about the social and economic exclusion due to stigma and discrimination, as it is symptoms and other real and/or perceived deficits that may be experienced by people living with mental health conditions.

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[18] World Health Organisation, op. cit.
[19] National Mental Health Consumer and Carer Forum (NMHCCF), *Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer and Carer Forum on Psychosocial Disability Associated with Mental Health Conditions*, NMHCCF, Canberra, 2011.
[20] CJ Murray et al., 'Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010',*Lancet*, vol. 380, no. 9859, pp.2197-223, Dec 15 2012.
[21] S Begg et al., 'Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors', *Medical Journal of Australia*, vol. 188, no. 1, pp. 36-40, 2008.
[22] Department of Health and Ageing, *Partners in Recovery (PIR) Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative - Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16*, Australian Government, Canberra,2012.
[23] V Morgan et al., *People living with psychotic illness 2010: Report on the second Australian national survey*, Commonwealth of Australia, Canberra, 2011.
[24] National Mental Health Consumer and Carer Forum, op cit. as per #20
[25] World Health Organisation (WHO), *International Classification of Functioning, Disability and Health: ICF*, Geneva, WHO, 2001.

The Disability Policy Environment

In July 2008, the Australian Government ratified the Optional Protocol (OP) of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).[26] The UNCRPD includes people with psychosocial disability and aims to:

> *promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity* (Article1, OP)

The National Disability Strategy 2010/2020 was endorsed by the Council of Australian Governments (COAG) in 2011.[27] It is an important vehicle for Australia meeting its requirements under the UNCPD.

The National Disability Strategy is structured under six broad policy outcome areas:

1. Inclusive and accessible communities
2. Rights, protection, justice and legislation
3. Economic security
4. Personal and community support
5. Learning and skills
6. Health and wellbeing.

Implementation of the strategy will be guided by three separate implementation plans over its ten-year life span. The first implementation plan, *Laying the Groundwork 2011–2014*, establishes the foundations to drive reform in the planning and delivery of both mainstream and disability-specific policies and services. It also establishes the basis for reporting and evaluation of the strategy. The second and third implementation plans, *Driving Action 2015–2018* and *Measuring Progress 2019 – 2020*, will recognise existing commitments under the strategy and consolidate actions that are driving ongoing improvement and better outcomes for people with disability.

A revised National Disability Agreement between the Commonwealth and states and territories was agreed to by COAG in July 2012.[28] Changes were made to reflect the policy direction concerning community-based care outlined in the National Health Reform Agreement, adding five new reform priority areas and improving the performance framework.[29]

[26] United Nations General Assembly, *Convention on the Rights of Persons with Disabilities*, Resolution adopted by the General Assembly, 24 January 2007, A/RES/61/106, United Nations, Geneva, 2006.
[27] Commonwealth of Australia, *2010–2020 National Disability Strategy: An initiative of the Council of Australian Governments,* 2011a.
[28] Commonwealth of Australia Council of Australian Governments, *Revised National Disability Agreement,* COAG, Canberra, 2012.
[29] Commonwealth of Australia Council of Australian Governments, *National Health Reform Agreement,* COAG, Canberra, 2011.

The National Disability Agreement's five strategic areas are:

1. Build the evidence base for disability policies and strategies
2. Enhancing family and carer capacity
3. Strategies for increased choice, control and self-directed decision making
4. Maintain innovative and flexible support models for people with high and complex needs
5. Develop employment opportunities for people with a disability.

The establishment of the NDIS relates to only the third strategic area, and many other actions of the National Disability Strategy and National Disability Agreement will need to be progressed to meet Australia's obligations under the UNCRPD. A more effective interface between the disability/social care and health/mental health sectors is critical to achieving the aspirations of the National Disability Strategy.

In 2012 the NSW state government launched its inaugural whole-of-government plan outlining commitment to removing structural and attitudinal barriers to access and participation that impact the lives of people with disability.[30] The *'Ready Together'* initiative continues the government's *'Stronger Together 2'* reforms which committed $2 billion in new funding for disability services from 2011/12 to 2015/16 to deliver 47,200 new places for people with disability to access support. *Ready Together* focuses this investment on what people say they most want: more flexibility, more choice and more control, and is implemented through the *'Living Life My Way'* framework. *Ready Together* also prepares NSW for the transition to the NDIS by July 2018.

As part of disability sector reform, two new laws have been introduced in NSW. The 2014 Disability Inclusion Bill protects the rights of people with disability and promotes community inclusion now and into the future.[31] The 2013 NDIS (NSW Enabling) Act enables government services to transfer to the non-government sector.[32] These were preceded by a 2012 agreement between the NSW and Commonwealth governments to implement the NDIS.[33]

The National Disability Insurance Scheme (NDIS)

The implementation of the NDIS by the agency originally known as Disability Care Australia, and now known as NDIA, is a staged process over five years from July 2013 to June 2018. The Year 1 trial of the NDIS through the NDIA commenced in four states as follows:

- South Australia for 4,600 children aged under 15 years
- Tasmania for 950 young people aged 15 to 24 years
- Barwon trial site in Victoria for 5,000 people aged under 65 years
- Hunter trial site in NSW for 10,000 people aged under 65 years.

The Australian Capital Territory, Northern Territory and Western Australia commenced their trial in July 2014 and Queensland implementation will commence in 2018. More information about the national roll-out is available on the NDIS website (www.ndis.gov.au).

[30] NSW Government, *National Disability Strategy NSW Implementation Plan 2012–2014: Creating a more inclusive NSW,* NSW Government, Sydney, 2012a.
[31] NSW Government, *Disability Inclusion Bill 2014,* NSW Government, Sydney, 2014b.
[32] NSW Government, *National Disability Insurance* Scheme (NSW Enabling) Act 2013, NSW Government, 2013.
[33] Commonwealth of Australia and NSW Government, *Heads of Agreement between the Commonwealth and NSW Governments on the National Disability Insurance Scheme*. Australian Government, Canberra, 2012a.

The structure of the NSW trial in the Hunter is described in the *Bilateral Agreement for NDIS Trial between the Commonwealth Government and NSW* and projections for numbers of existing and new clients based on NDIA information are as follows:

- Year 1 - 2013/14: 3,000 people Newcastle LGA (2,600 'existing' clients and 400 'new')
- Year 2 - 2014/15: 5,000 people Lake Macquarie LGA (748 'existing' clients plus 2,033 'new')
- Year 3 - 2015/16: 2,000 people Maitland LGA (1,200 'existing' clients and 830 'new'). [34]

In 2013/14 'existing' clients meant people currently receiving services from the NSW Department of Families and Community Services (FaCS) Department of Aged, Homecare and Disabilities (ADHC), who are being transitioned to NDIA by geographic area as indicated above. 'New' clients meant people newly receiving services through the NDIA, and also included some people currently receiving Commonwealth funded mental health programs who are phasing into the Scheme. (Appendix 2 describes some key Commonwealth funded community sector mental health programs)

The Bilateral Agreement also articulates the processes involved and the costs the Commonwealth and NSW governments will pay respectively with regards to NSW NDIS implementation. The NSW financial contribution is for existing ADHC funded disability support services and establishment of Tier 2 NDIS, primarily through the St. Vincent De Paul (SVDP) Ability Links program.

Ability Links NSW is a new initiative created to support the ongoing reforms of the disability service system in NSW. Families in every part of NSW will have access to an Ability Links Coordinator through the NSW Government commitment of $26.5 million per year for a total of 248 Ability Links NSW Coordinators, distributed as follows:

- Hunter region, where the service is delivered by SVDP. 35
- Sydney metropolitan area - 111
- Northern NSW - 31,
- Southern Highlands and the Illawarra - 20
- Western NSW - 24.

There will be 27 Aboriginal identified Ability Links NSW Coordinators working with both Aboriginal and non-Aboriginal communities.

It is notable that no NSW Health funded community sector mental health programs or services have been included as a financial contribution to the NDIS (e.g. tendered programs such as the Housing and Accommodation Support Initiative/HASI or NGO Grant Program recipients etc.). (Appendix 3 provides an overview of NSW Health funded community sector mental health programs).

[34] Commonwealth of Australia and NSW Government, *Bilateral Agreement for NDIS Launch between the Commonwealth Government and NSW (Schedule A to Heads of Agreement)*, Australian Government, Canberra, 2012b.

The NDIS has three 'tiers' of service

TIER 1 – All Australians (22.5 million people)

- minimise the impacts of disability through public awareness campaigns
- provide information to all members of the public
- assist in reducing social constraints of disability by supporting the purposeful integration of mainstream and other services

TIER 2 – Information, Linkages and Capacity Building/ILC (4 million people with a disability and their 800,000 primary carers)

- information, linkages & capacity building
- better link individuals to mainstream supports
- assist services to be more inclusive and responsive to the needs of people with disability
- direct investment towards evidence based interventions that improve outcomes for the individual

TIER 3 – Individual Funded Packages (410,000 people)

- individual funded packages
- need to meet eligibility criteria and develop a plan
- assist individuals identify goals and aspirations
- assist individuals develop comprehensive plans to achieve their goals
- fund reasonable and necessary supports to enable goals to be achieved[35]

Most early discussions about the NDIS have centred on eligibility for and access to Tier 3 individualised funded packages. The nature of Tier 2/ILC services is not yet fully understood, however the NDIS ILC Policy Framework released in July 2015 will be helpful in this regard.[36]

The ILC Policy Framework describes five 'streams' of ILC:

1. Information, Linkages and Referrals
2. Capacity building for mainstream services
3. Community awareness and capacity building
4. Individual capacity building
5. Local Area Coordination

Ongoing understanding of the interface between Tier 3 and Tier 2/ILC will be aided by the current review of the Commonwealth government's NDIS bilateral agreements with respective states and territories, and development of related transition plans by the end of 2015 for full NDIS implementation.

The *NSW Bilateral Agreement* also speaks to the need to ensure that adequate supports are available to meet current and future needs and aspirations of the following groups of people with high and/or complex support needs, including maximising social inclusion and community connectedness:

[35] Productivity Commission, *Disability Care and Support*, Report no. 54, Productivity Commission, Canberra, 2011.
[36] National Disability Insurance Scheme, *A Framework for Information, Linkages and Capacity Building*, Australian Government, Canberra, 2015.

- approximately 440 individuals with high support needs currently accommodated in Stockton and Kanangra (these are large ADHC residential centres in the NSW trial site)
- people with a disability who have had contact with the criminal justice system, placing themselves or others at serious risk of harm, and who require specialised support responses (subject to final resolution by the Design Working Group)
- individuals where other support arrangements have broken down and unplanned, short-term crisis support is required.

NSW wide NDIS transition is planned to commence in July 2016 and be completed by the end of June 2018 (at which time, ADHC will no longer exist). The program for this to occur has not yet been agreed but may be known from August 2015 when the NSW government is required to report on this to COAG. The lessons from the Hunter trial site will help to inform the scaling up of the NDIS both in NSW and nationally, and this document has been created to capture some of that learning.

The NDIS and Psychosocial Disability

It is estimated that when fully implemented about 57,000 Australians with psychosocial disability will be eligible for the scheme and individually funded packages (i.e. 13% of the total 430,000 NDIS population). Of these, it is estimated that around:

- 10 per cent (almost 6,000 people) would have 'intensive' support needs
- 25 per cent (14,000 people) would have 'high' support needs
  55 per cent (31,000 people) would have 'low' support needs[37]

The NMHCCF estimates at 230,000 the number of Australians with very high psychosocial disability support needs to be much higher than what the NDIS has planned for.[38] About 19,000 of the 57,000 proposed NDIS participants with psychosocial disability may be from NSW (i.e. 13% of 140,000 NSW NDIS population). Using this 13% figure, the Hunter trial site has the potential to assist up to 1,300 people with very high levels of psychosocial disability. However, the uptake of personalised disability support funding by people with mental health conditions in other countries has been consistently low.

Affirmative action is required to ensure that Australians with a psychosocial disability related to a mental health condition have access to NDIS Tier 3 services. In Scotland, the uptake of self-directed support funding by people with a mental health issue has been just 2% of the total number of packages. [39] In England, only 9% of eligible adults with a mental health issue received self-directed support funding compared with 41% of eligible adults with a learning disability in 2010/11.[40] A range of initiatives are now being undertaken to address these shortfalls. The reasons for this low uptake are unknown but may include:

- lack of knowledge about the opportunities presenting for self-directed funding
- poor knowledge of, and skills required to access the services available to support the health and social needs of people with mental health related disability
- lack of coordinated and integrated health and social services.

While the number of 'existing' ADHC and Commonwealth funded mental health program clients with very high levels of psychosocial disability is unknown, Tier 3 NDIA funded services and

[37] Productivity Commission, op. cit.
[38] NMHCCF, op. cit.
[39] J Ridley, H Spandler and A Rosengard, *Follow-Up Evaluation of Self-Directed Support Test Sites in Scotland*, Scottish Government Social Research, Edinburgh, 2012.
[40] Royal College of Psychiatrists and Association of Directors of Adult Social Services, *The Integration of Personal Budgets in Social Care and Personal Health Budgets in the NHS: joint position statement*, Royal College of Psychiatrists, London, 2013.

supports may be able to assist at least 424 people currently receiving few or no community support services during the trial period (52 in Newcastle, 108 in Lake Macquarie and 264 in Maitland - 13% of the potential 'new' clients). However by all measures, the actual number of potential new clients is likely to be much higher than this estimate (see 'MHCC Sector Benchmarking Project example of population planning for improved access to mental health treatment, rehabilitation and support' on pp. 77-78). With reasonable accommodations and other affirmative actions, the number of people newly accessing Tier 3 services and supports could potentially be much higher.

Experiences at the trial sites offer great potential for better understanding the opportunities and barriers presenting for people living with mental health conditions, and to offer thought and practice/service delivery leadership over the remaining years of NDIS implementation. While people with substantially reduced functioning as a result of their psychosocial disability will be eligible for NDIS, historically mental health disability/recovery support planning has been structurally 'siloed' from all other disability planning (e.g. intellectual, physical and sensory). This tradition is perhaps strongest in NSW where people with psychiatric (now known as psychosocial) disability were included in the *Disability Services Act 1993*, but with service provision being the responsibility of the Minister for Health (section 12A).[41] This suggests a high likelihood that non-mental health specialist disability organisations, both government and non-government, may have deskilled in the area of mental health/psychosocial disability rehabilitation and recovery support service provision.

Indeed, there are emerging tensions as to whether and how NDIS underpinning principles of 'permanent lifelong disability' can be reconciled with contemporary thinking and evidence based mental health practice relating to the philosophy and practice of trauma-informed and recovery oriented service provision, especially considering that mental health permanent disability can be 'episodic'.[42] This evidence base has most recently been articulated in the Commonwealth government publication '*National Recovery Oriented Mental Health Practice Framework'*.[43] Conversely, there is a possibility that the philosophy and practice of recovery oriented service provision has much to offer to a deeper understanding of NDIS notions of 'person centred care' and client 'choice and control'.[44]

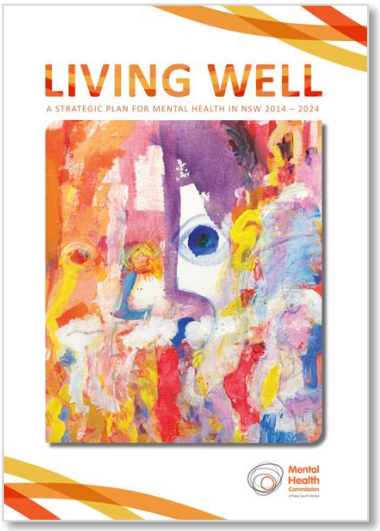
The NDIS and the Mental Health Sector

The mental health sector in Australia consists of a complex and increasingly fragmented mix of public, private, community sector and primary healthcare service providers. Public mental health services in NSW focus on the delivery of acute and sub-acute assessment and treatment services in both hospital and community based settings. Psychosocial disability and recovery support services have historically been the domain of Commonwealth and state and territory funded non-government community sector organisations.

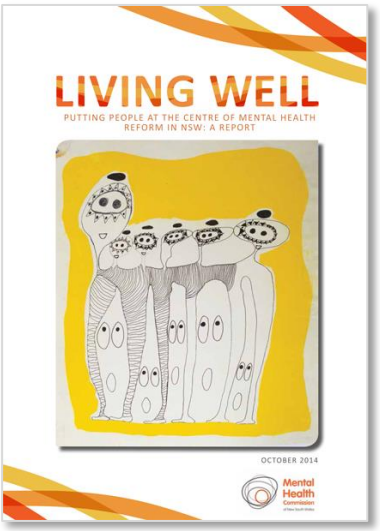
MHCC is the peak body representing non-government community managed organisations (NGOs/CMOs) working for mental health in NSW. As at 1 July 2013 our membership was 113 organisations providing services to people affected by mental health problems in NSW. (When organisational branch membership is included this figure increases to over 160). Many of the services provided to people with psychosocial disability within the Hunter trial site are discussed throughout this paper. (For more information about the community managed mental health sector and its services, The reader is referred to the following documents.[45],[46],[47],[48]

[41] NSW Government, *Disability Services Act 1993*, NSW Government, Sydney, 1993.
[42] M Slade and E Longden, *The empirical evidence about mental health and recovery: how likely, how long, what helps?* MI Fellowship of Victoria, Victoria, 2015.
[43] Commonwealth of Australia, *National Recovery Oriented Mental Health Practice Framework*, Australian Government, Canberra, 2013b.
[44] RichmondPRA, *Good Practice Guidelines for Person Centred Planning and Goal Setting for People with a Psychosocial Disability: A project report for Disability Care Australia*, RichmondPRA, Sydney, 2013.
[45] Community Mental Health Australia (CMHA), *Community Mental Health Australia: Taking Our Place*, MHCC, Sydney, 2012.

The Mental Health Commission of NSW was established in July 2012 under the *Mental Health Commission Act 2012* for the purpose of monitoring, reviewing and improving the NSW mental health system.[49] The Commission has a clear mandate to work across government and other service providers to drive reform across the mental health sector. In doing so, the Commission operates as a bridge between services to identify new ways they can work together to help people live well in the community. In October 2014, the Commission presented the NSW state government with their Strategic Plan for Mental Health in NSW along with a companion document describing the experiences and needs of people with mental health conditions.[50], [51] The activities and outcomes of this project have helped to inform the content of, and will continue to contribute to directions for, the NSW Government's 2014-2024 Strategic Plan.



The Strategic Plan provides some consideration of NDIS related directions. However, it was written in the early stages of NDIS implementation and in an uncertain mental health sector policy and funding reform environment. Subsequently, the NSW Health *Strengthening Mental Health Care in NSW* policy, developed in response to the Strategic Plan, provides $115M through to 2018/19 and is silent on the subject of the opportunities and impacts of the NDIS.[52] A whole-of-government response to the NSW Mental Health Strategic Plan is anticipated to be forthcoming. The three actions and other content specific to NDIS implementation from the NSW government's Strategic Plan is provided over page. Key NDIS related actions from the National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services are also provided.[53]



[46] J Bateman and T Smith, 'Taking Our Place: Community managed mental health services in Australia', *International Journal of Mental Health*, vol. 40, no. 2, Summer 2011, pp. 57-71.
[47] Mental Health Coordinating Council (MHCC), *Community Managed Mental Health Sector Report 2010,* MHCC, Sydney, 2010.
[48] MHCC, *30 Years Working for Mental Health*, MHCC, Sydney, 2013a.
[49] NSW Government, *Mental Health Commission Act 2012,* NSW Government, Sydney, 2012b.
[50] NSW Mental Health Commission, 2014a, op cit.
[51] NSW Mental Health Commission, *Living Well: Putting People at the Centre of Mental Health Reform in NSW*, NSW Mental Health Commission, Sydney, NSW, 2014b.
[52] NSW Health, *Strengthening Mental Health Care in NSW,* NSW Government, Sydney, 2014
[53] National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, National Mental Health Commission, Sydney, 2014.

NDIS Related Content in NSW Mental Health Commission Strategic Plan[54]

p.6 Forward
The Plan (also) cannot fully anticipate major changes to the environment in which these reforms will roll out. The NDIS, which will expand support choices for people with disabling mental illness, and activity-based funding, which will change how health funding flows from the Commonwealth to NSW, are two important examples of national initiatives with the potential to change significantly the lives and experiences of people in NSW.

p.15 1.10 A Role for Everyone
At the highest level there is the need for improved Commonwealth and state government co-ordination, particularly in terms of mental health funding and programs. This will require closer co-operation and planning at the district level but also in relation to major Commonwealth funding initiatives such as the NDIS, headspace and Partners in Recovery.

5. PROVIDING THE RIGHT TYPE OF CARE
5.1 Shift to community

Action
p.59 5.1.2 Local Health Districts will work with the NDIA to ensure that eligible people with a psychosocial disability obtain packages under the NDIS.

Into the community
p.60 With the right community-based support, including that offered under the NDIS, the vast majority of long-stay patients in NSW will be able to return to live in the community.

5.2 Deinstitutionalisation

Action
p.61 5.2.1 NSW Health, in partnership with the NSW Department of Family and Community Services, should complete the work of finding appropriate community accommodation and support for individuals still in long-stay psychiatric institutions by 2018. This work should consider the availability of community-based supports to be provided under the NDIS.

7. CARE FOR ALL
7.3 Mental health and intellectual disability
p.89 Addressing these issues (i.e. lack of disability sector and health resources and related 'siloing') has proved complex and may temporarily become more so as we move from a state-based disability service system to a national model of individualised packages with the introduction of the NDIS. This scheme is a welcome development and will offer consumers greater choice and control in how their non-clinical care and support is provided and managed. However, the reforms mean Health will lose its counterpart NSW agency, Ageing, Disability and Home Care. This issue is further described in Broader Context of Reforms, p.118.

p.90 (in discussing the physical and mental health needs of people with an intellectual disability) The implementation of the NDIS will offer the potential for improved services for those who are eligible, provided we achieve appropriate integration and partnerships among clinical mental health

[54] Mental Health Commission of NSW, 2014a, op cit.

services and community-managed and private service providers. For this key group, this Plan offers the opportunity to address long-standing systemic issues relating to access and co-ordination of care and support, and ensure that the potential of the NDIS is realised.

Action
p.91 7.3.3 As part of the NSW implementation plan for the NDIS, develop strategies to change from the present partnership between NSW Health and other state services with Ageing, Disability and Home Care, to one with the community-managed and private sectors. This will need to take account of the impact on:

- joint projects
- memorandums of understanding
- co-developed guidelines
- relationship management
- dispute resolution
- systemic and strategic planning.

8. Supporting Reform
8.3 Developing the community-managed sector
p.103 Many are also adjusting to the new individualised packaging and brokering system under the NDIS. The reforms raise real questions about the community-managed mental health sector's readiness for these changes.

p.103 The survival and growth of the sector will depend on its capacity to adopt business models that fit with the new contestable and customer driven environment, and on the continued professionalisation and accreditation of its workforce.

p.104 Some mental health CMOs are large enough to take care of their own workforce development needs, but smaller ones are unlikely to be able to meet workforce development needs without state funding support. Commonwealth funding is available through the NDIA for the workforce undertaking the role of disability support workers, but it is mostly unavailable for psychosocial support workers in agencies funded by NSW Health. In any event, mental health/psychosocial training is required to meet state government structural changes to the way in which mental health services will be delivered in the future.

Business models, innovation and data
p.105 With the roll-out of the NDIS over the next five years and the NSW move to competitive tendering for services, it is clear that CMOs need to quickly review their business models and determine how they will operate and compete in this new environment. Larger organisations or consortium models are more likely to have the critical mass to cope with the challenges and to take advantage of opportunities.

p.105 Finally, as noted in Better Use of Technology, p.107, there are capacity limitations within the CMO sector in relation to data systems which affect its ability to adapt to the large-scale reforms of NSW Health's Grants Management Improvement Program and the NDIS, as well as any reporting standard changes. But work on this stalled because of funding issues and much is still to be done.

10. Broader Context of Reforms

National Disability Insurance Scheme

pp.118-119 Under the NDIS, people with a psychiatric disability will be offered support if their impairment affects their communication, social interaction, learning, mobility, self-care or self-management, and the impairment affects or is likely to affect the person's capacity for social or economic participation.

For people with severe mental illness, the NDIS acknowledges their experience that severe psychological symptoms can be just as disabling as physical illness. The Scheme's emphasis on people's level of functioning rather than their diagnosis is in line with thinking that mental health is part of a person's overall wellbeing.

The NSW roll-out of the NDIS has started in the Hunter region. A range of reviews is under way to look at how to improve the Scheme's implementation. These reviews acknowledge that some things remain unclear, including how the Scheme will apply to people whose mental illness causes disability. At this time, it is not yet certain what level of mental health support will be included in an NDIS package. It also appears some people will fall through the gap as Commonwealth funded mental health support services, such as the Personal Helpers and Mentors Service, provide services to a broader group than would be eligible for the NDIS. While present participants have a guarantee that they will not be worse off, these services will not be available to new people unless they are eligible for the NDIS. This is a real concern for people living with a mental illness and is likely to place extra pressure on Local Health Districts.

These issues need to be closely monitored and the Mental Health Commission of NSW has partnered with *MHCC* to provide a project worker in the Hunter NDIS site to influence and learn from the early implementation of NDIS and how it applies to people who experience mental illness.

Another issue relates to governance at the intersection between mental health and disability, particularly in complex areas such as the criminal justice system. At present, NSW Health and the Department of Ageing, Disability and Home Care (ADHC) have a highly developed partnership in this area. But ADHC will cease to exist after the NDIS is introduced. From a service perspective, NSW Health will need to develop partnerships with community-managed and private disability service providers and the NDIA.

But with whom will NSW Health partner on strategic issues to ensure there are appropriately accountable services and models of care to meet the needs of clients with complex needs? As in other states, these matters are still being considered by government agencies, including Family and Community Services and NSW Health, as part of the NDIS implementation work.
The ultimate outcome in NSW may be assisted by proposed reforms under the NSW Disability Inclusion Act 2014 that specifically acknowledges psychosocial disability as a disability for the purposes of the legislation, in a similar manner to the NDIS.

The National Review of Mental Health Programmes and Services, National Mental Health Commission (2014)

Strategic direction 1 - Set clear roles and accountabilities to shape a person-centred mental health system

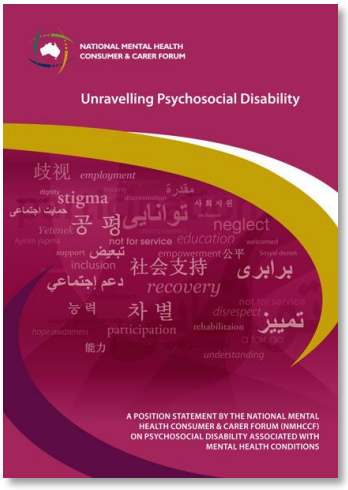
Recommendation 1.3 - Urgently clarify the eligibility criteria for access to the NDIS for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

What success will look like? There is a smooth transition for people with lived experience, their families and support people, as well as an integrated approach between the mental health system and the NDIS.

Project Overview

This report describes work undertaken by *MHCC* in partnership with the Mental Health Commission of NSW, to analyse processes around the inclusion of people with psychosocial disability within the NSW NDIS trial site in the Hunter region (Newcastle, Lake Macquarie and Maitland LGAs).

The work was initially undertaken for a period of 6 months commencing 3 June to 29 November 2013. It was subsequently extended to the end of June 2015 with agreement to a further third year of activity and in anticipation of full NSW roll-out. An approach to locate the *NSW Mental Health and NDIS Analysis Partnership Project* Project Officer/NDIS Mental Health Analysis position at the NSW NDIA Hunter office was supported at a national level. At a local level however, management, whilst remaining supportive of the concept of the role, expressed the need for greater separation.



The NSW *Mental Health and NDIS Analysis Partnership Project* has focused on adults aged 18 to 65 years with some consideration being given to the psychosocial rehabilitation and recovery support needs of both younger people and older people. The project, which is very wide and deep in its scope[55], has been guided by the recommendations arising from the NMHCCF position paper on *'Unravelling Psychosocial Disability'* (pictured) associated with mental health conditions. The recommendations of the NMHCCF in regard to better understanding the needs of people with psychosocial disability related to mental ill health have not been well progressed (Appendix 1). The implementation of the NDIS presents an important opportunity to progress not only these recommendations, but also Australia's commitments to people with significant disability related to a mental health condition under the UNCRPD.

Reporting on this activity was conducted through a project Steering Committee comprising members the Mental Health Commission of NSW, *MHCC* and the Project Officer/NDIS Mental Health Analyst (Tina Smith, *MHCC* Senior Policy Advisor/Sector Development) and other relevant participants as required.

[55] National Mental Health Consumer and Carer Forum, op. cit.

Understanding Psychosocial Disability

Psychosocial disability refers to the disability experienced by people with mental health conditions due to impairments and participation restrictions relating to the mental health conditions. Impairments and participation restrictions could include the loss of or limitation to physical, social, emotional, cognitive or sensory function, reduced ability to experience full physical health, and many more.

Psychosocial disability is distinct from psychiatric disability in that psychosocial disability refers to the social consequences related to mental illness, whereas psychiatric disability focuses on the medically defined illness, symptoms and impairments.

While not all persons with mental illness experience psychosocial disability, those who do are much more likely to experience significant disadvantages, including unemployment, poor housing, poor health and homelessness.[56]

Objectives

The 2013/14 objectives of the NSW *NDIS and Mental Health Analysis Partnership Project* proposed to better understand and make recommendations regarding:

- how psychosocial disability should be understood and included under the NDIS in terms of:
    - access and eligibility
    - existing mental health community sector and public mental health programs
    - equity, monitoring and safeguard mechanisms
    - workforce appropriateness

- the wider NDIS and health services interface, especially as this relates to the unmet physical health needs and high prevalence of substance use by people living with mental illness

- people presenting with multiple co-existing difficulties in addition to psychosocial disability, such as acquired brain injury (ABI), intellectual disability (ID) and other cognitive impairment/s as well as physical disability

- the suitability of the NDIA assessment tool/s developed for people with psychosocial disability

- the national discourse regarding the situating of psychosocial disability within the NDIS.

Tasks and activities undertaken to explore the project objectives and inform outcomes include:

1. **Network with stakeholders**
   Network with a diversity of NDIS and mental health stakeholders/key points of influence to better understand the situation for mental health in regard to NDIS implementation.
2. **NDIS legislation and the Bilateral Agreement**
   Better understand how implementation of the NDIS legislation and the Bilateral Agreement for the NDIS trial between the Commonwealth government and NSW supports the mental health needs of people with high and complex needs including:
    - people currently residing at the ADHC Stockton and Kanangra Residential Centres, the HNELHD Morisset Hospital, and other regional psychiatric hospitals

[56] National Mental Health Consumer and Carer Forum, op. cit.

- people with disabilities who are also known to the criminal justice system who may place themselves or others at serious risk of harm, and who require specialised support responses
- people for whom support needs have broken down and unplanned short term crisis work is required.

3. **NDIS national assessment tools**
   Explore application of the NDIS national assessment tool/s as this relates to assessing eligibility and planning for the needs of people with psychosocial disabilities (i.e. cognitive/ behavioural impairment/s associated with mental health conditions)
4. **Referral and assessment processes and pathways**
   Encourage NDIS flexibility in response to identified unmet psychosocial disability support needs through formalisation of referral and assessment processes/pathways
5. **Build on knowledge about unmet psychosocial rehabilitation and recovery support needs**
   Use *MHCC Sector Benchmarking Project* data to build on knowledge about, and better assess the unmet psychosocial rehabilitation and recovery support needs of the population living with mental illness in the Newcastle, Lake Macquarie and Maitland LGAs of the Hunter New England Local Health District (HNELHD).
6. **The interface between NDIS and Partners in Recovery**
   Explore the interface between the NDIS and the new Partners in Recovery (PIR) initiative in the Hunter also set to roll out from 1 July 2013 (deemed to be in scope for NDIS)
7. **The impact of NDIS on existing mental health programs**
   Assess the impact of the NDIS on people with psychosocial disability currently accessing the range of existing Commonwealth and State mental health programs (both those considered to be in and out-of-scope for NDIS)
8. **Review of the NSW Disability Services Act 1993**
   Contribute to discussions related to the current review of the NSW Disability Services Act 1993, especially as this relates to section 12A which refers to the psychiatric/psychosocial disability support needs being the responsibility of NSW Health Minister
9. **Review of the Community Services (Complaints Review and Monitoring) Act 1993**
   Contribute to discussions concerning the review of the Community Services (Complaints Reviews and Monitoring) Act 1993 (CS-CRAMA).
10. **Jurisdiction of the NSW Ombudsman and the Ministry of Health Official Visitors Program**
    Consult on legislation as applied to the jurisdiction of the NSW Ombudsman and the NSW Health Official Visitors Program over the NDIS trial sites, and potential implications for psychosocial support providers
11. **NDIS 'Applied Principles – Mental Health'**
    Strive to clarify NDIS 'Applied Principles - Mental Health' with regard to better understanding role delineations (i.e. treatment/support, rehabilitation/recovery, clinical/non-clinical)
12. **Roles and impacts of other funding mechanisms**
    Consider the roles and impacts of other relevant funding mechanisms on NDIS eligibility and access for people with psychosocial disability (e.g. NSW Disability Services Act review; introduction of activity based funding/ABF in mental health)

A final activity of the 2013/14 *NDIS Mental Health Partnership Project* was to capture in a final report the learning arising. Publication of the 2013/14 report was delayed due to the complexities of the mental health sector reform and NDIS implementation environments both at the NSW and national levels. This is understandable given the volume of activity and learning occurring around the early stages of NDIS implementation from a mental health sector perspective. The need for a high level of trust and confidence, while maintaining vigilance, is critical in the early stages of NDIS implementation.

This Report

This report describes activity in the NSW Hunter NDIS trial site between June 2013 and June 2015.

Following this introductory section, each of the 2013/14 project objectives and related outcomes are explored, and relevant recommendations made in response to these. The report ends with a discussion of the findings and recommendations, and identifies priority actions to strengthen both the position of people affected by mental illness, and the capacity of organisations that provide health and social services to them. The 12 activities above are considered within the context of the project objectives, outcomes, findings and recommendations. The seven identified priority actions informed the NSW *NDIS Mental Health Analysis Partnership Project* 2014/15 trial site activity as agreement was reached on subsequent priorities. The agreed emphasis moving into 2014/15 was advocacy and support for consumers, carer and community participation in NDIS design, implementation and evaluation, as well as contributing to research and development activity that is facilitating evolution of the NDIS.

The NSW Mental Health Commission and *MHCC* wish to thank the many people who have contributed to our shared learning about the situation of people with mental health and/or psychosocial disability conditions within the NDIS. Our thanks are particularly extended to people with lived experience of mental health conditions and those who support them in their journeys of recovery and social inclusion.

How to reconcile notions of recovery and permanent disability?

'Is it really the case that the Australian government is asking the hundreds of thousands of people living with mental health conditions, their families and carers, and the people that provide services to them to give up all hope that recovery is possible'?

Larry Davidson, PhD - Professor of Psychology, Department of Psychiatry
Visiting Sydney at the invitation of the NSW Mental Health Commission in July 2013

Overview of the NSW NDIS Mental Health Analysis Partnership Project
Trial Site Experience

NSW NDIS trial site implementation and mental health 'at a glance'

The NSW NDIS and Mental Health Partnership Project commenced by conducting individual meetings with MHCC member organisations between July and September 2013 to learn about their early experiences in the NDIS trial site. It was quickly ascertained that a large number of people in receipt of state and Commonwealth funded disability supports from within the Newcastle LGA were being 'transitioned' and 'phased' to the NDIA (i.e. to receive NDIA Tier 3 funded services and supports).

With regard to people with mental health conditions these are primarily:

- ex-licensed boarding house residents receiving supported accommodation and community based activities funded by ADHC (i.e. mostly day programs at centre based services)
- current licensed/assisted boarding house residents in receipt of Active Linking Initiative/ALI type services funded by ADHC (i.e. engagement and community based activities for boarding house residents)
- Commonwealth funded mental health program recipients (e.g. Personal Helpers and Mentors Service/PHaMS).

During the first two years, some people's funded services were increased and some decreased following review by the NDIA. Where a person, their family or carer, or an existing service provider has concerns about changes to funded supports, the NDIA has been very receptive to further review.

Existing service providers were originally being kept at a distance from NDIA access and planning (i.e. care planning process). This was stated to be out of respect to the NDIS participant's 'choice and control' about services required. This was problematic on occasion, with clients perhaps understating their support needs. Again, the NDIA have been open to service provider concerns in this regard. More collaborative practice with existing service providers and carers/families for access and planning has occurred from October 2013, while still respecting the participant's 'choice and control'.

Many new people being supported to access the NDIS were deemed eligible, and successfully accessed funded services and supports. These included people who were residing in sub-acute inpatient settings including Morisset Hospital and also people accessing HASI and other residential and non-residential NSW Health funded mental health programs. However, there continues to be a lack of clarity regarding the NDIA Tier 3 eligibility of people who may be receiving a NSW Health funded mental health program, whether residential or non-residential in nature.

The distancing of existing service providers has not been the experience of Hunter New England Mental Health (HNEMH) staff who report that the eligibility and access/care planning process has a potential for high impact on their acute/sub-acute mental health assessment and treatment priorities, despite also achieving successful positive outcomes for clients. The NDIA requirement for extensive psychosocial functional information is placing additional demands on the already under-resourced mental health sector across both government and non-government work settings.

HNEMH has shown leadership in engaging with the new Partners in Recovery (PIR) initiative to explore this mental health program's interface with the NDIS. However, negotiating three way meetings of the public mental health service, PIR and the NDIA have been challenging. HNEMH have met monthly with NDIA since November 2013, and they meet separately with PIR. PIR and the NDIA also meet separately.

In 2014, NSW NDIA established an internal Mental Health Special Interest Group where some eligibility and access requests and care planning processes are reviewed towards establishing benchmarks. In 2015, the NDIA established a national internal mental health community of practice to further their understanding of how to most effectively work with people affected by mental illness/psychosocial disability.

From July 2013, MHCC attended a fortnightly HNELHD/NDIA NDIS Health Working Group and this was a valuable forum for monitoring and exploring implementation and the very important health/disability interface. The focus of these meetings included mental health but was more broadly about the HNELHD/NDIA interface, with a particular focus on the transition of shared clients and services, such as ADHC funded Home and Community Care (HACC) program recipients where HNELHD is the funded HACC provider.

During 2014/15, a maturation of operational and governance structures has occurred, including establishment of an NDIS Operational Working Group that meets monthly with reporting 'Subject Groups' established for:

- physical health
- children and adolescents
- people with mental health conditions.

Planning for these structures followed a NSW FaCS and NSW Health 'NDIS Health Pathways' forum held in Newcastle on 17 October 2014, where mental health/psychosocial disability was a considerable topic of discussion in parallel to physical health care and the health/disability interface.

There is no consumer, carer or community representation to the Mental Health Subject Group.

The Hunter NDIS and Mental Health 'Community of Practice' Forum and consumer, carer and community participation

In October 2013, the NSW Mental Health Commission and MHCC met with community sector organisations in the Hunter interested in the opportunities presenting for people with mental health conditions through the NDIS. This initial meeting led to establishment of a quarterly Hunter NDIS and Mental Health 'Community of Practice' (COP) Forum that is hosted by MHCC and the NSW Mental Health Commission, and has since met a further seven times. The community sector agreed that the forum should be open to anyone with an interest in mental health and the NDIS, and wanting to learn from experiences at the trial site. Both HNEMH and the NDIA provide regular updates at the forums. During 2013/14, MHA also attended to provide an update on national directions. From December 2014, a NDIS Participant Consumer Update has been added to the program. (In addition to sharing their experience, this person also sits on the MHA NDIS Capacity Building Project Consumer and Carer Working Group).

At the end of June 2015 the COP Forum consisted of 317 people as follows:

- - 136 community sector workers from the Hunter
- - 75 community sector workers from outside the Hunter

- - 77 other people from the Hunter (mostly HNEMH staff)
- - 36 other people from outside the Hunter
- - 3 consumers.

While the Hunter NDIS and Mental Health COP Forum has attracted interest from other states and territories and the Commonwealth, it is of great concern that there has been little participation by people identifying with lived experience of a mental health condition and/or recovery, or their family and carers, other than people in paid work roles (i.e. both peer and non-peer).

A focus of the COP Forum has been addressing the absence of systemic mental health consumer, carer and community sector representation and participation during NDIS implementation in NSW.

2014

- March COP Forum included a 'Q&A' panel with consumer, carer and service provider representatives exploring people's experience of the NDIS and barriers to consumer and carer participation at a systemic level.
- In April, a meeting was held with consumers and carers at RichmondPRA on King in Newcastle to discuss the NSW NDIS trial and concerns that were arising about a growing number of people being assessed as ineligible for Tier 3 funded services and supports.
- June COP Forum included presentations by the peak bodies for consumers and carers in NSW: Being (formerly the NSW Consumer Advisory Group - Mental Health Inc.) and ARAFMI NSW (Association of Relatives and Friends of the Mentally Ill)
- September COP Forum highlighted consumer and carer experiences of the NDIS and included a presentation by the NSW Ombudsman Office about their role during NDIS implementation, particularly in regard to complaints and the monitoring of systemic issues.
- December COP Forum heard a presentation by Mr Eddie Bartnik, former WA Mental Health Commissioner and now Strategic Advisor to the NDIA, who emphasised the importance of co-design approaches undertaken with consumers and carers.

2015

- - March COP Forum was used to consult about the draft 'NDIS Tier 2/Information, Linkages and Capacity-building Framework' and National Disability Strategy 'Quality and Safeguards Framework'.[57]
- - July COP Forum saw the return of the NSW Ombudsman's Office to discuss the experiences of NDIS participants with mental health conditions with service providers, consumers and carers.. Service providers were consulted at the COP Forum and separate meetings followed with separate consumer and carer groups held at RichmondPRA on King.


The Mental Health Coordinating Council and the Mental Health Commission of NSW present

Hunter NDIS and Mental Health Community of Practice Forum

Friday 24th July 2015
10:00am - 1.00pm

Issues related to consumer, carer and community participation and representation in NDIS implementation are regularly discussed with NDIA, HNEMH, MHA and others. Opportunities will continue to be pursued related to enhancing consumer, carer and community representation and participation in NDIS implementation and evaluation.

More information about the COP Forum and other NSW mental health related NDIS activity is available on MHCC's website: http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx.

[57] MHCC, *Submission in Response to DSS - NDIS Quality and Safeguarding Framework: Discussion Paper - April,* MHCC, Sydney, NSW, 2015b

PROJECT OUTCOMES AND RECOMMENDATIONS

1. How psychosocial disability should be understood and included under the NDIS in terms of:

1.1 Access and eligibility

Outcome 1: At the end of 2013/14, 170 people with high levels of psychosocial disability related to mental illness had been found eligible for Tier 3 NDIS services in Hunter trial site.[58] However, the number of people with either a primary or secondary psychosocial disability accessing the Scheme needs to be closely monitored, including for those deemed ineligible, and clear benchmarks for eligibility and access need to be established.

Recommendation 1: Identify structures to provide iterative guidance regarding psychosocial disability and recovery support services access and NDIS eligibility (who is in and who is out).
Recommendation 2: Obtain greater clarity regarding service user needs, availability and access for people deemed ineligible for a Tier 3 funded support package.

The draft rules related to the NDIS were released on 5 March 2013 and the associated legislation passed on 16 May 2013. This followed two years of consultation and *MHCC*, along with other mental health sector representatives, made numerous submissions related to the access and eligibility of people with psychosocial disability during this time.[59],[60],[61],,[62],[63] Prior to this, *MHCC* undertook an international literature review and developed a position paper exploring self-directed funding and community managed mental health sector opportunities and challenges.[64]

> *The NDIS Act 2013 sets out when a person meets the eligibility requirements to be a participant in the Scheme (i.e. access to individual packages of supports).The requirements are met if:*
>
> - *the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and*
> - *the person's impairment or impairments are, or are likely to be, permanent; and*
> - *the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication, social interaction, learning, mobility, self-care, self-management; and*
> - *the impairment or impairments affect the person's capacity for social and economic participation; and*

[58] This has increased to 401 people at the end of June 2015 (see 'Access to Tier 3 of the NDIS' pp. 31-32 for a more detailed analysis).
[59] MHCC, *MHCC Submission to the Commonwealth Government NDIS Rules Consultation Paper*, MHCC, Sydney, NSW, March, 2013c.
[60] MHCC, *Submission to the National Disability Scheme Joint Taskforce Consultation Regulation Impact Statement National Disability Insurance Scheme*, MHCC, Sydney, NSW, February,2013.
[61] MHCC, *Submission to the Department of Family and Community Services - Reforming NSW Disability Support: Legislative Structure and Content Discussion Paper*, MHCC, Sydney, NSW, February, 2013d.
[62] MHCC, *Submission to the Senate Community Affairs Legislation Committee Inquiry into the National Disability Insurance Scheme Bill 2012*, MHCC, Sydney, NSW, January, 2013e.
[63] MHCC, *Submission to the Select Council on Disability Reform: Eligibility and reasonable and necessary support under the NDIS*, MHCC, Sydney, NSW, September, 2012.
[64] MHCC, *Self- Directed Funding and the Community Managed Mental Health Sector Opportunities and Challenges: Position Paper/ Literature Review,* MHCC, Sydney, NSW, November, 2011a.

- *the person's support needs in relation to his or her impairment or impairments are likely to continue for the person's lifetime.*

In relation to the above, an impairment that varies in intensity (for example because the impairment is of a chronic episodic nature) may be permanent, and the person's support needs in relation to the impairment may be likely to continue for the person's lifetime, despite the variation.

The final clarifying statement above is important as it helps to address the concern around the preceding emphasis on 'permanent disability'. That is, it allows for contemporary thinking about recovery from a mental health condition, where recovery is not necessarily about cure but living a valued and contributing life in the community, with conceptual thinking about disability/s that may be more permanent and enduring.

People can check their eligibility for NDIS by:

- on-line use of the 'My Access Checker' feature at the NDIS website: www.ndis.gov.au (this will not result in a definitive response regarding eligibility)
- calling the NDIA on 1-800-800-110 (you are asked to leave a message and will be called back)
- attending an NDIA office (for the Hunter trial site this is at 14 Auckland St, Newcastle NSW 2300 or Shop 1, Hilltop Plaza, Charlestown Rd, Charlestown NSW 2290).

In regard to mental health and psychosocial disability, HNELHD/HNEMH have been formalising their interface (i.e. 'referral pathways') with NDIA. However, this work is not in the public domain. For HNEMH, there is an intention to build on this through the subsequent inclusion of community sector mental health referral pathways, including for PIR and the NDIA NSW Tier 2/ILC and 'Ability Links' initiative. More recently, discussion about referral pathways has sometimes met with a response that such notions are not consistent with client 'choice and control', and that what services are in fact doing is supporting a person in their access of the NDIS.

The interconnectedness of NDIS (Tier 3 and 2 eligibility) and PIR cannot be underestimated with regard to the need for eligibility/access benchmarks and referral/assessment processes and pathways to be established. The episodic nature of mental illness/psychosocial disability means that people will move between these NDIS tiers in ways that are less likely, but equally possible, for people with intellectual, physical and/or sensory disability/s.

The 'transitions' of existing ADHC funded mental health clients residing in the Newcastle LGA to the NDIS from July 2013 progressed well, with some Lake Macquarie clients transitioning to the NDIA ahead of time. The NDIA has been very responsive and flexible where decisions about eligibility, access and planning, funding package amounts, etc. may need review, and the volume of work means that benchmarks are slowly beginning to emerge for scheme eligibility and access. However, the establishment of benchmarks still has some way to go, and more systemic approaches to data and outcome collections would be helpful in this regard.

Commonwealth funded mental health program clients began 'phasing in' to the NDIS from January 2014, and MHCC has advocated regarding issues related to large numbers of people being assessed as ineligible for Tier 3 funded packages. The NDIA guarantee of service for the ineligible group has been confirmed as being available through to the end of the three year trial period. *MHCC* is closely monitoring new referrals to Commonwealth programs, and especially PHaMS, to ascertain access barriers that may present for non-NDIS referrals (i.e. as NDIA seemingly has priority of access with 100% of this mental health program being 'in-scope' for NDIS).

Commonwealth Mental Health Programs 'In-Scope' for the NDIS

The following Commonwealth funded mental health programs have been deemed 'in-scope' for NDIS:

- Personal Helpers and Mentors (PHaMS) - 100% 'in-scope' for NDIS
- Partners in Recovery (PIR) - 70% 'in-scope' for NDIS
- Mental Health Respite -50% 'in-scope' for NDIS
- Day to Day Living Program (D2DL) - 35% 'in-scope' for NDIS.[65]

What 'in-scope' means in terms of service access and delivery for both people eligible and ineligible for NDIS Tier 3 funded services and supports is not yet understood, beyond it being an 'in-kind financial contribution'.

'In-kind' supports are existing Commonwealth or state/territory government programs delivered under existing block grant funding arrangements. For NSW, this is ADHC funded services.

While a substantial number of individual consumers, families and carers have now had experience of the NDIS, there is no specific, systemic avenue for them to collectively provide feedback to the NDIA. However NDIA collect satisfaction data from individual participants approximately one month after they have had their initial planning meeting. The NDIA also has mechanisms for individual feedback, complaints and reviews. The absence of a systemic mechanism is particularly critical as, on applying for the NDIS, consumers have to be assessed as 'disabled' in order to qualify for support funding which is at odds with the much valued recovery oriented support approaches within the mental health sector. This tension has been distressing for consumers in a variety of ways, and resolution of this may require amendments to the NDIS Act.

It became clear quite early in the project that the Hunter was the only 2013/14 Year 1 trial site with any significant amount of sustained mental health/psychosocial disability related activity from commencement of the NDIS. This includes consideration of the important interface of NDIS with PIR. A Hunter PIR report on their first year of operations indicates that more than 800 people have been referred, and 359 people accepted into the program since it commenced in November 2013.[66] However, there are continuing NDIS implementation tensions related to engagement, eligibility and access (i.e. who is eligible for Tier 3 funded support packages, who is not, and what the differences between these people are). The report describes that at the end of December 2014 there were 50 joint NDIS consumers and 32 applications pending from a total of 229 Hunter PIR clients in the three LGAs of the NDIS trial site. The report describes the Hunter PIR initiative experience of the NDIS and also key issues that have emerged relating to the:

- category 'coordination of supports'
- recognition of Hunter PIR's innovative sector reform and capacity building contributions
- risk of Hunter PIR-eligible people being excluded from the NDIS due to a range of barriers.

[65] Mental Health Australia, *Mental Health and the National Disability Insurance Scheme: Position Paper,* Mental Health Australia, Canberra, 2013
[66] Hunter Partners in Recovery, op. cit.

Access to Tier 3 of the NDIS

Total NDIS participants as at 30 June 2015 [67]

Implementation of the NDIS is proceeding well:

National
19,545 participants were eligible for the Scheme (107% of the bilateral target)
17,303 participants had an approved plan (94% of the bilateral target)

NSW
4,964 participants were eligible for the Scheme (99% of the bilateral target)
4,605 participants had an approved plan (92% of the bilateral target).

How many people with psychosocial disability have accessed Tier 3 of the NDIS?

At the end of June 2015:

National
1090 people with either 'Schizophrenia' or 'other psychiatric disability' as their primary disability had accessed the Scheme and had approved plans.

NSW
401 people with either 'Schizophrenia' or 'other psychiatric disability' as their primary disability had an approved plan (i.e. 37%).[68]

It is likely that data on psychosocial disability NDIS access includes other people:

- with a primary psychosocial disability whose plans have not yet been completed
- presenting with other complex and diverse health and social problems, including mental health conditions (i.e. secondary psychosocial disability).

However, this information was not reported for the end of June 2015.

The data available at the end of Year 2 indicates that:

- - people with psychosocial disability represent 6.3% of all people accessing the Scheme who had an approved plan nationally and this figure is somewhat higher in NSW at 8.7%
- - the total number of people with psychosocial disability who had an approved plan in the NDIS nationally is less than 2% of the full rollout target of 57,000 (this has increased from less than 1% at the end of Year 1)
- - the total number of people with psychosocial disability who had an approved plan in the NSW trial site is 31% of the MHCC benchmark target of 1,300 (i.e. 13% of the 10,000 people expected to access Tier 3 funded supports during the NSW trial).

The NDIA advise that these low figures, especially nationally, may be a result of the NDIS phasing schedule, and also artificially influenced by some states with young age cohorts.

[67] National Disability Insurance Scheme, *Report on the Sustainability of the Scheme: 1 July 2013 to 30 June 2015 - Prepared by the Scheme Actuary* July 2015, NDIA, Geelong, 2015c
[68] National Disability Insurance Agency 2015a, op. cit.

How many people have been found ineligible for NDIA Tier 3 funded services and supports?

22,563 access requests to the NDIS have been made by individuals, with 1,667 people found ineligible (7%).[69] Of these, 670 people were in NSW (40%). The number of these with psychosocial disability is not publically reported at either a national or state/territory level.

The NDIA quarterly reports inform us that the NSW trial site has the largest number of applicants deemed ineligible for access to Tier 3 funded supports. NDIA are reviewing all people deemed ineligible for Tier 3 NDIS nationally, which may help to progress the understanding of eligibility benchmarks. There is also a national project specifically exploring operational access for people with psychosocial disability.

MHCC was advised that some 35-40 people with psychosocial disability in the Hunter applied for the NDIS in 2013/14 but were declined access.[70] In May 2015, the NDIA advised MHCC that these people's circumstances have been reviewed and all decisions found to be sound.

What about my peers who have been denied access to the NDIS?

A former healthcare professional living with psychosocial disability related to Bipolar Disorder, and also physical disability as an effect of years of large doses of psychiatric medications, was successful in her access request for NDIS Tier 3 funded services and supports. The 20 hours per week package received includes participation and volunteerism at a centre-based program where many people with mental illness/psychosocial disability and their families and/or friends socialise, obtain assistance and have the opportunity to develop new skills. Several people from the centre-based program have been denied access to the NDIS. This NDIS participant is left wondering how their access to funded support services was approved when many of her peers, who are arguably more disabled but less articulate, did not. Everyone is looking forward to having clearer information, benchmarks and guidelines in regard to Tier 3 access.

Arrangements for people who do not need NDIS funded supports?

Ensuring that those people not requiring funded services are well supported by comprehensive community and mainstream services is imperative for Scheme sustainability. This will ensure that people receive the services and supports they require in the most appropriate way, and minimise the number of people who may otherwise require NDIS support. This complex work is expected to be completed by the end of 2015/16. This work will be undertaken by governments.

It is imperative to the success of the NDIS that Tier 2/ILC services are sufficient so that people do not feel a need to over represent their disability in order to access funded services and supports.[71]

[69] National Disability Insurance Agency 2015a, op.cit.
[70] This information was shared in a verbal communication by FaCS in July 2014.
[71] National Disability Insurance Agency, *2013/14 Annual Report*, NDIA, Geelong, 2014b.

The NDIS and the need for 'flexibility'

It will be important to monitor how the episodic nature of mental illness will sit within a structure largely built around functional impairments with far less variability, and how DisabilityCare (the NDIS) interfaces with the mental health legal system, clinical services, and programs such as Partners in Recovery. It will be important to monitor the impacts of changes to existing services for service users. Careful monitoring, strong advocacy, frequent communication and good change management practices will be critical to a successful transition.[72]

1.2 Existing mental health community sector and public mental health programs

Outcome 2: NDIS implementation has a very high impact on existing community sector and public mental health programs.

Recommendation 3: Engage with activities to map and rationalise acute, sub-acute and non-acute psychosocial rehabilitation and recovery/disability support programs in mental health programs (i.e. both community sector and government programs in NSW).
Recommendation 4: Engage with national policy recommendations to increase psychosocial disability and recovery support funding levels in NSW from 6/8% to 30% by 2024.

Both HNEMH and community sector organisations delivering services to people affected by mental health conditions report a high and growing impact on day to day service delivery resulting from NDIS implementation. However, it is evident that there is a high potential for more community based psychosocial disability and recovery support services to be accessed to help those people most disabled as a result of a mental health condition.

The NDIA is learning much about who people with mental health conditions are, their disability/recovery support needs, and the community sector, government, private and primary health care services that provide support and treatment to them.

Impact on Public Mental Health Programs

HNEMH for adults in the NSW NDIS trial site are summarised in Appendix 4. The HNELHD provides public mental health services in each of the three LGAs of the trial site and these focus on both community and inpatient acute and sub-acute assessment and treatment (i.e. 'clinical'/medical services). HNEMH reports a high impact resulting from NDIA requests of assessment information associated with new referrals to the scheme. The first referrals of mental health consumers to the NDIA were by a social worker at a HNEMH sub-acute hospital facility. People were referred who had been inappropriately residing in hospital for many months as a result of lack of appropriately supported community care. The volume of both treatment and psychosocial assessment information needing to be provided to the NDIA for an eligibility determination to be made is considerable. There is an expectation by the NDIA that the potential NDIS 'participant' will provide this information, but there are complications of performance, capacity and especially volition for a person to do this in a mental health context. The social worker estimates that the first three referrals to the scheme dominated her full time workload for the first three months of the Scheme. However, all three clients accessed funded Tier 3 support packages, and the potential for a more efficient use of specialist acute/sub-acute mental health services was

[72] Connetica, *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future: Perspectives Report,* (Eds), Mendoza, J, Elson, A. and Caloundra, G, Connetica, 2013.

quickly realised. This has resulted in consideration, and subsequent implementation, of more systemic approaches to the identification of people who could be potentially eligible for Tier 3 services allowing them to live well and stay well in the community.

For example, at the March 2014 Hunter NDIS and Mental Health COP Forum, HNEMH reported that they had made 63 referrals of people to NDIA from inpatient hospital sites. From these, 19 people had been accepted for Tier 3 funded community based services and supports, and others were still being assessed. It was uncertain how many have been deemed ineligible, but some of the reasons why included insufficient evidence (of disability?, over 65 years old, outside of the trial site, not a permanent disability, and not substantially reduced functional capacity etc.

HNEMH are now auditing their community team caseloads for the three LGAs of the NDIS trial. They can see the considerable benefits of supporting a person to access NDIS funded support services as these can help people to remain well (i.e. psychiatrically stable), thus freeing up much needed acute and sub-acute mental health services for others that need them. At the same meeting, NDIA indicated that they then had 89 clients with primary psychosocial disability, of which 79 now had plans, and that the numbers of eligible people with psychosocial disability related to a mental health condition is growing quickly.

Both HNEMH and NDIA later indicated they would no longer be able to provide updates on the numbers of people with psychosocial disability accessing the Scheme other than what is provided in NDIS quarterly reports. Unfortunately, the quarterly reports do not contain sufficient or detailed mental health/psychosocial disability data at the state and territory level. The absence of timely information about scheme eligibility and access will be a major challenge to efficiently maximising opportunities presenting through NDIS for people with mental health conditions. The lack of detailed data is also an obstacle to developing a mental health and NDIS research and development direction to maximise the learning from the trial sites.

NDIS presents opportunities for people to return to the community

A man has been inappropriately residing in a psychiatric hospital for many months. Prior to this he had been living in neglect with little food or furniture etc. and struggling to maintain his public housing tenancy due to very high levels of psychosocial disability. The hospital was reluctant to discharge him without community support, knowing that he would likely become acutely unwell again very quickly. He was referred to NDIA and initially deemed ineligible for Tier 3 funded services, but this decision was quickly reviewed. A care plan was developed and implemented to support his return to community living and a successful tenancy.

However, not all people with substantially reduced function as a result of a psychosocial disability are known to HNEMH, as their focus is on acute and sub-acute assessment and treatment of people with psychiatric illness. We know that only one in three people who need these specialist mental health services access them.[73] Many other people with mental health conditions live very difficult lives in the community, lives that often include transitional homelessness and frequent contact with emergency services and the criminal justice system.[74] For these people, the community sector provides a social safety net.

[73] Commonwealth of Australia, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, Australian Government, Canberra, 2009.
[74] NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments and the Criminal Justice System: Criminal responsibility and consequences,* NSW Law Reform Commission, Sydney, 2013.

Impact on Community Sector Mental Health Programs

There are about 22 community sector organisations providing around 41 mental health programs in the Hunter NDIS trial site. Appendix 5 and 6 provide an overview of these organisations and programs, and the program funding sources. The summary of the number of available programs above and below is complicated by the definition of 'program' varying across funding sources. This includes:

- 4 ADHC funded programs (2 residential and 2 non-residential)
- 13 NSW Health funded programs (4 residential and 9 non-residential; see also Appendix 3)
- 24 Commonwealth funded programs (7 non-residential; see also Appendix 2).[75]

This makes for a total of around 6 residential programs and 18 non-residential programs. For the purpose of this mapping, the NSW HASI program has been treated as one program type even though it has rolled out as a series of sequential programs over the past 10 years with varying housing settings, support levels and target populations.

MHCC most recently mapped NSW community sector mental health services and programs in 2010, and updated this information in early 2013 as an initial step in undertaking a *Sector Benchmarking Project*.[76], [77] The later review builds on the first and continues to establish planning benchmarks for community sector services for people affected by mental illness per 100,000 of population (data current as at early 2013 and therefore not inclusive of the Partners in Recovery/PIR initiatives that were subsequently established). Some of the implications of this work for NDIS implementation, the forthcoming NSW 'Partnerships for Health'/Grants Management Improvement Program reforms, and mental health sector reform are discussed later in this section and on pp. 76-79.

For the purpose of the NSW *NDIS Mental Health Analysis Partnership Project*, information about community sector mental health services in the NDIS trial site LGAs of Newcastle, Lake Macquarie and Maitland were extracted from the *Sector Mapping Project and Sector Benchmarking Project* data sets, and updated with 'program level' information about new programs (e.g. Commonwealth funded mental health program enhancements including PIR, NSW Health funded HASI Plus, and Boarding House HASI). The data was also updated for 'place' level information (i.e. the number of 'beds' in residential programs and the placement capacity, where known and/or established, for non-residential programs).

The NSW Bilateral Agreement with the Commonwealth government for NDIS implementation deems all current ADHC programs as being 'in-scope' for NDIS (i.e. they are part of the NSW contribution to the scheme).[78] Many of the 'transitions' to the NDIA of existing ADHC funded clients with 'primary' mental health conditions who reside in the Newcastle LGA, were planned to occur in the first six months of the scheme. Most of these people are both current and former boarding house residents who have been supported by community sector organisations for many years. The capacity of CMO staff and boarding house proprietors to contribute to eligibility and access processes has also been observed to be very stretched. The NDIA quickly recognised necessity for more 'collaborative' eligibility and access processes. This was acknowledged within the first

[76] MHCC, *The NSW Community Managed Mental Health Sector Mapping Report*, MHCC, Sydney, NSW, 2010.
[77] MHCC, *NSW Community Managed Mental Health Sector Benchmarking Project: Final Report* (confidential document), 2013e.
[78] Commonwealth of Australia and the State Government of NSW, 2012b, op. cit.

three months of implementation and has further added to the demands being placed on community sector organisations by NDIS implementation. This is viewed by the NDIA as a cost of doing business.

Commonwealth funded mental health program clients in the Newcastle LGA began 'phasing in' to the NDIS from January 2014, and MHCC has been advocating regarding issues related to large numbers of people being assessed as ineligible for Tier 3 funded packages. However to date, no one has been identified as having been disadvantaged as a result of this process, and the NDIA guarantee of service for people found to be ineligible has been confirmed as being available through to the end of the three year trial period. This is so that learning about Tier 3 benchmarks and the nature of Tier 2/ILC services can be operationalised through the experiences of the trial sites. *MHCC* continues to closely monitor new referrals to Commonwealth programs, especially PHaMS, the Day-to-Day Living Program and PIR, to ascertain access barriers that may present for non-NDIS referrals.

The early impact of the NDIS on PHaMS and the Day-to-Day Living Program

At the time of this report, there is no publically available data regarding outcomes of the 'phasing-in' to the NDIS of people receiving PHaMS, Day-to-Day Living Program or other Commonwealth mental health program services.

Up until May 2015, providers of PHaMS services in the Hunter reported that in their experience only 20 to 30% of existing clients may be eligible for Tier 3 NDIA funded services and supports.[79] The interface between the NDIS and the Partners in Recovery initiative may be increasingly important to understanding what services might be needed for current PHaMS clients found to be ineligible for the NDIS Tier 3. Some good news is that MHCC has to date been unable to identify a single PHaMS client that has been disadvantaged through being assessed as ineligible for Tier 3 funded NDIS services. Service providers however are reporting that the NDIS access experience can be very distressing for some potential participants. We continue to monitor this space vigilantly, including through the range of stakeholders attending Hunter NDIS and Mental Health COP Forums.

One Day-to-Day Living Program in the Hunter NDIS trial site reports that only about 50% of existing clients may be eligible for a Tier 3 NDIA funded services and supports.

While NDIA has been very responsive and flexible where review of decisions about eligibility, access and planning, funding package amounts, etc. may be needed, this too has added to the volume of work for both community sector and public mental health programs. The volume of work means that benchmarks are beginning to emerge for scheme eligibility and access. However, the establishment of benchmarks still has some way to go, and more efficient and systemic approaches to data and outcome collections would be helpful in this regard.

It is notable that NSW Health funded community sector mental health programs are not included in the current NSW NDIS Bilateral Agreement. This means that some services continue to be available for people deemed ineligible for Tier 3 NDIS. However, this is not the case for all states and territories, and this variability will have a flow-on effect to the operationalization of Tier 2/ILC services and supports. This situation could change for NSW through review of the Agreement that is intended to occur annually.

It is also unclear what impact the NSW Health 'Partnerships for Health' funding reforms (previously known as the Grant Management Improvement Program) might have on community sector mental health programs in NSW. New one year contracts with NGOs commenced from July 2014 and

[79] As at late August 2015 one PHaMS provider in the Hunter reported that NDIS Tier 3 access rates had increased greatly during the last quarter of 2014/15.

contestable contract retendering is planned to commence in 2015/16: http://www.health.nsw.gov.au/business/partners/Pages/default.aspx.[80] The situation for people not eligible for NDIA Tier 3 funded services and supports in the context of the 'Partnerships for Health' reform initiative is further discussed on pp. 76-79.

Partners in Recovery – A unique non-government mental health initiative

What is Partners in Recovery?

Partners in Recovery (PIR) is not just another disability support program but a unique and vitally important new national mental health initiative.

The 2011/12 Federal Budget announced $549.8M over five years to 2015/16 for the PIR initiative. The PIR: Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs (PIR) initiative aims to support people with severe and persistent mental illness who have complex needs, and their carers and families, by getting the necessary multiple sectors, services and supports to work in a more collaborative, coordinated and integrated way.

The ultimate objective of PIR is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:

- facilitating better **coordination** of clinical and other supports and services to deliver 'wrap-around' care that is individually tailored to the person's needs
- strengthening **partnerships** and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group
- improving referral pathways that facilitate **access** to the range of services and supports needed by the PIR target group, and
- promoting a community based **recovery** model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness who have complex needs.

The recent change in Australia's government has resulted in uncertainty about the PIR initiative. Only $430M has been committed to establish 48 of 61 planned PIR initiatives. Whilst it was announced that PIR has secured funding for a further year to June 2016, its future is unclear, especially given the recommissioning of Medicare Locals, which are the lead agencies for most PIR consortia nationally with the exception of NSW, as Primary Health Networks.

The NDIS and the PIR initiative are an important 'co-production'.[81] The PIR initiative targets 24,000 people in the group of 60,000 of the 600,000 Australian's thought to be most disabled as a result of a mental health condition.[82] The Hunter PIR initiative is very large. It covers a population of 708,061 with a projected 1,772 people living with serious and persistent mental illness and complex needs. It is estimated that 709 of these will be assisted by PIR during the three years of currently funded operation (i.e. 40% of the population estimated to be in need).

Hunter Partners in Recovery

[80] NSW Health, *Partnerships for Health: A response to the Grants Management Improvement Program Taskforce Report*, NSW Health (Integrated Care Branch), Sydney, 2013.
[81] J Slay and L Stephens, *Co-production in mental health: A literature review,* NEF, United Kingdom, 2013.
[82] Department of Health and Ageing 2012, op. cit.

The interface between public and community sector mental health programs, NDIA and PIR is critical to ensuring maximum access to community-based services and supports for people with mental health conditions. The Hunter is the only Year 1 NDIS trial site working with adults that also has a PIR initiative in it. For this reason, the trial site has attracted a lot of national interest regarding the emerging interface between PIR and NDIA.

While the focus of the NDIS is disability and functionality, the PIR is more holistic and focuses on complex unmet needs, including ensuring that people's often identified housing and health needs are directly addressed. *MHCC* believes that many, but not all people who have a mental health condition with complex health and social support needs requiring a response from multiple agencies, will be the same as those most likely eligible for NDIA Tier 3. This is because many of these people are thought to be likely to have high levels of psychosocial disability and require multiple health and social services for assistance to support their community living. However, early PIR/NDIS experience has not shown this to be true, with only 50 of their 229 trial site clients also receiving NDIS Tier 3 funded services and supports after one year of operations (22%).[83]

The PIR initiative has been identified in bilateral agreements between the Commonwealth and states and territories as a program that will provide a 70% 'in-kind' contribution to NDIS. It is believed that the percentage refers to the amount of cash in scope, not the number of clients. The Hunter PIR initiative seems to be billing the NDIS primarily for post-access 'coordination of supports' services. There have been some challenges in regard to the financial management of this arrangement and, indeed, with the NDIA and others perhaps not fully understanding the intent of the new PIR initiative.

The PIR Operational Guidelines encourage engagement with NDIS as it is transitionally implemented.[84] This means there will be a close working relationship between NDIS and PIR. The PIR organisation (PIRO) in the Hunter area is a Medicare Local led consortium and they will be required to meet a range of NDIS requirements as specified in their PIR funding agreement. As the NDIS is rolled out nationally, all PIR organisations will be required to meet a range of NDIS requirements.

Since PIR does not provide services as such, but is a time-limited service coordination program that also has a role in identifying and addressing gaps in local community responses to supporting people with mental health conditions (i.e. a population mental health sector development role), an argument can be made for it to be absorbed into NDIS eligibility and access processes, possibly at both the NDIA Tier 3 and 2 levels (i.e. so that there is an access pathway for those who are not assessed as Tier 3 eligible as well as an ongoing community development role for PIR). However, there has not been sufficient experience or any evaluations of the PIR/NDIA interface nationally for any clear directions for the future of PIR to have clarity.

HNEMH have undertaken internal time and motion studies and identified that the application process for NDIS ranges from 7 to 48 hours (average of 21 hours per submission). Also, the NDIA are increasingly requesting additional evidence to assist them to make an eligibility determination. This same issue has been the experience of other mental health community sector organisations, including PIR, as discussed at Hunter NDIS and Mental Health COP Forums.

The client target groups for NDIS, PIR and also the ADHC funded NSW Ability Links initiative for Tier 2 NDIS eligible people is provided at Appendix 7 as an early step towards developing an understanding of access pathways between these organisations/programs.

[83] Hunter Partners in Recovery, 2015, op. cit.
[84] Department of Health and Ageing, *Partners In Recovery (PIR) Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative Operational Guidelines for PIR Organisations,* Australian Government, Canberra, May 2013.

Partners in Recovery and the NDIS

Who is the Hunter PIRO?

The Hunter Medicare Local, as the lead agency for the Hunter Partners in Recovery Organisation (or 'PIRO') consortium, was focused from July through September 2013 on establishing operational systems, staff recruitment etc. Referrals to the PIRO commenced in November. The Hunter PIRO consortium comprises:

- Hunter Medicare Local (now the Hunter Primary Health Network)
- Aftercare
- Catholic Care
- Hunter TAFE
- Integrated Living
- Relationships Australia
- Samaritans
- Wesley Mission
- HNELHD (mental health services).

The Hunter Medicare Local covers a region larger than that of the NDIS Hunter trial site, and encompasses twelve LGAs. The Hunter PIRO has contracted with the following five CMOs to employ Support Facilitators at the following locations:

- Newcastle/Port Stephens - Wesley Mission (Newcastle is in the Hunter NDIS trial)
- Lake Macquarie - Neami National (Lake Macquarie is in the Hunter NDIS trial)
- Maitland/Cessnock/Dungog - Aftercare (Maitland is in the Hunter NDIS trial)
- Great Lakes/Greater Taree/Gloucester – RichmondPRA
- Muswellbrook/Singleton/Upper Hunter - Benevolent Society.

How many PIR Support Facilitators will there be?

The Hunter PIR program will engage approximately 18 Support Facilitators across the Hunter Medicare Local Region during the first year of service. This number will rise to approximately 28 during 2015/16 in line with increased client numbers. Each of the five (5) regional service areas will employ a different number of Support Facilitators relative to their anticipated client numbers.

Source: Hunter PIR website: www.hunterpir.com.au

How will NDIA work with PIR?

Hunter Partners in Recovery has been consulting extensively with NDIA to clarify roles and responsibilities, particularly where consumers may appear to be eligible for both programs. Given that there are only a handful of areas in Australia where NDIS and PIR overlap, both programs are encountering service coordination and delivery issues that have not been addressed previously. PIR and NDIS representatives are committed to partnering to ensure the best outcomes for consumers with severe and persistent mental illness, and will continue to share their knowledge and expertise to ensure this is achieved.

Source: Hunter PIR website: www.hunterpir.com.au

Who is a Partners in Recovery and NDIS client?

Jim is an example of a person receiving NDIS/PIR services. Jim is a 40 year old Aboriginal man living in public housing. His partner also has an NDIS package. Their children are no longer in in their care. Their tenancy was at risk due to hoarding and squalor, issues with neighbours including AVO's, and other matters before the courts. Their mental health was not being addressed, including no linkages to medical or psychological treatment. A hoarding and squalor cleaning service funded by NDIS was provided by Catholic Community Services.

PIR linked Jim to a GP who undertook a comprehensive physical and mental health check. Jim saw a psychiatrist and clinical nurse specialist with the local public mental health service. Jim is now taking medication and seeing his Dr regularly. Medication is webster packed and he has built a relationship with his local pharmacist. Jim's court matters were resolved and PIR is assisting Jim and his partner to increase contact with their children. Jim's tenancy is no longer at risk and his neighbours have invited him over for a BBQ. Jim is no longer phoning Housing NSW on a regular basis to raise concerns. PIR is negotiating changes with his NDIA Support Planner to gain assistance with additional goals identified. Jim's partner didn't have 'Coordination of Supports' in her plan but she effectively received this given our involvement with Jim.

1.3 Equity, monitoring and safeguard mechanisms

Outcome 3: Concerted efforts to promote legislative reform that integrates supported decision-making into national and state disability and mental health legislation needs to be undertaken to ensure development of an effective national framework for quality and safety predicated on the rights of people with disabilities associated with NDIS implementation.

Recommendation 5: Provide monitoring and safeguard mechanisms that provide oversight and accountability across mental health community managed and for-profit providers both in terms of safety, best practice and consumer and carer satisfaction.
Recommendation 6: Provide complaint mechanisms that support people to initiate and follow through with appeals and complaints, and provide supported decision making opportunities for people who require assistance in advocating for themselves.

What are safeguards?

'Safeguarding' refers to the range of activities that aim to minimise the risk of harm for a person with a disability, and protect their intrinsic human rights. Safeguarding activities seek to support and empower people to exercise choice and control over their lives. The literature shows that the most effective safeguards are those that are created though culture and practice based on respect, support and empowerment.[85]

Safeguards refer to supports and mechanisms at an individual, organisational and systems level that promote, enhance and protect a person in the following domains:

- human rights
- decision making, choice and control
- accessible appeal and complaints mechanisms
- safety and privacy
- citizenship, wellbeing and quality of life.

When individuals are vulnerable and at risk of compromised outcomes in the above domains, establishing safeguards to minimise vulnerability and risk can provide preventative and proactive responses, and maximise the person's skills and capacity to navigate the environment, as well as establishing responses to critical incidents.

Mandated safeguards (e.g. reporting risk, critical incidents, unexplained injuries and inappropriate restrictive practices) should be specified in the legislation and its underpinning regulations, and operate at a systems level to include a range of informal and formal supports and mechanisms applicable to the individual, the community, and their disability services.

The NSW policy, funding and legislative environment with regard to NDIS implementation is complex and rapidly evolving, and this is particularly true in relation to quality and safeguards. A *National Quality and Safeguards Framework* is under development, a draft of which was made available for consultation in March 2015. The scale of the consultation is far ranging and includes matters related to:

- NDIS quality and safeguarding
- building participants' capacity
- monitoring and oversight
- NDIA provider registration
- systems for handling complaints
- ensuring staff are safe to work with participants
- safeguards for participants who manage their own plans
- reducing and eliminating restrictive practices in NDIS funded supports.

MHCC's submission addressed all these issues. It highlighted the importance of enhanced supported decision making practice, and also encouraged the inclusion of issues related to involuntary mental health practice including but not limited to seclusion and restraint.[86] The latter issue seems to be primarily perceived as a mainstream health issue, and failure to consider this may become an area of tension in achieving integrated and coordinated health and disability/social

[85] Government of South Australia, *Safeguarding People with Disability Overarching Policy 2013 -2016,* South Australian Government, 2013.
[86] MHCC, *MHCC Submission in Response to Department of Social Services National Disability Insurance Scheme Quality and Safeguarding Framework, MHCC, Sydney, NSW,* 2015c.

services that uphold people's human rights under the UNCRPD. For NSW, the consultation was preceded by review of the *NSW Disability Services Act 1993* resulting in new 'disability inclusion' legislation, which is described in more detail below, and subsequent amendments to the NSW arrangements for quality and safeguards at the NDIS trial site.[87]

The NSW Ombudsman's Office has important roles and functions that relate to safeguards for people experiencing a diversity of impairment. By mid-2014 there was clarity that the NSW Ombudsman's Office has new legislative responsibilities to conduct ongoing reviews into the effectiveness of aspects of the NDIS (i.e. monitoring, review and inquiry functions). These roles and functions operate through provisions of the *NSW Community Services* (Complaints, Reviews and Monitoring) *Act 1993* and related provisions in the *NSW Ombudsman Act 1974* (with the latter now having been amended to accommodate for the Ombudsman's new role and functions under the *Disability Inclusion Act 2014*).[88], [89], [90]

All Commonwealth and state and territory governments are developing a national quality and safeguard framework for the National Disability Strategy, including but not limited to the NDIS. The NSW Ombudsman's office is contributing to this undertaking. However, completion of the final framework may be some years away. What is really in its formative stage at this point in time is an understanding of what best practice looks like in the context of supported and substitute decision making, as it affects the ability of a diversity of workers across the mental health/disability human services sectors to support NDIS participants as well as those ineligible.

In relation to this matter, the Australian Law Reform Commission released a discussion paper in May 2014 seeking responses to a proposal to enhance 'Equality, Capacity and Disability in Commonwealth Laws'. [91] The paper proposed reductions in use of restrictive practices in disability service provision including coercive mental health treatment. It proposes a new approach to individual decision making at the Commonwealth level and provides an opportunity to guide law reform at the state and territory level. Reform at this level is critical to the implementation of Australia's obligations under the UNCRPD, including implementation of the National Disability Strategy and NDIS, because many important areas of decision making are governed by state and territory law including in relation to guardianship, administration, financial management, powers of attorney and consent to medical treatment. The intention is that states and territories will examine relevant legislation to see how the approaches represented by the proposed National Decision-Making Principles and associated Guidelines might be incorporated, most fundamentally by facilitating a shift from guardianship-directed substitute decision making to self-directed supported decision making. This direction is supported by *MHCC* in our submission in response to the discussion paper.[92]

From a mental health/psychosocial disability perspective there has been little progress in regard to understanding the equity, monitoring and safeguard mechanisms that will be put in place around NDIS implementation. This is especially true in relation to the unique situation of people with mental health conditions who may be subject to involuntary mental health treatment including seclusion/restraint practices both in hospital and the community, and for people with forensic mental health status. All states and territories have mental health laws that regulate consent to medical treatment, including the involuntary detention and treatment of people with severe mental illness. Generally, mental health laws have provided for treatment based on a person's need for

[87] National Disability Insurance Agency and New South Wales Government, *Quality Assurance and Safeguards Working Arrangements for the Trial of the NDIS in NSW,* Australian Government, Canberra, 2014.
[88] NSW Government, *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), *Current*, NSW Government, Sydney, 1993.
[89] NSW Government). *NSW Ombudsman Act 1974* (NSW), *Current*, NSW Government, Sydney, 1974.
[90] NSW Government, *Disability Inclusion Act, 2014* (NSW), NSW Government, Sydney, 2014.
[91] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Law (Discussion Paper 81),* Australian Law Reform Commission, Canberra, 2014.
[92] MHCC, *Submission to Australian Law Reform Commission. Equality, Capacity and Disability in Commonwealth Laws: Discussion Paper 81*June 2014, MHCC, Sydney, NSW, 2014a.

treatment and the risk of harm posed to themselves and others. However, the UNCRPD asserts that there is no need for involuntary treatment, an assertion that the Australian government has not agreed to.[93]

Amendments to the *NSW Mental Health Act 2007* passed through both houses in late 2014, and will be in force from 31 August 2015. Whilst under review, *MHCC* and many others advocated for greater inclusion of supported decision making practice including use of 'Advance Directives'. Disappointingly, the final amendments do not include these two concepts. However, *MHCC* welcomes the amendments to the *Mental Health Act 2007* (NSW) assented by way of the *Mental Health Amendment (Statutory Review) Act 2014* (NSW). The *Mental Health Act 2007* (NSW) now restates the primary objective of the Act to be "to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered". The Act has removed the word 'control' from, introduces the concept of 'recovery' to the 'Objects' of the Act, and refers only to 'care and treatment'. This change may reflect a legislative intention to give greater weight to the views of consumers when decisions are being made about care and treatment under the Act. This concept has also been added to the Principles of Care and Treatment of the Act, including:

> *"to support people with a mental illness or disorder to pursue their own recovery; requiring that every reasonably practicable effort should be made to obtain the informed consent of people with a mental illness or mental disorder in the development of treatment and recovery plans, to monitor their capacity to consent and to support persons who lack capacity to consent to understand those plans."*

In addition to the *Mental Health Act*, a number of other NSW instruments of law have been under review since 2013, with the objective of further enhancing equity, monitoring and safeguard mechanisms for vulnerable people. This includes the *NSW Guardianship Act 1997 and NSW Disability Services Act 1993* (replaced by the *NSW Disability Inclusion Act 2014*). In addition, NSW Health and NSW Mental Health Commission have undertaken an independent review and evaluation of the NSW Health Official Visitors Program. This report has not been publically shared but our understanding is that an expansion to the Official Visitor's role covering the mental health community managed sector is not forthcoming.

Similarly, a complex legislative review is in process across all states and territories. It appears that the national movement to align disability legislation to the UNCRPD and National Disability Strategy/NDIS implementation is heavily influencing the NSW context with regards to both the scale and pace of reform. This situation is further complicated by a complex reconfiguration of the mental health sector, which is undergoing a parallel reform process. This includes discussion on Australia's predominantly risk averse perspective that broadly supports involuntary detention on the basis of mental illness and continuing condition (as understood in the Mental Health Acts of several states /territories) but which is in direct opposition to the principles expounded in the UNCRPD.

[93] United Nations, 2006, op. cit.

Review of the Disability Services Act 1993 (NSW)

The Disability Services Act 1993 has been the primary legal instrument utilised in NSW for providing supports and services to people with disability. The Disability Services Act 1993 (NSW) was reviewed with the aim of creating new legislation that better reflects current thinking about the rights of people with disability, and that fosters person-centred supports and services. In January 2013 the NSW Department of Family and Community Services (FaCS) released an Issues Paper: Reforming NSW disability support – the fundamental legislative issues and a more detailed Discussion Paper: Reforming NSW disability support - legislative structure and content for public comment. Consultations were held across NSW during February and March 2013.

In October 2013 FaCS released a Feedback summary paper on the reform of NSW disability laws. Broadly speaking, it encouraged alignment of the revised 1993 Act with the UNCRPD and the National Disability Insurance Scheme Act 2013. In December 2013 an exposure draft of the Disability Inclusion Bill 2014 (NSW) was released, and MHCC provided comment in response to this.[94] The Bill was tabled to government in May 2014 and subsequently enacted.

The Act has two intentions:

1. to create a framework for disability inclusion across government, including a state wide Disability Inclusion Plan, government agency Disability Action Plans, and to establish the NSW Disability Council as a consultative body on matters relating to people with disability. These are referred to by Government as the 'legacy provisions'.

2. to set out provisions for funding, policy and regulation of disability supports and services that are consistent with contemporary approaches to support. These are referred to by Government as the 'transitional provisions'. The transitional provisions will cease to operate over time as the NDIS takes over the responsibility for funding, policy and regulation of disability support.

[94] MHCC, *Submission to the NSW Department of Families and Community Services - NSW Disability Inclusion Bill 2014* February, MHCC, Sydney, NSW, 2014d.

The Disability Inclusion Act 2014 (NSW)

The Disability Services Act 1993 was the primary legal instrument utilised in NSW for providing supports and services to people with disability. Following the review it has been replaced by the Disability Inclusion Act 2014 (NSW).

The Disability Inclusion Act 2014 (N 41) (NSW) has been enacted together with the supporting Regulation (Dec 2014) that sets out further detail about the operation of the Act.

The amended Act is predicated on a rights-based inclusion framework. It gives new powers to the NSW Ombudsman who can now scrutinise the systems in place for preventing, handling and responding to reportable incidents of abuse and neglect in a wide range of services, including supported group accommodation and centre-based respite. With these new powers, the NSW Ombudsman has become more active within the Hunter NDIS trial site, and has taken a lead role nationally in developing monitoring and safeguard mechanisms.

Overall, the Disability Inclusion Act 2014 (NSW) seeks to bridge the gap in service provision arrangements between now and the full implementation of the NDIS when the nature of the National Disability Strategy quality and safeguarding framework are more fully known. It aims to address disadvantages and barriers resulting from the community's response to disability. The Act proposes to pave the way for accessible communities and mainstream services for those most at risk of marginalisation and exclusion. The regulations of the Disability Inclusion Act 2014 and the forthcoming NSW Implementation Plan for the National Disability Strategy are vital in shaping the success of the Act.

The Act aims to better recognise the human rights of people with disability and to help people move to the new funding arrangements under the NDIS.

The Act:

- makes it clear that people with disability have the same human rights as other people
- promotes the inclusion of people with disability by requiring government departments and local councils to engage in disability inclusion action planning
- supports people with disability to exercise choice and control through individualised funding wherever possible
- - provides safeguards for people accessing NSW funded disability supports and services, including new employment screening requirements and the need for disability accommodation providers to report abuse or neglect of people with disability to the Ombudsman.

The *Disability Inclusion Act 2014* (NSW) contains general principles that align with the UNCRPD. It acknowledges the human rights of all people with disability. The Act uses a similar definition of disability as used in the UNCRPD: that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The UNCRPD also includes principles recognising the needs of particular groups, such as Aboriginal and Torres Strait Islander people with disability, people with disability from culturally and linguistically diverse backgrounds, women with disability and children with disability. The definition recognises that disability results from barriers in society that prevent or limit inclusion.

The *Disability Inclusion Act 2014* (NSW):

- requires NSW to have in place a progressive four year *State Disability Inclusion Plan* that sets out whole-of-government goals that support the inclusion in the community of persons with disability, and improves access to mainstream services and community facilities by people with disability
- requires NSW public sector authorities to have in place a progressive *Disability Inclusion Action Plan* related to its functions, which sets out the measures the authority will take to ensure that persons with disability can access its services
- establishes the Disability Council of NSW which is comprised of persons with disability and others with expertise in disability to monitor the implementation of government policy in relation to people with disability and their families, and generally advise government on issues impacting upon persons with disability and their families
- provides for the funding and regulation of disability services provided by the NSW Government and by non-government agencies, including specification of the Standards with which such services must comply
- provides for eligible persons with disability and their families to receive government funding for disability supports and services directly so that they can establish and manage their own arrangements
- establishes a system of employment screening for staff and volunteers who work with people with disability in disability services, and for the reporting of serious incidents involving abuse and neglect of people with disability in supported accommodation or respite services funded under the Act to the NSW Ombudsman.

While people with 'psychiatric' disability were included in the NSW *Disability Services Act 1993,* the provision of services and supports for them was the responsibility of the Minister of Health (Section 12 A of the Act). The *Disability Inclusion Act 2014* refers to people with psychosocial disability (in terms consistent with the UNCRPD) and is silent on the topic of where the funding of services and supports may come from for people not accessing NDIS Tier 3.

Summary of safeguards

During the Hunter trial, the NSW quality assurance frameworks will apply to relevant new and existing funded client support, while a nationally agreed quality and safeguards framework is under development.

All jurisdictions are working together to develop a nationally consistent quality and safeguards framework across individual – natural/informal and formal, service, system and community levels. This will be underpinned by the National Standards for Disability Services.

Sister Myree Harris, NSW Coalition for Appropriate Supported Accommodation
Boarding House Reform Advocate

MHCC proposes that in their current form, the National Standards for Disability Services will not provide a quality and safeguards approach that is sufficiently recovery-oriented and trauma informed to protect people with mental health conditions.

1.4 Workforce appropriateness

Outcome 4: NDIS workforce development directions need to include consideration of the complex skills required for working with people with mental health conditions and/or psychosocial disability in both peer and non-peer work roles, and the qualifications and professional development pathways associated with these.

Recommendation 7: Pursue directions to establish the peer workforce within both government and non-government organisations involved in the provision of services under the NDIS.
Recommendation 8: Undertake activities to promote the complexity of skills required in psychosocial disability and recovery support work, including the skills required for complex care coordination.

The NDIA has worked with the Commonwealth Department of Social Services (DSS) to develop a high-level 'NDIS Integrated Market, Sector and Workforce Strategy'.[95] The strategy provides a vision of what a robust and mature NDIS market will look like and how it will function and provide guidance for implementation directions. With regard to workforce, it aims to:

> *"… ensure there is a diverse and flexible workforce supply to support people with a disability into the future".*

'Key area of actions' identified are to:

- assist the sector to develop a sustainable and diverse workforce
- encourage innovative and efficient use of the workforce
- develop a skilled workforce to support the NDIS.

It is estimated that the disability sector workforce will need to more than double in size between now and full implementation,[96] increasing from approximately 73,600 full time equivalent (FTE) workers to an estimated 162,000 FTE workers (i.e. a shortage of 88,400 FTE workers). Solutions to address this shortfall will likely include a significantly increased number of allied health professionals and a proportion of volunteer carers who move into paid disability care roles. It will also require capacity building by disability service delivery organisations with a focus on new roles, expanded services and consumer-led (e.g. peer work) care models in the home and community.

While many examples of possible workforce development directions are provided, there are no specific strategies as yet agreed that will be used to ensure that there is a sufficient supply of workers with the right values and skills to provide the services required by NDIS participants, especially in relation to the skills required to provide services and supports to people with mental health conditions. The *Integrated Market, Sector and Workforce Strategy* mentions the possible establishment of a 'Transforming the Workforce Program'. This may be a direction for continuation of the *NDIS Sector Development Fund* (i.e. workforce project/s funding).

[95] Disability Reform Council, *NDIS Integrated Market, Sector and Workforce Strategy*, Australian Government, Canberra, 2015.
[96] ibid.

One mental health specific example of encouraging innovation and efficiency in NDIS workforce development relates to building skills in supporting people with complex needs, as follows:

> *"… to ensure the NDIS meets the needs of participants with mental health issues, it will be necessary to engage the sector to define mental health support roles, related job design and training requirements and establish how these roles differ from, and overlap with, other disability support roles".*[97]

It is unclear to what extent the community managed mental health sector has been factored into the above workforce estimates, as this workforce is not comprehensively included in the Australian Institute of Health and Welfare (AIHW) disability workforce minimum data set. While the size of the workforce providing psychosocial disability and recovery support services is not known, some foundational work has been undertaken to estimate its size and composition.

Understanding the community sector mental health workforce[98]

The National Mental Health NGO Workforce Scoping Study confirmed the size of the sector to be about 800 organisations and its workforce was estimated to range between 15,000 to 26,000 employees (CMHA conservatively estimate this to be about 12,000 FTE).[99] By way of comparison, the public mental health service direct care FTE is about 21,000.[100], [101] 42 % of responding organisations have been delivering services for more than 20 years. 43% of workers identified as having health qualifications, mostly in social work, psychology or nursing, and 34% of workers had a vocational qualification with the majority of these being at the Certificate IV and Diploma levels. The study struggled to categorise the diversity of services being provided.

Projections have not been made for community sector psychosocial disability and recovery support workers. In addition to poor data collections, doing so would be further complicated by the increasingly close working relationship that exists between 'clinical' and 'non-clinical' mental health services. Australian projected mental health 2025 workforce shortages are at least 8,800 FTE.[102] This is mostly doctors and nurses working in public and private 'clinical'/mainstream mental health services (i.e. those services that have as their core focus the provision of assessment and treatment services for acute and sub-acute mental health conditions).

There are considerable challenges in quantifying and monitoring change in Australia's mental health workforce across all work settings (i.e. community sector, public, private and primary health care). However, this is especially true for the community sector mental health workforce (whether qualified or unqualified, university or vocationally qualified, peer or non-peer work roles). The *HWA Mental Health Workforce Study* is a foundational piece of work that aims to the build the quantitative evidence on workforces delivering services to mental health consumers, to understand the existing workforce, and to support future workforce planning.

[97] ibid. p 21.
[98] CMHA , op cit., p9
[99] National Health Workforce Planning and Research Collaboration, *Mental Health Non-Government Organisation Workforce Project Final Report*, Health Workforce Australia, Adelaide, 2011.
[100] Australian Institute of Health and Welfare (AIHW), *Mental Health Services in Australia 2007-08, Mental Health Services no.12*, Cat. no.HSE 88, AIHW, Canberra, 2010.
[101] According to the 2013 National Mental Health Report, this figure had increased to 24,292 FTE in 2010/11. It is likely that the community sector mental health workforce has also continued to grow through a range of new programs being introduced, most recently the extensive national Partners in Recovery initiative.
[102] Health Workforce Australia, *Health Workforce 2025 (Volumes 1, 2 & 3),* HWA, Adelaide, 2012.

The first step in the study was the development of a *Mental Health Workforce Data Planning Inventory.*[103] The inventory identifies the current availability of quantitative data on workforces delivering services to mental health consumers, and highlights related data limitations and gaps. A major limitation is that there is no national data collection for mental health service provision in the NGO sector, despite their contribution to mental health service provision having increased substantially in recent years. The AIHW is currently developing the Mental Health Non-Government Organisation Establishments National Minimum Data Set (MH NGOE NMDS), which once established, will allow routine, standardised collection of data relating to mental health NGOs. The planned implementation for the MH NGOE NMDS was 2014/15, however, delays in this are anticipated.

As a result of work undertaken through the ADHC funded Industry Development Fund, the NSW NDS hosted two consultation forums focused on workforce issues in Newcastle, NSW in July 2013. Issues explored included:

- attraction and recruitment of new staff
- retention and development of existing staff
- sector growth and competition
- skill profiles required by the sector now and going forward
- industrial relations
- current workforce responses to the NDIS, perceptions of challenges and opportunities.

Following the forums, a report was compiled detailing the issues and challenges raised.[104]

In February 2014, the DSS contracted with NDS to produce a report on workforce issues facing the disability sector as a prelude to developing their proposed *National Disability Strategy - Workforce Strategy*. The report is to address workforce needs in the current trial sites, as well as any issues that will develop when full national rollout occurs. The report was delivered to government in August 2014. While the proposed National Disability Strategy Workforce Strategy does not seem to be proceeding, the NDS paper has informed development of the Integrated Market, Sector and Workforce Strategy.

The need to better understand and teach the skills required for psychosocial disability and recovery support work with people living with mental illness and with a range of people with cognitive behavioural impairments including intellectual disability and organic/acquired brain injury, was discussed at the NDS workforce consultation in the Hunter. A concern is that directions of the Integrated Sector, Market and Workforce Strategy may not sufficiently include consideration of what is already known about the skills required for effective mental health support work, particularly in an NDIS context.

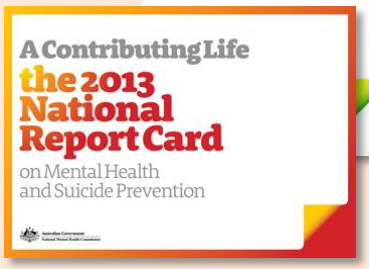
MHCC collaborated with NDS in development of their workforce strategy paper. This included a joint forum on NDIS Organisational and Workforce Readiness held in partnership with MHA on 29 July 2014 in Sydney. A key finding from the workforce stream of the forum was that while the projected recruitment and retention issues are similar for community sector mental health and disability services, the skills issues are different. While community sector mental health programs have been providing services that are person-centred and, increasingly, client self-directed for some time, the disability sector has deskilled as this relates to mental health work. This is not surprising given the historical structural siloing of the health/mental health and disability sectors.

Mental health, aged care and primary health care sector reform in Australia is occurring in parallel to disability sector reform. The National Mental Health Commission provides guidance on mental

[103] Health Workforce Australia, *Mental Health Workforce Planning Data Inventory*, HWA, Adelaide, 2013.
[104] National Disability Service, *Workforce and the Launch of the NDIS in the Hunter*, NDS NSW, Sydney, 2013.

health sector reform including directions for workforce development. It is important that mental health workforce development directions are considered in planning disability sector workforce development directions as this relates to the needs of NDIS participants with mental health conditions. These directions are important because they are in support of the economic and social participation of people living with mental health conditions as articulated by the National Mental Health Commission.

National Mental Health Commission 'Contributing Life' Report Card/s Recommendations Related to Workforce [105], [106]



Recommendation 8 (first included in 2012 report card): Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

The target for this is: Improve employment rates of adults over 18 with mental illness and their carers.

The indicator for this is: The proportion of the population with mental illness in employment as a ratio of the employment rate of the general population.

Recommendation 13 (first included in 2013 report card): A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce.

"Delivering recovery-focused services must involve growing and properly supporting our peer workforce. Without exception, the peer workforce includes both people with lived experience and personal carers. To do this we need clear employment provisions and working conditions, training opportunities, professional capabilities and workforce development strategies, including supervision and mentoring requirements. All must be standardised nationally."

The target for this is: Increased numbers of peer workers in mental health related support services, with 50% of services employing peer workers in meaningful roles in four years, and 100% in 10 years.

The indicator for this is: The proportion of mental health related support services employing peer workers in meaningful roles.

Actions related to achieving the peer work target are:

- all governments and agencies must work together and with suitably experienced people with lived experience and their families to agree and implement a National Mental Health Peer Workforce Development Framework
- this framework must identify a target and implementation strategy for the employment of peer workers in all support and treatment settings.

[105] National Mental Health Commission, *A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention*, NMHC, Sydney, 2013.
[106] National Mental Health Commission, *A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention*, NMHC, Sydney, 2012.

What is peer work?

A Peer Worker is a person who is employed in a role that requires them to identify as being, or having been, a mental health consumer or carer. Peer work requires that lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary.[107]

The National Mental Health Commission's Mental Health Peer Work Qualification Project aims to develop and support a nationally recognised qualification for peer workers (Certificate IV in Mental Health Peer Work) to facilitate the broader engagement of peer workers throughout the mental health sector. In 2013/14, MHCC were engaged on behalf of Community Mental Health Australia to develop the learning and assessment materials that will encourage the delivery and uptake of the Certificate IV in Mental Health Peer Work qualification nationally.

These materials are being made freely available on the National Mental Health Commission's website as they are refined through 2014/15 piloting:
http://www.mentalhealthcommission.gov.au/peerwork

Peer workers are people who have lived experience of mental illness, either directly (i.e. consumer workers) or within their family (i.e. carer workers), and are employed specifically to share this experience and knowledge to help other people and families experiencing mental health conditions. Peer workers are employed around the country in a range of different ways. Roles may include peer support, advocacy, health promotion, coordination or education. Peer workers may be employed in outreach services, inpatient units, day programs, and telephone services amongst other service types.

In 2014 HWA completed the second component of their Mental Health Workforce Study: the *Mental Health Peer Workforce Project* which included a range of information-gathering activities, site visits and interviews to compile information about the experiences of peer workers from around Australia; a literature scan; and an online survey of mental health peer workers.[108], [109] The project report makes recommendations for the future development of the peer workforce.

Currently, the peer workforce in Australia appears to be small, and often there is a lack of role clarity and workplace supports for these workers. The Mental Health Peer Workforce Study proposes a more systematic approach to the adoption of the mental health peer workforce, for example, through the establishment of National Mental Health Peer Workforce Development Guidelines.[110]

The opportunities for development of peer work roles have broader applicability across the community services and health sector in Australia (i.e. peer work roles in disability, homelessness, substance misuse work etc.). While these roles are critical to more effective service delivery, they also provide employment pathways for people with disadvantages, and will help to address projected workforce shortages.

Considerable work has been undertaken over the past ten years to introduce a voluntary minimum standard of Certificate IV or equivalent in mental health/psychosocial disability recovery support

[107] Health Workforce Australia, *Mental Health Peer Workforce Study,* HWA, Adelaide, 2014a.
[108] ibid.
[109] Health Workforce Australia, *Peer Work Literature Review*, HWA, 2014b.
[110] A draft framework for mental health peer workforce development was developed by HWA prior to their ceasing operations in July 2014.

work for both peer and non-peer work roles. There is concern that this could unintentionally be eroded through NDIS implementation and associated workforce development directions. This is because psychosocial disability and recovery support work is not well recognised and/or valued. Some stakeholders are even questioning if specialist support work skills (i.e. in disability, home and community care, aged care and mental health work) are required, and if minimum qualifications are necessary for entry level disability support work.

The community managed mental health sector, through CMHA, has long advocated for the Certificate IV in Mental Health and/or Mental Health Peer Work or equivalent to be a voluntary minimum standard for community sector work with people with mental health conditions, and has been developing its workforce against this standard. Through the NDIS a tension has arisen as to the need for formal qualifications in disability support work. The NDIS project proposal *"to define mental health support roles, related job design and training requirements and establish how these roles differ from, and overlap with, other disability support roles"* will be essential to resolving this tension. The role delineations and interdependencies between 'clinical' and 'non-clinical' mental health work roles and functions (i.e. treatment, rehabilitation, support, prevention/promotion, early intervention etc.) regardless of work setting, whether NDIS-specific or 'mainstream', will also need to be better understood.

Considerable industry/market consultation has been undertaken to understand vocational mental health work job roles through development of the Certificate IV in Mental Health and Certificate IV in Mental Health Peer Work qualifications. Further work to understand common mental health work capabilities across a range of work roles and work settings was concluded by HWA in July 2014 as a third component of their Mental Health Workforce Project.[111] Efficiencies for any future directions to better understand mental health support roles should be mindful of this body of work.

MHCC supports directions for better understanding job roles and certification/regulation of the disability support workforce, regardless of qualifications and skills, including the incremental formalisation of practice recognition for psychosocial disability and recovery support workers. This is likely to be the space in which tensions between entry level/foundational qualifications/skills attainment and solutions for projected NDIS workforce shortages are resolved. Aspects of these processes may be further considered through activity related to implementing the NDIS Integrated Market, Sector and Workforce Strategy and the further development of the Quality and Safety Framework.

[111] Health Workforce Australia, *National Mental Health Core Capabilities*, HWA, Adelaide, 2014c.

NDIS Workforce Ready

NDIS Workforce Ready is a research project funded by the Practical Design Fund.[112] The NDIS Workforce Ready Project researched options for professional certification of disability support workers, and presented a draft model for professional certification to support the objectives and principles of NDIS. The research found that many people agree about what makes a good support worker. However, there were many different ideas about what workers should have to do to be certified, and how a system of certification would be regulated.

The report recommends that a system of certification be introduced one step at a time. In the first stage, a voluntary register of support workers should be set-up and tested in the NDIS Australia trial sites. Worker's references and police records should be checked before they are listed on the register. It is recommended that in the future the register should become compulsory. Also in the future, workers who want to show that they have a higher level of skill and knowledge should be able to apply for higher levels of certification.

The project report includes the findings from the research and recommends how a system of certification could be set-up to provide recognition for good support workers, and give people with a disability and their families more choice and control over who provides their quality care and support.

2. The wider NDIS and health services interface, especially as this relates to the unmet physical health needs and high prevalence of substance use by people living with mental illness

Outcome 5: Role delineations between the NDIS and health need to be better understood and operationalised, especially as this relates to understanding what a 'clinical' and/or 'non-clinical' treatment, rehabilitation and/or support service is; what work settings these occur in; and which health and community service workers provide them.

Recommendation 9: Ensure that people's care plans extend beyond arrangements for the treatment of mental illness and consistently include items related to supporting self-directed health and well-being and meeting the personal goals of the individual.
Recommendation 10: Ensure that assessment and care planning processes make routine use of psychometrically sound tools for screening substance use issues.

[112] NDIS Workforce Ready Consortia: Cootharinga North Queensland Inc., AVANA, Australasian Disability Professionals, and Deakin University, *NDIS Workforce Ready - Project Report: June 2013*, 2013.

NDIS interface with mainstream services[113]

"An important aspect of the NDIS design recognises the National Disability Strategy and that people with disability should, wherever possible, be supported through mainstream services and the community, not just formal supports funded by the NDIS. The NDIS is directed by a series of principles that determine whether supports should be funded by the NDIS or by mainstream systems. Since the NDIA commenced on 1 July 2013, the agency has been working closely with governments and the broader community to apply these principles in each of the trial sites. The NDIA has also been working with Commonwealth and state and territory government agencies to clarify the roles and responsibilities of mainstream services and the NDIA for the supports included in participants' individual plans. Mainstream services of particular interest to the Agency are health, mental health, child protection, education, employment services, and housing and justice".

New solutions are emerging through the NDIS

A homeless man with numerous physical health problems and also mental health and substance misuse issues approaches a local emergency services program for housing assistance. He is deemed ineligible for transitional housing as his support needs are too high, and is referred to NDIA where he is assessed as eligible for Tier 3 funded services. While the Agency is unable to assist with permanent housing as this is a housing sector responsibility, he is helped to access the emergency service provider's transitional housing program with four hours a day of additional support funded by the NDIA. Because the support chosen by the man is 7- 9 am and 5-7 pm, and the service is traditionally staffed 9 am to 5 pm, they successfully explore options for flexibly expanding their operating hours.

… but old problems also persist!

A woman with a serious mental health condition and psychosocial disability was supported by a primary health care organisation to apply for access NDIA Tier 3 services. The woman's physical health concerns included obesity, Type 2 diabetes, high blood pressure and metabolic disease. The woman was initially declined access to the NDIS as her concerns were said to be mostly health related and the NDIA does not fund health services. Following discussions of the woman's need it was later agreed that the NDIA may, amongst other services and supports, be able to fund disability support to access health care services as assistance in getting to health care practitioners was needed. This is not just transportation but assistance in negotiating the relationships with her numerous health care providers, while developing the supports and skills for more fully self-directed health care access.

For people with high levels of psychosocial disability, community support services are often required to access healthcare. However, these supports are more than just direct assistance/personal care type disability support. Psychosocial disability and recovery support practice includes the service coordination skills required to coordinate a complex range of health and social services, and it will be important to the success of the NDIS that these skills are recognised.[114]

We must be vigilant to ensure that as ADHC withdraws from service delivery that the NSW Health/LHDs and the NDIA respond to the challenge of more integrated service delivery across the health and social care portfolios.

[113] National Disability Insurance Agency, *2013/14 Annual Report*, NDIA, Geelong, 2014, p. 57.
[114] MHCC, *Care Coordination Literature Review and Discussion Paper, MHCC, Sydney, NSW,* 2011b.

The NDIS has developed *'Principles to Determine the Responsibilities of the NDIS and other Service Systems'.* [115] These other service systems are:

- Health
- Mental health
- Early childhood development
- Child protection and family support
- School education
- Higher education and Vocational Education and Training (VET)
- Employment
- Housing and community infrastructure
- Transport
- Justice
- Aged care.

The challenges in defining the boundaries between services that are the responsibility of the health/mental health system or the NDIS are considerable, and NSW Health and FaCS/ADHC have struggled to overcome issues related to the health and disability/social care interface for decades. For example, an agreement between NSW Health and ADHC to increase access to specialist mental health acute and sub-acute assessment and treatment services has only had limited success.[116] With ADHC withdrawing from service delivery by 2018 it will be interesting to see if the NDIA and NSW Health can rise to the challenge of bringing health and disability/social care closer together. The early learning from the NSW Hunter trial site is being used to increase the likelihood of this.

Following are the applied principles for the NDIS working with health and mental health respectively (and these are understood to be under review at the time of publication of this report).

[115] National Disability Insurance Scheme, *Principles to Determine the Responsibilities of the NDIS and other Service Systems* (April), Australian Government, Canberra, 2013.
[116] NSW Health, *Memorandum of Understanding and Guidelines between Ageing, Disability and Home Care, Department of Human Services NSW and NSW Health in the Provision of Services to People with an Intellectual Disability and a Mental Illness,* NSW Government, 2010.

NDIS Applied Principles – Health (p. 3)

1. Commonwealth and state and territory health systems have a commitment to improve health outcomes for all Australians by providing access to quality health services based on their needs, consistent with the requirements of the National Healthcare Agreement and other national agreements, and in line with reasonable adjustment requirements (as required under the Commonwealth Disability Discrimination Act or similar legislation in jurisdictions).

2. The above **health systems will remain responsible for the diagnosis and clinical treatment of health conditions**, including ongoing or chronic health conditions, and other activities that aim to improve the health status of Australians, including general practitioner services, medical specialist services, dental care, nursing, allied health services (including acute/post-acute), preventive health, care in public and private hospitals, pharmaceuticals, and other universal health entitlements.

3. The above health systems will also be responsible for funding time limited, goal-oriented services and therapies where the predominant purpose is treatment directly related to the person's health status, or after a recent medical or surgical event, with the aim of improving the person's functional status including rehabilitation, palliative care, or post-acute care.

4. The **NDIS will be responsible for supports related to a person's ongoing functional impairment** and that enable the person to undertake activities of daily living, including "maintenance" supports delivered or supervised by clinically trained or qualified health practitioners where this is directly related to a functional impairment and integrally linked to the care and support a person requires to live in the community and participate in education and employment.

NDIS Applied Principles - Mental Health (p.4)

1. The health system will be responsible for:

a. supports related to mental health that are clinical in nature, including acute, ambulatory, continuing care, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs

b. any residential care where the primary purpose is for inpatient treatment or clinical rehabilitation, where the service model primarily employs clinical staff

2. The health and community services system will be responsible for supports relating to co-morbidity with a psychiatric condition where the co-morbidity is clearly the responsibility of that system (e.g. treatment for a drug and/or alcohol issue).

3. The NDIS will be responsible for non-clinical supports that focus on a person's functional ability, including those that enable people with mental illness or a psychiatric condition to undertake activities of daily living and participate in the community and in social and economic life.

The role delineation interface between the NDIS and other existing service systems requires much greater clarity. The experiences of the NDIA and others within the trial sites are meant to inform review of the principles, including NDIS implementation deliberations with COAG.

The NDIA later developed operational guidelines building on the above principles and further explaining the NDIS will interface with 'clinical' health/mental health services for assessment and

planning purposes.[117], [118] *The Operational Guidelines - Planning and Assessment - Supports in the Plan - Interface with Mental Health* states that the 'health system' is responsible for:

a. supports related to mental health that are clinical in nature, including acute, ambulatory and continuing care, rehabilitation/recovery, or

b. early intervention supports related to mental health that are clinical in nature, including supports that are clinical in nature and that are for child and adolescent developmental needs, or

c. any residential care where the primary purpose is for inpatient treatment or clinical rehabilitation, or where the services model primarily employs clinical staff, or

d. supports relating to a co-morbidity with a psychiatric condition where the co-morbidity is clearly the responsibility of another support system (e.g. treatment for a drug or alcohol issue), or

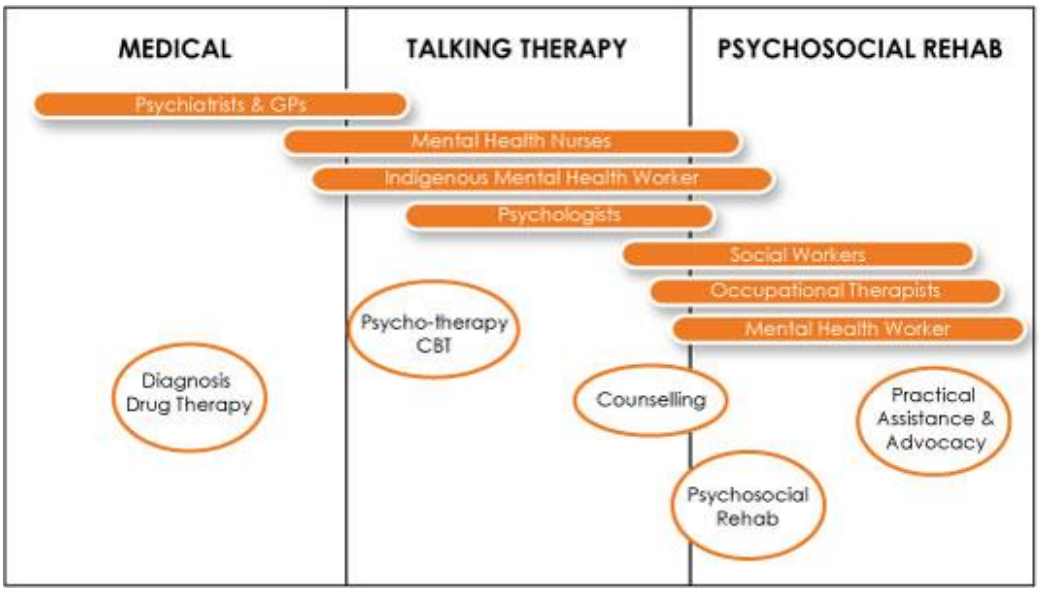
e. the operation of secure mental health facilities that are primarily clinical in nature (p. 3).

From the above, it is clear that there is much work to be done in understanding what a 'clinical' and 'non-clinical' service is (i.e. acute, sub-acute and non-acute assessment, treatment, rehabilitation and support), especially as this relates to psychosocial rehabilitation and recovery support practice. The complexities of the mental health sector mean that it is increasingly difficult to differentiate the skills required for community-based mental health work across a range of work settings (i.e. community sector, government/public, private and primary healthcare). Furthermore, recovery is a journey that is owned by a person with a mental health condition and not something that service providers give them.

The roles and functions of community-based mental health workers in both government and non-government work settings were considered in a 2009 research project.[119] The study was part of a larger project exploring skills articulation (i.e. what skills do community mental health services and workers need for effective service delivery, and what improvements might be made to education and training structures to achieve these). The study concluded that the largely artificial silos that currently exist between government/non-government services, clinical/non-clinical work roles and university/vocational training must be addressed so the most effective allocation of mental health dollars for provision of recovery-oriented community mental health can be achieved (i.e. medical, talking therapies and psychosocial rehabilitation - see Figure 3). This work needs to be extended to include the vocational roles of primary health care services and other mental health service providers including GPs and peer workers.

[117] National Disability Insurance Agency, *Operational Guideline - Planning and Assessment - Supports in the Plan - Interface with Health,* NDIA, Geelong, 2014c
[118] National Disability Insurance Agency, *Operational Guideline - Supports in the Plan - Interface with Mental Health,* NDIA, Geelong, 2014d.
[119] Community Services and Health Industry Skills Council, *Mental Health Articulation Project Synthesis Report - Main findings and recommendations,* CS&HISC, Sydney, 2009.

Figure 1: Practice and Occupational Boundaries in the Community Mental Health Sector



FaCS and NSW Health convened a Health Pathways Forum in Newcastle on 18 October 2013. It focused on exploring the disability and health NDIS interface and included an emphasis on people with mental illness/psychosocial disability. While the complex and diverse health and social problems of many people living with mental health conditions was acknowledged, to date no pathways to address these have been forthcoming. Indeed, as previously identified, some staff at NDIA note that the notion of 'pathways' might be contradictory to notions of a person's individual 'choice and control'.

In the initial stages of the Hunter NDIS implementation, an operational group with Health, AHDC, NDIA and *MHCC* representation was established to facilitate activities and processes related to implementation. Since February 2014, the operational implementation group has been in the process of maturing and now also has physical health, mental health and child/adolescent working groups. The maturing structures may help to facilitate more coordinated and integrated service delivery. The introduction of Activity Based Funding within NSW Health services may also be helpful in this regard. The NDIS Operational Group reports upwards to FaCS and the NSW NDIS intergovernmental implementation group. The NSW Department of Premier and Cabinet also plays an important role in NDIS implementation on behalf of the NSW government.

With regard to the physical health care needs of people living with mental health conditions, we know that on average they are dying much earlier than other Australian's and have significantly greater physical health concerns. NDIA care plans typically do not address people's physical health care needs unless concerns are identified by a participant. It is unclear how routinely a person's healthcare needs are being screened beyond the likely screening for a presence of psychiatric medications. We know that good practice in mental health work supports a person's access to a physical health care assessment at least annually and as needed. Important but complex notions such as the iatrogenic effects of mental health treatment, including but not limited to the use of psychiatric medications, still do not appear to be well understood.

With regard to people with substance use/misuse problems, and the high prevalence of these problems for people with mental health conditions, again there appears to be no routine assessment of these issues during assessment and care planning processes unless a person chooses to self-identify these behaviours as a problem that requires support. The NDIS Act states that people with substance misuse issues are excluded from the scheme. This raises further

barriers to disclosure and is not consistent with known evidence based practice in working with people with coexisting mental health and substance use issues. Given the above, we have to date been unable to identify a single person excluded from Tier 3 eligibility on the basis of a substance misuse problem.

The interface between NDIA and NSW Health (and for the NSW trial site, the HNELHD and HNEMH) while critical, is not sufficient in and of itself to address the whole-of-life health and social needs of people with disabilities. The ability of NDIS to connect participants with mainstream services in transport, health, education and housing will be crucial to its long term success. Appropriate representation and participation of people with disabilities, including people with psychosocial disability related to mental ill health and their families and carers, is essential to ensuring more effective integrated and coordinated health and social services.

From a mental health sector perspective, achieving integrated and coordinated health and social services will be difficult to achieve without also considering the 'Applied Principles - Health', especially given the poor physical health of people living with mental illness. Terms of Reference for the new Mental Health Working Group of the Hunter NDIS Operational Group, and related parallel structures emerging within HNEMH, have not yet been finalised. To achieve integrated and coordinated health and social services it will be important for 'clinical' (e.g. treatment) and 'non-clinical' (e.g. support) work roles and functions across a range of mental health work roles are considered by the Working Group. This could potentially build on earlier work undertaken by HNEMH to clarify 'clinical' and 'non-clinical' tasks and activities, and to strengthen coordinated and integrated care for adults with a mental health condition.[120]

[120] Hunter New England Mental Health Service (HNEMHS), *Collaborative Care Arrangement between Hunter New England Mental Health Service and Mental Health Non-Government Organisations,* HNEMHS, Newcastle, 2013.

Mental Health and the NDIS across the Lifespan

What about young people with mental health conditions and the NDIS?

Much of the early learning about the NDIS and young people has occurred within the South Australian and Tasmanian trial sites that focus exclusively on children and young people. From a mental health sector perspective, the NSW trial site experience has mostly related to adults under 65 years of age. Nevertheless, it is well understood that prevention, promotion and early intervention is important for reducing severity of psychosocial disability. While the in-principle agreement views mental health prevention and early intervention as a health/'clinical' responsibility, the very nature of these programs is that they offer much more than assessment, diagnosis and treatment by health professionals.

An 'early intervention' eligibility criterion was included that was intended to provide people accepted into NDIS, termed participants, with access to supports designed to minimize or reduce functional impairment, reduce the need for future supports, or improve the sustainability of informal supports. There are tensions around this as this relates to mental health.

The Australian Government's $2.2 billion 2011/16 mental health reform package includes the expansion of youth-focussed mental health and wellbeing. Commonwealth funded mental health programs for young people include both the Headspace and the Early Psychosis Prevention and Intervention Centre (EPPIC) programs, neither of which is 'in-scope' for NDIS. The EPPIC model promotes early detection and management of psychosis and holistic support resulting in better mental health and social outcomes for young people experiencing early psychosis, and their families and carers. An additional 40 DSS funded community-based Family Mental Health Support Services are being rolled out progressively and they will provide family focussed early intervention support to assist children and young people who are at risk of, or affected by, mental illness. These are also not 'in-scope' for NDIS.

There is still much to be learned about the role delineations between medical/'clinical' and social/'non-clinical' services and supports as they relate to mental health and the NDIS, especially in the area of promotion, prevention and early intervention for people of all ages with a newly emerging mental health condition.

What about older people with mental health conditions and the NDIS?

People over the age of 65 years are not able to access NDIA funded services and supports as a new client. However, there is a 'guarantee of service' for all existing NSW ADHC clients for the three years of the trial site. For example, if you were in receipt of a Home and Community Care (HACC) service on 1 July 2013, you can't be disadvantaged as a result of NDIS transition while are being trial site issues are being identified and resolved through until June 2016 (and possibly June 2018). Another example relates to residents of large ADHC residential centres. People older than 65 years will continue to receive a service even if not eligible for NDIA funded services and supports.

The interface between the NDIA and aged care reform will continue to be considered throughout the NDIS roll out to ensure that any potential disadvantages to older Australian's with disabilities are minimised. For example, it is currently proposed that around $45K is not the highest level of funded community supports and services that a person 65 years and older could receive through the aged care system. This will not be sufficient or equitable for older people with severe and profound disabilities.

3. People presenting with multiple co-existing difficulties in addition to psychosocial disability, such as ABI, ID and cognitive impairment as well as physical disability will also be explored.

Outcome 6: NSW Health needs to work closely with ADHC as this relates to the closure of their large residential centres and exits to community living for people with stable mental illness who no longer need hospital-based psychiatric services; these transitions should be both recovery oriented and trauma informed.

Recommendation 11: Advocate for the needs of people with co-existing difficulties to be provided with services consistent with the International Classification of Functioning, Disability and Health approaches.
Recommendation 12: Ensure assessment for specific decision making capacity and provide services that ensure supported decision making, as well as support and information for families and carers.

The vast majority of people presenting for NDIS Tier 3 services and supports appear to have co-existing and diverse health and social issues. People with high levels of psychosocial disability rarely have mental health issues only, and people with intellectual disability, acquired brain injury and other forms of cognitive impairment often experience poor physical health, substance misuse and/or co-existing physical/sensory disability. Furthermore, at the first meeting between the NSW Mental Health Commission, *MHCC* and NDIA in the Hunter held in October 2013, it was noted that nearly all people being seen by them had mental health concerns, and that many faced barriers in accessing hospital and community-based public and private acute and sub-acute mental health assessment and treatment services when needed.

The NDIS is not about the specific diagnosis, but NDIA does need enough information about the person's impairment to determine if it meets NDIS access criteria. In order to meet the access criteria, there needs to be enough information that there is no known evidence-based treatment that would remedy the condition and it does not require further medical treatment or review in order for its likely permanency to be demonstrated. NDIA also needs to confirm if the impairment results in a substantially reduced functional capacity. In addition, the person will need lifetime support from the NDIS.

While it is not a requirement that a person have a diagnosis to enter the Scheme, this can be useful for establishing impairment and disability. This is good for people living with mental health conditions to know, as not all people identify as being mentally ill but they can still benefit from community-based support. Furthermore, it is not always diagnostically, culturally or developmentally appropriate for a final diagnosis to be made. For example:

- Personality disorders, such as Borderline Personality Disorder associated with complex trauma which is extremely disabling, are not diagnosed in people under 18 years old.
- Aboriginal and Torres Strait Islander and other culturally diverse people do not often frame their experiences of mental health conditions/distress in terms of medical illness.
- People with the early onset of a potentially disabling mental health condition do not always benefit in terms of engaging with health and social care services by being 'labelled' with a diagnosed mental illness.
- People who have been traumatised through adverse childhood experiences, and/or as a result of their experience of having a mental health condition, will actively avoid voluntary contact with specialist mental health assessment and treatment services.

Sometimes it is unclear exactly what health and/or social/disability circumstances a person is experiencing, and it can take a long time for people to reach agreement on this. People with complex cognitive impairments due to, for example, intellectual disability, acquired brain injury and early dementia etc., are well known to slip between the cracks of various human service systems while these assessments occur. Similarly, people with a range of intellectual, physical and/or sensory disability/s often experience difficulty in accessing specialist mental health assessment and treatment. This is especially problematic for people with intellectual disability where the prevalence of mental illness is three times higher than for other Australian (i.e. three in five as compared to one in five).

The NDIS presents opportunities for the health and disability sectors to have different conversations about these matters. The most relevant framework for structuring these conversations is the WHO International Classification for Functioning, Disability and Health.[121] [122] A good place to progress approaches to integrated service delivery is with people with high and very complex needs who are exiting large residential centres and sub-acute psychiatric hospitals. In the Hunter NDIS trial site this includes:

NSW Health
Morisset Hospital (130 'patients'; see Appendix 4 for a ward breakdown)

FaCS/ADHC
Stockton Centre (462 residents, most aged 40 - 65)
Kanangra Centre (co-located with Morisset Hospital; 70 residents who require a higher level of security)

Work has commenced at all the above sites to better understand the range of opportunities presenting for people to return to community living.

The NSW Ombudsman's Office explored the numbers and needs of people residing in non-acute inpatient psychiatric facilities in NSW in 2012.[123] At that time the number of people at Morisset Hospital ready to exit to community living was not known. An audit indicated that perhaps 6 people at Morisset Hospital were ready to exit to community living but lacking access to the support services required to do so. HNEMH have since advised that the number of people ready to exit to community living is likely much higher than this, but again, this is pending access to appropriate levels of community support. In 2014, a three day-a-week project commenced at Morisset Hospital to further explore the opportunities presenting through the NDIS. Many patients at Morisset Hospital have multiple co-existing difficulties in addition to psychosocial disability. This activity is consistent with the HNEMH 2014/18 Strategic Plan and 2013/14 Operational Plan that have a priority action to identify a 'capital solution' for places like Morisset Hospital.[124], [125]

Some precedence was established early in the NDIS trial regarding the potential eligibility of people who were inpatient/residing at the 20 bed sub-acute facility in Newcastle. Morisset Hospital has subsequently supported many of its inpatients who have been deemed ready for discharge should appropriate community services be available through their access to NDIS. Some of these people have now relocated to the community. The main barrier for others to leave is the lack of affordable community-based housing. Solutions for this are being sought in partnership with the community managed mental health sector.

[121] WHO, *International Classification of Functioning, Disability and Health: ICF, World Health Organization, Geneva,* 2001. Available from: http://www.who.int/classifications/icf/en/
[122] WHO, *Towards a Common Language for Functioning, Disability and Health: ICF The International Classification of Functioning, Disability and Health*, WHO, Geneva, 2002. Available from: http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf
[123] NSW Ombudsman, *Denial of Rights: The need to improve accommodation and support for people with psychiatric disability: A Special Report to Parliament under s.31 of the Ombudsman Act 1974*, 2012.
[124] Hunter New England Mental Health, *2014/18 Strategic Plan*, HNEMH, Newcastle, 2014a.
[125] Hunter New England Mental Health, *2013/14 Operational Plan,* HNEMH, Newcastle, 2014b.

In addition, NSW Health has started a 'Mental Health: Hospital to Community' initiative (MH-HCI). This is part of the 'Strengthening Mental Health Care' direction for 'Assisting long-term patients to live in the community'. This activity aims to return 380 people to the community from non-acute psychiatric hospitals across NSW, including some people inappropriately residing in acute psychiatric hospitals.

Returning to the community from Morisset Hospital

At the September 2014 COP Forum NDIA shared the story of four women who previously resided at Morisset Hospital who were now living successfully in the community. All women live with very disabling Schizophrenia and have a range of positive psychotic symptoms that don't respond well to medication, including paranoia and delusions. These women are now sharing a home in the community and doing very well.

The agency's initial assessments of some of the women indicated that hospitalisation was the preferred option. However, the women also had many strengths to support community living, including being highly motivated for community living.

Indeed, one of the women 'absconded' from the hospital on the weekend after meeting the NDIA Support Planner, independently make her way to the Newcastle community where she had been informed she might possibly be placed in available accommodation.(She returned to the hospital in time for dinner).

What about people currently residing in the large ADHC Residential Centres?

The NSW government have identified an $88M capital solution for people currently residing at the ADHC Stockton and Kanangra Residential Centres and other large NSW residential centres either provided or funded by ADHC. This is referenced in the Bilateral Agreement as an ADHC 'in-kind' financial contribution to NDIS, and there are staged plans for downsizing/closing these facilities over the next few years. The Bilateral Agreement is silent on the topic of sub-acute hospital-based extended care services at Morisset Hospital and elsewhere in NSW.

There are about 440 people at the FaCS/ADHC residential centres in the Hunter who are to be dispersed across the state through a process of family and/or community re-unification.

The closure of the ADHC large residential centres in the Hunter NDIS trial site has been the subject of considerable media attention largely fuelled by carers and families who have concerns about their family member's future, ADHC staff who face possible job loss, and related unions and professional associations.

The joint standing committee on the NDIS visited Newcastle in June 2014 and transcripts from that event indicate that only about 80 people who live in Stockton actually have a person responsible or family members living in the Newcastle area. It is therefore expected that a considerable number of people will actually choose to relocate their family members to other parts of the state, with their friends, and in purpose-built housing that meets their needs better than Stockton.[126] Planning for this to occur has progressed substantially including consideration of people's mental health related treatment and support needs. The committee emphasises that the closure of the Stockton Centre was not a consequence of NDIS. It was a decision of the NSW government as part of its long-held

[126] Transcript from the Joint Standing Committee on NDIS Newcastle Hearing/s June 2014.

policy of deinstitutionalisation of state run residential centres. As such, the closure of the Stockton Centre is not a matter of direct relevance to the NDIS. It appears that the NSW government will either fully or at least substantially fund the cost for alternative accommodation for all residents leaving the Stockton Centre. On advice from NDIA, the committee understands that it has no obligation to contribute to this cost from its budget.

A family member's thoughts about the closure of the large residential centres

"I would like to make the point that there are a lot of relatives who are very supportive of all this, who are supportive of the closure of Stockton and the move into group homes. My sister has been in Stockton for 60 years … I think, in the future, when people have a choice, it will be a lot better world."

Mr Ron Sharkey in his evidence to the Joint Standing Committee

The NDIS and People with Very Complex Needs

Entering the NDIS with complex needs

The first person supported to access NDIS from Morisset Hospital was a person with very complex health and social needs and an extensive history of falling through the cracks of various service systems. The person first began having behavioural problems in early childhood, and these went largely unaddressed into early adulthood due to different views regarding the diagnosis of an intellectual disability and/or mental disorder. The person went on to develop serious substance misuse issues. Life was further complicated following a series of head injuries which resulted in an acquired brain injury. The person was at Morisset Hospital for a three month intensive neuropsychiatric assessment to determine how they might be best assisted with their health and wellbeing, including consideration of community living. With confirmation of eligibility for Tier 3 funded support, this person's options for community living and a valued contributing life have greatly expanded.

People with disabilities known to the criminal justice system

To date there has been little activity undertaken to systemically explore opportunities that may present through NDIS for people with disabilities who are also known to the criminal justice system. Such people may place themselves or others at serious risk of harm, and typically require complex and specialised support responses. These issues are being considered by NDIS at a national level.

MHCC has been largely unsuccessful in unearthing any early experiences that relate to people who are on involuntary community treatment orders or who have forensic status under the 2007 Mental Health Act (NSW) and related legislations. One exception to this is early experiences where people transitioning from ADHC to NDIA were not self-disclosing forensic issues. Another issue arising is the willingness of NDIA to pay for assessments under section 42 of the Mental Health Act which has historically been a barrier to accessing community care. We are also informed of challenges arising in relation to the transition of ADHC funded adult clients of the Community Justice Program.

MHCC communication with the NSW Department of Juvenile Justice revealed that their Hunter office has not had any success in the first 18 months of NDIS implementation in supporting young people with disability and other complex health and social circumstances to access the Scheme.

Clearly, there is much work to be undertaken in using the trial sites to explore the criminal justice NDIS interface.

People who need crisis work

Similarly, there has been little activity undertaken to date to explore the opportunities presenting through the NDIS for people with disabilities who need crisis work. Crisis work is here defined as unplanned short-term crisis work for people whose support needs have broken down and immediate intervention is required. This is likely because NDIA have been responsive to concerns about the planned services and supports of people transitioning to them from ADHC funded services. In the case of new people, the Agency is clear that it is not meant to replace mainstream services and nor can it solve our countries affordable housing crisis. An illustration of the way NDIA worked with existing providers to flexibly respond in assisting a homeless man was described on p 54.

The NDIA office in the Hunter have been on a very steep learning curve in regard to their experience of people with mental health conditions and NDIS. Their openness to learning means that the likelihood of crisis is greatly reduced.

In 2014, the key contact for mental health related matters within the Hunter NDIA came into this role from a community sector background, and brought with her a 'recovery' framework to compliment her 'clinical' skills. Her focus was to better understand and improve NDIS assessment and care planning processes for people with mental health conditions. At our September COP Forum she told the story of a woman living with Dissociative Identity Disorder who was thought to be ineligible on the basis of high functionality. The woman, who is the parent of a young child and a 14 year old daughter who self-harms, found the NDIA assessment process distressing, and dissociated many times. She dissociates an average of 5 times a week resulting in many crisis situations. The woman house shares with a friend and this main form of informal social support was under enormous pressure. The information upon which the initial NDIS eligibility decision was made was very old. New and more comprehensive information has supported NDIA engagement and the participant's access.

Everyone is learning…

4. The suitability of the assessment tool/s developed for people with psychosocial disability.

Outcome 7: Continued advocacy is required for assessment tools and processes more suited to the needs of people with mental illness/psychosocial disability.

Recommendation 13: Advocacy for use of a more suitable assessment tool that is psychometrically sound for a wide range of impairments/disabilities.
Recommendation 14: Mandated use of tools that explore consumer and carer satisfaction.

The access and care planning (or 'assessment') tools being used NDIA have not been declared publically. Information was made available that the tools are a modified version of the Support Intensity Scale (SIS).[127] SIS measures an individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports they require. SIS was designed to be part of person-centred planning processes that help all individuals identify their unique preferences, skills, and life goals. The SIS's psychometric properties (i.e. reliability, validity etc.) have only been established for people with intellectual disability. The SIS is intended to be used by a person with a four year health science degree, and includes an interview with the person and someone who knows them well. Neither of these standards are being applied by NDIA.

Through obtaining some early samples of de-identified NDIA care plans, it has been possible to ascertain aspects of NDIA access and care planning process (see Appendix 8). While the care planning process appears comprehensive, concerns have been raised that plans may lack the flexibility that people with psychosocial disability require (i.e. to modify services and supports against their needs and choices at any given point in time). In saying this we acknowledge that:

- everyone is learning how to best work with people with psychosocial disability
- some NDIS participants have designated 'flexible' funding (e.g. one person receives 60 hours a year for assistance with household tasks, i.e. cleaning. She can use this when she is more disabled than usual when recovering from an acute episode)
- NDIA support categories are increasingly being 'bundled' to allow for greater flexibility over time (see Appendix 9 for more information about NDIA support categories as at 30 June 2015).[128]

It is likely that NDIS access and planning processes will continue to modify as:

- a result of trial site experience
- trial site learning is scaled up to a national understanding
- the NDIS outcomes framework becomes known
- evaluations of NDIS and PIR initiatives are finalised after 2015/16.

[127] American Association of Intellectual and Developmental Disabilities, Support Intensity Scale, 2004.
[128] Introduction of further changes to the NDIS 'Catalogue of Supports' and related price guidelines are anticipated in August 2015 resulting in further flexibility in service delivery. These will be associated with the categories of the emerging NDIA Outcomes Framework.

The NDIS is introducing an outcomes based approach to access and care planning

On 1 August 2015, NDIA introduced a new Price Guide and redefined the supports funded to align to the forthcoming NDIA Outcomes Framework.[129] The support categories in the new price guide are:

- Assistance with daily life at home, in the community, education and at work
- Transport to access daily activities
- Supported independent living
- Improved daily living skills
- Improved relationships
- Improved living arrangements
- Improved health and wellbeing
- Improved learning
- Finding and keeping a job
- Increased social and community participation
- Improved life choices
- Assistive technology
- Vehicle modifications
- Home modifications

This reclassification increases the emphasis of NDIA as funding participant outcomes, and increases the choice and control of participants in the delivery of those outcomes.

A pilot of the NDIA Outcomes Framework was conducted from January to March 2015. The results of the pilot, along with feedback from consultation with the disability sector, are being used to improve the framework. The need to develop a shorter form to assist in participant planning arose from this pilot.

Implementation of the Outcomes Framework short form, and aligning of participant funding to its domains, will occur during August 2015. This will encourage the delivery of supports that strive to achieve positive outcomes for participants, their families and carers.

The community managed mental health sector currently uses a range of tools for assessment and outcome measurement purposes.[130], [131] The tools in use vary in regard to their psychometric properties, ease of administration and the type of outcomes intended to be measured. The most common tool in use is the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS).[132], [133]

During consultation to develop the NDIS, there was advocacy for NDIA to use the very comprehensive World Health Organisation (WHO) Disability Assessment Schedule 2.0 (WHODAS 2.0). WHODAS is an instrument developed to assess behavioural limitations and restrictions to participation experienced by a person, independent from a medical diagnosis.[134] The conceptual frame of reference for this instrument is the International Classification of Functioning, Disability

[129] National Disability Insurance Agency, *NDIA Price Guide VIC/ NSW/ TAS - 1 August 2015,* NDIA, Geelong, 2015d.
[130] Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia, *Implementing Routine Outcome Measurement in Community Managed Organisations,* AMHOCN, Sydney, 2015.
[131] Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia, *National Community Managed Organisation (CMO) Outcome Measurement Project: Final Report to the Mental Health Information Strategy Standing Committee*, AMHOCN, Sydney, 2013.
[132] M Slade, G Thornicroft, L Loftus, M Phelan and T Wykes,, *CAN: Camberwell Assessment of Need - A comprehensive assessment tool for people with severe mental illness*, Royal College of Psychiatrists, London, 1999.
[133] Siggins Miller, *Participant's Manual: Training workshop for PIR tools and resources (Facilitated by Siggins Miller Consultants for the Department of Health and Ageing Partners in Recovery Initiative),* Department of Health and Ageing, 2013.
[134] WHO, *WHODAS II - Disability Assessment Schedule Training Manual: A guide to administration*, WHO, Geneve, 2004. Available from: http://www.who.int/icidh/whodas/training_man.pdf

and Health (ICF).[135], [136] The ICF belongs to the Family of International Classifications of the WHO, and is directly related to the ICD-10 (international statistical classification of diseases and health problems) (WHO 1992). The psychometric properties of the WHODAS have been well established across a range of disability types.[137]

The WHODAS 2.0 covers six domains:

1. Cognition - understanding & communicating
2. Mobility - moving & getting around
3. Self-care - hygiene, dressing, eating & staying alone
4. Getting along - interacting with other people
5. Life activities - domestic responsibilities, leisure, work & school
6. Participation - joining in community activities

Nationally, PIR assessment and care planning for the delivery of time-limited service coordination is achieved through mandated use of a modified CANSAS. PIR has added three additional items to the standard CANSAS. The modified CANSAS is complimented by optional health and wellbeing 'advance directive' plans that are considered to be good practice in person-centred self-directed recovery-oriented and trauma-informed mental health work. They also serve to illustrate how supported decision making approaches can be achieved to better assist people during times where their capacity to make informed decisions may be diminished. The overview of the modified PIR CANSAS assessment and care planning tool is provided as Appendix 10.

With regard to outcomes measurement, Hunter PIR uses the RAS-DS (Recovery Assessment Scale - Domains and Stages) to assess client's perceptions of progress in their recovery journey.[138] The RAS-DS tool helps clients to identify individual strengths and progress achieved across several domains of recovery including 'personal', 'social' and 'clinical'. It has been developed at the University of Sydney, and Hunter PIR has joined with several other PIR programs also using the RAS-DS to monitor client outcomes. PIR also has a focus on identifying and measuring the development of partnerships with other organisations to improve service access and responses for consumers.

PIR assessors are encouraged to gather information from a wide range of sources. The CANSAS needs assessment measure has had its psychometric properties assessed for use with mental health clients, however it is not particularly sensitive to change over time, which is a strength of the RAS-DS. CANSAS information is also supplemented through the collection of a PIR Minimum Data Set.

Information provided to NDIA as part of the 'evidence of disability' information is used by NDIA to make an access determination for funded services and supports. This is not limited to NDIS evidence of Disability form and NDIA have, for example, indicated that they can make use of a range of evidence, such as data collections using the WHODAS, CANSAS, RAS-DS etc. as evidence in determining NDIS Tier 3 eligibility. Non-government services working with people with

[135] WHO, *International Classification of Functioning, Disability and Health: ICF*, WHO, Geneva, 2001. Available from: http://www.who.int/classifications/icf/en/

[136] WHO, *Towards a Common Language for Functioning, Disability and Health*, ICF The International Classification of Functioning, Disability and Health, WHO, Geneve, 2002.
http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf

[137] S Federici, F Meloni.WHODAS II: Disability self-evaluation in the ICF conceptual frame, in JH Stone, M Blouin,(Eds), International Encyclopaedia of Rehabilitation, Centre for International Rehabilitation Research Information and Exchange (CIRRIE), Buffalo, New York, 2010.

[138] N Hancock, J Scanlan, A Honey, A Bundy and K O'Shea. Recovery Assessment Scale – Domains & Stages (RAS-DS): Feasibility and measurement. *Australian and New Zealand Journal of Psychiatry,* 2015.

mental health conditions and including PIR initiatives are encouraged to use existing assessment and outcomes information where this exists and is current.

For NSW Health mental health services like HNEMH, the availability of people's psychosocial functional assessment information is likely to vary considerably both across and within LHD mental health teams. Again, this is not surprising given their focus on acute and sub-acute assessment and treatment. In NSW, LHD mental health services use a suite of materials known as the Mental Health Outcome and Assessment Tools (MH-OAT) for assessment and care planning purposes. These tools focus on gathering information relevant to government reporting requirements and providing acute and subacute assessment and treatment services. For example, the primary psychosocial/functional assessment tool use is the LSP16 (Life Skills Profile - 16 items). The short version of this tool is used because it focuses on the symptoms associated with an acute mental health episode only, as opposed to the longer 32 item tool which also focuses, for example, people's social support networks, housing situation and employment circumstances.

A vehicle needs to be identified for continuing national discussion about the suitability of the assessment and outcome measurement tool/s developed for people with psychosocial disability to be used by NDIA and others in supporting people in their access to NDIS. This will be an important national discourse along with the identification of research and development directions that are dependent on good data collection processes.

Demonstrating flexibility in access to services and support …

A young man had been residing inappropriately in an acute psychiatric hospital in the Hunter area for some weeks and had no clear discharge plan. The man was well known to HNEMH as someone who needed additional community support in order to maintain good mental health and to improve his social circumstances, including connections with family and friends who had struggled to support him. The hospital staff referred the man to the new Partners in Recovery (PIR) initiative. A PIR Support Facilitator spent time at the hospital getting to know the man and talking with him about the help he wanted and needed. The CANSAS assessment that was conversationally undertaken provided rich information of likely eligibility for Tier 3 NDIS services. PIR supported the man to access NDIS funded supports. They then worked with the man to identify a community sector organisation with a supported accommodation vacancy. The man was then able to be discharged from hospital and into community care within two weeks.

… but not yet flexible enough!

NDIS Outcomes Framework

The Agency is undertaking extensive work to develop a participant outcomes framework. The framework will include measurement across domains such as:

- - choice and control
- - daily activities
- - relationships
- - home
- - health and wellbeing
- - lifelong learning
- - work (employment and education)
- - social, community and civic participation

It is understood that outcomes related specifically to families are also being considered.

The Outcomes Framework will allow the NDIS to continuously evaluate what drives good outcomes as well as associated costs.

Research and development for mental health and the NDIS

MIND Victoria has undertaken an important piece of foundational research at the Victorian trial site in Barwon. The community living service and support need priorities chosen by people living with a psychosocial disability were identified to be:

- improved health
- economic security
- more social connections
- safe housing
- personal life (i.e. closer ties with families, and intimate relationships)

This finding resulted from use of an appropriate methodology that was sensitive to the unique needs and decision-making processes of people with high levels of psychosocial disability.

This research was conducted with researchers with lived experience of a mental health condition and recovery (i.e. peer researchers) and also in partnership with the Centre for Mental Health, the Melbourne School of Population and Global Health, the University of Melbourne, and the School of Health and Social Development at Deakin University.[139]

[139] L Brophy, A Bruxner, E Wilson, N Cocks, M Stylianou and P Mitchell, *People making choices: the support needs and preferences of people with psychosocial disability*, Mind Australia, Heidelberg, VIC, 2014.

5. The national discourse regarding the positioning of psychosocial disability within the NDIS.

Key outcome 8: The NDIS Mental Health Analyst Partnership Project has positioned both the NSW Mental Health Commission and MHCC to contribute to the national discourse regarding the positioning of psychosocial disability within the NDIS.

Recommendation 15: Strengthen mechanisms for sharing the learning from the Hunter NDIS trial site both across NSW and nationally.
Recommendation 16: Continue to engage with national projects and initiatives exploring the situation of mental health/psychosocial disability within the context of NDIS (e.g., MHA, DSS, NDIA Mental Health Sector Working Group, etc.).

From the commencement of the NSW *NDIS Mental Health Analysis Partnership Project*, *MHCC* and the NSW Mental Health Commission have worked closely with a range of state and territory and national stakeholders to better understand the positioning of mental health/psychosocial disability within the NDIS. It is *MHCC's* view that mental health continues to largely not be seen as a disability issue, and that much education is needed in regard to this. This is not surprising given the structural siloing of mental health from the disability portfolio in NSW and elsewhere over many decades. We now know that health and disability cannot be viewed as being separate from one another, and that responses to these issues need to also consider people's environments.

NSW contributions to the national discourse have most notably included conversations with:

- other state and territory community sector mental health peak bodies with NDIS trial site experience and/or preparation activities, and Community Mental Health Australia (CMHA: CMHA is an alliance of the state/territory community managed mental health sector peak bodies)
- Mental Health Australia (MHA)
- the Commonwealth Department of Social Services (DSS) and the NDIA
- the National Disability Service (NDS - the Australian disability sector peak body for disability services providers).

In addition, in 2014 there was high demand for national presentations describing early Hunter trial site experiences. Frequent contacts from and conversations with people wondering what NDIS might mean for them, particularly in the context of overall mental health community sector reform, were experienced throughout the NSW *NDIS and Mental Health Partnership Project.*

CMHA
The CMHA Executive Leadership Group meet regularly and discuss matters related to NDIS design and implementation. In October 2014, CMHA established an NDIS Working Group to share experiences at a peak body front line level. In the first instance, this included representatives from NSW, Victoria and WA. Other states and territories will join as they gain further NDIS experience. CMHA continues to work closely with MHA, DSS and the NDIA on NDIS implementation as this relates to people affected by mental health conditions and the services that support them. Aspects of this work are described below.

MHA
MHA has been an early driver of the national discourse on NDIS and mental health. In 2013/14 MHA received $440K in funding through the NDIS Sector Development Fund, to explore consumer and carer readiness for the NDIS. Much of this work focused on mental health sector readiness, with a particular focus on community sector readiness. MHA were approached by the DSS in

December 2013 to develop a proposal related to possible directions for the Scheme as this relates to people with mental health conditions and the services that support them.[140]

MHA have since developed a draft needs analysis describing the experiences of the mental health sector with NDIS implementation during 2013/14, and have made related recommendations for future directions.[141] A further two years of project funding was secured, and the current directions of the NDIA/DSS funded MHA NDIS Capacity Building Project are:

- Work Stream 1: Project governance, stakeholder collaboration and communications
- Work Stream 2: Specific Projects
    - Consumer and Carer Capacity Building Activities
    - Service Provider Capacity Building Activities
    - Sector Capacity Building Activities

NSW and *MHCC* have been well represented in MHA's NDIS work including *MHCC* sitting on the NDIS Capacity Building Project Advisory Group, and NSW representation to all of its Working Groups as follows:

- **Scheme Design and Administrative Arrangements**
  Tully Rosen/*MHCC* (until December 2014), Mark Cliff/RichmondPRA (Hunter) and Sally Regan/PIR (Hunter Medicare Local)
- **Assessment and Eligibility**
  Rob Ramjan/SFNSW and Nicola O'Brien/Neami National (Hunter)
- **Monitoring, Evaluation and Service Quality**
  Tully Rosen/*MHCC* (until December 2014), Janelle Heatley/Aftercare (Hunter) and Mark McMahon/SFNSW (consumer representative)
- **Supported Decision Making and Diverse Groups**
  Kieran Condell/SFNSW
- **Organisational Readiness and Workforce**
  Tina Smith/*MHCC* (Chair).

In addition, MHA have funded CMHA to undertake two sector capacity building projects which are due to conclude in 2015:

- **Design of Individual Supports for People with Psychosocial Disability**
  The WA Association of Mental Health is the lead agency for aspects of this project and MHCC participates on the Advisory Group. The NDIA is also a project partner and is separately undertaking other aspects of the project.
- **NDIS Mental Health Workforce Development Scoping Project**
  MHCC is the lead agency for this project and is working in collaboration with Human Capital Alliance International Pty. Ltd. who authored the workforce development paper underpinning the National Mental Health Commission's review of mental health programs.[142]

The findings of both projects, along with other DSS and NDIA initiated activities are assisting in scaling up the mental health related learning from NDIS trial sites.

[140] Mental Health Australia, *Providing Psychosocial Disability Support Services through the NDIS: a proposal for the NDIA*, MHA, Canberra, 2014b.
[141] Mental Health Council of Australia 2014a, op. cit.
[142] L Riddout, V Pilbeam and D Perkins, *Final Report on Workforce Requirements in Support of the 2014 National Review of Mental Health Programmes and Services,* National Mental Health Commission, Canberra 2014.

DSS and NDIA

MHCC, both independently and on behalf of CMHA, have participated in national forums and working groups convened by DSS and NDIA. This included an October 2013 DSS forum with consultant Paul O'Halloran, who was contracted by the DSS to develop a paper related to psychosocial disability and NDIS.[143]

An important event in the national NDIS and mental health discourse has been the three year appointment in April 2014 of Eddie Bartnik, former WA Mental Health Commissioner. His role is to be a strategic advisor to NDIS in regard to progressing understanding of the situation for people with psychosocial disability, local area coordination functions, and clarifying the operations of Tier 2/ILC services across all disability types.

The NDIA priority direction for mental health in 2014/15 has been to further develop strategies for supporting individuals with a mental illness eligible for the Scheme.[144] This has been supported by the NDIS Independent Advisory Council (IAC). Mental health sector representatives to the IAC are:

- Ms Janet Meagher AM, consumer advocate and representative
- Dr Gerry Naughtin, CEO, MIND Australia.

Considerable work has progressed in 2014/15 to better understand the NDIS experience of people with mental health conditions. A major achievement has been the establishment of an NDIS Mental Health Sector Reference Group, chaired by Eddie Bartnik, and including consumer, carer and community sector representation. The NDIS Mental Health Sector Reference Group was established to develop a strong working partnership between the mental health sector and NDIA. Further information about the work of the reference group, including meeting 'Communiques', are available on the NDIS website: http://www.ndis.gov.au/mental-health-sector-reference-group

Another national initiative of high importance to our rapidly growing understanding of the NDIS and mental health is the *Operational Access for People with Psychosocial Disability Project*. Initial findings and recommendations of this project are currently under consideration and this is understood to be occurring in the context of all the learning that has accumulated through all NDIS national projects, and across the experiences of the first two years at the trial sites.

The national NDIS and mental health projects that are underway will inform development of an efficient pricing model for supports specific to addressing the needs of participants living with a psychosocial disability.[145]

NDS

MHCC began to meet with NDS in 2013 to discuss NDIS organisation readiness/capacity building activity, and in March 2014 entered a Memorandum of Understanding with them for shared directions where possible. These discussions have in part related to access to a range of resources for NSW Health funded CMOs delivering mental health/psychosocial disability programs that have been made available through both the NSW Industry Development Fund (i.e. $17M via ADHC from the 2009/10 state budget through to June 2015) and Commonwealth DSS NDIS Sector Development Fund (with this funding also through ADHC). These funds have allowed NDS to undertake considerable NDIS and 'contestable market' capacity building for non-government disability organisations in NSW.

Shared activity has included cross-mapping our respective NSW memberships (see Appendix 11). This quantified the disadvantage being experienced by 71% of MHCC member organisation that are primarily NSW Health CMOs delivering mental health/psychosocial disability programs that do

[143] P O'Halloran, 2015, op. cit.
[144] National Disability Insurance Scheme 2014c, ibid., p. 65.
[145] National Disability Insurance Agency 2015a, op. cit.

not also receive ADHC funding. The needs of these organisations in the context of NDIS implementation needs to be better understood. This circumstance of mental health community sector exclusion from state based capacity building activity does not appear to exist for any other state or territory. The national position is that this is a NSW matter that needs to be resolved internally as it presents a high risk to community sector mental health services readiness for a range of impending reforms.

Access to the $122.6 million 2012/16 Commonwealth Sector Development Fund, and earlier 2012/13 $10M Practical Design Fund, by NSW and other some other state and territory CMOs providing support and other services to people with mental health condition has been quite limited. (see Appendix 12 for information about mental health specific Practical Design Fund Projects that predated the MHA NDIS Capacity Building Project).

MHCC **Presentations**

In 2013 at our August Regional Forums in Armidale, Wollongong, Orange and Hornsby, *MHCC* presented on and consulted regarding the NSW *NDIS Mental Health Analysis Partnership Project.* This was followed by a presentation and consultation at the December 2013 *MHCC Big Issues Forum* and AGM. From these meetings it was apparent that people wanted a lot more information about what the NDIS is, eligibility criteria, what it might mean for people affected by mental health conditions, their families and carers, and service providers, and how it might impact on them and their organisations both now and beyond the trial site experiences. People continue to have variable levels of knowledge about the NDIS and this is especially the case outside the trial sites. The intent of work undertaken both individually by *MHCC* and in partnership with the NSW Mental Health Commission is to capture and share the learning of the trial site, primarily with *MHCC* member organisations and other stakeholders in NSW, and across a range of reforms.

Jenna Bateman, CEO, MHCC at the Orange MHCC Regional Forum in 2013

Some requests of *MHCC* in 2014 for national presentations regarding the Hunter experience include:

- MHA and Mental Health Council of Tasmania NDIS Organisational Readiness Forum on 6 February
- Australian College of Mental Health Nurses Conference in Canberra on 21 March
- MHA Council of Non-Government Organisations (CONGO) in Canberra on 10 April
- Individual paper at the THEMHS Conference in Perth on 28 August
- Featured symposium at the THEMHS Conference in Perth on 29 August
- National Respite Association (formerly Interchange) on 23 October.

These occurred in addition to numerous NSW presentations and consultations in 2014 and 2015, some of which have been mentioned elsewhere in this report.

Mental Health Community Sector Reform

NSW organisations both within and outside of the Hunter trial site continue to reflect on what the NDIS will mean in the context of national and state mental health sector reform. It is hoped that the NSW *NDIS and Mental Health Analysis Partnership Project* and the learning arising from it which is partially captured in this report, might contribute to better understanding of this.

For NSW, future directions for the NSW Health 'Partnerships for Health' mental health program funding reforms (previously known as the Grants Management Improvement Program) are an important component of this discourse. *MHCC's* position and related recommendations in regard to Partnerships for Health mental health program reform were made available in a January 2015 briefing and recommendations paper.[146] In addition to the complexities of NDIS implementation and mental health sector reform at both the NSW and national levels, anticipated NSW Health funded NGO mental health program re-commissioning is further complicated by the re-commissioning of Medicare Locals as Primary Health Care Networks currently underway, especially as 75% of these in NSW are lead agencies for PIR consortia across NSW.

Taken together, NDIS implementation and *Partnerships for Health* reforms mean that health and community services are going to have to work more closely with one another on local community level planning to better respond to whole populations of people who are in need of better access to mental health treatment, rehabilitation and support services. One example of an approach to this is the *Sector Benchmarking Project* that was undertaken by *MHCC* in anticipation of the above reform directions.

[146] MHCC, *Briefing and Recommendations Community Managed Mental Health Sector Considerations for the Partnerships for Health Reform Process,* MHCC, Sydney, NSW, 2015b.

MHCC Sector Benchmarking Project example of population planning for improved access to mental health treatment, rehabilitation and support

MHCC's 2013 *Sector Benchmarking Project*[147] builds on earlier work undertaken through the 2010 Sector Mapping Project[148] and incorporates the methodology of the National Mental Health Service Planning Framework (NMHSPF).[149] The *Sector Benchmarking Project* builds on these by making NSW LHD and LGA level projections for non-government community managed mental health services per 100,000 of population aged 18 to 65 years. The project also contains a 2013 stocktake of CMO services and presents a gap analysis between this stocktake and the population targets of the NMHSPF, thus providing an assessment of need across the range of CMO service types. The data can also be accessed by LGA but is not recommended for planning purposes with populations of less than 100,000.

As previously noted, at the commencement of the *NDIS Mental Health Analysis Partnership Project,* the *Sector Benchmarking Project* data for the Newcastle, Lake Macquarie and Maitland LGAs was used as a basis for mapping community sector mental health services (see Appendix 4). This information was built on throughout the project to include program name, funding source and 'places' (i.e. capacity) where available and/or applicable. It demonstrates the diversity of the community managed mental health sector and the growth that has occurred since the 2012 *Sector Mapping Project*, given current state and national policy and funding directions for community based mental health services.

The *Sector Benchmarking Project* data tells us that most CMO HNELHD mental health services are in the three trial site LGAs, and that there are few programs outside of that. Similar information is also available for all of NSW, and this data has been shared in confidence with the *National Mental Health Service Planning Framework Project* (NMHSPF), the NSW Health Mental Health and Drug and Alcohol Office, LHD Mental Health Directors and the NSW Mental Health Commission for the purpose of mental health service planning.

An example of how this data can be useful for community-based mental health service planning is provided in Table 2 p.78. This shows that reliable population estimates for the numbers of people with severe/profound mental illness/psychosocial disability can be made for the HNELHD and various sub-catchments of it (although not at the LGA level for smaller regional/rural communities of less than 100,00K). It is notable that these figures are much higher than the estimates of either the NDIS or PIR initiative.

[147] MHCC 2013, op. cit.
[148] MHCC 2010, op. cit.
[149] Commonwealth of Australia, *National Mental Health Service Planning Framework* (draft and confidential), Australian Government, Canberra, 2014.

Table 2: Population 18-64 years in Various Parts of the HNEHLHD Catchment with Severe and Persistent Mental Illness

Geographic Area	2011 Census Population	Number of People with Severe Mental Illness	Estimates of people known to HNEMH	Estimates of people not known to HNEMH
Hunter New England	527,090	9,277	5,367	3,910
Hunter	421,907	7,425	4,096	3,329
New England	105,131	1,850	1,271	579
Newcastle LGA	99,762	1,756	1,737	19
Lake Macquarie LGA	117,338	2,065	1,126	939
Maitland LGA	49,671	874	637	237
NDIA trial site (3 LGAs)	266,771	4,695	3,500	1,195

Note: The calculation of population need was projected using NMHSPF assumptions and estimates. The *Sector Benchmarking Project* population estimates are 3,469 people with 'severe and persistent' mental illness per 100K population (3.5%), of which 1,760 have identified needs to access psychosocial rehabilitation and recovery support services per 100K. Psychosocial rehabilitation services are defined as both 'clinical' and 'non-clinical'.

There is currently no detail on which part of the psychosocial rehabilitation figure is the responsibility of NSW Health, and which part is the responsibility of NDIS, however these people would all require full packages of care (either a NSW Health funded set of program places and/or a Tier 3 NDIS package with multiple components). Furthermore, the role delineations between 'clinical' rehabilitation (noted in the 'in-principle agreement' to be a mainstream health services responsibility) and psychosocial rehabilitation need further operationalisation.

Sector Benchmarking Project projections do not accommodate for the impact of existing public, private or primary health care mental health services and psychosocial rehabilitation services (disability and recovery support) that may be available within any catchment. More detailed local level place/capacity information across a range of service settings is required for this to occur. For example, HNEMH has seven hospital-based inpatient mental health facilities with most of these places (i.e. 'beds') existing within the three NDIS trial site LGAs (see Appendix 5). For the remainder of the HNELHD there are small clusters of hospital based inpatient services only in the regional communities of Taree, Tamworth and Armidale. There are few hospital based inpatient services elsewhere across this geographically vast metropolitan, regional and rural LHD.

The *Sector Benchmarking Project* also demonstrates that the HNELHD is currently the least resourced for community sector mental health services than any other part of the NSW, with most of these resources sitting within the three LGAs that make up the NDIS trial site. This is important to know as NSW moves forward with the *Partnerships for Health* reforms. Through the *Partnerships for Health* funding reforms, NSW funded packages of support for people with mental health conditions may actually decrease and this means increased uncertainty regarding which people with what mental health conditions will have access to services. While the NDIS provides important opportunities for individuals to access funded services and supports, this will not be sufficient for achieving the full aspirations of mental health sector reform, either at the NSW or national levels.

A final note on the national discourse as this applies to NSW

The community sector has also expressed concern about what renegotiation of the Commonwealth and NSW Government's NDIS Bilateral Agreement might mean in the context of the NSW Health *Partnerships for Health* reforms. *MHCC* is informed that the recommissioning tendering process may be dependent on the whole-of-government response to the *NSW Mental Health Commission Strategic Plan* and Commonwealth Government's response to the *National Mental Health Commissions Review of Mental Health Programs and Services*. However these will likely be high level documents, and NSW Health needs to determine their *Partnerships for Health* mental health program procurement plan which will enable the community sector to plan for change depending on the new services that are purchased and detailed information on the tender process itself. It will also be important for community sector, public, private and primary health mental health services to understand how their service will work within and outside of NDIS eligibility.

A greater understanding of which state and territory funded community sector mental health programs are in and out of scope for NDIS will be critical to setting benchmarks for, and further operationalising Tier 3 and Tier 2/ILC services and supports. The Commonwealth government's forthcoming response to the *National Mental Health Commissions Review of Mental Health Programmes and Services*, anticipated for late 2015, may take us forward to better understanding what services will remain available or need to be developed for people not eligible for NDIS Tier 3 funded services and supports.

Both *MHCC* and the NSW Mental Health Commission are delighted to be in the privileged position of contributing to both the NSW and national discourse regarding the positioning of psychosocial disability within the NDIS.

An early consumer comment on the NDIS and mental health

> *" …we are yet to really see the NDIS land on the ground for mental health consumers and we've really got to see how services will work together …. "*
>
> Mr Bradley Foxlewin, NSW Deputy Mental Health Commissioner[150]

[150] NSW Mental Health Commission Media Release, 3/7/2013.

DISCUSSION AND PRIORITY ACTIONS

The initial objectives, findings and outcomes of the NSW *NDIS Mental Health Analysis Partnership Project* have been considered in the previous section along with associated recommendations for taking this learning forward. The volume of potential activity related to the impacts and opportunities presenting through NDIS for people affected by a mental health condition is considerable. For this reason the recommendations have been synthesised into seven priority actions, and these have formed the basis of *MHCC's* discussion with the NSW Mental Health Commission and others in negotiating the NSW *NDIS Mental Health Analysis Partnership Project* work plan for 2014/15 and beyond.

The seven priority actions initially identified are:

1. Effective representation and participation of consumers, their families and carers, and mental health service providers in NDIS implementation and evaluation.
2. Increased recognition and understanding of the needs of people affected by psychosocial disability.
3. Pursuit of collaborative, recovery-oriented and trauma-informed health and wellbeing approaches to services and supports planning/review processes.
4. Research and development analysis of trial site experiences including the collection of comprehensive data.
5. Development of strategic directions for NDIS psychosocial disability and recovery support workforce development.
6. Influence development of the framework for NDIS quality, and safeguard mechanisms in NSW and nationally.
7. Contribute to the national discourse regarding NDIS and mental health.

Priority Action 1: Effective representation and participation of consumers, their families and carers, and mental health service providers in NDIS implementation and evaluation

Recommendations 1, 2, 7, 9, 12, 14 and 15

The representation and participation of consumers, their families and carers, and mental health service providers in NDIS design, implementation and evaluation is critical to building effective services that are responsive to community need. For people with very complex health and social issues, including but not limited to people with psychosocial disability, this won't be achieved through individualised Tier 3 approaches alone. The redesign of scarce mental health sector treatment, rehabilitation, and disability/recovery support services requires systemic representation and participation that extends beyond government entities.

Understandably there is a good deal of angst regarding the design and implementation of the NDIS among many people with mental health conditions and their families and carers. Some NDIS participants have struggled as the services and supports they are used to that were previously funded by ADHC, change shape and evolve. There are people who have been denied access to the Scheme who are confused about what help is available to them. There are people who are functionally more able or better supported than others to navigate these changes.

There are concerns about the extent to which the NDIS will include and support families and carers, and how their support needs will be identified and delivered. There is also an inherent tension between the traditional role of carers in supporting decisions of those living with psychosocial disability and impaired decision making capacity, and the self-directed funding model

aimed at promoting choice and control by the person with a mental health condition. ARAFMI Mental Health Carers Australia have issued a NDIS policy brief that speaks in more detail and makes recommendations in regard to both the needs and disability support contributions of carers and families.[151] Carers NSW have released a discussion paper about the experiences of families and carers in the Hunter trial site.[152]

This report does not make any recommendations in regard to carers and families beyond the need for enhanced participation and representation in co-design of NDIS. In acknowledging this, we note that the focus of NDIS is people with disabilities, not carers and families, and also that strategic area two of the *National Disability Agreement* seeks to enhance family and carers capacity.

Activities to achieve this in NSW are:

- continue to support and advocate for consumer, carer and community sector representation on the maturing HNELHD and NDIA NDIS Operational Group Mental Health Working Group and related structures
- more frequent communication with consumers and carers being, or potentially being, impacted by NDIS implementation within the trial site
- identify strategies for greater involvement of Being (formerly the NSW Consumer Advisory Group/CAG) and ARAFMI NSW in NDIS design and implementation both within and outside of the Hunter trial site

Priority Action 2: Increased recognition and understanding of the needs of people affected by psychosocial disability

Recommendations 1, 2, 5, 8, 9, 13 and 15

Psychosocial disability resulting from a mental health conditions continues to not be well understood. Without an increased recognition and understanding of the needs of people living with psychosocial disability that is informed by the voice of lived experience, Australia will be unlikely to meet the target of 57,000 people with psychosocial disability accessing NDIS. The voice of lived experience is critical to ensuring high levels of confidence of consumers, and their families and carers, in the Scheme.

Greater literacy is needed regarding the term ‘psychosocial disability’ including the types of services and supports that may be required by people. The systemic participation and representation of people affected by mental health conditions in NDIS design and implementation is fundamental to achieving a greater understanding of psychosocial disability, and to achieving the NSW target of at least 19,000 people by 2018.

While relationships between NDIA and public mental health services are an important pathway toward identifying people who may be eligible for NDIS, this is not sufficient on its own when only one in three people needing mental health treatment services are accessing them. Many people with mental health conditions that have, or are at risk to develop, psychosocial disability are living impoverished lives in our communities. Many have been traumatised and re-traumatised by their experience of a mental health problem, resulting in significant trust issues. They require assertive outreach/in-reach to achieve service access.

[151] Arafmi Mental Health Carers Australia, *Policy Brief: Involving carers and family members in the NDIS,* Arafmi Mental Health Carers Australia, Heidelberg, VIC, 2014.
[152] Carers NSW, *The NDIS One Year In: Experiences of carers in the Hunter trial site,* Carers NSW, Sydney, 2014.

Activities to achieve this in NSW are:

- pursue the 2013/14 data for all people with a psychosocial disability in the trial site who were deemed eligible/ineligible for both PIR and Tier 3 funded services, and use this information to further educate stakeholders about psychosocial disability in the context of NDIS
- undertake research activity to better understand the view of consumers and carers in the trial site about their experiences of NDIS
- expand and pilot the concept NDIS outreach, engagement and pre-planning services in the trial site, and use this information to further educate stakeholders about the needs of people with psychosocial disability and other mental health conditions in the context of the NDIS.

Priority Action 3: Pursuit of collaborative, recovery-oriented and trauma-informed health and wellbeing approaches to services and supports planning/review processes

Recommendations 1, 2, 3, 4, 8, 9, 13 and 15

Collaborative, recovery-oriented and trauma-informed health and wellbeing service delivery approaches that are within the bounds of NDIS legislation must be adopted by NDIA. At the Hunter trial site this is both organically and strategically occurring through the Agency's experiences of people with psychosocial disability, their families and carers, and contact with the community sector organisations and peak bodies that assist them, including the NSW Mental Health Commission, While this learning approach is important it needs to be scaled up and made even more strategic.

Collaborative, recovery-oriented and trauma-informed health and wellbeing service delivery approaches are not learnt through attendance at foundational mental health training such as Mental Health First aid which teaches people to identify, respond and refer to people with acute mental health symptoms. Effectively balancing notions of permanent disability and recovery requires a framework of understanding that extends beyond notions of clinical/medical recovery to an understanding of personal recovery.

While NDIA is not a service provider but a purchaser of services, these nuances are important for them to understand as they will be increasingly important to the financial viability of the Scheme with regard to the establishment of Tier 3 and 2 eligibility and service benchmarks. NDIS being better informed about notions of collaborative, recovery-oriented and trauma-informed service-delivery/practice will be important to both resolving pricing issues that are emerging, and retaining and building effective organisations that can deliver outcomes for people with psychosocial disability.

Activities to achieve this in NSW are:

- continue to convene the quarterly Hunter NDIS and Mental Health COP Forums, including the attendance of NDIA, HNEMH and MHA
- make available MHCC's Mental Health Connect and Trauma Informed Care and Practice training to NDIA staff in the trial site
- host a NSW forum relevant to reconciling notions of permanent disability and recovery.

Priority Action 4: Research and development analysis of trial site experiences including the collection of comprehensive data

Recommendations 1, 2, 3, 9, 10, 11, 13, 14 and 15

To scale up and make even more strategic the learning that is occurring in the trial site, a research and development direction is required that includes increased access to relevant data by consumers, carers, community sector organisations, *MHCC*, Being, ARAMFI NSW and the NSW Mental Health Commission.

The challenges of obtaining relevant data for the purpose of mental health services planning are considerable at both the state and territory and national levels. Most mental health sector data that does exist is mostly related to the provision of government delivered hospital and community based acute mental health services. The NDIS provides a unique opportunity to capture non-acute/sub-acute data relevant to people with mental health conditions in the context of their psychosocial disability and recovery support needs. This will be important to better understanding clinical/non-clinical, mainstream health/mental health and NSW Health/NDIA roles and functions.

State level data collections linked to research and development directions will also become increasingly important to understanding how needs assessment, Tier 3 and 2 access/eligibility, and funded/unfunded NDIA and NSW Health NGO funded services and supports provided to people with disabilities are translating to 'remaining within the funding envelop' for NDIS. For example, while we know that the average annualised package cost in NSW at the end of June 2015 is $33,600 (and excluding the Stockton large residence) we have no idea of what a package for a person with psychosocial disability costs or consists of.[153]

Stronger linkages need to be made with the consortium of researchers, academics and disability experts that has been commissioned to conduct the evaluation of NDIS trial sites. Headed by the National Institute of Labour Studies (NILS), the study is monitoring and evaluating the experiences of both participants and providers in order to provide insights and lessons learned before the full national rollout of NDIS.

Activities to achieve this in NSW are:

- make formal approaches to FaCS, NDIA Hunter office and DSS/NDIA nationally about access to data being collected about people with mental health conditions
- pursue agreements with both the NILS and Flinders University, who are the lead evaluators for the PIR initiative, to liaise with the *NDIS Mental Health Analysis Partnership Project* on ways to strengthen NSW NDIS evaluation approaches as they relate to people with mental health conditions
- continue to promote and encourage the involvement of NDIA in directions for implementation of the national MH NGO MHDS and NMHSPF.

[153] National Disability Insurance Agency 2015c, op. cit.

Priority Action 5: Development of strategic directions for NDIS psychosocial disability and recovery support workforce

Recommendations 7, 8 and 15

Strategic directions for NDIS psychosocial disability and recovery support workforce recognition and development are required as it is unlikely that they will be progressed through a National Disability Strategy/NDIS Workforce Strategy that was to be developed in anticipation of the full roll-out of NDIS from 2018.

Any forthcoming NDIS Integrated Sector, Market and Workforce Strategy disability workforce direction will likely focus on the traditional disability workforce. This workforce and its' skills, training, recruitment and retention requirements is much better understood in the context of intellectual, physical and sensory disability than it is in the context of psychosocial disability. For effective implementation of NDIS, a greater understanding of the skills necessary for collaborative, recovery-oriented and trauma informed service delivery/practice will be required, especially as these relate to psychosocial disability and recovery support settings (as opposed to acute assessment and treatment settings). Achieving this will require a greater understanding of community sector mental health workforce development activities in each of the states and territories, as there are similarities and difference in regards to issues nationally.

Development of the peer workforce will become an important strategy to address projected workforce shortages, and is equally important to helping organisations understand the value of collaborative, recovery-oriented and trauma-informed service delivery. However, to ensure the quality of services and supports being provided, caution must be taken to understand that there will be a need to strengthen both peer and non-peer work roles and workforce development directions in community sector settings as NDIS is being fully implemented. Failure to do so could result in role strain and role confusion for peer workers and less than optimal outcomes for NDIS participants and their families and carers.

Targeted workforce development and learning strategies are required so that people engaging in assessment/care planning and providing support services to people with psychosocial disability have sufficient skills, knowledge and understanding to identify and meet the needs of participants and their carers.

Activities to achieve this in NSW are:

- undertake activities to promote greater recognition of the complexity of skills required in psychosocial disability and recovery support work, including the skills required for complex care coordination
- make available to NDIA staff in the trial site a customised version of the 'Understanding Peer Work' training course that CMHA/MHCC has developed for the National Mental Health Commission, and orient them to related NSW and national peer workforce development initiatives
- promote and support the uptake of peer work roles within community organisations struggling to recruit sufficient, or sufficiently flexible staff to deliver NDIA funded services and supports to people with psychosocial disabilities.

Priority Action 6: Influence development of the framework for NDIS quality and safeguard mechanisms

Recommendations 2, 5, 6, 12, 15 and 16

The development of a national framework for NDIS quality and safeguard mechanisms will take some years to complete. However, the new roles and functions of the NSW Ombudsman's Office that flow on from the Disability Inclusion Act 2014, as these relate to the NDIS trial site, will be vitally important in contributing to this national discourse.

The old 1993 Disability Services Act meant that the Ombudsman's Office interactions with people with 'primary' mental health conditions, and in particular psychosocial disability, was limited. For this reason it is important that the Ombudsman's Office has good access to consumers, families and carers, and community sector service providers within the NDIS trial site. The Ombudsman's Office has been active within the Hunter NDIS and Mental Health COP Forum and indicates an intent for continued participation.

MHCC's early experience has validated that there is considerable work to be undertaken in regard to people better understanding the importance of supported decision making in achieving personalised funding approaches. *MHCC* is now represented at a national forum that is looking at this issue across a range of disability and service types. This work will cross inform our representations across a wide range of policy and sector development functions including, but not limited to, the NSW *NDIS Mental Health Analyst Partnership Project.*

We will also continue to undertake representation related to the UNCRPD requirements in relation to involuntary/coercive mental health treatment, including seclusion and restraint, as these too are relevant to development of the national quality and safety framework. However, the intensity of this will likely increase as the next review cycle of the NSW Mental Health Act 2007 commences in 2016.

Activities to achieve this in NSW are:

- continued engagement with the NSW Ombudsman's Office in better understanding their new roles and functions in the trial site that flow on from the Disability Inclusion Act 2014, as these relate to people with psychosocial disability
- continue to advocate for and promote the importance of supported decision making practice in ensuring collaborative, recovery-oriented and trauma-informed service delivery
- contribute to development of the national quality and safety framework on the basis of experiences and learning from the trial site.

Priority Action 7: Contribute to the national discourse regarding the NDIS and mental health

Recommendations 1, 2, 4, 8, 9, 11, 12, 14, 15 and 16

The experiences of mental health consumers, carers and service providers in the state and territory trial sites provide a unique opportunity for a structured approach to identifying problems and testing innovative solutions for people with psychosocial disability. The roles of the state and territory peak bodies and CMHA, through their access to consumers, carers and community sector organisations, is critical to harnessing this learning.

Evidence from personalised funding initiatives in England and Scotland suggest that capacity building initiatives for mental health need to be sector specific and be:

- based on local partnership at each site between all key stakeholders, including consumer and carer organizations, clinical mental health services and NGOs
- funded over an extended period to encourage sustained effort, recognizing that complex system change takes time
- able to trial innovative solutions based upon an approach of 'learning by doing'.[154]

The establishment of mental health specific learning networks across the trial sites will be critical to maximising the learning and opportunities that arise from NDIS.

It is important that the state and territory peak bodies and CMHA, including the NSW *NDIS Mental Health Analysis Partnership Project,* continue to work with MHA, the NDIS Mental Health Sector Reference Group and other stakeholders to contribute to the national discourse regarding NDIS and mental health.

Activities to achieve this in NSW are:

- continued engagement with the *MHA NDIS Capacity Building Project*
- formal representations to DSS and NDIS/NDIA regarding access to Sector Development Funds by community sector organisations working with people with psychosocial disabilities
- continuation of the NSW *NDIS Mental Health Analysis Partnership Project* in 2015/16 and possibly beyond.

[154] T Williams and G Smith, 'Can the National Disability Insurance Scheme Work for Mental Health?', *Australian and New Zealand Journal of Psychiatry*, vol.48, no. 391, 2014.

Concluding Remarks

The NDIS trial sites provide a welcomed opportunity for a planned approach to identifying problems and testing innovative solutions for mental health consumers and carers. *MHCC's* early experiences at the NSW Hunter trial site and the actions identified above, have informed the basis of the *NDIS Mental Health Analysis Partnership Project* activity in 2014/15.

Importantly, the NSW *NDIS and Mental Health Analysis Partnership Project* now aligns with the NSW Government's *Mental Health Strategic Plan* as follows:

- **8.3 Supporting Reform: Developing the community-managed sector**
- **10. Broader Context of Reforms - NDIS.**[155]

In 2014/15, the project agreed to the following objectives that support the core functions of the NSW Mental Health Commission in monitoring implementation of the strategic plan.

NSW Mental Health Commission core function 1: Promote and facilitate the sharing of knowledge and ideas about mental health issues.

Objective 1.1: Advocate for the importance of individual and systemic consumer, carer and community sector participation in NDIS planning, implementation and evaluation

Activities

- continue to advocate for consumer, carer and community sector representation at all levels including Hunter New England Local Health District/HNELHD and National Disability Insurance Agency (NDIA) NDIS Operational Group Mental Health Working Group, other Hunter local groups/committees, state level groups/committees and national groups/committees
- facilitate more frequent communication with consumers and carers being, or potentially being impacted by NDIS implementation within the trial site
- identify strategies for greater involvement of Being and ARAFMI NSW in NDIS design and implementation both within and outside of the Hunter trial site.

Objective 1.2: Provide consumers, carers and the community sector with the opportunity to attend and learn about current issues and opportunities presented through the NDIS for people with a mental health issue and those that provide services to them

Activities

- continue to convene the quarterly NDIS Mental Health Community of Practice Forum
- organise the distribution of invitations, previous minutes, meeting agenda, and organise speakers
- promote greater recognition of the complexity of skills required in psychosocial disability work.

NSW Mental Health Commission core function 2: Undertake and commission research, innovation and policy development in relation to mental health issues.

[155] NSW Mental Health Commission 2014a, op.cit.

Objective 2.1: Influence policy decisions relating to mental health and the NDIS

Activities

- work with NDIA and in particular the Strategic Adviser to NDIA, to further understand the eligibility of people with a mental illness for the scheme through the use of Hunter experiences and data
- work with NDIA, Mental Health Australia (MHA) and the NSW state government to further understand Tier 2 and its intersection with mental health
- work with NDIA, MHA and the NSW state government in relation to the national discourse around NDIS with mental health
- contribute to the development of the National Quality and Safety Framework.

Objective 2.2: Ensure that any research undertaken in relation to NDIS is informed by the experiences of the Hunter trial site

Activities

- further develop the relationship with the Flinders University consortium in relation to the evaluation of the trial of the NDIS
- establish a relationship with Flinders University in relation to the capacity building project for Partners in Recovery
- maintain a relationship with the NSW Ombudsman in relation to their oversight role in the Hunter trial site as prescribed in the Disability Inclusion Act 2014.

Some outstanding issues that the NSW *NDIS and Mental Health Partnership Project* has not addressed directly but that have never-the-less been on MHCC's radar include:

- housing
- criminal justice/forensic
- the role of voluntary services and community groups
- carer and family support services, including respite
- access to talking therapies (psychological services, counselling and psychotherapy)
- issues for rural and remote communities (which includes large parts of the HNELHD and NSW)
- diversity including but not limited to people who are:
    - Aboriginal or Torres Strait Islander
    - Culturally and linguistically diverse
    - Gay, Lesbian, Bisexual, Transgender, Intersex or Queer.

In 2013 the World Health Organization agreed upon an action plan to provide comprehensive, integrated and responsive mental health and social care services in community based settings.[156] The inclusion of people with psychosocial disability in the UNCRPD and NDIS are important steps to ensuring that this happens in parallel with other COAG mental health, aged care and primary health care sector reforms.

The NSW Mental Health Commission and *MHCC* are privileged to be in a position to inform these directions both in NSW and nationally. The learning from the NSW *NDIS Mental Health Analysis Partnership Project* trial site activity will help to inform directions for implementation of the Commission's 2014/24 Strategic Plan and NSW Health reform of community sector mental health programs.

[156] WHO 2013, op. cit.

Getting ready for the full roll-out of the NDIS

The full roll-out of the NDIS in NSW is planned to occur between July 2016 and June 2018. Some things that you might consider in getting ready if you are not in a trial site:

- familiarise yourself with what NDIS is and stay informed about what we are learning about how it works
- understand the language of NDIS and learn how to reconcile this with recovery oriented language[157]
- begin to identify people with high levels of psychosocial disability that might be eligible for Tier 3 funded services and supports
- engage in pre-planning with these people to:
- help potentially eligible people put together written information about how their disability affects their life
- assist potentially eligible people to think about their hopes and dreams for their lives
- become aware of and meet with the various support providers in your local area that might support people in aspiring to their hopes and dreams
- discuss with people their four options for personalised funding money management arrangements and what is required for self-management:
    - Self-managed
    - NDIA managed
    - Other managed
    - A combination of the above
- convene or participate in a local community meeting to discuss what your mental health sector can be doing to get ready for NDIS
- encourage the local public mental health service to conduct an audit of clients known to them that might be eligible for NDIS
- encourage your local Partners in Recovery program, where these have been established, to develop a list of people known to them that may be eligible for the NDIS
- ensure that the information about any current clients is current and comprehensive. This is especially true for people receiving PHaMS and Day-to-Day Living Program services, for people in NSW, and people with primary mental health conditions in receipt of ADHC funded disability support services (e.g. former boarding house residents).

- where accessible use the NDS NDIS capacity building resources, including the Organisational Toolkit, to assess and build the readiness of your community sector organisation for the NDIS
- ensure that your organisation's policies, procedures and practices are NDIS ready
- create a new role within your organization for an NDIS Liaison Officer or similar who can assist frontline workers, people with psychosocial disability and their families and carers to prepare for the NDIS and understand funded services and supports.

[157] MHCC, *Recovery Oriented Language Guide, MHCC, Sydney, NSW,* 2013a.

A dedication … thank you Janet Meagher AM

Janet grew up in Newcastle and during her childhood she suffered violent abuse from her mother. She escaped by joining a convent where she intended to become a nun. In her twenties, after a very public breakdown, Janet was diagnosed with schizophrenia and was sent for ten years to Gladesville Mental Hospital. After her release she became a leading advocate for the international mental health consumer movement. Janet served as a Commissioner on the National Mental Health Commission, and has been awarded an Order of Australia for her work.

Janet recently 'retired' but continues to work with the NDIS Independent Advisory Council. Janet's many contributions to the consumer movement, including through her own lived experience that recovery from a mental health condition is possible, are acknowledged.

This MHCC publication describing the first two years of consumer, carer and mental health sector related experiences within the NSW Hunter NDIS trial site from a community managed mental health sector perspective, is dedicated to Janet's generous and valued contributions to ensuring the health and wellbeing of Australians.

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Recommendations Arising from the National Mental Health Consumer and Carer Forum Position Paper on Psychosocial Disability Associated with Mental Health Conditions [158]

The National Mental Health Consumer and Carer Forum (NMHCCF) makes the following urgent recommendations in regard to better understanding the needs of people living with psychosocial disability related to a mental health condition. The 'scorecard' comments as indicated by the key below have been made by *MHCC* and indicate insufficient activity with regard to progressing the recommendations.

Key: C = commenced, X = some progress but not substantial

Recommendation	Status
Psychosocial disability	
1. Disability support arrangements in Australia must address the psychosocial disability support needs associated with mental health conditions.	C
Social inclusion	
2. The NMHCCF calls on the Australian Government to enhance its social inclusion agenda to appropriately reflect the identified needs of its citizens with a psychosocial disability, consistent with the National Disability Strategy and Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities.	C
Who are people with a psychosocial disability?	
3.1 Better data on prevalence of psychosocial disability needs to be developed and made available to provide indicators of need for this significantly disadvantaged group.	X
3.2 In the absence of current specific data on the prevalence of psychosocial disability in Australia, any consideration of long term disability care and support initiatives must:	
• work with the sector to agree appropriate interim estimates make provision for people with severe and profound psychosocial disability. This will include budgeting for a minimum figure somewhere between 149,800– 206,000 of people with mental illness who were estimated to have a severe or profound core activity limitation. These figures should be continually updated and inform ongoing support assessments.	C
• conduct ongoing work to ensure that people with a psychosocial disability who require significant supports, but who do not have a severe or profound core activity limitation, are able to have their disability support needs addressed in the same way as others with that same level of disability.	X
Who are carers of people with a psychosocial disability?	
4.1 Work needs to be undertaken in the psychosocial disability support sector to reduce the unreasonable burden faced by carers of people with a psychosocial disability. This should include a review of access to carer benefits, allowances and disability support trusts.	X
4.2 Any disability support initiatives must work closely with mental health carers to ensure that their needs, and those of the consumers that they advocate for, are met.	X
Characteristics of common impairments related to mental health conditions	

[158] National Mental Health Consumer & Carer Forum (2011). *Unravelling Psychosocial Disability, A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions.* Canberra: NMHCCF.

Recommendation	Status
5.1 Disability support services workers need specialised training in psychosocial disability. This training will be most effective when it's development and implementation is directed by people with a lived experience of psychosocial disability.	X
Recovery and psychosocial disability	
5.2 Disability support services for people with a psychosocial disability need to acknowledge the unique role that recovery plays in the experience of mental health consumers and carers, and work with them to achieve recovery focussed services.	C
Identification and assessment of psychosocial disability	
6.1.1 Research needs to identify the impacts of psychosocial disability and evidence based approaches to mitigate these. This must be undertaken in consultation with people with a psychosocial disability and their carers.	C
6.1.2 Australian data collection, classification and assessment tools for disability need to include measures of psychosocial disability that focus on functioning and environmental impacts.	X
6.1.3 Specific tools need to be developed to apply the conceptual framework of the *International Classification of Functioning, Disability and Health* to the assessment of psychosocial disability.	X
6.1.4 Current data collection, classification and assessment tools as well as processes for determining psychosocial disability support needs across all sectors, must be reviewed in consultation with consumers and carers to ensure that they better reflect the support needs of people with a psychosocial disability.	X
6.1.5 Assessments undertaken for people with psychosocial disability need to be administered by people trained in the use of appropriate assessment instruments and psychosocial disability issues, including support requirements and available support resources.	X
Lack of housing options and homelessness	
6.2.1 People with psychosocial disability urgently require development and implementation of a whole-of-government approach to the provision of a range of accommodation supports including: • safe, affordable and secure housing • appropriate support services that can assist them to maintain tenancy and work with them to achieve the community participation goals they have identified.	X
6.2.2 This accommodation strategy should be informed by current and former successful supported housing models.	X
Low income, interrupted education and poor labour force participation	
6.3.1 Measures must be implemented to provide training to services in psychosocial disability support needs and to include consumers and carers in policy development and the delivery of generic and specialist psychosocial disability employment services.	X
6.3.2 Peer workers need to be employed in the disability, employment and income support sectors to: • provide support to people with a psychosocial disability in navigating those service systems • assist those services to improve their culture and eliminate stigma around mental illness and psychosocial disability.	C
Communication and social isolation	
6.4.1 Options to support the social interactions of people with a psychosocial disability need to be expanded urgently. These need to include the expansion of social support networks ,one to one advocacy, and advice support options for people with psychosocial disabilities.	X
6.4.2 These options need to be implemented as part of a comprehensive targeted strategy to tackle community stigma around mental health conditions.	X
Lack of disability support services for psychosocial disability	
6.5.1 The range of services for people with psychosocial disability needs to be urgently reviewed to ensure that appropriate services are available and accessible.	X
6.5.2 Agencies offering generic disability supports urgently need better information and training to be able to identify and address the support needs of people with psychosocial disability.	X
Poor physical health and co-occurrence with other health conditions	
6.6 Disability supports for people with psychosocial disability must be integrated with health	X

Recommendation	Status
services to ensure that people with psychosocial disability have access to effective health care to support their physical and mental healthcare needs. Where possible, innovative models, including technological options should be used to assist in service delivery that meets people's needs and is provided in consultation with those people.	
Stigma and discrimination	
6.7 Tackling stigma and discrimination around mental health conditions and providing education on psychosocial disability urgently need to become a key element of national psychosocial disability support including: • including service providers and the general population on a community wide basis • as part of ongoing long term national disability care and support • as a key element of the *National Disability Strategy* • as part of core training for disability support services.	X
Lack of community awareness about psychosocial disability	
6.8 Initiatives to build the capacity of public institutions to meet the needs of people with a psychosocial disability need to be expanded. This would build on the momentum of community wide anti-stigma campaigns and must include: • implementation of consumer and carer informed education and training initiatives for staff and policy makers • partnership arrangements with consumer and carer policy advisors • employing specialist support officers designated to assist people with psychosocial disability to navigate organisational systems such as government service providers.	X
Barriers for carers	
6.9 Carers of people with a psychosocial disability urgently need: • better information services such as an expansion of Commonwealth Carelink services to provide information on mental health supports for both consumers and carers • carer peer support for information, advice, mentoring and navigating systemic supports available to them and to consumers they support • education and training in supporting someone with a psychosocial disability and caring for oneself • accessible respite that meets the needs of mental health consumers and carers • recognition of costs involved in caring and that this is reflected in income support and more appropriate assessment processes for carer allowance and carer payment • improved service provision from Centrelink • inclusion of carers in planning for psychosocial disability support.	X
Service requirements of people with a psychosocial disability and their carers	
7.1.1 Mental health consumers and carers need disability support services that maximise their potential to manage everyday life and participate in the community by using personalised services that support their recovery.	C
7.1.2 Supports need to be flexible to meet the changing needs of mental health consumers and carers in recovery, and meet the immediate needs of those most vulnerable to relapse.	X
7.1.3 Peer workers should be part of the disability support services workforce to provide expertise in servicing people with a psychosocial disability.	C
7.1.4 Mechanisms such as memoranda of understanding need to be developed to support better relationships and the delivery of streamlined and integrated service provision between clinical services and disability support services.	X
Self-directed funding arrangements for personalised services	
7.2 Australian mental health consumers with psychosocial disabilities and their carers should to be able to use the power of their choice to develop the disability supports that they want, and must be included in any *National Disability Insurance Scheme*.	C
7.3 Self-directed funding options need to include development and implementation of appropriate support mechanisms for people with a psychosocial disability to ensure that they are able to effectively control decision making about their lives.	X

Commonwealth Funded Community Sector Mental Health Programs

Department of Social Services (previously FaHCSIA) Targeted Community Care

Personal Helpers and Mentors Program
The Personal Helpers and Mentors (PHaMS) service assists people to reintegrate into society and to improve the quality of their lives by connecting with mainstream community, social, leisure and vocational education services. Through system collaboration, PIR promotes collective ownership and encourages innovative solutions to ensure effective and timely access to the services and supports required by people with severe and persistent mental illness and complex needs to sustain optimal health and wellbeing.

Family Mental Health Support Services
Family Mental Health Support Services (FMHSS) activities target prevention and early intervention, with a particular focus on Indigenous families and those from a culturally and linguistically diverse background, empowering and strengthening families through information, education and skills development.

Mental Health Respite Carer Support Program
The Mental Health Respite Program (MHRP) provides a range of flexible respite options for carers of people with severe mental illness/psychiatric disability, and carers of people with intellectual disability.

Department of Health

Partners in Recovery
Partners in Recovery (PIR) aims to support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way.

Day to Day Living Program
Day to Day Living in the Community (D2DL) is a structured activity program, working to improve the quality of life for individuals with severe and persistent mental illness. The initiative provides day programs to increase the ability of clients to participate in social, recreational and educational activities with the aim of living at an optimal level of independence in the community.

Headspace
Headspace is an innovative early intervention program for young people 12 to 25 years that provides health advice, support and information. They help with general health, mental health and counselling, education, employment, alcohol and other drug services and any other services.[159]

[159] This is not technically a community sector mental health program but a community based consortium like Partners in Recovery. About 30% of headspace programs nationally have a community sector organisation as the lead agency. The planned growth of Early Psychosis Prevention and Intervention (EPPIC) programs should also be monitored for NDIS and community sector relevance.

Department of Education, Employment and Workplace Relations (DEEWR employment programs; these programs will be shifting to DSS)

This is a complex programmatic area undergoing considerable change and reform. Introduction of the new Employment PHAMS will be helpful to track in this context, however, there is no Employment PHAMS in the Hunter NDIS trial site (the nearest location is the Central Coast).

NSW Health Funded Community Sector Mental Health Programs

NSW Health NGO Grant Program
The NSW Health Non-Government Organisation (NGO) Grant Program provides funding to eligible organisations for the provision of specified health services and projects in NSW. The NSW Health NGO Grant Program provides a range of mental health programs at the Hunter NDIS trial site and across NSW. This includes both residential and non-residential service types.

The program accounts for over two-thirds (69%) of all NSW Health funding allocated to the NGO sector. In 2012-13, funding through the NGO Grant Program is around $149 million. A further $67 million in additional funding is provided to NGOs on an ad-hoc basis. Funding is allocated by the NSW Ministry of Health and by Local Health Districts.

The NGO Grant Program funds a wide range of health and related services including direct health services, health promotion, community development, social research, and advocacy. It spans a number of program areas, including Aboriginal health, mental health, drug and alcohol, AIDS and infectious diseases, oral health, women's health, youth health, and chronic illness.

Organisations funded to provide NGO Grant Program 'mental health' programs in the NDIS trial site are:

1. Baptist Community Services
2. ARAFMI Hunter
3. Lifeline - Newcastle and Hunter (historically not considered to be a mental health program but telephone counselling services are now being re-categorised as mental health)
4. Life without Barriers
5. RichmondPRA
6. Samaritans Foundation
7. Schizophrenia Fellowship of NSW

The NGO Grant Management program is currently in a period of review and transition through the NSW Health Grants Management Improvement Program that is underway (most recently known as the 'Partnerships for Health' initiative). The NGO Grant Program is governed by the NSW *Health NGO Policy Framework* and NSW Health Operational Guidelines Non-Government Organisation Grant Program (under review). The current NGO Grant Program has been extended to 30 June 2015. Transition to the new funding model will take place during 2013/14 and 2014/15. For more information visit: http://www.health.nsw.gov.au/business/partners/Pages/gmip-taskforce-report-response.aspx

The Ministry of Health commenced a Grant Management Improvement Program (GMIP) in 2012 to improve grants administration and introduce opportunities for new partnerships with NGOs and other community providers. The GMIP introduced a new granting policy in 2013. This may involve fewer and larger NGOs and more 'tendered' mental health programs, as opposed to grants. More information about the GMIP is available at:
http://www.health.nsw.gov.au/business/partners/pages/default.aspx

The following information about existing NSW Health 'tendered' mental health programs is from this website: http://www0.health.nsw.gov.au/mhdao/program_information.asp

Housing and Accommodation Support Initiative (HASI)
HASI is a partnership established in 2003 between NSW Health, Housing NSW and the NGO sector. HASI provides stable and secure accommodation linked to support services (accommodation support, clinical care and rehabilitation) for people with a mental illness or disorder and varying levels of disability.

HASI recognises the interdependence of stable housing, accommodation support services and clinical mental health services. The program's specific aims are to:

- provide people with ongoing clinical mental health services and rehabilitation within a recovery framework
- assist people to participate in community life and to improve their quality of life
- assist people to access and maintain stable and secure housing
- establish, maintain and strengthen housing and support partnerships in the community.

HASI demonstrates the benefits of a partnership approach in facilitating improved outcomes and community participation for people with a mental illness. The joint aims of all partners of HASI include:

- a more efficient and effective co-ordination of care for consumers
- exploring and enhancing the interface between specialist mental health services (both acute & rehabilitative), general practitioners and the NGO sector in NSW
- enabling and facilitating stable housing outcomes for all HASI consumers
- facilitation of consumer, family and carer participation.

Across NSW HASI supports 1135 mental health consumers living in social and private housing and ranging from very high support (8 hours per day) to low support (5 hours per week) levels. 38% of people (n=376) receive high to very high levels of support. A HASI Plus program is also being introduced that will provide higher level residential support to people.

Aboriginal HASI
Aboriginal people continue to experience homelessness at a disproportionate level across Australia. High rates of mental health and wellbeing issues also confront Aboriginal communities in Australia. The need to improve the mental health and emotional and social wellbeing of Aboriginal communities is clear, and research shows a need for new approaches to achieve this.

In recognition of these needs NSW Health developed a new model of service delivery for HASI that is culturally appropriate for Aboriginal people. This new stage of HASI delivers support packages to 100 Aboriginal people across NSW.

The new model emphases a holistic approach that reflects the complex needs of the individual and their support networks including their family and community. It also recognises the various social and cultural impacts on the individual's social and emotional wellbeing.

HASI PLUS
$35.1 million over five years from the National Partnership agreement on Mental Health will go to a program expanding the support for people moving from hospitals who still require a high level of care.The Housing and Accommodation Support Initiative (HASI) Plus will provide 200 packages of between 16 and 24 hours of daily support for people with mental illness who are at risk of moving in and out of institutional care.

Boarding House HASI
In-reach support services to assisted boarding house residents who have been assessed as having mental health issues, through the provision of low support packages.

NSW Family and Carer Mental Health Program
This initiative explicitly recognises the need for families' and carers' participation. Under this program, mental health services facilitate family and carer involvement in consumer assessment, treatment and intervention (where appropriate) and supports family and carer roles in local mechanisms for systemic participation.

The program focuses on the delivery of:

- Family friendly mental health services - supporting and training (public mental health) staff to include explicitly families and carers in the service system and be responsive to their unique needs
- Mental health family and carer support programs - direct support services delivered through NGOs that provide education and training to build coping skills and resilience, individual support and advocacy, and infrastructure support for peer support groups
- Improved access to generic family and carer supports.

More information about the NSW Family and Carer Mental Health Program is available at: http://www.health.nsw.gov.au/mhdao/Pages/family-mh.aspx

Recovery and Resource Services Program (RRSP)
The RRSP is designed to increase the capacity of NGOs to provide support and access to quality mainstream community social, leisure and recreation opportunities and vocational and educational services for people with a mental illness, based on the best available evidence and practices. It is an integral part of the continuum of care provided by Local Health Districts.

Appendix 4

Overview of Hunter New England Local Health District Adult Mental Health Services in the NSW NDIS Trial Site

The following is a brief summary of community-based services for adults and hospital based services in the three LGA's of the NDIS trial site only. Hunter New England Local Health District (HNELHD) also has a range of services for children and adolescents, older people and other specialist services that are not listed.

For more extensive information please visit: http://www.hnehealth.nsw.gov.au/mh/services/mhsf.

Community Mental Health Teams (please call 1-800 011 511 for access)

Newcastle Adult Mental Health and Rehabilitation Team
Phone: 02 4964 7000 (Admin), Fax: 02 4064 7001
72 Watt St, Newcastle NSW 2300 (Barracks Building, James Fletcher Campus)

Lake Macquarie Adult Mental Health and Rehabilitation Team
Phone: 02 4904 9000 (Admin), Fax: 02 4904 9049
Location: 29 Smith St, Charlestown NSW 2290

Hunter Valley Adult Mental Health and Rehabilitation Team
For the Adult Team - Phone: 02 4939 2900 (Admin), Fax: 02 4939 2901
For the Rehabilitation Team - Phone: 02 4939 2940, Fax: 02 4939 2941
Location: Unit 10, 555 High St, Maitland NSW 2320 (Melbee House, Maitland Hospital)

Hospital Based Services

Unit	Beds	Location/Address	Phone	Fax
Newcastle				
Psychiatric Emergency Care Centre	4	Mater Mental Health Centre Edith Street, Waratah NSW 2298	1800 011 511	4033 5359
Psychiatric Intensive Care Unit	8	Mater Mental Health Centre Edith Street, Waratah NSW 2298	4033 5369	4033 5375
Short Term Acute	66	Mater Mental Health Centre Edith Street, Waratah NSW 2298		
		Newcastle Mental Health Unit	4033 5316	4033 5321
		Lake Macquarie Mental Health Unit	4033 5336	4033 5341
		Mental Health Substance Use Unit (North)	4033 5460	4033 5465

Unit	Beds	Location/Address	Phone	Fax
		Mental Health Substance Use Unit (South)	4033 5440	4033 5441
		Mater Mental Health Centre		
Older People	22	Edith Street, Waratah NSW 2298	4033 5440	4033 5441
		James Fletcher Campus		
Intermediate Stay	20	Church St, Newcastle NSW 2300	4924 6960	4924 6965
Subtotal (A)	120			
Lake Macquarie (Morisset)				
		Morisset Hospital		
Cottages - Low support	47	Off Dora St Morisset NSW 2264	4973 0222	4973 3442
Rosella - High support	14			
Kaoriki - Neuropsychiatry	12			
Kestrel - Medium secure	30			
Ibis - Older People Unit	27		4973 0335	4973 0277
Subtotal (B)	130			
Maitland				
		Maitland Hospital		
Short Term Acute	24	550 High St, Maitland NSW 2320	4939 2456	4939 2290
Subtotal (C)	24			
TOTAL (A+B+C)	**274**			

List of MHCC Organisational Affiliates in the Hunter NDIS Trial Site - 1 July 2013[160]

MHCC Organisational Members in Hunter (not repeated if below as Branch Members)

1. Baptist Community Services (no branch membership)
2. Benevolent Society - head office in Sydney
3. Carers NSW - head office in Sydney
4. Castle Personnel Services Ltd.
5. Catholic Healthcare - head office in Sydney
6. House With No Steps - head office in Sydney
7. Life Without Barriers
8. Mai-Wel Limited
9. Mission Australia (no Hunter branch membership) - head office in Sydney
10. New Horizons (no Hunter branch membership) - head office in Sydney
11. Samaritans Foundation
12. SFNSW (no Hunter branch membership) - head office in Sydney
13. Wesley Mission (no Hunter branch membership) - head office in Sydney

MHCC Branch Members in the Hunter (head office in Sydney)

14. Aftercare - PHaMS Maitland
15. ARAFMI NSW (Hunter)
16. Break Thru People Solutions - Newcastle
17. Compeer Program - Newcastle (St Vincent de Paul/SVDP)[161]
18. Lifeline - Newcastle & Hunter
19. Neami - Carrington
20. Neami - Maitland
21. RichmondPRA Hunter Area

Not MHCC members but providing MHS in Hunter

22. Hunter Medicare Local
23. Newcastle Family Support Service

[160] This list does not include MHCC members Catholic Care Social Services (Hunter-Manning), Integrated Living or Relationships Australia who are Hunter PIR consortium members as they are not providing a mental health specific program/service in the Hunter NDIS trial site.
[161] SVDP are also the providers of NDIS Tier 2 Ability Links services in NSW.

Funding Sources of Community Sector Mental Health Programs in the Hunter NDIS Trial Site[162]

Organisation	Funding Source			Comments
	NSW Health	NSW ADHC	Commonwealth	
MHCC Members providing services in Hunter NDIS Trial Site				
Aftercare			PHaMS *(Maitland) 54/60 clients* PIR Maitland	*Maitland/Cessnock PHAMS only and new Newcastle office. And PIR Cessnock and Dungog*
ARAFMI NSW (Hunter)	NGO Grant *Families and carers*			*Newcastle only*
Baptist Community Services	NGO Grant? *Homeless Outreach*			*Is this still funded?*
Benevolent Society				*Children/no MH specific? PIR Upper Hunter*
Break Thru People Solutions			DEEWR	*Employment*
Carers NSW			MHRCSP	*New funding, start December*
Castle Personnel Services Ltd.		ALI *(Newcastle & Lake Macquarie, 36 clients and many others MH issues*	DEEWR	*Employment*
Catholic Healthcare				*Is hoarding and squalor a mental health issue (ADHC and 'in-scope' for NDIS)*
House With No Steps		ALI *(Lake Macquarie) 79 clients?*		*Lake Macquarie (Riverview BH)*
Lifeline - Newcastle & Hunter	NGO Grant *Helpline & counselling*			
Life Without Barriers	NGO Grant? *Leisure and recreation*	CBA *(ex BH)*		*Is this still funded?*
Mai-Wel Limited				*Intellectual disability with MH interests*
Neami National	HASI *(15)* HASI BH *(60)* HASI Plus *(5)*		PIR LM	*Newcastle, Lake Macquarie & Maitland*
Mission Australia			PHaMS *(Newcastle) (70/80 clients)*	*Primarily Newcastle. Homeless/MH interest*
New Horizons	HASI *(ATSI, 8)*	SA *(ex BH), 51 clients and some are 65 yrs+*	PHaMS *(45 clients in Newcastle and 63 in Lake Macquarie, this includes 9 refugees in Lake Macquarie)*	*Services are across Newcastle & Lake Macquarie*

[162] The key to the many acronyms used in this table is provided on page 110.

Organisation	Funding Source			Comments
	NSW Health	NSW ADHC	Commonwealth	
RichmondPRA	NGO Grant *Supported accommodation (18)* *Disability Support Program (social support?)* HASI HASI Plus RRSP *(Maitland)*	SA *(ex BH, 33 clients)*	D2DL *(Newcastle)*	*Services are across Newcastle, Lake Macquarie & Maitland* *PIR North (Taree and New England part of HNMLHD)*
Samaritans Foundation	NGO Grant *Kaiyu Konnect* *Monets/Banksia (vocational)*	CBA (ex BH)	Headspace *(Maitland)*	*Organisation is primarily ID but also important MH specific programs*
Schizophrenia Fellowship NSW	NGO Grant *Social support/community development* *Forensic MH program* MHF&CSP (Newcastle, *AKA 'Carer Assist')*			*Primarily Newcastle and support groups elsewhere in Hunter. Note: Hunter based forensic MH program funded through South East Sydney Local Health District*
St.Vincent de Paul	Compeer *(volunteer companions)*			*Now also Tier 2 NDIS Ability Links*
Wesley Mission			*PIR Newcastle*	*And PIR Port Stephens NGO Grant for youth service in Newcastle but this is not MH specific*
Not MHCC members but providing MHS in Hunter				
Hunter Medicare Local			Headspace *(Newcastle)* PIR	*3 LGAs (HNE)*
Newcastle Family Support Service			F&CMHP	*Newcastle only*

Key

Please also note that additional details about the NSW Health and Commonwealth funded mental health programs are provided in Appendix 2 and 3.

NSW Health

- 'NGO Grant' is the NGO Grant Program or other 'ad hoc' NSW Ministry of Health funds.

- Tendered Programs
    - HASI - NSW Health Housing and Accommodation Support Initiative (tender)
    - MHF&CSP -The Mental Health Family and Carer Support Program (this is part of the Family and Carer Mental Health Program)
    - RRSP - Resource and Recovery Services Program

ADHC

- Primarily, but possibly not limited to, NSW Boarding House Reform Program funded support packages
    - ALI - Active Linking Initiative (for remaining boarding house residents)
    - CBA - Community Based Activities (mostly 'day centre' type services for ex-boarding house residents)
    - SA - Supported accommodation (ex-boarding house residents, they typically also receive CBAs)

Commonwealth

- Department of Social Services (DSS, previously FaHCSIA) Targeted Community Care
    - PHaMS - Personal Helpers and Mentors
    - FMHSS - Family Mental Health Support Services
    - MHRCSP - Mental Health Respite Carer Support Program

- Department of Health
    - PIR - Partners in Recovery
    - D2DL - Day to Day Living in the Community
    - Headspace

- DEEWR - Department of Education, Employment and Workplace Relations (employment programs - these programs will be transitioning to DSS)

Appendix 7

A Brief Comparison of Eligibility for NDIS, Ability Links and Partners in Recovery and Other Relevant Access Pathways Information

NDIS	Ability Links	PIR
The Act sets out when a person meets the disability requirements. The requirements are met if: • the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and • the person's impairment or impairments are, or are likely to be, permanent; and • the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication, social interaction, learning, mobility, self-care, self-management; and • the impairment or impairments affect the person's capacity for social and economic participation; and • the person's support needs in relation to his or her impairment or impairments are likely to continue for the person's lifetime. In relation to the above, an impairment that varies in intensity (for example because the impairment is of a chronic episodic nature) may be permanent, and the person's support needs in relation to the impairment may be likely to continue for the person's lifetime, despite the variation	Ability Links NSW is for: • people with disability (9 - 64 years and who are generally not accessing specialist disability services) • carers and families of people with disability • the community	Inclusion criteria: • the client has complex needs that require substantial services and supports from multiple agencies (this is the main inclusion criteria as PIR is about coordination of services and supports across sectors) • the client has a diagnosed mental illness that is severe in degree and persistent in duration, and is willing to be referred for ongoing clinical treatment • the client has had recent engagement with services where there is a pressing concern about their mental health and/or related issues (this could include for instance, a hospital admission related to their mental illness) • existing service arrangements and coordination between services have failed, have contributed to the problems experienced by the client, and are likely to be addressed by acceptance into PIR • the client consents to being involved in PIR. Note: Individuals referred to PIR organisations do not have to have a diagnosed severe and persistent mental illness with complex needs. However, obtaining such a diagnosis should be a priority.

Other Relevant Referral Pathways Information		
NDIS	**Ability Links**	**PIR**
Refers to Ability Links when person is not eligible for NDIS	This can provide short term and essentially community development work activity/s to increase social inclusion.	PIR organisations will need to establish appropriate processes to handle referrals that are not accepted, to ensure the individual receives the supports they require outside of PIR. For instance, the client is referred back to the referrer with advice of other supports and services available in the region, or referred directly to more appropriate supports in the community. A PIR client may 'exit' a PIR organisation when stable arrangements are in place, and they are accessing the required services and supports to meet their needs with no need for additional coordination or flexible funding support. PIR organisations could consider registering PIR clients as 'active' or 'non-active' recognising that some clients may need support periodically and at different levels of intensity. Non-active clients could access the PIR organisation as the need arises and as they are able to benefit from it. PIR organisations will be required to determine how best to manage clients in the longer term, following the provision of more intensive support received as 'active' clients.

Appendix 8

Overview of NDIS Care Plans (as at 30 June 2015)[163]

Goals and other key issues assessed in this two or more session care planning process are also translated into a shorter care plan version for the participant's use.

The NDIA Support Planner identifies care plan content in consultation with the NDIS participant. As a general rule this excludes the participant's current provider if they are also a registered provider.

Goals (up to 8 areas can be considered)

- Choice and control
- Economic participation
- Independence
- Health and wellbeing
- Education
- Personal relationships
- Living arrangements
- Social participation

Frequency of Need for Supports (6 domains and 6 point rating scale that contributes to determining funding amounts)

- Mobility
- General Tasks
- Self Care
- Learning
- Communication
- Interpersonal Interactions and Relationships

A. Never
B. Less than weekly
C. Weekly (but less than daily)
D. 1-2 times a day
E. 3-5 times a day
F. More than 6 times a day

Support Categories (10 categories that are used to explore current supports)

- Communication
- Community & social life
- Domestic life
- Education
- Employment
- General tasks/demands
- Interpersonal relationships
- Learning/knowledge
- Mobility
- Self-care

[163] Please note that a new and more streamlined approach is being transitionally introduced from 1 August 2015 that is aligned to the new NDIA Price Guide (i.e., support categories) and forthcoming NDIS Outcomes Framework and as discussed on pp. 68 & 71.

Participant Context (18 questions to explore the person's current situation and preferences with designated response categories)

- The things that are most important to me are?
- The things in my life that are really working for me are?
- Things that I like are?
- The things would I would most like to change are?
- The things I would really like to try are?
- Who do you usually live with?
- What are your current living arrangements?
- Do you have primary or (shared equal) caring responsibility for children?
- What is the main form of transport you use to get around outside the home?
- What social activities do you participate in the home or familiar places with family and friends?
- On average, how often do you participate in social activities with family or friends?
- What community activities do you participate in?
- On average, how often do you participate in Community activities?
- What is your current employment status (main activity)?
- If working, are you working full-time or part-time employment?
- Are you currently undertaking any form of study?
- What level of study are you currently doing?
- If studying, are you studying full-time or part-time?

Outcomes – How Satisfied? (9 items)

- Overall how satisfied are you with your level of community involvement?
- Overall, how satisfied are you with the study you have completed?
- Overall how satisfied are you with your working arrangements?
- Overall how satisfied are you with your health and wellbeing?
- Overall, how satisfied are you with your living arrangements?
- Overall, how satisfied are you with your personal relationships?
- Overall, how satisfied are you that you can make choices about and have control over your life?
- Overall thinking about your life in general, how satisfied are you with what you are achieving in life?
- Overall, how confident are you that your future needs will be met?

Plan Objectives (up to eight areas can be considered)

- Choice and Control
- Economic participation
- Independence
- Health and wellbeing
- Education
- Personal relationships
- Living arrangements
- Social participation

Funded Supports

All the above are then translated to a funded support package (i.e. support service type, hours a week, frequency/days per week etc.). This is also translated to a weekly support plan including time of day that various events are planned to occur.

Summary of NDIS Support Categories (as at 30 June 2015)[164]

As a registered NDIS provider, organisations are asked to nominate the types of support services that they will provide and a summary of these as at 30 June 2015 is below.

1. Accommodation/ tenancy assistance
2. Assistance in coordinating or managing life stages, transitions and supports
3. Assistance to access and maintain employment
4. Assistance to integrate into school or other educational program
5. Assistance with daily life tasks in a group or shared living arrangement
6. Assistance with daily personal activities
7. Assistance with travel / transport arrangements
8. Community nursing care for high care needs
9. Development of daily living and life skills
10. Interpreting and translation
11. Early intervention supports for early childhood
12. Management of funding for supports under a participant's plan
13. Household Tasks
14. Participation in community, social and civic activities
15. Physical wellbeing activities
16. Specialised assessment of skills, abilities and needs
17. Therapeutic supports
18. Training for independence in travel and transport
19. Behaviour support

There is also a substantial list of 'Assistive products and equipment' supports that have not been included in the above summary. These categories further break down to about 700 sub-categories. Each support type has a set unit price costing (e.g. per hour of support provided) and these vary between states and territories.

The unit price costs have been reviewed to allow for greater flexibility. This was undertaken as a step toward deregulation of pricing. From 1 July 2014, participants were able to 'roll-up' or 'bundle' supports to increase flexibility in the way they use their funds. Furthermore, supports and associated pricing were also categorised as being:

- **Core** (e.g. disability supports and services) : A support that enables a participant to complete activities of daily living and enables them to work towards their goals and meet their objectives:
  - Community access
  - Personal care
  - Transport.
- **Capacity building** (e.g. prevention, promotion and early intervention activities): A support that enables a participant to build their independence and maximise skills so as to progress towards their goals.
- **Capital** (e.g. equipment): An investment, such as assistive technologies, equipment and home or vehicle modifications.

[164] Please note that a new and more streamlined approach is being transitionally introduced from 1 August 2015 that is aligned to the new NDIA Price Guide (i.e., support categories) and forthcoming NDIS Outcomes Framework and as discussed on pp 68 & 71.

Partners in Recovery Assessment and Care Planning

Partners in Recovery (PIR) has mandated use of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS). CANSAS provides a snapshot of a client's needs in the previous one month across 22 domains as listed below. A further three PIR additional need domains have been added to the assessment and care planning process as indicated below.

1. Accommodation
2. Food
3. Looking after the home
4. Self-care
5. Daytime activities
6. Physical health
7. Psychotic symptoms
8. Information on condition and treatment
9. Psychological distress
10. Safety to self
11. Safety to others
12. Alcohol
13. Drugs
14. Company
15. Intimate relationships
16. Sexual expression
17. Child care
18. Basic education
19. Telephone
20. Transport
21. Money
22. Benefits

PIR Additional Need Domains (non-mandatory)

23. Employment and volunteering
24. Cultural and spiritual
25. Other services

After considering all of the above, the PIR Action Plan (non-mandatory) then gives each person the option for a:

- My Health and Wellbeing Plan (this taps into themes of 'hopes and dreams' content)
- Wellness Plan (to revisit what has been achieved so far)
- Your Crisis Action/Relapse Plan (advanced directive for when unwell)
- Emergency Arrangements
- Family/Supporter/s Plan
- Children's Safety Plan
- Other Commitments Plan
- Consent to sharing of PIR Action Plan information
- Agreement of services and supports to be provided.

There is also a mandatory Consent Form including a 'Your Information, It's Private' information sheet.

MHCC Cross Membership with National Disability Service (NSW) and Eligibility for Industry/Sector Development Funds 12 June 2014

There are 20 *MHCC* member organisations delivering services in the three LGAs of the NSW Hunter NDIS Launch Site. A further two organisations are important to the delivery of services to people affected by mental illness and/or psychosocial disability in that area. An early analysis of these 22 organisations indicated that many were not benefitting from NDIS capacity building funding being provided to NSW ADHC funded organisations (64% or 14/22 organisations receive ADHC funding and 36% or 8/22 do not - see the Table A below). More recent analysis has demonstrated that this situation is better in the Hunter than for the rest of NSW.

This analysis was repeated for all NSW *MHCC* member organisations (i.e. to also include those outside of the Hunter launch site). Of *MHCC's* 112 member organisations as at 1 July 2013, 31 receive ADHC funding (28%) and 33 are NDS members (29%). Those NDS members receiving ADHC funding are eligible for ADHC Industry Development Funds (IDF - the IDF primarily focuses on NDIS readiness but is also part of larger ADHC/NDS quality improvement strategy targeting NSW disability organisations).

The main findings of the NSW statewide audit are that:

- 28% of *MHCC* member organisations are eligible for NSW IDF and other capacity building funding (n = 31/112)
- 71% of *MHCC* member organisations are not eligible for NSW IDF and other capacity building funding (n = 79/112)

Detailed information about the NSW findings is provided in Table B.

Early analysis indicates that many of the organisations that are not IDF eligible are not providing psychosocial and/or other disability services. Some examples of this would be mental health education/promotion programs, peer support programs, counselling services, emergency/homeless services, and community housing or employment support providers. Many of these providers are small to medium in size.

However, there are some very large organisations that do provide psychosocial disability services that are missing out on IDF and other more recent DSS/NDIA funded NDIS capacity building opportunities, such as:

- Schizophrenia Fellowship of NSW (SFNSW)
- Uniting Care Mental Health

The more recent DSS/NDIA capacity building funds have been provided to ADHC by the NSW government with seemingly no or little consideration of the NDIS organisational and workforce readiness needs of NSW Health funded NGOs, including but not limited to mental health programs.

An offer has been made to provided limited organisational readiness support to four organisations not currently accessing capacity building support: SFNSW, Lifeline, Hunter Medicare Local (including the Partners in Recovery Program), and the Newcastle Family Support Service.

This analysis indicates that there are about 79 - 81 *MHCC* member organisations that could benefit from additional NDIS capacity building activities. It has been suggested that we might canvas these to further ascertain any that are in receipt of ADHC funding that have not been identified to us by NSW NDS and/or to better understand their capacity building needs.

Table A: MHCC Cross Membership with NSW NDS at the NSW NDIS Hunter Launch Site and Eligibility for Industry Development Funds

	NDS Member	IDF Eligible (i.e. ADHC funded)
MHCC Members providing services in Hunter NDIS Launch Site		
1. ARAFMI NSW	N	N
2. Aftercare	Y	Y
3. Baptist Community Services	N	Y
4. Benevolent Society	N	N
5. Break Thru People Solutions	Y	Y
6. Carers NSW	N	N
7. Castle Personnel Services Ltd	Y	Y
8. Catholic Healthcare	N	Y
9. House With No Steps	Y	Y
10. Lifeline - Newcastle & Hunter	N	N
11. Life Without Barriers	Y	Y
12. Mai-Wel Limited	Y	Y
13. Mission Australia	N	Y
14. Neami National	N	N
15. New Horizons	Y	Y
16. RichmondPRA	Y	Y
17. Samaritans Foundation	Y	Y
18. Schizophrenia Fellowship NSW	N	N
19. St.Vincent de Paul	N	Y
20. Wesley Mission	Y	Y
Subtotal A (n=18)	(10/20) 50%	(14/20) 74%
Not MHCC members but providing MHS in Hunter		
21. Hunter Medicare Local	N	N
22. Newcastle Family Support Service	N	N
Subtotal B (n=3)	0%	0%
Total A+B (n=21)	(10/22) 45%	(14/22) 64%

Table B: MHCC Cross Membership with NSW NDS in NSW and Eligibility for Industry Development Funds

MHCC Organisational Member (n = 112)	ADHC FUNDED	NDS MEMBER
Eligible for NSW IDF and Other Capacity Building Funding (n = 31 or 28%)		
1. Aftercare	Y	Y
2. Anglicare	Y	Y
3. Baptist Community Services	Y	Y
4. Break Thru People Solutions	Y	Y
5. Carers NSW	Y	Y
6. Castle Personnel Services	Y	Y
7. Catholic Healthcare	Y	Y
8. CatholicCare - Ageing, Dementia & Disability Care (Hunter Manning)	Y	Y
9. Central Coast Disability Network	Y	Y
10. Community Care Northern Beaches	Y	Y
11. Community Links Wollondilly	Y	Y
12. Community Options Illawarra	Y	Y
13. Community Programs / CRANES	Y	Y
14. House With No Steps	Y	Y
15. Independent Community Living Australia	Y	Y
16. Jewish Care	Y	Y
17. Life Without Barriers	Y	Y
18. Mai-Wel Limited	Y	Y
19. Mental Health Carers ARAFMI NSW	Y	Y
20. Mission Australia (Sydney City Mission)	Y	Y
21. Neami	Y	Y
22. New Horizons	Y	Y
23. Newtown Neighbourhood Centre	Y	Y
24. On Track Community Programs	Y	Y
25. RichmondPRA	Y	Y
26. Samaritans	Y	Y
27. St Vincent de Paul Society	Y	Y
28. Sunshine	Y	Y
29. The Benevolent Society	Y	Y
30. The Disability Trust	Y	Y
31. Wesley Mission - Mental Health Support Services	Y	Y
32. Blue Mountains Food Service		Y
33. Care Connect		Y

MHCC Organisational Member (n = 112)	ADHC FUNDED	NDS MEMBER
Not Eligible for NSW IDF and Other Capacity Building Funding (n = 79 or 71%)		
1. ACON - Darlinghurst	N	N
2. Action Foundation for Mental Health Inc.	N	N
3. Adults Surviving Child Abuse	N	N
4. Alcohol & Drug Foundation NSW	N	N
5. Australian Kookaburra Kids Foundation Inc.	N	N
6. B Miles Women's Foundation	N	N
7. Bennelong's Haven Ltd.	N	N
8. Billabong Clubhouse	N	N
9. Black Dog Institute	N	N
10. Bobby Goldsmith Foundation	N	N
11. Brown Nurses	N	N
12. Catholic Social Services NSW/ACT	N	N
13. Centacare - Community Lifestyle Support (Port Macquarie)	N	N
14. Centacare - New England North West	N	N
15. Centacare - Wagga	N	N
16. Central Queensland Medicare Local	N	N
17. Cessnock Community Healthcare	N	N
18. CHESS Head Office (Coffs Harbour Employment Support Service)	N	N
19. Club Speranza	N	N
20. CO AS IT	N	N
21. Exodus Foundation	N	N
22. Family Drug Support	N	N
23. Good Grief Ltd.	N	N
24. GROW NSW	N	N
25. Heal for Life Foundation	N	N
26. Home in Queanbeyan	N	N
27. Hope Street	N	N
28. Hornsby Ku-ring-gai Association	N	N
29. Interrelate Family Centres	N	N
30. Jewish House Limited	N	N
31. Justice Action	N	N
32. Kamira Alcohol & Other Drug Treatment Services	N	N
33. Kedesh Rehabilitation Service	N	N
34. Lifeline - Newcastle and Hunter	N	N
35. Link-Up (NSW) Aboriginal Corporation	N	N
36. Liverpool Youth Accommodation Assistance Company	N	N
37. Lou's Place	N	N
38. Make a Difference	N	N
39. Mandala Community Counselling Service	N	N
40. Manly Drug Education & Counselling Centre	N	N
41. Mental Health Association NSW	N	N
42. Mental Health Recovery Institute	N	N
43. Mind Australia - South Australia	N	N
44. Mountains Community Resource Network	N	N
45. Murrumbidgee Medicare Local	N	N
46. NALAG Centre for Loss & Grief Dubbo	N	N
47. NSW Consumer Advisory Group (CAG)	N	N
48. Oakdene House Foundation	N	N

MHCC Organisational Member (n = 112)	ADHC FUNDED	NDS MEMBER
49. One Step at a Time Counselling	N	N
50. ONE80TC	N	N
51. Peer Support Foundation Limited	N	N
52. Rape & Domestic Violence Services Australia	N	N
53. Roam Communities	N	N
54. Rosemount Good Shepherd Youth & Family Services	N	N
55. Schizophrenia Fellowship of NSW	N	N
56. South West Women's Housing	N	N
57. Southern Community Welfare Inc.	N	N
58. St Luke's Anglicare	N	N
59. Stepping Out Housing Program	N	N
60. Suicide Prevention Australia Inc.	N	N
61. Support, Opportunity and Care Inc.	N	N
62. Survivors & Mates Support Network	N	N
63. Sydney Women's Counselling Centre	N	N
64. Ted Noffs Foundation	N	N
65. The ARC Group NSW Inc.	N	N
66. The Oolong Aboriginal Corporation	N	N
67. The Salvation Army	N	N
68. The Station Ltd.	N	N
69. The Wayside Chapel	N	N
70. Uniting Care - Institute of Family Practice	N	N
71. Uniting Care Mental Health	N	N
72. UnitingCare - Children Young People and Families	N	N
73. Wagga Women's Health Centre	N	N
74. WAYS Youth Services	N	N
75. Weave Youth and Community Services Inc.	N	N
76. Wesley Mission - Dundas	N	N
77. Western Sydney Medicare Local (Wentwest)	N	N
78. WHOS (We Help Ourselves)	N	N
79. Wollongong West Street Centre	N	N

Appendix 12

NDIS Practical Design Fund Mental Health Projects

During 2012/13 there were 73 Practical Design Fund projects of which only four are mental health/psychosocial disability specific.

For more information about all projects please visit:
http://www.ndis.gov.au/practical-design-fund-project-descripti

ARAFMI (WA)
Develop best practice guidelines for organisations to work effectively with carers and family members of people with psychiatric disability in Aboriginal communities.

Mental Illness Fellowship Victoria
Adapt training material for mental health peer educators to include the NDIS.

Queensland Alliance for Mental Health
Develop a best practice practical guide for people with enduring psychiatric disability to engage with self-directed care and to exercise choice and control.

RichmondPRA (NSW)
Develop best practice guidelines for person-centred planning and goal setting for people with psychiatric disability.

mhcc
mental health coordinating council