

**Anglicare Australia submission to  
the Joint Standing Committee on the  
NDIS inquiry into the provision of  
services under the NDIS for people  
with a psychosocial disability  
relating to a mental health condition**

**- Attachment 2**

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

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

## The size of the problem

The projections for future funding for psycho social disability under the NDIS is that the Government has adequate funds to support up to 57,000 when the scheme is fully rolled out by 1 July 2019 but 229,000 with moderate to severe mental health issues who are currently supported by services will be ineligible under the NDIS.<sup>1</sup>

## Gaps in meeting need

Under the current test of eligibility, people have to have a 'permanent and significant type of disability' but for many people with mental health issues or psycho social disability, the nature of their illness is episodic and not on-going which would disqualify them from access to NDIS supports although they are currently receiving block funded supports. This is a particular issue for those people currently receiving psycho social support in the PHaMS program who experience episodic illness but not permanent functional disability.

Anglicare notes that people with mild to moderate presentations within current block funded programs are being well supported thus reducing the impact on the crisis health system . Withdrawal of these supports for this group of people will generate increased occurrences of crisis and significant burden on the health care system. The saving achieved by withdrawal of these supports will be more than offset by the increasing demands which will be made on the health system. The proposed alternative for these people has been self-help and online mental health resources but many of our clients are not in a situation where this is feasible – many cannot help themselves and some do not even have computer access. Reduced support in management of their condition may lead to increased stigma, isolation and exclusion within their local community.

Anglicare Sydney also notes that evaluation of their PhaMS program has revealed significant beneficial outcomes for participants in the program:

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<sup>1</sup> Mental Health Australia , (2016) *The Implementation and operation of the psychiatric disability elements of the NDIS: a recommended set of approaches*, p6

- **Increased opportunities for recovery:** The value of the PHaMs approach in assisting people with a mental illness to engage or re-engage with the recovery process and with the health care system was affirmed. In particular it was found that the local program was successful in helping clients to formulate and achieve goals, in providing connections with other services and in fostering or maintaining trust in support services. The majority of clients believed that there had been at least minor improvements in various aspects of their self care through their PHaMs involvement, including confidence in managing their mental illness, ability to look after themselves and reduction in felt levels of stress.
- **Goal setting and goal achievement:** Goal setting is seen as a vital component in helping people to recover from mental illness and the formulation of an Individual Recovery Plan (IRP) is central to the approach used by the local service. The evaluation found that most clients of the service were meeting recovery goals, with twenty seven of a group of 32 clients studied meeting more than half of their goals.
- **Enhanced client access to support services:** Client surveys revealed high levels of trust in services and high levels of satisfaction with support workers, with the program itself and with other services used by clients. Around three-quarters of clients nominated at least one other service to which they had been referred by the local PHaMs service. Such referrals made to other services are typically “warm” referrals, where the client may be accompanied by the support worker.
- **Increased community participation:** The local PHaMs service provided several psychosocial activities for clients including cafes, gardening and walking groups. Since becoming involved in PHaMs, over half of clients surveyed reported that their social connections had improved while the remainder reported no change. There was other evidence of improved social connections with many social goals being achieved by clients as part of their IRPs, including further development of social skills and networking, increased use of community infrastructure such as public transport, volunteering and working.

It should also be noted that current block funded programs enable significant support to be provided via case management and significant trust has developed between participant, agency and the support networks which are involved in a time of crisis. See the case study below from an Anglicare Sydney PHaMs worker:

*Last Thursday one of the PHaMs participants, who I've worked with for over a year, experienced a personal crisis and required support.*

*After clearing my diary for the day, I went to the participant's home to help her manage her overwhelming emotional state, marked by psychotic symptoms such as hallucinations and delusions. Amongst other things, I had to communicate with her GP to substantiate concerns around missed medications, I had to organize a temporary home for her cat, and inform relatives and friends of her condition. I made a call to emergency to get an ambulance as the participant's condition deteriorated. During this process I was able to advocate for the participant with the paramedics and emergency staff to not only explain her situation but provide both medical, mental health and circumstantial information to better facilitate a cohesive admission process. Time and again participants in our care have expressed how*

*difficult and traumatizing the admission and hospitalization process is for them; having a key person to advocate and support them through a crisis is invaluable.*

*At the hospital, the paramedics commented on how impressed they were by the amount of compassion, concern, time and support I provided the participant. They stated that they did not see this often in their line of work. I explained that at Anglicare PHaMs this level of care was not an exception as our organization fosters a culture of compassion towards those most vulnerable.*

*I've since reflected on this recent experience and I'm concerned that with the introduction of funding changes, as mental health case managers, we may not be able to provide this simple form of compassion and support towards our clients because our support becomes a mathematical equation of time=pre-planned individual consumer allocated funding. The very nature of mental health issues does not fit neatly within this paradigm and on occasions we're required to focus our attention on those who need some extra care. What will this look like for us in the future with all the funding changes? I'm loath to think that providing some fundamental human compassion, in the form of time and all it allows, will be thwarted by a system that relies on an allocated amount of time. Ultimately service providers will become disillusioned and our vulnerable participants will be affected not only further exacerbating mental health issues but straining relationships with the very service providers who are there to protect them.*

For these participants and others with moderate to severe psycho social presentations, what will be the outcome if these block funded programs which currently provide such supports are dismantled in order to support the NDIS funding model?

## **Effective assessment**

It is Anglicare's understanding that those with significant functional limitation which is ongoing will be eligible but access depends on the accuracy of the assessment and Anglicare is concerned that a number of planners do not have experience of psycho social or psychological illnesses to be able to make such an assessment.

## **People who are ageing**

Anglicare is concerned that people experiencing psycho social disability who are close to the age of 65 will be considered to come under the umbrella of aged care when they turn 65 years and no longer be eligible for psycho social supports. It is Anglicare's understanding that people under the age of 65 years currently receiving support through psycho social programs with serious mental health issues and turn 65 currently can continue to be supported until their aged care needs are so great that they can then access residential aged care.

Anglicare is seeking clarity around this issue – will people with a mental health NDIS package be able to retain this package once they turn 65 years? What mental health supports will be available for these

people once they turn 65 if they cannot retain an existing NDIS package? Many may be high functioning physically and not require residential aged care but their psycho social functioning may be significantly impaired which is not part of the consideration for MY Aged Care eligibility.

## Carers

Mental Health Australia estimates that there are 153,600 mental health consumers whose carers require ongoing support and who may not receive future supports under the NDIS.<sup>2</sup> Anglicare Sydney notes that funding is being progressively reduced to carer support programs but many of the people for whom they care will not be eligible for an NDIS package leading to significant gaps and shortfalls in service delivery to these families.

- b. the transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular;
  - i. whether these services will continue to be provided for people deemed ineligible for the NDIS;

Anglicare Sydney notes that the transition process is slow – getting planning appointments is difficult and even more challenging if these are to be face to face. Further, having a support service involved in the planning process is not being encouraged by planners. People are registering for planning appointments but by the time they get assessed they are reporting back to us that it can be up to 6 weeks before the participants gets a response.

Interagency reports (PIR) have reported back significant shortfalls in the numbers transitioning across – because the NDIA has not had the capacity to do the assessments and planning required.

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

## Rushed nature of the process

Feedback from carers with participants in the NDIS with mental health is that the carers are not being involved in the planning process. An Anglicare Sydney carer has made the following observations:

*Jane is currently caring for two people with mental health issues and feels that NDIS is trying to rush the whole transition/process by getting Carers to do over the phone planning meetings which doesn't work*

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<sup>2</sup> Ibid

*for her as she has 2 Recipients. The NDIS won't allow the Carer do the planning meeting for both Recipients in one go, they told her that they'll do one now and another one later – not an ideal scenario when carers struggle to find the time and space to do such interviews given their caring responsibilities. She has also observed in discussions with her current case manager that:*

- *NDIS sometimes don't follow up promptly*
- *She feels more depressed now with the whole transition because nothing is clear or transparent. She feels that it's all about business and marketing, it's not about vulnerable people who need assistance and their best interests.*
- *She feels that NDIS just wants to fast track all these planners/plans out and let the family decide what to do, however they don't know what they are choosing, families don't know what their choices are.*
- *She feels that all the workshops she attended haven't been great because the information keeps changing.*
- *She wants to have a complete and thorough planning meeting, she doesn't want to be rushed or misled or find out things at the last minute.*

Anglicare Sydney coordinators have been hearing this kind of feedback from Carers and their family members on the phone and through some group activities over the last 3 months.

Participants in the planning process also require a great deal of documentation – it was estimated by one coordinator that it can take more than 22 unfunded hours to get this documentation in place.

## **CALD experience**

Anglicare Sydney operates a Commonwealth funded carer CR Carelink Centre in SW Sydney where the majority of clients are from a CALD background. Feedback from a number of CALD carers who have gone through the planning process with a LAC / NDIA Planner is that the process has not been helpful, many felt disempowered and excluded from the planning process

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

For those participants who are eligible for a package there are concerns from the agency perspective that the funding model will be inadequate. The pricing scale does not represent the skill level required to provide the support for people with complex mental health issues. It requires workers with a significant level of skill and experience – usually a SCHADS level 4 not a level 2 – otherwise there are people who are not really skilled or trained appropriately dealing with complex clients.

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

In SW Sydney we have a number of hidden carers under the old system in the CALD community for people caring for those with significant mental health issues and these are not on the radar for current NDIS transitioning since they are not in the current block funded system. Anglicare Sydney is concerned that a number of potential CALD participants are not being identified and/or supported. This is an issue of concern since CALD participants can remain largely hidden. It has been estimated by FECCA that for every 1 CALD participant using the mainstream disability services there are three in the community who have not been using any supports (FECCA 2015) and these may well miss out on the NDIS transitioning process.

...any related matter.

## **Regulatory Compliance**

Under the current block funded programs, there are rigorous guidelines around outcomes and recovery based practice but it is not clear under the NDIS funding packages how organisations will be regulated on delivering outcomes for the clients.

In working in a competitive market with clients exhibiting significant mental health issues, there is a requirement on the part of the practitioner to challenge the client to identify their issues and how to manage them. However with the consumer directed package model, clients may then change services because they find it challenging to have their issues addressed and, in the longer term, clear outcomes will not be achieved. Some organisations may resist recovery based practice relying on the maintenance of a business model where the consumer is always right and cannot be challenged. Such a business model does not necessarily work in the mental health space which requires a recovery based model.