

National Disability Services

Submission to the Royal Commission into
Victoria's Mental Health System

5 July 2019

1. Introduction

National Disability Services (NDS) welcomes the opportunity to contribute to the Royal Commission into Victoria's Mental Health System (the Royal Commission). The Royal Commission offers an exceptional opportunity to consider and recommend on a comprehensive and integrated system to better meet the needs of all Victorians living with mental health needs.

Sixty-one percent of the 200 NDS disability service member organisations in Victoria identify 'psychosocial supports' as being a service they offer.¹ There is anecdotal feedback that an increasing proportion of such services in Victoria will consider providing psychosocial support in the near future to NDIS participants. Our members have direct experience of the impact of gaps – both within and between – the National Disability Insurance Scheme (NDIS) and Victoria's mental health system. This submission is informed by their experiences.

2. Background and Context

The Victorian mental health system is widely recognised to be struggling at every entry point along the service system, as the result of many years of underinvestment by successive governments.² Limited investment in preventative programs is contributing to a fractured system with increasing pressures on tertiary health services and other service systems. A Victorian Auditor-General's report highlighted that these demand pressures have lifted the thresholds for access to services, which creates flow-on effects.³ Australian Institute of Health and Welfare reports show that the number of Victorian mental health patients who accessed acute services through police, ambulance and self-presentations to hospital emergency departments increased from 28,757 in 2004–05 to 54,114 in 2016–17.⁴

A contributing factor to the current problems with the mental health system in Victoria was the government's decision to contribute community mental health funds to the state's NDIS funding contribution. In September 2015, the Victorian government signed a Bilateral Agreement with the Commonwealth government for the full scheme roll-out of the NDIS in Victoria. Under that agreement, Mental Health Community Support Services (MHCSS) programs and corresponding funding were to transition over to the NDIS by 2019, with the understanding that people living with a severe, persistent mental illness would be eligible for, and be covered under, the

¹ Based on data derived from NDS's internal Customer Relationship Management system.

² Mental Health Victoria, *Saving Lives. Saving money.* 2018. [Accessible here](#)

³ Victorian Auditor-General's Office Report, *Access to Mental Health Services*, March 2019.

[Accessible here](#)

⁴ Ibid

NDIS for their supports previously delivered by state-funded MHCSS programs. Other Australian jurisdictions did not choose to shift the funding for community mental health services to NDIS.

Unfortunately only a small segment of the large number of people who had previously received services for a mental health condition each year will be eligible to receive NDIS funded supports. A report in April 2019 showed that only a quarter of those in defined programs⁵ had been deemed eligible for the NDIS;⁶ other reports have shown only 10% of people with severe mental illness living in Victoria being eligible for the NDIS at full roll-out.⁷ This is contributing to significant service gaps for Victorians who are in need of community mental health services.

A lack of clarity about the eligibility of people with mental ill-health for the NDIS has also been a persistent issue. Further compromising the system's ability to meet demand is the fact that many people who experience mental illness do not seek support, or may disengage from services. Disengagement may be due to a range of factors, including insufficient resources under the NDIS for providers to build rapport and trust with a client.

In addition, providers have identified the requirement for significant resources to support participants with psychosocial disability and highlighted the often insufficient hours allocated in these participants' plans.

It is acknowledged that the NDIS is working to address some of the issues relating to their engagement with these participants, and is developing a Psychosocial Pathway, which promises to deliver improved processes and a recovery-oriented practice approach in the NDIS. The recent introduction of a new pricing tier for participants with 'complex support needs' is also welcomed.

Continued work is needed to ensure that Victorians with significant need can access the NDIS psychosocial pathway. The benefits of this would include increased social and economic participation of these Victorians. Moreover, the Victorian government has committed to meeting this need (in conjunction with the Commonwealth) in its Mental Health Plan, with the recognition that Victorians need a system which works together well, regardless of who funds it.⁸

One reason for why the NDIS is perceived as struggling to adequately support people with psychosocial disability, may be due to a significant underestimate of the numbers of such potential participants in the original Productivity Commission's

⁵ Such as: Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), and Support for Day to Day Living (D2DL).

⁶ *Tracking Transitions of People from PIR, PHaMs, and D2DL into the NDIS*, Commonwealth Mental Health Programs Monitoring Project – NDIS (Phase 2 report). [Accessible here](#)

⁷ Hancock, N., Bresnan, A., Smith-Merry, J., Gilroy, J., Yen, I., & Llewellyn, G. (2018). *NDIS and Psychosocial disability – the Victorian Story: Insights and Policy Recommendations from Expert Stakeholders*. Report prepared for Psychiatric Disability Services of Victoria and SalvoConnect. [Accessible here](#)

⁸ *Victoria's 10-Year Mental Health Plan*, State of Victoria, Department of Health and Human Services November, 2015. [Accessible here](#)

work, which has underpinned the design and structure of the Scheme. In 2011 the Productivity Commission estimated that 12% of (or 57,000) people living with a severe, persistent mental illness would be 'in scope' for the NDIS across Australia. This was subsequently updated to 65,000 people, in line with population growth.⁹ The PC indicated those anticipated to be included in the NDIS were individuals who:

- have a 'severe and enduring mental illness';
- have significant impairments in social, personal and occupational functioning that require intensive, ongoing support; and
- require extensive health and community supports to maintain their lives outside of institutional care.

In addition, participants must meet age, residency and permanency requirements. The Productivity Commission's target definition excludes a much larger cohort of people with severe and enduring mental illness, who also require community support. The Australian Government Actuary estimates delineated 424,000 people in Australia with mental illness requiring some kind of community support.¹⁰

NDS questions whether the Productivity Commission's estimate of only 12% of NDIS participants as living with a severe and enduring mental illness has significantly constrained the potential of the NDIS to address many of Victoria's mental health needs.

In a recent consultation with NDS Victorian members, the following specific concerns regarding NDIS and people with psychosocial disability were raised:

- Fragmentation:
 - Lack of integrated pathways between non-NDIS funded and NDIS funded supports, and a lack of early intervention and scaffolding services.
- NDIS planning processes:
 - Negative outcomes experienced as a result of delayed planning review processes and excessive wait times due to staffing caps within the NDIA.¹¹
 - Inconsistencies in NDIS plan allocation for people with similar needs illustrate that the Scheme has the potential to increase inequalities. Recent research supports this, showing that social factors can constrain or enable the ability of individuals to exercise choice within personalised care schemes and entrench health inequalities, using the NDIS as a case study.¹²

⁹ Productivity Commission (PC) (2011). *Disability Care and Support: Productivity Commission Inquiry Report*, 54(2), Canberra. [Accessible here](#)

¹⁰ *NDIS Costings – Review by the Australian Government Actuary* (AGA), p14, AGA (2012).

¹¹ *NDIS Pathway Reform*. [Accessible here](#)

¹² Malbon, E., Carey, G., & Meltzer, A. *Personalisation schemes in social care: are they growing social and health inequalities?* BMC Public Health, 19(1), 805. 2019. [Accessible here](#)

- o An inability to address capacity building and community inclusion goals in an NDIS plan if a person's pressing mental health needs are not being met.
- The role of support coordination:
 - o As a new role operating within the NDIS, focusing on capacity building, support coordination is in need of further definition and consistent application if the role is to function as it was intended. Those experienced in delivering psychosocial supports report the need for face-to-face hours built into plans for rapport and trust building, which has proved difficult under an individualised supports scheme.
 - o The lack of case management for participants with complex needs can contribute to blockages at the health and justice service systems interfaces with the NDIS.
 - o Insufficient hours for support coordination are often reported, which is further complicated if participants change support coordination providers and then have reduced hours to implement a plan.
 - o A need for the reinstatement of case management services to support people outside the remit of the NDIS.
- Investment into trauma-informed frameworks and research designed to work within the NDIS is needed.
- Lack of sufficient recognition and support of the role of unpaid carers

3. Recommendations

NDS' submission¹³ will focus on the following four recommendations:

1. That the Victorian government create a comprehensive continuum of expanded mental health services integrated with effective and sufficient NDIS funded services for people living with psychosocial disability;
2. That the Victorian government provide targeted and strategic investment into building and training the psychosocial workforce;
3. That the Victorian government develop and implement a Victorian housing strategy to improve access to housing for people with disability, including those with psychosocial support needs;
4. That the Victorian government fund a suite of supports, training and strategies aimed at supporting people with mental health needs to gain and maintain employment.

Creation of a comprehensive continuum of expanded mental health services integrated with effective and sufficient NDIS funded services for people with psychosocial disability

¹³ NDS generally agrees with the recommendations developed by Mental Health Victoria in consultation with the sector, in their submission to the Commission.

Victoria needs a continuum of expanded mental health services catering for people with acute needs through to mild mental health concerns. NDIS funded services need to be an integrated element of such a network of supports. Such a system should include a comprehensive suite of preventative, early-intervention mental health programs, to replace decommissioned programs in the community mental health sector. These included services such as club houses, men's sheds, state government funded informal day services, and other community supports.

The component of the mental health system funded by NDIS also requires further development, to build upon the promising indications with the psychosocial pathway. NDS urges the Victorian government to back current moves to 'get the NDIS back on track', with advocacy in regard to the following:

1. Independent Pricing
2. A reduction in NDIA red tape
3. Real sector safeguards, including integration with mainstream services
4. Better NDIS Planning
5. More focus on employment for people with a disability, and a National Workforce Strategy

These issues with NDIS implementation have had flow-on effects to Victoria's mental health system. Furthermore, the Victorian government should continue to advocate that the NDIA continues to improve the way the NDIS responds to participants with psychosocial support needs and dual disabilities. For case studies which illustrate this point further see *Appendix A*.

We also recommend that the Victorian government advocates nationally for a review of the Productivity Commission estimate of only 65,000 NDIS participants requiring psychosocial supports at full roll-out, to better reflect the number of Australians who are living with severe and enduring mental illness.

Provision of targeted and strategic investment into building and training the psychosocial workforce

A skilled, sufficiently large and diverse psychosocial workforce is critical to the delivery of high quality services and to the sector. NDS is aware of many anecdotal reports of skilled workers leaving the sector in recent years, in the wake of service recommissioning, funding reductions and in response to the impact of NDIS prices. We are now in a situation of significant workforce shortages across the disability sector, including in relation to psychosocial supports.

Such workforce shortages and subsequent opportunities occur within a complex, multifaceted ecosystem and require a systemic response which includes long-term commitment and investment to attract, retain and train workers. Regional and rural areas magnify some workforce challenges and bring about others, necessitating

place-based solutions. Alongside the exiting of a skilled psychosocial workforce, NDS is hearing reports of NDIS providers who are providing psychosocial supports for the first time, or considering doing so.

Concerns about the psychosocial workforce are amplified when taken within the context of concerns about the NDIS workforce as a whole. To meet demand, the NDIS workforce will need to have doubled in size from beginning of rollout to 2019, whilst maintaining the quality of supports through appropriate training.¹⁴ The Productivity Commission has warned that ‘the disability care workforce will not be sufficient to deliver the supports expected to be allocated by the NDIA by 2020’.¹⁵

It is noted that the areas of mental health and disability - which were previously two distinct sectors with providers operating in a siloed manner - are now much more fluid as a result of NDIS. The shift to a joint workforce, which responds to participant needs spanning psychosocial, disability and dual disability, requires investment in targeted workforce training and programs to support NDIS workers delivering mental health and disability services, often to participants with dual disability support needs. NDS urges that additional investment in this workforce, which is critically needed, be designed to complement and build upon existing disability workforce initiatives and resources.

Further issues relating to workforce which were raised in a recent consultation with NDS Victorian members included:

- Given thin margins in NDIS pricing, training needs to be incentivised and resources allocated to attract and retain a psychosocial workforce. The lack of funding for training and staff support is impacting on service quality and sustainability across the service sector.
- The NDIS workforce includes Local Area Coordinators (LACs) and NDIS planners, who all require a sound understanding of, and training in, mental health.
- Guidance and support is needed for organisations to employ a peer workforce, acknowledging the power of lived experience.
- Providers working with participants with dual disabilities are seeing increasing behaviours of concern. The workforce is in need of dual disability capacity, to understand and to be able to deal with co-occurring intellectual disability and mental health needs. There is also insufficient training for people to work with other primary disabilities with co-occurring mental health needs.
- Built-in support is needed for workers fluent in languages other than English who wish to develop psychosocial support capabilities, linking skills to verbal and skill competencies.
- The lack of mental health knowledge among disability support workers and lack of disability knowledge among the mental health workforce needs to be bridged.

¹⁴ National Disability Insurance Agency (April 2016) *Victoria Market Position Statement*, p 27. [Accessible here](#)

¹⁵ Productivity Commission (October 2017) *Study Report: National Disability Insurance Scheme (NDIS) Costs*, p336. [Accessible here](#)

- The Free TAFE Priority Courses program should be reviewed to ensure they include training for students on Recovery-oriented Practice in the NDIS.
- Support is needed for a frequently mobile psychosocial workforce, who can be at risk of burnout, often with reduced ability to debrief.

Development and implementation of a Victorian housing strategy to improve access to housing for people with disability, including those with psychosocial support needs

Due to structural trends experienced in the housing system there is a critical shortage of appropriate, affordable and safe housing.¹⁶ People with a history of mental illness are far more likely to live in social or supported housing in Australia, and so are most likely to be impacted by this enduring shortage.¹⁷ There is a complex, bi-directional relationship between mental ill-health, housing and homelessness.¹⁸ Mental health and housing policies should not be siloed, as there is a growing recognition that funding spent in housing results in gains in the health and mental health portfolios, in the form of reductions in funding spent, and improvement in outcomes.

There should be an expansion of programs that offer time-limited support during a person's mental ill-health or associated crisis, with access to brokerage funds that can support tenancy sustainment. Programs like Victoria's Private Rental Access Program and Tenancy Plus have proven both cost-effective and effective at achieving tenancy sustainment interventions.¹⁹

Housing First programs have resulted in residents with psychosis, and discharges from psychiatric hospitals, requiring fewer days' admission to mental health units each year when compared to the period before they were housed.^{20,21} Remarkably, these improved outcomes for housed consumers were achieved without an increase in residents' use of community mental health care services. Improved outcomes instead reflected greater stability, improved consumer/clinician relationships, and resultant greater adherence to treatment plans.²²

¹⁶ Community Housing Industry Association (CHIA) Victoria, *Impacts of a changing mental health sector on community housing tenants*, May 2019. [Accessible here](#)

¹⁷ Brackertz, N., Wilkinson, A., & Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Professional Services Paper, prepared for the National Mental Health Commission. Australian Housing and Urban Research Institute Limited, Melbourne, p. 16. [Accessible here](#)

¹⁸ Brackertz, N. Davidson, J. and Wilkinson, A. (2019) *Trajectories: the interplay between mental health and housing pathways, a short summary of the evidence*, report prepared by AHURI Professional Services for Mind Australia, Australian Housing and Urban Research Institute, Melbourne. [Accessible here](#)

¹⁹ Council to Homeless Persons, 2019, *Council to Homeless Persons pre-budget submission 2019-2020*, p.5. [Accessible here](#)

²⁰ Holmes, A., Carlisle, T., Vale, Z., Hatvani, G., Heagney, C., & Jones, S., 2017, *Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness*, in Australian Psychiatry, Volume 25 Issue 1, pp. 56-59. [Accessible here](#)

²¹ Parsell C., Petersen, M., Moutou, O., Lucio, E., and Dick, A., 2016, *Brisbane Common Ground Evaluation*, University of Queensland. [Accessible here](#)

²² Ibid

Lack of suitable housing options exacerbates pressure on acute mental health services. The NSW Ombudsman found that a lack of appropriate accommodation options was a key factor preventing the discharge of mental health patients. This led to both reduced availability of acute beds for other patients, and to mental health staff referring inpatients to inappropriate housing options to promote earlier exits.²³ Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.²⁴

Exiting acute care into homelessness is self-defeating. Homelessness is not only destructive to a person's mental health, but a lack of suitable accommodation undermines the provision of subacute and outpatient support required by hospital-leavers.

The number of Victorians who have exited mental health facilities into homelessness has grown by 55 per cent since 2012-13.²⁵ The number of people accessing Victorian homelessness services who report having a mental health issue has increased by 84 per cent in this same period.

NDS has been consistently advocating to the Victorian government for the development and implementation of a Victorian housing strategy for people with disability. It is recommended that this include targeted strategies to address the specific housing needs, including barriers to access, for people with mental ill-health - the majority of whom lie outside the remit of the NDIS.

NDS notes the comprehensive review undertaken and key findings laid out by AHURI Professional Services on the interplay between mental health and housing pathways,²⁶ and the work done by Council to Homeless Persons in creating a messaging guide in the context of the Commission.²⁷

Investment in a suite of supports, training and strategies aimed at supporting people with mental health needs to gain and maintain employment.

The participation and productivity of people with mental ill-health in employment depends on the opportunities for them to acquire skills, and access the necessary

²³ NSW Ombudsman, 2012, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability*, p.55. [Accessible here](#)

²⁴ Discussion in meetings between clinical mental health and homelessness services, 2018

²⁵ Australian Institute of Health and Welfare (AIHW), 2019, *Specialist Homelessness Services Collection*. [Accessible here](#)

²⁶ Brackertz, N. Davidson, J. and Wilkinson, A., *Trajectories: the interplay between mental health and housing pathways, a short summary of the evidence*, report prepared by AHURI Professional Services for Mind Australia, Australian Housing and Urban Research Institute, Melbourne 2019. [Accessible here](#)

²⁷ Council to Homeless Persons, *Messaging guide to the Royal Commission into Mental Health; Housing, homelessness and mental health*, 2019. [Accessible here](#)

supports to find and maintain employment. The benefits flow both ways, leading to improved mental health outcomes for the people in employment, and increased workforce participation, which leads to overall increased income generation for the economy.²⁸ It is imperative that the episodic nature of mental ill-health be taken into account when providing employment support for people with mental health needs. People living with episodic mental illness are particularly disadvantaged in the employment market as they may require unanticipated, intensive periods of support to assist them to retain their employment.

Better employment outcomes for Victorians with mental health needs could be achieved by taking into account the episodic nature of mental illness and the vocational and non-vocational supports required. These types of supports, such as supports already offered by Disability Employment Support (DES) providers, could include an extensive suite of supports for employers, such as assistance with job re-design; mental health awareness training and support for staff peers; linkages to relevant health care providers; and ongoing employee support by the DES or employment provider. This model of support benefits the employer through retention of the employee's skills and knowledge, reduced staff turnover, reduced absenteeism and enhanced employee wellbeing as well as linking employers with other types of government assistance. Supports for prospective employees could include preparation for employment including well-designed employment readiness programs, and evidence-based training programs.

Collective mental health outcomes could be improved by reframing societal definitions of economic and social contributions to be broader and more flexible, acknowledging that paid employment may not be achievable for everyone, and that improved participation in voluntary work, education, training or social enterprise is of vital importance to people with mental health needs. This notion is supported by the Productivity Commission's Mental Health Issues Paper²⁹ and the NDIS Act, which supports the independence and social and economic participation of people with disability.³⁰

About NDS

National Disability Services (NDS) is the peak body in Victoria and Australia for non-government disability service providers. NDS has more than 200 members in Victoria and almost 1,000 members nationally. NDS provides information and networking opportunities to its members and policy advice to state, territory and Commonwealth governments. We have a diverse and vibrant membership, comprised of small, medium and larger service providers supporting thousands of people with disability. Our members collectively provide the full range of disability services, from accommodation support, respite and therapy to community access and employment. Our members employ over 8,000 people in Victoria alone and are

²⁸ Productivity Commission (PC), *The Social and Economic Benefits of Improving Mental Health*, Productivity Commission Issues Paper, January 2019. [Accessible here](#)

²⁹ Ibid.

³⁰ The National Disability Insurance Scheme Act 2013, No. 20, 2013. [Accessible here](#)

supported by countless volunteers in delivering vital services to Victorians with disability.

NDS is committed to improving the disability service system to ensure it better supports people with disability, families and carers; and to building a more inclusive community. NDS has a deep commitment to supporting the implementation of a successful National Disability Insurance Scheme (NDIS) and is supporting service providers across Victoria as they complete their transition to the new Scheme and attempt to thrive in a new landscape.

NDS is pleased to provide this submission to the Royal Commission into Victoria's Mental Health System.

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Appendix A

Case Studies (de-identified)

The following case studies illustrate ways in which the introduction of the NDIS has disrupted services for people living with a psychosocial disability in Victoria. All names have been changed to protect the identities of the people concerned.

Case Study 1

Jane is a 53-year-old woman who lives alone. She has a diagnosis of severe depression and anxiety. Jane has been receiving MHCSS funding since August 2014 and before this was with a day program and PHaMs since August 2009. She was regularly receiving weekly one-on-one support and attending a walking group, art group and women's group on a weekly basis. She felt well supported and always had a support worker, peer worker or team leader available to discuss her mental health issues and receive support when needed. Since transitioning over to the NDIS, Jane's mental health has deteriorated and she has disengaged from services, refusing to work with allocated support workers. She has had hospital admissions and Prevention and Recovery Centre (PARC) admissions this year as well as receiving case management from ██████ Health.

Jane has stated that she wants to go back in to PARC regularly as she feels supported at the facility. She has been told that there is a three-month wait. On 9 May 2019 Jane had messaged a peer to say that 'she was lost and was going to die'. Staff tried to call her but she would not answer her phone. Staff called Police and the mental health triage service to report the incident. Staff drove around to her house and were able to gain access to the house without breaking in as her neighbour had a key due to ongoing issues with Jane. Jane finally messaged back to staff and stated she was out shopping and that she was fine. Staff let her know that they had to act on the conversation that she had and that they had to do a welfare check. This is not the first time that this has happened. There was another incident at the beginning of the year where Jane was found hiding in the neighbour's garden. She was then taken to hospital. With no support worker being able to step in and out when needed, Jane is falling through the gaps and needs regular clinical support to become well. She has not been taking her medication regularly and needs constant reminding to do this. Clinical services are under pressure and are unable to offer the flexible support that Jane requires to maintain her mental health.

Case study 2

Jim is a 39-year-old man with Psychosis and Dissociative Identity disorder. He lives independently with his dog and works part time in the disability sector when he is well. Before transitioning to the NDIS he was receiving adequate access to mental health services from an NDS member under the MHCSS funding model. He could attend groups, have weekly one-on-one support and also call in to the office and speak with peer workers, support workers and team leaders if needed, as he became unwell periodically. During this time he had a 10-year period of functioning well in society and staying well, holding down a job and maintaining his housing. He could attend PARC for respite when he needed to and did not have to be clinically case managed for this to happen. Since the introduction of the NDIS the admission criteria has changed and he is not able to access this service anymore. He regularly sees his psychologist and psychiatrist but, due to the MHCSS funding ceasing and [an NDS member's] group centre closing, Jim's mental health symptoms have increased. The group centre was a place of respite and familiarity for Jim and many other consumers. His voices/identities remained calm and allowed him to function without tormenting him or punishing him for being well. He had friends and staff who were familiar with him and understood what he was going through.

Since the ceasing of MHCSS services and the transition to the NDIS, Jim has deteriorated in his mental health and his voices have become more aggressive and telling him constantly to end his life. Due to the voices he has not been able to work and this has had a flow-on effect to the point where he has had to see [an NDS member's] Financial Counselling Services due to increasing debts and cost of living.

Jim received a good package for his first NDIS plan in April 2018 but with his deterioration of mental health was not able to access services as his support workers that he had built trust and rapport with, had moved on to other roles due to lack of funding in the NDIS. He was quoted on groups and one-on-one support but only attended a handful of times due to being so unwell. His new plan came through last week where it was cut drastically from \$60,000 in the first year to \$38,000 in the second year.

Due to the changed nature of services and supports, Jim has deteriorated in his mental health and does not have the weekly supports he requires. He is not able to access appropriate and adequately trained staff who he has a rapport and relationship with. He has attended a local drop in centre who have hired peer workers. Jim has stated that these peer workers are unwell themselves and are not able to offer him support as they are currently working through their own issues. Also, the other staff at the drop in centre are always too busy to talk. He is weighing up whether it is worth continuing with this. Jim stated he does not know what to spend his money on in the NDIS and is happy to pay more for experienced and reliable staff but does not know where to find them.

Case Study 3

“For the past 15 years my wife has lived with an acute psychiatric illness. This has seen her admitted to hospital several times, with the usual length of stay being 5 weeks. My role is both as husband and carer, and I also work full-time in order to support us both. The stresses of caring are very high, which places a burden on our relationship and my own health.

“My provision of care reduces [hospital] admissions, helps with medication compliance, and assists with post admission recovery and overall stability. The cost savings to the government are substantial due to this involvement in my wife’s care. The best outcomes are when we work as a team with myself as the main carer, and when other services and support people are involved. For ten years we have utilised many of the psychosocial services provided by [REDACTED] which are an integral part of the team keeping us both as well as possible.

“There was one time my wife had become quite unwell while on a group walk with consumers and a MHCSS support worker. The worker was able to recognise my wife had deteriorated and had considered calling emergency services or the mental health triage service. However, her experience in the mental health space enabled her to take another course of action. The worker decided to take my wife home and place her into bed. The worker also knew how to de-escalate the situation by providing my wife with sensory objects that could calm her. When stabilised the worker called me and I quickly returned home from work to assist. After a few days of rest my wife recovered and we prevented another admission to hospital.

“There is no doubt in my mind that a less experienced person would have called emergency services and my wife would have been admitted [to hospital]. Every time my wife is admitted, her condition becomes much worse due to the nature of hospital environments. Knowing how to provide support and care is critical for carers and MHCSS staff. Without this skill base, consumers and family members will be put at risk. The NDIS funding does not pay enough to retain highly skilled support staff and I believe this will be of detriment to my wife and myself.

“Having a mental illness is not a choice, just like having a disability is not a choice. Mental health issues can be just as debilitating as a disability – believe me, I live with both. If you have never suffered from a mental illness or disability, you will never understand the huge impact it can have on your life, until it happens to you, so please don't think you know what's best and just give a tick or a cross when assessing my NDIS plan. Understand I need this service provider in my NDIS plan for my health and wellbeing.”

Case Study 4

“Adam suffers from severe schizophrenia and is plagued with negative voices. He manages this with medication and strictly limited activity. Leaving the home increases the negative voices and is sometimes unbearable. Adam’s house is extremely dirty because cleaning triggers the negative voices. He can manage only one activity per day.

“I am a specialist mental health worker from [an NDS member provider]. I assist Adam to regularly visit the GP and attend specialist appointments. I take notes and provide written records to him. I also prompt Adam to follow through with treatment for a complicated health issue. After many years of building a trusted professional relationship, Adam consented to have me assist him clean the bathroom and to support him to visit a city-based health specialist. Adam requires a great deal of gentle persistence to deal with everyday tasks and appreciates the personal support provided by a specialist mental health worker who understands his mental health condition and will provide assertive support.

“I’m concerned that when Adam loses the support of a consistent specialist mental health worker that he will find it too difficult to engage with supports because the various unskilled workers may not all understand his special needs. I’m concerned that Adam may thus have more hospital admissions and eventually lose his independence.”

Case Study 5

An NDS member organisation states that the NDIS pricing structure has made it incredibly difficult for mental health support to be managed in accordance with an individual’s needs. Where a generic support worker role can work with an individual during periods where they are largely well, there is no provision made for more specialised support in times of crisis. This statement is illustrated by the following case study.

Peter is a 56-year-old divorced man with paranoid schizophrenia living in a bungalow on his daughter’s property.

Peter has constant auditory hallucinations of several unknown voices telling him to kill himself. He finds this extremely difficult to manage and as a result has had several hospital admissions in recent months.

Peter is very high functioning having been an Alcohol and Other Drugs counsellor for many years and also worked for many years for Child Protection with these symptoms active.

Peter has been approved for an NDIS plan. This unfortunately makes him ineligible for MHCSS programs he was previously accessing. He has been referred to an NDIS approved Social Worker – but she has little concept of mental illness and especially psychosis.

The NDIS does not cover the cost of psychiatrist visits. There are very few bulk-billing psychiatrists and many charge several hundred dollars above the gap fee per visit. [Previously] the need for a psychiatrist was minimal as the GP was able to liaise with the mental health nurse in relation to medication options, hospitalisation, and so on. This will now not be an option for Peter who is on a Disability Support Pension and will not be able to afford this.

Peter's daughter is fearful that her father will avoid going to see a psychiatrist because of the cost and that he will become increasingly difficult for her to manage.

Case Study 6

"My name is [removed to protect identity]. I have significant mental health issues, Generalised anxiety disorder, post-traumatic stress disorder, depression which got that bad it unfortunately lead to psychotic depression. My depression must be closely monitored along with the rest of my mental health issues.

My mental health has a major impact on my life on a daily basis and can be extremely challenging to deal with and debilitating for me.

My mental health issues do not just disappear. Because I take medications and my issues are lifelong conditions that affect me on a daily basis, it is paramount for me to get support. Following several psychotic episodes, I was connected to a Community Mental Health clinic for several months and since my discharge have been supported by my Community Mental Health worker. Having a Mental Health support worker to visit me a few hours a week would greatly improve my mental health as I could have someone to support me that has fresh eyes and different insights. Having a community service worker to suggest strategies and techniques to use and who has an ear to listen, would help me as this also takes pressure off my relationships with family and friends.

To be able to be involved with programs run by this organisation to help with my mental health would be a significant improvement in my life as this would give me an opportunity to interact with other people who also have mental health issues, which in turn then means that I do not feel as isolated within my community.

To not have this support from this organisation would significantly disadvantage me in the community, by isolating me."