Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PETER RUZYLA

I, Peter Ruzyla, Chief Executive Officer of EACH of 20 Melbourne Street, Ringwood, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Professional background and qualifications

2 I am the CEO of EACH (previously known as Eastern Access Community Health and Maroondah Social and Community Health Centre). I have held this position for 30 years.

3 I am also the CEO of EACH Housing Limited. EACH Housing Limited is a social housing provider. I have held this position for 10 years.

4 I am a registered psychologist. Prior to my role at EACH, I worked as a psychologist in various educational, policy and disability support services.

5 I have around 40 years' experience in the not for profit, community, social services and education sectors.

6 I hold the following qualifications:

(a) a Bachelor of Arts (University of Melbourne);

(b) a Diploma of Education (University of Melbourne);

(c) a Diploma of Educational Psychology (Monash University);

(d) a Masters of Educational Studies/Psychology (Monash University);

(e) a Graduate Diploma Special Education (Victoria College); and

(f) a Graduate Diploma Business, Health Management (RMIT).

7 Attached to this statement and marked "**PR-1**" is a copy of my curriculum vitae.

What is EACH – what services does it provide and in what activities does it engage?

8 EACH is a community-based organisation that provides holistic and integrated primary care, psychosocial and disability support, and community health services (including mental health services) to those in the community.

9 EACH also provides child, youth and family support, early years services, social housing for people with enduring disabilities, oral health and dental services, financial counselling and gamblers help services, and health promotion. EACH works extensively within the Aboriginal and Torres Strait Islander communities, particularly in the Outer East Melbourne area.

10 EACH offers over 150 programs and has a workforce in excess of 1,000 staff and 250 volunteers across Australia. It provides services in over fifty sites across Victoria, New South Wales, the Australian Capital Territory, Queensland and Tasmania.

11 EACH provides a number of mental health services (through various different funding arrangements, which I discuss further below) including:

(a) Mental Health Community Support Services (Victorian State funded);

(b) Personal Helpers and Mentors (Commonwealth funded);

(c) Day to Day Living (Commonwealth funded);

(d) Early Intervention Psychosocial Initiative (Victorian State funded in partnership with hospital clinical services);

(e) Headspace (Commonwealth funded youth mental health);

(f) Supporting Kids in Primary Schools (self-funded by EACH); and

(g) NDIS Psychosocial Disability Support (Commonwealth funded).

12 EACH also receives funding to provide mental health related services, including drug and alcohol services, alcohol and drug residential rehabilitation, benzo diazepam recovery services, homeless youth nursing program, social housing for people with severe mental illness (through EACH Housing Limited), problem gambling services and family violence services.

13 EACH provides therapeutic counselling services such as cognitive behaviour therapy for people with anxiety and depression. It also provides services that are non-clinical, community based support services, which are called recovery-orientated services. These services support consumers in identifying their goals in life and assisting them to develop a plan to achieve those goals. EACH workers work with consumers over a period of time to achieve their recovery goals. This approach is based on the principle of recovery which is that recovery is not a cure, but you can learn to live with your symptoms in a way that is better than what you are currently experiencing.

14 EACH also employs people with a lived experience of mental illness. These people are known as peer workers. A peer worker working with a key mental health support worker

can often create breakthrough experiences for people who quite frankly are sometimes very traumatised by their experience in the clinical mental health system.

15 While EACH provides services that are clinical and therapeutical in nature, the services are provided in community settings with a recovery focus.

What are the criteria for people affected by mental illness to access EACH's services and how do consumers access EACH's services?

16 EACH's services are accessible to the general population. However, EACH prioritises its assistance to the most disadvantaged populations, including:

(a) people with low income;

(b) people experiencing homelessness;

(c) the forensic population;

(d) people from refugee or recent arrivals backgrounds;

(e) people with severe and enduring mental illness;

(f) people with addictive behaviours;

(g) people living with a disability;

(h) members of the Aboriginal and Torres Strait Islander communities; and

(i) people who experience stigma, social exclusion or discrimination, including people within the LGBTQI+ community.

17 EACH is one of the Registered Independent Community Health Services that was started in 1974. Victoria has a unique service response to address the needs of people with mental health concerns through Victoria's system of Community Health Services. There are 84 Community Health Services in Victoria, covering every Local Government Area.

18 Most Community Health programs in Victoria are governed by the Hospital Networks, but there are also 29 independent Community Health Services which are registered under the Health Services Act and are independent not-for-profit companies limited by guarantee.

19 Community Health Services in every area typically consist of a combination of medical, dental and allied health treatment services, psychosocial counselling services, health promotion and a range of other services, which are responsive to local community needs.

20 For example a Community Health Service may provide refugee health services in areas with large resettlement programs or drought assistance services to rural areas or be mobilised to provide vaccination services for flu seasons or other health campaigns. In this way, Community Health Services provide a unique, flexible and responsive platform for health and community service delivery at local levels.

21 While Community Health Services are located in discrete municipalities, they generally do not apply geographical barriers (or zoning) for consumers who wish to access a particular Community Health Service.

22 EACH uses a fee scale to assess an individual's eligibility for services. If a person can afford the private sector, we are able to charge a fee for the service (but usually that consumer will access the private sector, as the wait times in the private sector are generally shorter).

23 Consumers generally access EACH's services through referrals from a range of sources including general practitioners, other NGOs and community service organisations, or from self-referral through our central telephone number or the contact details on our website.

Does EACH assist people affected by mental illness of all degrees of severity and complexity?

24 EACH provides support to people experiencing a range of mental health problems. This includes mild to moderate mental illness (for example, depression or anxiety) through to severe and enduring long-term mental health conditions, such as schizophrenia or borderline personality disorder. The mental illness often co-exists with experience of homelessness, family violence and drug and alcohol problems, and often a significant history with the justice system.

25 The services and supports required by this group are sometimes referred to as the 'missing middle'. These are the support levels that some people with severe mental illness require which are beyond that which can be provided by a general practitioner or 10 sessions of counselling through a Medicare Benefits Scheme funded Mental Health Plan, and below the threshold for treatment by the clinical mental health system. That is the area that causes us the most concern, because these people are the most vulnerable. If they remain without appropriate treatment and support, their symptoms inevitably escalate to the point that a crisis occurs or they become so unwell that they can experience a crisis or an emergency and become patients of the acute mental health system.

26 At the other end of the spectrum in terms of degree of severity or complexity, EACH provides a range of counselling or therapy services which are effective in terms of early intervention and prevention.

27 For example, EACH provides access to maternal and child health services and we also have a childcare centre, which means that EACH is ideally located for picking up and responding to post-natal depression, for example, or adjustment to parenting-type problems. That is usually manageable through a brief intervention, several sessions either through a GP recommendation or referral for a Medicare Benefits Scheme funded Mental Health Plan. Those kind of walk-in, walk-out restorative care services are something which EACH also provides.

What other parts of the mental health system are your consumers likely to use (or want to use)?

28 Consumers accessing EACH's services may also use the clinical mental health system in times of crisis. For example, some of EACH's consumers experience severe and enduring mental health conditions, which in some cases are episodic conditions. These conditions can require the consumer to be hospitalised to restabilise. However, once stable and discharged, consumers may seek ongoing community based support from EACH.

Does EACH have connections or links to clinical services? If so, what are they and how do they work?

29 EACH has partnerships with clinical mental health service providers. The main purpose of these partnerships is to provide consumers with ongoing community support once they are discharged from the clinical service. EACH has recently obtained funding to provide a support service for people being discharged from the acute system to be picked up by a community mental health worker. This is a new service and will provide an opportunity for the acute clinical system to triage patients on discharge from the hospital and to provide an appropriate mix and level of support to ensure that the right community supports are in place at this vulnerable time.

30 In my experience, consumers are being discharged more rapidly from the clinical mental health system. This is concerning for the cohort of people living with mental illness who experience recurrent episodes of crisis. For example, psychiatric schizophrenia is a recurrent episodic condition which means that people are likely to experience episodic reoccurrence of symptoms (sometimes because they stop taking their medication) and require hospitalisation to stabilise. Once they have stabilised, the person ought to be referred to people at the community worker level for ongoing support. At the moment

the hospital sector is trying to provide that support and they are just not able to stretch that far. This new service will try to strengthen this gap.

31 In my view, this is the part of the system that is struggling the most and which NDIS is not able to replace (I discuss this further below). Previously, the community sector was able to pick up consumers in day programs through day centres, at which people with mental illness could connect with support workers on a low impact, semi-structured, or fully structured basis. If a person needed help, they could find someone to talk to. If they needed to engage with meaningful group activities there was a range of these available. If they wanted to learn new skills, there were skill development programs provided. This type of resource has been decommissioned from the current system.

How is EACH funded and how does this create complexity with the running of EACH's mental health services?

32 EACH receives both State and Commonwealth funding.

33 For each of the mental health services that EACH receives funding for (as identified in paragraph 11 above), there is a separate contract and funding arrangement which includes performance targets and specifications around eligibility for each service. The funding, performance targets and eligibility criteria are different for each service. For example, performance for some services may be measured based on number of episodes of care, while others may be measured by hours of service delivery, and eligibility criteria will also vary.

34 Attached to this statement and marked "**PR-2**" is a summary of the various eligibility criteria for the range of services offered by EACH.

35 This results in a service offering that is incredibly fragmented to navigate from a client's point of view and complex to manage from a service provider perspective. Instead of being a mental health service that is adaptable and flexible according to the needs of consumers, EACH is constrained by having to ensure that the supports it provides match the criteria for eligibility specified by each funding source.

36 Our mental health services work as a team to provide coordinated care and appropriate responses to clients' presenting needs, although this can be complicated if the service response does not meet the targets specified in the funding contract. This can result in services being determined by what the funding will allow, rather than what the client may need to best assist their recovery at that time. This requires adept management of staff and services 'on the ground' to achieve integration between the various services, as well as accountability back to the different funding streams.

37 EACH maintains that one of our core businesses is mental health. As a consequence, if the Commonwealth and State governments package mental health in 10 different ways, then EACH has to shape itself accordingly. That is what you find the community sector doing - constantly shaping itself in order to match the funding in order to deliver on its purpose. So instead of being customer-centred care, it is funding-centred care.

38 A further complication for access and navigation of the various mental health services, or mental health related services, is that for each new type of funding, there is often a new and separate intake phone number. For example, the drug and alcohol service, benzo diazepam recovery service, and problem gambling services each have their own telephone number to access the service.

39 With services being fragmented and having different providers and different eligibility criteria it means that there is a proliferation of phone numbers and access points. Consumers looking for a service may have to try multiple numbers before finding the 'right' number. The Primary Health Networks have tried to rationalise this to an extent by developing their own mental health intake services for those that they fund and so we are increasingly directing enquirers to the Primary Health Networks who will establish eligibility and urgency and then allocate out to the appropriate providers.

40 The introduction of the NDIS has added further complexity. I discuss this below.

Why are those with the poorest health status the least well served by the system?

41 The determinants of health (social, economic, education, housing as well as individual characteristics and behaviours) play a significant role in shaping the way people access services. Research[1] has established that reduced income and unemployment, poor educational outcomes, experience of homelessness and stigma are all risk factors for poor mental health.

42 A lack of ability to pay for private health services means that people with mental illness who are also experiencing social and financial disadvantage have fewer choices for accessing health services and can find the fragmented nature of the service system all the more daunting. Experience of housing insecurity and frequent moves compounds the problem of access to services as each new location means needing to work out what the particular service network is in their area, what the new entry points are and establishing new support relationships as well as spending time on waiting lists.

43 Aside from people who are born into poorer socioeconomic and disadvantaged circumstances who experience more of the risk factors for mental illness, young people who may not be from disadvantaged households but who develop mental illness in

[1] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva. World Health Organisation.

adolescence or early adulthood are prone to experience a breakdown in the 'protective factors' for mental illness such as secure housing, support of family and friends, employment or education.

44 For example, as severe mental illness tends to affect people in their late teens or early adult life, this is often the same time that people are forming important social relationships, starting their career or commencing tertiary education.

45 Experiencing mental illness in these formative years can mean that people lose friends, compromise relationships with family, drop out of education or employment and experience homelessness. These factors impact on (amongst other things) the ability for that person to access mental health services and receive appropriate support. This is because they are more likely to be transitory, lack access to a regular GP or health provider and lose their support networks who could otherwise help steer them towards appropriate services.

46 Once a person with a mental illness is connected with an appropriate level of supports it is essential to their on-going health that they experience this in a stable and secure way as disruptions to the services they are receiving can precipitate high anxiety and, over time, a reduction in help-seeking behaviour through feeling overwhelmed just when they need the support the most.

Why is it important to understand the local community and deliver community health right?

47 EACH aims to tailor its community mental health services to the particular circumstances of the local community.

48 For example, the mental health service in Healesville will be much more tailored towards an urban fringe environment and needs to have a strong focus on outreach and the ability to provide transport, to take people to appointments due to distance and poor transport and also to be culturally appropriate in responses to the large Aboriginal Community.

49 By contrast, in Box Hill where there is a high Chinese population, EACH provides a quite different approach recognising the familial and cultural patterns of the community, as well as the better access to a wider range of services within reasonable proximity. In both locations it is important to understand and be responsive to the cultural factors that surround concepts like mental illness as well as treatment interventions such as counselling.

50 Different locations have different levels of service (resources) such as access to GPs, psychologists, low cost housing and transport as well as employment opportunities.

These are all factors that service providers have to take into account in tailoring their service response to different communities.

What is the scale of unmet need in Victoria?

51 Unmet need is everywhere throughout the system.

52 The Department of Health's Stepped Care approach to mental health includes five levels of severity of mental illness:

(a) Step one: well population;

(b) Step two: at risk groups (early symptoms, previous illness);

(c) Step three: mild mental illness;

(d) Step four: moderate to severe chronic mental illness; and

(e) Step five: severe mental illness, in acute phase.

53 In my view, the acute and clinical system is overburdened. Even with more funding, I think this system will never meet the level of demand for people experiencing acute symptoms of mental illness. This is the most expensive end of the health continuum. The cost of operating an acute bed in hospital is significantly above the cost of running a community mental health support program. In my opinion, more people can be maintained and kept well at a lower unit cost in a well-resourced community mental health system than can be managed by treating people who have become acutely unwell in the hospital mental health system.

54 Unless more focus, effort and resources are placed on keeping the high-risk population from becoming acutely unwell, this group will inevitably end up in cycling through the acute system. Without the buffering and stabilising effect of the community mental health system, significantly more people will end up there, and even more money will be needed to treat the acutely unwell in hospital, at the highest unit cost.

55 Further, this is not the appropriate focus of effort and resources if we want to achieve a population that enjoys positive mental health and wellbeing. It is like investing in band aids when the real effort should be in teaching people how not to fall over and how to enjoy living fulfilling lives. This is happening in other areas of chronic disease management such as cardiovascular disease, diabetes or chronic pain management, where similar community based interventions and support programs are working to keep symptoms at bay, teach symptom self-management as well as providing access to low impact on going groups for peer support. These are cost effective interventions which can be monitored and escalated to acute treatment if required. The same model should apply in the area of mental illness.

56 In my view, the largest unmet need is with the middle cohort at steps three and four. This is because with the step one and two levels, these consumers generally respond quite well to limited episodes of intervention. However, for people experiencing the moderate to severe and enduring mental health conditions who need long term based interventions, there is limited and fragmented support available to them until they present at the step five acute end of the spectrum.

57 In other words, in a resource limited environment, placing more services at the moderate end of mental illness will prevent more people from progressing to the severe end of the continuum and as this is a larger population, the resources would be doing more good for more people, changing lives toward recovery rather than repairing lives after the traumatic experience of episodes of acute mental illness.

58 Better coordination of services across the stepped care model will also better identify those people who do not respond well to interventions at the mild level and who are at greater risk of progressing to moderate and severe mental illness if not responded to appropriately.

59 The most recent funding for the system has been directed to between steps four and five. The Victorian State Government has funded approximately $50 million into strengthening that connection between the post clinical discharge from the acute hospital sector and the community sub-acute level and we're just beginning to see the roll out of support services for people working more closely within that clinical/community (sub-acute) intersection.

60 However, at the moment, the sub-acute system is fragmented, under resourced and difficult to access. A person can't access the clinical system unless they come through the hospital or through the emergency department. There needs to be an early intervention service and easily accessible entry points to the community mental health system for people seeking help without having to reach the acute stage.

61 It is like funding the ambulance at the bottom of the waterfall, you really need to have upstream interventions to sustain people at earlier stages of their mental health recovery and preventing them from entering the revolving door of acute mental health services.

62 Further, the Prevention and Recovery Care (PARC) centres (which were established to provide that sub-acute setting which could allow a step up and step down option) are now functioning as discharge half way houses back into the community (all step down), rather than as a step up service from the community when people might require additional supports. It is no longer possible to refer to a PARC from the community level

due to the beds being fully occupied by people discharged from an acute hospital episode.

What are the key drivers of unmet need?

63 The key driver of unmet need is the loss of the secondary prevention and early intervention part of the mental health system and a well-functioning community mental health recovery support service. Secondary prevention is the term used to describe the prevention of symptoms from getting worse, once a problem such as mental illness has occurred. Primary prevention is when an intervention prevents the condition occurring at all.

64 For over 30 years, EACH's experience has been at working with and supporting people with a mental illness from getting worse (secondary prevention) and also supporting them towards recovery (minimising symptoms and coping better with those symptoms).

65 This has required the ability to use a wide range of flexible, responsive and adaptive interventions which can meet group needs, individual needs and also change according to the mental state of an individual over time. Sometimes this has been low-intensity social support, structured social activity and relationship building programs, counselling and other therapeutic interventions, skills development and sometimes practical support such as housing, employment and material aid such as food and clothing.

66 Community based mental health services act as the prevention end of the acute mental health system and this part of the mental health system is most in need.

67 The challenge is where to intervene with the most impact and longest term gains. From my experience, people with moderate to severe needs (in terms of complexity) require more support on a continuous basis to prevent their symptoms reaching a level of acuity where they require an acute, hospital intervention.

68 From my understanding, most of the new mental health services are funded on an episodic basis and do not meet the long term recovery needs of people with moderate to severe mental illness who require the security of knowing that they can access consistent, high quality and responsive services over a longer period.

69 This does not mean that they will always require the highest levels of support, but that the supports need to be flexible enough, yet stable enough, to adapt to the clients' changing needs and that this service needs to be funded at a level that is sustainable and is attractive to appropriately skilled staff.

70 I have heard clients in the past express concern that if they disengage with the community mental health system because they feel well enough to not need regular, on-

going support, their concern is that if they do begin to become unwell again that they will have difficulty re-engaging with the support system due to things like waiting lists or eligibility criteria or a feeling that the system won't be there when they need it.

What kinds of impact does unmet need have on people affected by mental illness?

71 Mental illness is one of the only health conditions where the more unwell someone becomes, the more unlikely that person is to seek help. This means that, for those with unmet need, their conditions are likely to continue to deteriorate over time, until they reach a point where the acute end of the service system has to be mobilised in a crisis.

72 It is imperative that the mental health system makes seeking help simple and easy to navigate, but also provides easy access to a skilled workforce of community mental health workers who can build rapport and trust with people with mental illness and can identify when symptoms are deteriorating and intervene early.

Are there barriers to people affected by mental health, accessing psycho-social services? If so, what are they?

73 One of the main barriers is that the system is incredibly fragmented and difficult to navigate, which means that consumers seeking assistance do not know what services are available, where they might be and whether they may be eligible for those services.

74 For example, a young man in his mid-20s who had lived most of his life in out of home care contacted a manager within our service who he had met by chance at a forum. He was experiencing deep depression and grief following the suicide of a close friend and stated that he had no idea where he could turn to for support. It is not good enough that such a vulnerable young person has to rely on a serendipitous contact and have the courage to call for help in order to access the mental health system at the right level to receive the right care in a timely manner. In my view, this is a good indication of how difficult the system is to navigate that people feel reliant on a chance meeting with someone who happens to be able to point them in the right direction to access the right service.

75 We are also beginning to see tenants in the public housing sector who in the past might have been supported by a community mental health trained housing worker but this service is in the process of being decommissioned and replaced by NDIS (for those who are eligible) or being transitioned to a range of other mental health systems such as Stepped Care or other relatively new interventions for people who are not eligible for NDIS. A recent example that was brought to my attention was of a tenancy worker from a large Housing Association having to evict a mother and her adult son, both with a mental illness due to problems with neighbours and other tenancy related concerns. They were housed in a hotel while alternative long term accommodation was being

sought. I was told that the son had not left the room since November and was entirely dependent on his mother for his medication. The mother and son did not have an NDIS package. We put them in touch with the Primary Health Network because we weren't able to work out what they were eligible for. In the past, Community Mental Health support service personnel, with appropriate mental health training would have been available to support this family and the tenancy officer. In fact, had services been able to be put in place early enough the tenancy may not have broken down.

76 In my view, the system is almost impossible to navigate even for service providers, let alone consumers. In both cases, EACH was able to find a pathway to assist with the navigation, but these examples shows that there are barriers to accessing support within the system and that the system relies on personal contacts and serendipity rather than being a reliable and coherent system which people can access easily to get the right treatment at the right time and in the right place.

Are opportunities being missed to help people when they first need treatment and support? If so, how?

77 If a client is unable to derive full benefit from the sessions provided under the Medicare Benefits Scheme as part of a Mental Health Plan, there is only a fragmented mental health system to fall back on.

78 A key challenge is knowing what services are out there and how to access them, in particular, working out whether you are eligible for that service.

In your experience, what has the commencement of the NDIS meant for access to psycho-social support programs?

79 The NDIS is a very important piece of social policy, but in my opinion, it does not meet the needs of people with mental illness who have fluctuating or variable support needs.

80 The NDIS funding system does not lend itself to a recovery oriented service. The NDIS Plan, which specifies the services that the individual is eligible for is a static plan. It doesn't accommodate the flexibility that is required to meet the changing needs of people with a severe mental illness. Service providers who deliver different supports despite what is specified in the plan can often find that they are not paid for the services provided. Due to the NDIS processes, plan changes can be very difficult to achieve and are not timely.

81 A recent report of the Commonwealth Mental Health Programs Monitoring Project titled *Tracking Transitions of People from PIR, PHaMS and D2DL into the NDIS*, tracked the transitions of people from three of the Commonwealth-funded mental health services

called Partners In Recovery (PIR), Personal Helpers and Mentors (PHaMs) and Day to Day Living (D2DL) into the NDIS.[2]

82 Attached to this statement and marked "**PR-3**" are extracts of what I consider to be the key findings of this report.

83 The findings of this report highlight what we are experiencing on the ground. For example, a client I recently saw in conjunction with her access worker was presenting because she was deeply distressed that after three and a half years of stability, working with her PHaMS worker, this was to come to an end and she was anxious and overwhelmed by the uncertainty of this transition. She was unclear and not confident in the program she might transition to and had heard that 90% of PHaMS clients (such as herself) were found to be ineligible for NDIS. While this statistic may not be correct, this is the understanding she had and which added to her distress. She cares for an autistic son and her husband also has 'difficulties' (unspecified). She was both a carer of a son with a disability as well as a person struggling with depression and anxiety. She reflected that the previous 3 and a half years of stable mental health support had taught her how to manage her symptoms and to gradually regain control of her life. She was distressed that this was being lost and she was overwhelmed by what was going to happen to her and her family – which relied on the stability of her mental health and coping skills for their own wellbeing.

84 We are beginning to see this type of presentation almost daily as people become increasingly distressed that they are going to fall through the cracks of the new mental health system and the NDIS. While we can do our best to reassure clients and try to make 'warm referrals' and handovers, the reality is that the system to which they are being referred is not clear at all.

85 Even when they have been reassured, I have seen that the thought of the change itself has been overwhelming. I doubt that we were able to anticipate or plan effectively for the size of this negative impact on the mental health of our clients through this transition. I hope that the systems that support people with mental illness improve and that the next generation of clients and workers in the NDIS and other mental health services will experience a much more stable and responsive system than that which we are all currently going through.

[2] Community Mental Health Australia and the University of Sydney (April 2019) *Tracking transitions of people from PIR, PHaMS and D2DL into the NDIS: Commonwealth Mental Health Programs Monitoring project – Interim report*.

How has EACH changed the way it provides services in response to the introduction of the NDIS?

86 Prior to the implementation of the NDIS, EACH supported approximately 1,000 clients with mental illness and employed approximately 150 mental health trained and skilled staff to do so.

87 EACH now supports approximately 800 NDIS clients (with various disabilities, although the majority are psychosocial) with a reduced mental health workforce of approximately 30 staff. Over the last 12 months we have lost approximately 120 mental health staff.

88 The mental health trained and skilled workforce has been largely lost to other sectors and we are beginning to fill NDIS 'shifts' with a non-mental health skilled workforce. This is making the service more financially viable due to the lower rates of pay of these workers, but is creating a higher level of complaints and concerns about the appropriateness of the new support staff as they are not necessarily mental health trained.

89 Clients who were a registered client of a State funded community mental health service, were automatically deemed to be eligible for NDIS. But clients of a federally funded program were not automatically deemed to be eligible. Not all of EACH's clients transferred to the NDIS.

90 The annual grant previously allocated to EACH to support a targeted population of clients with mental illness in managing their symptoms, supporting their recovery and managing relapse or deterioration in a controlled way has been replaced by individually funded NDIS plans with inflexibility and an overly burdensome administrative system and associated costs.

91 NDIS plans and funding are great adjuncts and supports to mental health support. For example, being able to fund TAFE courses and access to planned social activities, but is not a good vehicle for funding the relational based supports that can be provided by skilled mental health worker who, along with their client, can develop and facilitate recovery over time.

92 We are yet to see whether the new pricing structure for NDIS-funded services will be at a level that will sustain the employment of a qualified and skilled mental health workforce.

In your experience, what are the complexities and challenges that confront the NGO sector in adapting to changes in funding models?

93 It is a period of high level turbulence and uncertainty in terms of funding and service system change and fragmentation. It is difficult to keep up with the changes to funding guidelines and eligibility criteria as old programs wind down and new programs are established. Most new mental health funding is being targeted to people who are ineligible for NDIS which would appear to be appropriate, except when we consider that those people who are eligible for an NDIS package are not getting what I would regard as a mental health recovery service, but a disability support service.

94 Some clients who may be eligible for NDIS are actually opting out and refusing to apply on the basis that they would prefer to keep the services that they currently have and they know that once they have a been assessed as eligible for a NDIS package, they will lose eligibility to non-NDIS mental health services.

Recommendations

95 Victoria's mental health system is a highly fragmented, difficult to access and difficult to navigate service system. This needs to be addressed. One of the options immediately available to government is to leverage the existing Victorian Statewide network of Community Health Services as a universal 'front door' or community gateway to the mental health system. At the moment the two main entry points are the GP or the hospital, neither of which are expert in navigating the various aspects and resources of the community sector. Community Health Services have a long history of providing a service access role on an informal basis, but this could be formalised and leveraged to provide local, accessible and welcoming entry points for enquiries or referrals into the mental health system.

96 The funding allocations need to be less fragmented and allow for a broader range of interventions to be flexibly accessed according to needs over time. This would require the multiple, discrete and fragmented sources of funding to be 'rolled up' into more flexible systems of recovery-oriented mental health care that respond to consumer needs as they change between individuals and over time.

97 We need broader categories of support for people with mental illness and we need to be able to rely on the judgement and professionalism of people in the sector to be able to tailor responses to people's mental health needs, rather than to give them what the funding specifies they're eligible for in an NDIS Plan that was developed months ago.

98 NDIS Planners need to consider also whether the plan was developed when the person was well and at their best, or was it developed when they were at their worst? This

would make a huge difference in terms of what is approved in the Plan as well as the size of the Plan (financially). Overall, Planners need to be more skilled in mental health.

99 The placement of more resources at the acute clinical mental health system will have a temporary, palliative impact but will not change the fundamental drivers for mental health service demand in the community, and is ultimately counter-productive to long-term mental health recovery.

100 There needs to be funding for sustainable long-term, evidence-based engagement with people with severe and enduring mental illness in their non-acute phase. We need to have a system which is able to respond to consumers' needs, and to stay connected for a substantial length of time in a financially sustainable way for service providers.

101 Increased support for comorbidities such as addiction support services, physical health and oral health services.

102 Increased support for carers and family support services (including family violence services) need to be central parts of the mental health system.

103 At a population level, people with severe and enduring mental illness are amongst the most disadvantaged in the community. The mental health system should be focused on the social determinants of health. This will have transformative effect on the mental health system at a population level as this approach would address housing, family support, employment, justice services and treatment services in an intersectoral way.

104 While this is acknowledged as requiring a transformational change, government commitment to a population-based intersectoral approach would have a generational impact.

105 The mental health of the most vulnerable population will only improve once there is a concerted effort to provide sustained, recovery-oriented services, supported by better access and simpler navigation through what is a very complex system.

sign here ▶ 

print name Peter Ruzyla

date 4 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PR-1

This is the attachment marked 'PR-1' referred to in the witness statement of Peter Ruzyla dated 4 July 2019.

PETER RUZYLA
CEO, EACH SOCIAL AND COMMUNITY HEALTH

ABRIDGED RESUME

Over a career spanning 40 years I have worked at senior leadership levels across the not-for-profit, community health, social services, child, youth and family sectors as well as education sectors. Most recently as a member of the Universal Services Working Party established by Minister Mikakos. This has involved working as an educator, registered psychologist, senior policy officer, CEO and closely with government as a member of a number of Taskforces and Ministerial Working parties.

I am committed to creating supportive environments where everyone can build on their strengths and enjoy better health, social and economic opportunity. I drive the delivery of high quality and safe community health services and seek social justice, participation, choice, and equity for vulnerable members of our community.

STRENGTHS INCLUDE:

- Proven experience in applying principles of evidenced-based research and consumer participation into program design, with a focus on accessibility of programs.
- Commitment to working collaboratively across the sector to achieve improved health outcomes within our communities.
- Ability to strategically engage with a broad range of diverse stakeholders and lead consortia groups to deliver programs in partnership with other agencies.
- Strategic and practical business leadership skills, including program design and management.
- Commitment to quality, co-design, innovation, and continuous improvement.

CAREER SUMMARY

1989 – 2000	**CEO**	**Maroondah Social and Community Health Centre**
2000 – 2014	**CEO**	**Eastern Access Community Health**
2014 - current	**CEO**	**EACH**
2009 - current	**CEO**	**EACH Housing Limited**
1986 -1987	**Senior Integration Officer (Educational Psychology)**	**Integration Unit, Ministry of Education**
1976 – 1986	**Educational psychologist**	**Various metropolitan locations**
1973 - 1975	**Secondary Teacher**	**Omeo Higher Elementary School**

KEY APPOINTMENTS

2016 - 2017	**Member**	**Ministerial Taskforce; Universal Services Working Party**
2015 – current	**Board Director**	**Boorndawan Willam Aboriginal Healing Service**
2011 – 2018	**Board Director**	**VICSERV (Victoria's peak body for psychiatric disability support services); now Mental Health Victoria**
2011 – current	**Board Director**	**Health Issues Centre**
2011	**Joint Chairperson**	**Statewide Primary Care Partnership Chairs Committee**
2006 – 2010	**Director**	**Bonsai Social Firm – trading as Bonsai Imagination Tree (commercial social enterprise)**
2001 - 2005	**Chairperson**	**Care Connect**
2001 - 2009	**Board Director**	**Care Connect**
1995 – 2000	**Board Director**	**VHA trading company (Hospital Supplies Australia Ltd); Annual company turnover $200mill**
1991 - 1996	**Council Member**	**Victorian Community Health Accreditation and Standards Program**
1989 – 1992	**Chairperson**	**Ministerial Regional Intellectual Disability Planning Committee**
1989 – 1992	**Member**	**WorkCare Appeals Board**
1987 – 1989	**Coordinator**	**Geelong School Support Centre (clinical and operational management of centre)**

EDUCATION AND QUALIFICATIONS

1971	**Bachelor of Arts, University of Melbourne**
1972	**Diploma of Education, University of Melbourne**
1978	**Diploma of Educational Psychology, Monash University**
1986	**Masters of Educational Studies/Psychology, Monash University**
1988	**Graduate Diploma Special Education, Victoria College**
1996	**Graduate Diploma Business; Health Management, RMIT**

MEMBERSHIP OF PROFESSIONAL ASSOCIATIONS

Australian Health Professionals Registration – Registered Psychologist

Australian Psychological Society (APS) - Registered member 30+ years

Australian College of Health Service Management

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PR-2

This is the attachment marked 'PR-2' referred to in the witness statement of Peter Ruzyla dated 4 July 2019.

Funded program name	Funding Body	Eligibility Criteria
Accessible Psychological Interventions (PHN Stepped Care)	PHN (stepped care model)	Former Allied Psychological Services (ATAPS) • Must have assessment and diagnosis of mild-moderate mental illness(except for children under 12 years or people at risk of suicide) such as mild depression or anxiety • Have a GP or treating psychiatrist managing their care in a primary health setting • Have a current GP Mental Health Treatment Plan Priority groups: • Children under 12 years • People residing in residential aged care • Aboriginal and Torres Strait Islander people • People experiencing homelessness • People at risk of suicide • CALD • Women with perinatal depression • People with substance use disorders and a mental illness • People experiencing family violence
Mental Health Integrated Complex Care	PHN (stepped care model)	Former Mental Health Nurse Incentive Program. • Must have assessment and diagnosis of mental illness that is significantly impacting social, personal or work life; have complex needs; or be at risk of hospitalisation • Have a GP or treating psychiatrist managing their care in a primary health setting • Have a current GP Mental Health Treatment Plan • Have a health care card • Are not eligible for NDIS or Partners In Recovery
PHaMs	Department of Social Services	Program ceased 30 June 2019 and moved into Continuity of Support (CoS) or the National Psychosocial Support Measure (NPS). All eligible clients for NDIS have transitioned. Those ineligible will receive ongoing CoS to ensure clients have access to long-term responsive support. Those who are yet to test their eligibility or waiting for an access decision or approved support plan for NDIS are eligible to receive NPS for a period of up to 12 months. Former eligibility criteria: • Aged 16-64 years • No formal diagnosis required • Reside in eligible LGA's • Life severely affected by mental illness • Can self-refer or be referred by family, agencies,

		schools or health providers
D2D Living	Department of Health and Ageing	Program ceased 30 June 2019 and moved into Continuity of Support (CoS) or the National Psychosocial Support Measure (NPS). All eligible clients for NDIS have transitioned. Those ineligible will receive ongoing CoS to ensure clients have access to long-term responsive support. Those who are yet to test their eligibility or waiting for an access decision or approved support plan for NDIS are eligible to receive NPS for a period of up to 12 months. Former eligibility criteria: • Aged 16-64 years • No formal diagnosis required • Reside in eligible LGA's • Life severely affected by mental illness to manage daily activities and to live independently • Can self-refer or be referred by family, agencies, schools or health providers
Continuity of Support (CoS)	PHN	CoS is a program that will provide psychosocial support to people who are currently accessing services from PIR, D2DL or PHaMS and have been assessed as being ineligible for the NDIS. Support and services commissioned through the PHNs will help clients to achieve similar outcomes to those they received from PIR, D2DL and PHaMS. This measure will provide ongoing funding, ensuring CoS clients have access to long-term, responsive support. CoS is available from 1 July 2019.
Early Intervention Psychosocial Response	DHHS	Consumers aged 16-64 years with an emerging or established mental illness can receive up to 12 months services: • Must be receiving a service from Hospital Mental Health services • Does not qualify for NDIS due to age, assessed level of disability or Citizenship • Likely to be eligible for NDIS but needs support while their application is being processed • Has a significant, permanent or likely to be permanent impairment as a result of mental illness • Unable to access psychosocial supports due to significance of MH condition • Homeless or at risk of homelessness • At risk of deteriorating on discharge from bed-based

		clinical MH services • Young person with severe mental illness
Partners in Recovery	PHN	Program ceased 30 June 2019 and moved into Continuity of Support (CoS) or the National Psychosocial Support Measure (NPS). All eligible clients for NDIS have transitioned. Those ineligible will receive ongoing CoS to ensure clients have access to long-term responsive support. Those who are yet to test their eligibility or waiting for an access decision or approved support plan for NDIS are eligible to receive NPS for a period of up to 12 months. Former eligibility criteria: • are experiencing severe and persistent mental illness; • have complex needs that require input from multiple agencies; • require substantial support and assistance to engage with these agencies, to meet the person's needs; • have no existing coordination arrangements in place OR arrangements are not meeting their needs, or may be contributing to the problems experienced by the person
National Psychosocial Support Measure	PHN	12 month service to help prevent people falling through the gaps and assist people who are severely impacted by mental health issues but who might be expected to recover, who might only need support intermittently, or who will probably respond well to treatment. E.g. postnatal depression, early stages of schizophrenia, severe anxiety who can't leave the house, or someone who doesn't have a formal diagnosis. People accessing the service will receive support that's individualised for their specific needs and which supports their recovery goals. Service provided: • to people with severe mental illness who are not currently receiving supports through another program, or • to existing clients of PIR, D2DL or PHaMS who have not yet tested eligibility for supports under the NDIS, or who are waiting to receive an access decision or approved support plan for the NDIS.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PR-3

This is the attachment marked 'PR-3' referred to in the witness statement of Peter Ruzyla dated 4 July 2019.

Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS Commonwealth Mental Health Programs Monitoring Project – Interim Report, Phase 2 (April 2019)[3]

"31 organisations across the country provided data on 61 PIR, PHaMs or D2DL programs, contributing to the ability to collectively create this robust national 'picture'.

"Overall, 50% of people currently using PIR, PHaMs and D2DL had not yet applied for the NDIS. There were 1578 (19%) of the 8162 people in the report who did not want/were unable to apply or, had to date not started the complex process of building the evidence required to apply.

"Of the 50% of people who had applied, only half had been assessed as eligible, a quarter had been found ineligible, and a quarter were still waiting to hear, or their outcome was unknown. Thus, of the currently active PIR, D2DLL and PHaMs clients, 25% are now supported through the NDIS and 75% are not.

"There are also identified problems with the assessment, approval and planning process. The 61 programs reported large variance in:

(1) The proportion of people assessed as eligible

(2) The lengths of time people had to wait for applications to be assessed

(3) The length of time before those found eligible received their plan

(4) The appropriateness of plans

"[There is a] high proportion of people who have applied and been assessed as ineligible. Outcome data was provided for 3,796 of the overall 4118 people who had applied for access to the NDIS. Overall, only 1769 people (46.6) received a positive or eligible outcome. The overall proportion of clients who were eligible was higher in the PIR program (55.1%). 30.2 and 36% percent of PHaMs and D2DL clients respectively were deemed eligible. There is a very inconsistent outcome rate across individual PIR, PHaMs and D2DL programs. Some individual programs reported 100% success rates while other reported 0% success. Also, of note is the large proportion of people still waiting to hear the outcome of their application and therefore, their eligibility at this point remains unknown.

"Almost 20% of clients across the three federal programs are either not going to apply for the NDIS or have not started gathering evidence in order to do so (17% PIR; 23% PHaMs and 36% D2DL)".

[3] See https://cmha.org.au/wp-content/uploads/2017/04/CMHA-and-University-of-Sydney-NDIS-Tracking-Transitions-Phase-2-Report-version-3.pdf.