NATIONAL DISABILITY INSURANCE SCHEME (NDIS) TRANSITION PILOT PROJECT

A lived experience lens on service continuity for people transitioning from State psychosocial programs to the NDIS

FINAL REPORT

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- Members of the Project Partners Group (PPG) and the NGO Survey Working Group
- Staff at the Mental Health Coalition of SA
- Participants of workshops, focus groups and individual interviews

Your information, insights and interest have helped guide the Project direction, findings and recommendations.

Project Team
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**GLOSSARY & DEFINITIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Access Request</td>
<td>The process of applying for access to the NDIS as a participant, with the goal of meeting eligibility</td>
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<tr>
<td>ASP</td>
<td>Accommodation Support Program, a State funded NGO psychosocial support service referred by MHS</td>
</tr>
<tr>
<td>CSS</td>
<td>Community Support Services, an Australian Government funded program delivered by NGOs</td>
</tr>
<tr>
<td>GP Access</td>
<td>State funded support service delivered by NGO mental health psychosocial services accessed via GP or private psychiatrist referral and does not require public MHS involvement</td>
</tr>
<tr>
<td>HASP</td>
<td>Housing and Accommodation Support Partnership, a State funded NGO mental health psychosocial support and rehabilitation service referred by MHS</td>
</tr>
<tr>
<td>Health Liaison Officer</td>
<td>As part of a hospital discharge pilot in SA, NDIS Liaison Officers work with the Local Health Networks and key hospital staff, providing a single point of contact to improve communication and escalation between SA Health and the NDIA¹</td>
</tr>
<tr>
<td>IHBSS</td>
<td>Intensive Home Based Support Service, a State funded support service delivered by NGO mental health providers, referred by MHS</td>
</tr>
<tr>
<td>IPRSS</td>
<td>Individual Psychosocial Rehabilitation Support Service, a State funded NGO mental health service referred by MHS</td>
</tr>
<tr>
<td>Justice Liaison Officer (JLOs)</td>
<td>Are employed by the NDIS to work across state and territory justice systems, to provide a single point of contact for workers within state and territory justice systems to coordinate support for NDIS participants in youth and adult justice systems²</td>
</tr>
<tr>
<td>LAC</td>
<td>Local Area Coordination (LAC) and their Coordinators (LACs) have been set up by the NDIS to help deliver the NDIS in local communities. They assist people who are eligible and ineligible for NDIS funded services³</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Health Network</td>
</tr>
<tr>
<td>Lived Experience Vignettes</td>
<td>De-identified lived experience stories to highlight service and system issues for people transitioning to the NDIS</td>
</tr>
<tr>
<td>MHS</td>
<td>Public South Australian (SA) mental health services</td>
</tr>
<tr>
<td>NDIS Support Provider</td>
<td>An organisation that provides NDIS supports to participants living with a psychosocial disability; generally, a different workforce than one that provides psychosocial rehabilitation support services</td>
</tr>
</tbody>
</table>

¹ Sourced from - June 2019 | COAG Disability Reform Council Quarterly Report, P64
| **NDIS Complex Needs Pathway** | Established to provide specialised support for participants with disability who have other challenges impacting their lives such as mental health issues, incarceration or homelessness, and need a higher level of specialised supports in their plan. This approach includes specialised planning teams, NDIA liaison and support coordinators; people who have the networks, skill and knowledge of government and community services to provide the support required for complex needs⁴ |
| **NDIS eligibility** | A person is eligible for NDIS supports, and becomes a participant when they have met eligibility requirements for the NDIS |
| **NDIS Plan** | A written agreement worked out with each participant, stating their goals and needs and the reasonable and necessary supports the NDIS will fund for them⁵ |
| **NDIS Psychosocial Disability Transition Task Force** | Convened at the request of the Minster for Health and Wellbeing and chaired by the Chief Psychiatrist, the purpose is to: monitor the impact of the NDIS transition arrangements on both clients and the service providers, with a particular focus on continuity of service to clients; advise on appropriate action to address continuity of service including remedial action necessary by services, programs and jurisdictions; develop solutions and advise on appropriate action; and identify future issues that may arise⁶ |
| **Psychosocial service programs** | “psychosocial” refers to the dynamic relationship that exists between psychological and social effects, each continually interacting with and influencing the other. “Psychological effects” are those which affect different levels of functioning including cognitive (perceptions and memory as a basis for thoughts and learning), affective (emotions), and behavioural. “Social effects” pertain to altered relationships, family and community networks, and economic status.⁷ ‘Psychosocial support’ broadly refers to the actions that address both psychological and social needs of individuals, families and communities |

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⁶ ToR, South Australian National Disability Insurance Scheme (NDIS) Psychosocial Disability Transition Task Force, P1
| **Specialist Support Coordination** | Definition according to the NDIA – “This is a higher level of support coordination. It is for people whose situations are more complex and who need specialist support. A specialist Support Coordinator will assist you to manage challenges in your support environment and ensuring consistent delivery of service.” Specialist Support Coordinators are required to provide the hours of support within the individual’s NDIS Plan. |
| **State Psychosocial allocation and review meetings** | Convened by LHN MHS and involving State psychosocial and housing services, these meetings determine allocation to specific State funded support services and provide a review mechanism for specific clients. |
| **State Psychosocial programs** | (used interchangeably with State psychosocial rehabilitation programs), referred to frequently in this report are services funded by the South Australian (SA) Government contracted through SA Health for the delivery of psychosocial support by the NGO mental health sector to people living with mental illnesses which impact their ability to live successfully and safely in the community. |
| **Support Coordination** | Definition according to the NDIA – “This support will assist you to build the skills you need to understand, implement and use your plan. A Support Coordinator will work with you to ensure a mix of supports are used to increase your capacity to maintain relationships, manage service delivery tasks, live more independently and be included in your community.” Support Coordinators are required to provide the hours of support within the individual’s NDIS Plan. |

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8 NDIA website: https://ndis.gov.au
9 Ibid
KEY MESSAGES

The Mental Health Coalition of South Australia’s (MHCSA) National Disability Insurance Scheme (NDIS) Transition Pilot Project (the Project) investigated risk to service continuity for people with psychosocial disability who are transitioning from State funded individual psychosocial service programs to the NDIS.

The Project explored and sought feedback on the consumer experience of the NDIS through the stages of Access, Planning and Implementation. A community-based consultation approach targeted consumers, carers and service providers directly involved in the transition process to report on positive service outcomes, challenges to engagement with the NDIS, potential gaps in service, and recommendations for service improvement. Three main information gathering methods offered multiple stakeholder inputs:

- Consumer survey (n=182)
- Stakeholder workshop, focus group, and individual consultations
- Service provider de-identified lived experience stories as illustrations

Findings highlighted many challenges to engagement with the NDIS for clients from State psychosocial programs, including potential loss of service continuity as a consequence of exiting respective State programs and transitioning to the NDIS. State psychosocial programs were identified as an important pathway to the NDIS by supporting clients through the process of access and planning and working closely with NDIS providers to address unmet need during transition. For some clients fully transitioning to the NDIS was not possible due to a range of needs not being met within NDIS Plans. In these situations, risk to loss of service was reduced when NDIS and State psychosocial providers worked side by side to meet client need.

The Project concluded that clients of State psychosocial programs were more likely to engage with the NDIS when the following service principles applied:

- Clients received advocacy support from State psychosocial non-government organisation (NGO) support workers, public mental health service (MHS) clinicians, and carers, to negotiate the NDIS process and gain eligibility
- Clients were supported by State psychosocial providers (with carers if possible) at NDIS planning meetings
- There was open communication and cooperation between key service stakeholders, carers and NDIS Planners, working together with the client to develop NDIS Plans
- State psychosocial NGO support workers and NDIS support providers worked collaboratively to ensure effective handover periods involving face to face meetings with clients;

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10 Refer to Final Report ‘Information Gathering Methods’ for more detail on stakeholder representation
to build rapport and engagement with NDIS providers, and
address any areas of unmet need

- State psychosocial NGO support workers continued to work side by side with NDIS Support Coordinators to mitigate gaps in service.

Pathway to NDIS Access

State funded psychosocial programs were an important supportive pathway for people to test their eligibility for the NDIS. Consumer survey respondents commented on the importance of support received through State psychosocial programs to deal with the administrative processes of NDIS and the stress and uncertainty of applying:

“I don’t think I would have been able to do this process without my [state NGO psychosocial] support worker. I would have stopped after the first paperwork (Access Request) as it was difficult to understand and it made me feel very anxious” (Consumer survey participant)

“I would not have been able [to apply] by myself. I would not have even known that I was eligible. I am worried that this new system won’t suit me. I am quite anxious about the change and sad to lose my current support worker” (Consumer survey participant)

Ninety percent (n=116) of consumers surveyed\(^{11}\) (n=129) received support from State psychosocial support workers to apply for the NDIS. Eighty percent (n=98) of consumers surveyed\(^{12}\) (n=123) found assistance to apply for NDIS either very helpful or extremely helpful.

Service Collaboration & Effective NDIS Planning

NDIS Planning was reported to be inconsistent and at times inequitable. De-identified lived experience stories highlighted an underutilisation of NDIS Plans especially where Plans did not include Support Coordination. In other instances, NDIS Plans did not have a good balance of capacity building and core supports or were under resourced commensurate with the NDIS participant need.

“Why are some people getting plans that meet needs and others not? What factors influence this? Is it a lack of consistency..?” (Carer focus group)

In contrast, risk of poor NDIS planning was reduced when there was meaningful sharing of information and collaboration between NDIS planners, State psychosocial service providers and when possible, carers.
State psychosocial NGO providers highlighted that face to face contact with NDIS planners at planning meetings allowed for:

\(^{11}\) A total of n=122 participants responded to the question: “Has someone helped you to apply for NDIS?”
\(^{12}\) A total of n=129 participants responded to the question: “How helpful did you find that support to apply for NDIS?”
• a more informed understanding of the NDIS participant’s situation
• the type of supports required
• and developing strategies to address any areas of risk

The project found that the advocacy and assistance provided by State NGO support workers during the planning process including attendance at planning meetings, was highly valued by consumer survey participants:
• Seventy percent (n=35) of consumers who attended NDIS Planning Meetings (n=50) indicated they were satisfied or very satisfied with their NDIS Planning Meeting

“I found the process very difficult to understand and without the support of my IPRSS [worker] in preparing for the meeting and support during the meeting….I would have found the process very overwhelming and triggering for my anxiety....” (Consumer survey participant)

Service providers and carers gave several examples where NDIS participants received extensive psychosocial disability support. In particular, core supports could be offered across seven days (including weekends if required), and were considered to be very effective in assisting NDIS participants with self-care, home maintenance, pursuing personal interests and attending community groups.

“[The NDIS Plan works well] with the right package [and the] right service [especially if it] includes support coordination and practical supports such as cleaning and gardening” (NGO workshop)

It was also noted that there are positive outcomes for people with comorbid physical health conditions.

“NDIS Plans are working well for clients with mental illness and physical disability” (MHS clinician)

Mitigating risk of gaps in service at NDIS Implementation
Risk of gaps in service was most prevalent at the NDIS Implementation phase as the transition process can be impacted by a range of factors. Fifty percent (50%) of the lived experience vignettes from NGO psychosocial support workers were about client scenarios at one of the following stages:
• The NDIS Plan is in place and awaiting a suitable NDIS provider – in some cases (especially remote country) it was found that expending NDIS funds was not possible due to the limited availability of NDIS providers
• The NDIS provider has engaged and there is a handover process where State psychosocial support workers collaborate with the NDIS provider to ensure a safe transition

8
NDIS services are in place but on hold due to the NDIS participant experiencing an acute phase of illness requiring intensive support and/ or hospitalisation

The NDIS Plan is in place however the State psychosocial provider must remain involved to meet client need

People were most likely to exit their respective State program and transition to the NDIS when:

- An individual’s psychosocial support and mental health treatment needs were stable and/ or predictable
- NDIS Plans included a reasonable level of Support Coordination (capacity building) and core supports
- NDIS service agreements involved NDIS providers with the capacity to understand the impact of mental illness and psychosocial disability
- Effective handover occurred between State psychosocial support workers and NDIS providers
- Carer and/ or other supports were involved in shared decision making

“[Positive outcomes occur when] other sustainable supports exist [for clients] to complement the NDIS process; [for example] a family member, carer or other support agency”

(Local Area Coordinator in reference to NDIS Access, Planning and Implementation for clients of State funded psychosocial programs)

Higher risk to gaps in services for people transitioning to the NDIS from State psychosocial programs occurred when there was complexity, challenging behaviours, mental ill health requiring acute treatment services, comorbid health conditions, and/or situations necessitating Guardianship involvement. Risks were reduced when State psychosocial providers and NDIS Support Coordinators worked collaboratively to ensure effective handover and/ or continued to work side by side to manage unmet need.

Recognition of key model and workforce differences between State psychosocial programs and NDIS support coordination was pivotal to ensuring service delivery met client need:

- State psychosocial programs provided a responsive and flexible service closely linked to mental health treatment and rehabilitation
- NGO support workers skill base included trauma informed care, mentoring and coaching and the application of psychosocial rehabilitation principles
- By comparison the NDIS Support Coordination operated within the boundaries of NDIS service agreements focussed on psychosocial disability support
- Typically NDIS Plans were prescriptive and closely linked to a billing schedule which could only be altered by review
- Recruitment of disability staff with an understanding of psychosocial disability to provide core supports was difficult and variable
“[NDIS] Support Coordinators are asking us to stay involved as NDIS Plans are not meeting the client’s needs” (IPRSS NGO manager)

Service Improvements

Approaches to service continuity for clients varied across mental health Local Health Networks (LHNs) with State psychosocial service providers often unclear what to expect from the NDIS and transition processes. Transition planning by State psychosocial NGO service providers and MHS clinicians to address unmet need were usually individual and/ or organisation specific responses, rather than a systemically governed process.

The feedback from the service provider consultations emphasised the need for guidelines and protocols clarifying the role and function of service stakeholders, to ensure greater consistency and safety for people transitioning from State psychosocial programs to the NDIS.

There is an opportunity to build on State psychosocial programs as a supportive transition pathway to the NDIS. This could be done by:

- Incorporating NDIS activity as core business within State psychosocial models with guidelines on handover processes and/ or scenarios requiring NDIS and State psychosocial providers working side by side
- Establishing formal service partnership agreements between the NDIA and State psychosocial programs inclusive of lived experience to improve service systems and address inconsistent practice

In the short term, existing regional State psychosocial allocation and review meetings could provide a formal starting point for addressing transition issues by:

- Utilising the allocation and review meetings to monitor and coordinate referrals to the NDIS at a local level
- Including attendance from NDIA staff (e.g. Local Area Coordinator, Health Liaison Officer, Justice Liaison Officer – or similar role) at allocation and review meetings in a consultancy role to facilitate NDIS access, planning and implementation.

Service Development

Collaborative partnerships at State and local levels will be required for the ongoing evaluation of the service interface between State psychosocial programs and the NDIS. Whilst there have been improvements to NDIS processes, there remains the need for greater access to NDIS internal streamlined processes, involving NDIA staff with skill and knowledge of the impact of mental illness and psychosocial disability. The NDIS complex needs pathway is an example of this but access is reported as limited by service providers and carers.
Limitations to the Project did not allow for an analysis of outcomes for people who had exited State psychosocial programs and transitioned to the NDIS. Information on the following longer term outcomes for this cohort would guide service development:

- The extent of improved psychosocial disability support
- Any gaps in service relating to mental and physical health outcomes
- Improvement in quality of life including social connectedness, housing, employment and education outcomes

To ensure that people who have exited from State psychosocial programs to the NDIS continue to receive adequate services, an ongoing evaluation of this group is recommended at the State and local level.
INTRODUCTION

The Mental Health Coalition of South Australia’s (MHCSA) National Disability Insurance Scheme (NDIS) Transition Pilot Project (Project) reports on how best to support service continuity for people transitioning from State funded non-government organisation (NGO) mental health psychosocial and rehabilitation support programs to the NDIS. This is of immediate importance given issues being raised about potential gaps in service during transition.

SA Health commissioned the MHCSA to undertake the Project following accounts received by the South Australian (SA) NDIS Psychosocial Disability Transition Taskforce\(^\text{13}\) (the Taskforce) of difficulties encountered by people transitioning to the NDIS.

The Project brief was to identify clients with a psychosocial disability where transition can be improved with particular attention to:

- How transition to the NDIS will be managed to ensure participants are able to commence their NDIS Plan prior to State funded psychosocial services ceasing
- Any gaps between services a client currently receives through State funded psychosocial programs, and the services a client receives under their NDIS Plan
- Emerging trends in service gaps and issues for people with psychosocial disability through NDIS access, planning and implementation

Information on the consumer journey through the NDIS access, planning and implementation stages were collected to highlight, positive service experiences; challenges and barriers to engagement with the NDIS; gaps in service; and opportunities for improvement.

The Project Team included a Peer Project Worker position ensuring a lived experience lens across Project design, implementation and analysis of findings. Understanding and tracking the consumer perspective and journey was integral to the Project Plan.

A Project Partners Group (PPG – Appendix 1) representing key stakeholders NGO psychosocial rehabilitation services, Office of the Chief Psychiatrist, Department for Health and Wellbeing (DHW), the MHCSA, lived experience representatives, NDIA and public mental health services (MHS) provided guidance to the Project.

\(^{13}\) The Taskforce is chaired by the Chief Psychiatrist (Office of Chief Psychiatrist, Department for Health and Wellbeing) with responsibility to monitor and address service issues and risks for people transitioning from psychosocial programs to the NDIS. Membership consists of senior delegate representation from Non-Government Organisations (NGOs), Lived Experience, the National Disability Insurance Agency (NDIA), NDIS, the MHCSA, Statutory Officers (Community Visitors, Health Complaints Commission and Public Advocate), Primary Health Networks (PHNs) and Local Health Network (LHN) Mental Health Services (MHS).
The Project findings are to inform the Taskforce on risk to service continuity for people with psychosocial disability transitioning to the NDIS from State psychosocial programs and to make recommendations on systemic service improvement.
SA PSYCHOSOCIAL REHABILITATION PROGRAMS

SA funded psychosocial rehabilitation programs in scope for the Project were:

- Individual Psychosocial Rehabilitation Support Services (IPRSS)
- Housing and Accommodation Support Partnership (HASP)
- GP Access
- Intensive Home Based Support Services (IHBSS)
- Accommodation Support Program (ASP – Country SA)

The NGOs providing State mental health psychosocial services and in scope for the Project were: Centacare, Life Without Barriers (LWB), Mind Australia, Neami National and Uniting SA.

The State psychosocial service models\textsuperscript{14} are underpinned by the evidence that formal collaboration between key service stakeholders (public MHS, community based State psychosocial support services and public and community housing services\textsuperscript{15}) improves confidence and capacity for community living for people experiencing serious mental illness.

 Clients of State psychosocial and rehabilitation programs can experience ‘complex health, lifestyle and behavioural support service needs related to their mental health’\textsuperscript{16} requiring one to one advocacy and support across a range of life domains. With the exception of GP Access, all programs operate within an agreed service partnership between NGO providers and clinical MHS maximising access to treatment, rehabilitation and psychosocial support. GP Access is often a pathway for people exiting tertiary MHS and has service partnerships with GPs and/ or private psychiatrists within southern and western metropolitan areas. All programs provide individual psychosocial support and all have clients who experience psychosocial disability and are therefore potentially eligible for the NDIS.

Past evaluations\textsuperscript{17} of State psychosocial and rehabilitation programs identify several positive outcomes:

- Decreased psychiatric admissions
- Increased attention to physical health needs
- Reduced presentations to emergency services and length of psychiatric admissions
- Improved quality of life
- Improved social connection
- Stabilised housing

\textsuperscript{14} Information about NGO programs from SA Health website: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/departmen+t+of+health/system+performance+division/non-government+mental+health+partnerships

\textsuperscript{15} Brackertz, N et al (November 2018)

\textsuperscript{16} Individual Psychosocial Rehabilitation and Support Services, Service Model, November 2013

\textsuperscript{17} Refer Health Outcomes International (HOI) and Social Policy Research Centre.
INFORMATION GATHERING METHODS

The Project utilised three main approaches to the collection of information:

1. A Consumer Survey
2. Stakeholder Consultation\(^{18}\) inclusive of carers
3. De-identified lived experience vignettes from State psychosocial NGO support workers, public MHS providers and NDIS Support Coordinators

All stakeholders who participated in the survey or consultation gave consent to be involved in the Project. Information remained confidential and was de-identified.

Consumer Survey

To gain consumer perspectives on the experience of transition to the NDIS a questionnaire using the SurveyMonkey platform was offered to clients registered with State psychosocial programs. This was an opportunity for clients to voice their views about the transition to the NDIS.

An NGO Survey Working Group (Appendix 2) was established to provide oversight of the administration of the survey and to ensure national standards for service evaluation were met. All participants gave their consent to be involved in the survey and it was explained that participation was completely voluntary and they could opt out at any time. All information collected was de-identified.

Survey participants were identified through the State NGO psychosocial providers. NGO support workers delivered the survey. This was an agreed process due to the recognition that many clients within the programs in scope live with significant disadvantage and disempowerment, and to hear their voices they needed support to minimise distress and facilitate their participation. Clients of Intensive Home Based Support Services (IHBSS) were not expected to participate in the survey. Typically, people requiring IHBSS support were likely to be experiencing acute or sub-acute phases of mental ill health.

The survey was open for a period of eight weeks and offered online or as a hard copy. Most participants were assisted by their NGO support worker to complete the survey in hard copy with the support worker then entering the information into SurveyMonkey.

Survey administration was through the NGO Survey Working Group representing the NGO providers in Project scope. This ensured support workers were briefed on the process for

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\(^{18}\) Consultation included a series of workshop, focus groups, small group and individual interviews with key stakeholders including consumers and carers, Non-Government Organisation (NGO) State psychosocial providers, public Mental Health Service (MHS) clinicians, National Disability Insurance Agency (NDIA) providers and National Disability Insurance Scheme (NDIS) Support Coordinators.
delivering the questionnaire prior to commencement to provide as consistent a process of survey delivery as possible, in a safe and supportive environment for survey participants, to maximise the number of participant returns.

Support workers were continuously updated on progress of the survey and provided with assistance as required. During the data collection period the Project Team visited each of the NGO provider sites to meet with support workers involved in delivering the consumer survey. These team visits provided an opportunity to answer any survey administration issues and gain further insights from NGO support workers about the consumer experience transitioning to the NDIS.

Stakeholder Consultation
A qualitative community based consultation approach helped guide the Project direction and was structured to:

- Examine factors contributing to positive service outcomes
- Identify difficulties and challenges experienced during the transition to NDIS
- Highlight gaps in service and disruption to service continuity
- Explore opportunities for service improvement

Stakeholder consultation included:
- An NGO Workshop (46 participants) representing each of the State NGO psychosocial providers
- A Carer Focus Group (8 participants) representing family members of people having received or who were receiving State psychosocial services. Individual Interviews were also held with carers (11 participants) identified through State psychosocial providers who were not able to attend a focus group but wished to contribute to the Project
- A public MHS focus group (15 participants) with representation from community based public mental health clinicians, managers and Program Coordinators across Southern Adelaide Local Health Network (SALHN), Central Adelaide Local Health Network (CALHN) & Northern Adelaide Local Health Network (NALHN). Further individual and small group meetings were held with MHS clinicians and program managers (16 participants) not represented in the focus group
- A combined NDIS Support Coordination (5 participants) & State Psychosocial Provider (7 participants) focus group addressing system issues that support service continuity for people transitioning from State psychosocial programs to the NDIS
- Individual meetings held with Country mental health and NGO providers (7 participants) and NDIA/ NDIS providers (12 participants)
Recording of information during the stakeholder consultation occurred in several ways:

- Individual stakeholders made written comments in response to key consultation questions. These were collated, analysed and themed.
- The NGO workshop and other focus group discussions were documented and collated. To corroborate information and findings summary notes from each session were distributed to participants to review and provide any additional comments.
- The Project team kept written documentation from individual stakeholder meetings and from State NGO psychosocial and MHS clinical team meetings.

Mostly consultation occurred face to face however on occasions a tele conference option was used.

Lived Experience Vignettes

De-identified lived experience vignettes to highlight service issues were received from service providers. The majority of vignettes were requested from State psychosocial NGO support workers as part of the Project information collection method. Several were also received from MHS clinicians and NDIS Support Coordinators following stakeholder consultation. The aim was to identify service system issues relating to challenges and barriers experienced during transition from State psychosocial programs to the NDIS.

The lived experience vignettes purposely targeted situations where there were service difficulties being experienced by clients transitioning from State psychosocial programs to the NDIS. This was in line with the Project requirement to track the consumer journey from State psychosocial programs to the NDIS and report “on any deficits in meeting the mental health needs and transition issues in the hand over period”\(^{19}\).

To provide balance, service providers were also asked to provide lived experience examples of successful transition to the NDIS from State psychosocial programs with the view to examining factors contributing to a positive outcome.

\(^{19}\) Part of the NDIS Transition Pilot Project contract description.
FINDINGS – CONSUMER SURVEY

State Funded Psychosocial Rehabilitation Programs Reported by Respondent

Graph 1: Q1. What is the name of your State Program you have been involved with? (182 responses)

The majority of respondents were from the IPRSS Program (n=130). This is reflective of the IPRSS program size compared with other programs. Table 1 gives an indicative comparison of the total number of current clients in the IPRSS, HASP and GP Access programs for October 2019 and the number of participants from each of those programs responding to the consumer survey\(^\text{20}\).

Table 1: Number of participant survey responses compared to IPRSS, HASP and GP Access\(^\text{21}\) program size

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Clients</th>
<th>Total Number of Survey Participants</th>
<th>Percentage of Survey Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPRSS</td>
<td>521</td>
<td>130</td>
<td>25%</td>
</tr>
<tr>
<td>HASP</td>
<td>70</td>
<td>11</td>
<td>16%</td>
</tr>
<tr>
<td>GP Access</td>
<td>89</td>
<td>19</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>680</td>
<td>160</td>
<td>24%</td>
</tr>
</tbody>
</table>

\(^{20}\) Client numbers are indicative, based on the Consumer Activity Recording System (CARS) for October 2019

\(^{21}\) Excluding IHBSS and ASP, including Country IPRSS
Demographics

Graph 2: Q20. Your gender (164 responses)
Male 61% (n=100) Female 38% (n=63) Prefer not to say (n=1)

Graph 3: Age range (165 responses)

Graph 4: Aboriginal and Torres Strait Islander Peoples status (162 Responses)
### NDIS Access

Participants were asked if they had applied for the NDIS and to best describe their situation based on one of eight scenarios.

Table 2: Have you applied for the NDIS? Please select the scenario below that best describes your situation.

<table>
<thead>
<tr>
<th>Answer</th>
<th>Scenario</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>I don’t know what NDIS is</td>
<td>13</td>
<td>7.26%</td>
</tr>
<tr>
<td>No</td>
<td>I know what NDIS is, but haven’t started thinking about it</td>
<td>6</td>
<td>3.35%</td>
</tr>
<tr>
<td>No</td>
<td>I have been thinking about it, but haven’t started preparing to apply</td>
<td>5</td>
<td>2.79%</td>
</tr>
<tr>
<td>No</td>
<td>Currently in the process of gathering evidence and preparing documentation to submit</td>
<td>17</td>
<td>9.50%</td>
</tr>
<tr>
<td>No</td>
<td>I have chosen not to apply</td>
<td>16</td>
<td>8.94%</td>
</tr>
<tr>
<td>Yes</td>
<td>I have submitted an access request, but have not had a decision yet</td>
<td>17</td>
<td>9.50%</td>
</tr>
<tr>
<td>Yes</td>
<td>I have submitted, and my submission was successful</td>
<td>70</td>
<td>39.11%</td>
</tr>
<tr>
<td>Yes</td>
<td>I have submitted, and my submission was not successful</td>
<td>35</td>
<td>19.55%</td>
</tr>
</tbody>
</table>

Graph 4: (179 responses)
There was a high rate of success for clients of State psychosocial programs gaining NDIS Access. Thirty-nine percent (n=70), identified as having NDIS Access\textsuperscript{22}.

There was also a significant level of activity by clients of State psychosocial programs to gather evidence in preparation to apply for the NDIS. Taking into account only those respondents who answered yes to applying for the NDIS (n=122), seventy-one percent (n=87) were either collecting evidence and preparing for submission to the NDIS or had submitted an access request.

The high success rate for clients from State psychosocial programs gaining NDIS Access is further emphasised when considering the outcomes for those respondents who have applied for the NDIS:

- Fifty-seven percent (n=70) of participants who answered yes (n=122) to applying for the NDIS were successful with NDIS Access

In the same group (n=122):

- Twenty-seven percent (n=35) of participants were unsuccessful
- Fourteen percent (n=17) were still awaiting a decision

Survey participants found ineligible for NDIS were often distressed. Participants who had been unsuccessful commented on feeling discouraged to reapply, losing hope and feeling overwhelmed.

“Not sure if I will resubmit another NDIA access request. It’s too complicated a lot of effort is involved and a big letdown when not accepted. I get more out of IPRSS supports and still want the program to stay”

“Very upset that a lifelong disability didn’t provide automatic [transition to] the NDIS”

“A lot of work went into the application [and] it was also very hard hearing [and] reading all the negative remarks about the effect of my mental health diagnosis on my life. It was disappointing that my mental illness was not recognised as something major to qualify as my application was rejected [and] added to my depression”

\textsuperscript{22} When considering only those respondents who answered yes to applying for NDIS the percentage of clients gaining NDIS Access increases to 57%
A small percentage of survey participants chose not to apply for the NDIS

Graph 5: Q3. At this stage, I have chosen not to apply to NDIS because? (22 responses)

Twelve percent (n=22) of participants chose not to apply for the NDIS with half of this group (n=12) indicating they did not think they would be eligible.

“I have seen terminally ill and permanently disabled people be rejected, why would I be eligible if they aren’t?”

“I feel I would be taking funds away from people that need them”

None of the survey participants indicated ‘not having support’ as a reason for not applying to the NDIS.

Importance of advocacy support to apply for NDIS Access

Participants (129 respondents) identified receiving support to apply for the NDIS from:

- State NGO community support workers: 90% (n=116)
- Mental Health Service clinicians: 22% (n=28)
- Family/ Carer/ Friend: 15% (n=19)
The majority of participants highlighted the importance of advocacy support to help with applying for NDIS. Eighty percent of participants (n=98) from a total of 123 respondents indicated the support to apply for NDIS as either being very helpful (n=57) or extremely helpful (n=41).

Participant comments reflected the difficulty experienced with the application process and the need for support to apply.

“I don’t think I would have been able to do this process without my support worker. I would have stopped after the first paperwork (Access Request) as it was difficult to understand and it made me feel very anxious”

An important part of advocacy support was assisting participants deal with the stress and uncertainty of applying for the NDIS.

“I would not have been able by myself. I would not have even known that I was eligible. I am worried that this new system won’t suit me. I am quite anxious about the change and sad to lose my current support worker”

“I am concerned about losing current supports if I am found eligible for NDIS”

None of the survey participants indicated ‘not having support’ as a reason for not applying to the NDIS.

Survey participants commented on their preference to remain with their respective State program.

“I have been receiving 2 hours of support a week from my IPRSS worker for the last 2 years and this is the best I have been so I don’t want to lose IPRSS support”
Appealing or Resubmitting

Graph 8: Q4. If your application was unsuccessful what did you decide to do? (35 responses)

<table>
<thead>
<tr>
<th>Decision</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decided not to resubmit or appeal</td>
<td>13</td>
</tr>
<tr>
<td>Decided to resubmit</td>
<td>10</td>
</tr>
<tr>
<td>Decided to appeal</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
</tr>
</tbody>
</table>

Thirty-five participants identified an unsuccessful outcome with their NDIS submission. Of those:

- Forty-nine percent (n=17) of participants decided to either appeal or resubmit
- Thirty-eight percent (n=13) of participants decided not to resubmit or appeal

Given the high level of advocacy support for participants during the initial NDIS submission it is reasonable to assume participants would have received similar assistance with resubmitting or appealing. Without this support it could be suggested fewer people would have considered either appealing or resubmitting.

Advocacy support with NDIS Planning

Seventy percent of participants (n=35) from a total of fifty respondents who attended a NDIS planning meeting indicated they were satisfied or very satisfied.

Graph 9: Q5. How satisfied or dissatisfied are you with your NDIS planning meeting? (63 responses)

Survey participants commented on the importance of support at the NDIS Planning stage.
“I found the process very difficult to understand and without the support of my IPRS [support worker] in preparing and during the meeting I would have found the process very overwhelming and triggering for my anxiety. The meeting lasted two hours and... was too long... I was completely exhausted by the end as I was tired. I... became quite anxious I would not be given the supports I need”

NDIS Plans
Seventy percent (n=36) from a total of fifty-one respondents with initial NDIS plans reported being satisfied or very satisfied.

Graph 9: Q6. How satisfied or dissatisfied are you with your NDIS initial plan? (52 responses)

<table>
<thead>
<tr>
<th>Satisfaction Level</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>25</td>
</tr>
<tr>
<td>Satisfied</td>
<td>9</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>2</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>4</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Waiting on my NDIS initial plan</td>
<td>0</td>
</tr>
</tbody>
</table>

Whilst there was a high satisfaction from respondents to their initial NDIS Plans the effectiveness of the initial plans is not as clear. Responses to Question 12 (below) suggest that the amount of Support Coordination or Specialist Support Coordination would not be as effective.

Graph 11: Q12. Is there Support Coordination or Specialist Support Coordination allocated to your NDIS plan? (48 responses)

<table>
<thead>
<tr>
<th>Allocation Status</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>28</td>
</tr>
<tr>
<td>Unsure</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
</tr>
</tbody>
</table>

Fifty-eight percent (n=28) of participants with NDIS Plans report having either Support Coordination or Specialist Support Coordination. However, for 10 of these 28 respondents the average hours of Support Coordination or Specialist Support Coordination in plans amounted
to 2.5 hours per month. Whilst some clients are receiving Support Coordination or Specialist Support Coordination in their Plans, indications (from stakeholder consultation\textsuperscript{23}) suggest that the amount within their Plans does not meet need.

Graph 10: Q8. What type of NDIS Plan management did you choose? (52 responses)

Forty-four percent (n=23) of participants identified choosing Plan managed for the NDIS Plan type. This is a positive trend given that Plan managed could be considered the best\textsuperscript{24} NDIS Plan option especially where clients do not have support from carers.

Confidence with using the NDIS on-line portal

Graph 12: Q18 How confident are you that you could navigate the NDIS online portal to access your support plan information. (127 responses)

The majority of survey participants did not have confidence using the NDIS on-line portal. The NDIS on-line portal is not a reliable form of communication for clients from State psychosocial programs. Fifty-five percent (n=70) survey participants (from a total of 122 responses) were

\textsuperscript{23} Refer Stakeholder consultation.

\textsuperscript{24} Several stakeholders commented that Plan Managed was the more effective option for people in State psychosocial programs as it offers both a degree of flexibility (choice and control) and support with implementation.
either not so confident or not at all confident using the NDIS portal. Six respondents were very confident and one respondent extremely confident.

Other Respondent Comments
The participant comments below are in addition to those already made in the quantitative section above.

1. A significant number of survey participants preferred to remain with their current State psychosocial program rather than apply for the NDIS

“[I] didn’t really want NDIS. I wasn’t happy about it as I wanted to continue with [State psychosocial program]"

“I was kind of forced to test my eligibility.......... otherwise I won’t get any service at all. I was declined access and I decided not to [resubmit or appeal] as I didn’t want to lose my IPRSS worker........so I am happy that I am not eligible for NDIS”

“I didn’t want to apply for NDIS but I wasn’t given choice as [I] had to [test my] NDIS access”

2. Survey participants commented on the importance of assistance with understanding and managing the NDIS application process

“I don’t know what’s going on.......I have no idea what NDIS does even though my worker has tried to explain it to me. I don’t get it”

“Applying for NDIS funding was very difficult, frustrating and stressful. My social support worker and other support did most of it for me and I would not even have been able to apply without them. The [guidelines] are not clear [and the] NDIA workers....not very helpful [it was] a very distressing experience”

“I don’t think I would have been able to do this process without my support worker. I would have stopped after the first paperwork (Access Request) as it was difficult to understand and it made me feel very anxious.”

“I would not have been able to apply by myself. I would not have even known that I was eligible. I am worried that this new system won’t suit me. I am quite anxious about the change and sad to lose my [State psychosocial] support worker”

“The whole process is stressful, particularly trying to understand how things are done..”
3. Several survey participants commented on the impact of being found ineligible for the NDIS

“Not sure if I will resubmit another NDIA access request it’s too complicated a lot of effort is involved and a big let down when not accepted I get more out of IPRSS supports.”

“I am] very upset that having a lifelong disability didn’t [give an] automatic transition [to] the NDIS”

“It took so long for [NDIS] to reject the application....I did not hold much hope to be accepted...I was so disappointed.....it added to my low [self worth]”

4. Survey participants highlighted the importance of support during NDIS planning

“The wait time from when my access request was approved and my planning meeting scheduled was too long...I have waited 4 months.....and I have not had my planning meeting [scheduled] yet”

“I am unsure at this stage if the plan will meet my needs or if I will be able to manage the many different aspects of my plan......I do have support coordination [in my NDIS plan but] I am not feeling confident that I will be able to work well in such a new and confusing system”

“I didn’t know what support coordination was but the lady was really helpful and worked with me and my mental health support worker in getting the right supports for me”

5. Survey participants expressed concern about losing supports

“I am concerned about losing [my] supports if I am found eligible for NDIS”

“I haven’t begun with NDIS supports yet. It is possible that in some ways the NDIS will give me more help than the state funded service, but it could also be worse, I do not know yet and this makes me nervous. I am also sad that I will no longer have my state funded worker, as I have gotten to know her and feel very comfortable with her.”

Conclusion

Consumer survey participant comments described the need for support and advocacy to deal with the confusion, frustration and uncertainty associated with testing their eligibility for the NDIS. This included:

- Assistance with making the decision to apply for NDIS
- Support with the practical requirements of NDIS Access
- Advocacy in communication with the NDIA/NDIS
- Support with NDIS Planning including attendance at Planning meetings.
Consumer survey participants identified State psychosocial programs as providing valuable assistance and support during NDIS Access and Planning. Without the advocacy and support provided through State psychosocial programs clients would be significantly disadvantaged and unlikely to negotiate the NDIS access and planning stages. This finding concurs with other reports\textsuperscript{25}.

\textsuperscript{25} Smith-Merry J., et al, January 2018 (p16)  
Mental Health Australia NDIS: Psychosocial Disability Pathway 2018 (p30)
FINDINGS – STAKEHOLDER CONSULTATION

To maximise learnings, the Project Team consulted as widely as possible with stakeholders who were either supporting clients through the NDIS process (including carers) or providing services as part of the peoples’ transition from State funded psychosocial programs to the NDIS. The following table is an indicative summary of stakeholder participation by numbers:

Table 3 Indicative number of Project participants by stakeholder representation

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Description</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers</td>
<td>Specifically associated with the Consumer Survey</td>
<td>182</td>
</tr>
<tr>
<td>Non-Government Organisations (NGOs)</td>
<td>State NGO psychosocial providers, including support workers and team managers</td>
<td>46</td>
</tr>
<tr>
<td>Carers</td>
<td>Includes focus group and individual interviews with carer consultants and carers nominated through NGOs</td>
<td>19</td>
</tr>
<tr>
<td>Public Mental Health Service (MHS) staff</td>
<td>Includes focus group and individual interviews with team managers and clinicians</td>
<td>31</td>
</tr>
<tr>
<td>NDIS/NDIA staff</td>
<td>Includes Support Coordination, Local Area Coordination and NDIA staff</td>
<td>13</td>
</tr>
<tr>
<td>Country Providers</td>
<td>Includes NGO and clinical services</td>
<td>7</td>
</tr>
</tbody>
</table>

Stakeholder consultation was conducted through an NGO workshop and focus groups with:
- NGO psychosocial provider and MHS team visits
- And individual meetings with consumer and carer advocates, MHS clinicians, NGO and MHS Senior Managers, NDIS Support Coordinators, and NDIA staff.

Key questions asked of stakeholders were specifically focused on the transition process:
- ‘What is working well?’
- ‘What are challenges and barriers?’
- ‘Where are there gaps in services?’
- ‘What service improvements can be made?’

The discussion in this section is reinforced by several individual, group and workshop participant quotes and summary notes. The quotes capture the nuance and range of stakeholder experience with the NDIS.

Stakeholder themes and findings are reported in three categories:

1. Working Best - A description of factors contributing to a positive NDIS transition process and outcome
2. Challenges, Barriers & Gaps - Identification of challenges and barriers to engagement with the NDIS and any gaps or risk of gaps in service continuity

3. Service Improvement - Proposed opportunities for systemic service improvement

Working Best

The findings below are a synthesis of the information provided in the NGO workshop, focus groups and individual interviews. They are a summary of what service providers and carers considered works best for clients transitioning from State psychosocial programs to the NDIS.

1. **NDIS Access for people registered with State psychosocial programs is best achieved when there is advocacy on behalf of the client from State psychosocial program mental health clinicians and NGO support workers and where possible inclusive of carers.**

Workshop and Focus Group participants gave numerous examples where people with psychosocial disability receiving services through State psychosocial programs require advocacy and support to negotiate the NDIS. This includes assistance with gathering relevant information on functional impairment, completing necessary documentation and meeting timelines; all critical elements in determining eligibility for the NDIS.

> "I could not have dealt [with the NDIS process] without the support of my daughter’s [mental health] keyworker [spending] many hours helping me to complete forms and deal with the bureaucracy" (Carer interview)

Providing advocacy and support for clients transitioning to the NDIS has become a significant function of NGO State psychosocial provider activity. In collaboration with MHS it is an important service response to ensuring clients have suitable NDIS Plans in place especially where carers/family are not involved.

> "[State psychosocial] NGOs are doing NDIS applications often [and] advocating for improved packages” (MHS Clinician focus group)

> "At least 25% of support workers’ time is related to supporting clients with NDIS. For some support workers this percentage is much higher, up to 50% at times” (IPRSS NGO manager)

State NGO psychosocial support workers and Mental Health clinicians highlighted the importance of understanding the NDIS in order to assist clients with applications and transition. Mental Health clinicians reinforced the importance of having access to information about the NDIS application process. In some community mental health teams there are clinicians with a dedicated NDIS consultancy role.

> “Having an NDIS resource person [dual mental health clinician] based in the Mental Health Team/ Region [has been beneficial]” (MHS focus group)
Some mental health community teams have NDIA Local Area Coordinators (LACs) attend community team meetings.

“Attendance by Local Area Coordinators at clinical meetings is improving clinicians understanding of NDIS and establishing working relationships” (MHS senior clinician)

State NGO psychosocial services have incorporated NDIS specific in-service training.

“Staff are being trained in NDIS having undertaken NDIS training [through] online modules and wherever possible face to face sessions with Local Area Coordinators” (IPRSS NGO manager)

Carers also expressed the value in having access to NDIS information to assist with advocacy support.

“[NDIS] information sessions [and] information sheets are helpful” (Carer focus group)

2. Development of NDIS Plans is most effective when there is meaningful sharing of information and collaboration between key stakeholders – client, MHS, NGOs, GPs, carers and NDIA Planners.

Face to face stakeholder contact during NDIS planning allows for a more informed understanding of the client’s situation, the type of supports required and any areas of risk. Being able to reference mental health specialist reports, inform and clarify existing NGO psychosocial supports and involve carers are all factors contributing to effective NDIS Plans.

“[NDIS Planning works well] when there is good communication with Mental Health teams, GPs and any other party involved in the client’s care [and] when stakeholders are working collaboratively” (NGO workshop)

“When planning meetings have been a collaborative process they have been more successful” (NGO workshop)

Equally important is working with an NDIS Planner and/ or a Local Area Coordinator who has an understanding of mental illness and the impact of psychosocial disability on a persons’ life.

“Some Local Area Coordinators have been helpful and sensitive to clients’ needs and guided the process well” (NGO workshop)

“[Works well] when Local Area Coordinators [have] knowledge of mental health” (NGO workshop)
Comments from the NGO workshop highlight the value of the Carer’s Statement\textsuperscript{26} as well as the NDIS Planning Tool as contributing to effective planning.

3. **NDIS Plans for people transitioning from State psychosocial programs are of most value when there is adequate NDIS support coordination with core supports.**

NDIS Plans with a combination of support coordination and core supports can provide clients with disability supports not previously available through State funded psychosocial programs.

> “Some consumers have been able to get a bigger package than [is provided through] HASP [Housing and Accommodation Support Partnership]” (NGO workshop)

Workshop and Focus Group participants indicated that NDIS support coordination should be an integral component of NDIS Plans for clients of State psychosocial programs and specialist support coordination incorporated where there are more complex issues. Participants noted that NDIS Plans and engagement with NDIS services is effective when Support Coordinators are open to advice and input from State psychosocial service providers. The problem of low hours of support coordination in Plans was identified.

> There “is a need for more specialist Support Coordinators” and “support coordination across the board” (NGO workshop)

> “Support Coordination included in [NDIS] plans has improved” (NGO workshop)

> “Support Coordination remains at a low level in most NDIS plans, creating a gap in service” (NGO Team Manager)

Workshop and focus group participants observed the positive impact NDIS core supports can have on a person’s life. A number of clients experiencing psychosocial disability and receiving core supports are reported to have improved quality of life.

> “[The NDIS Plan works well] with the right package [and the] right service [especially if it] includes support coordination and practical supports such as cleaning and gardening” (NGO workshop)

Where clients have co-existing disability (e.g. psychosocial and physical) NDIS Plans have been very helpful. In some instances, NDIS plans provide core supports on weekends and overnight support which the client could not previously access on a regular basis through state programs. State psychosocial programs such as IHBSS, HASP and IPRSS can provide weekend

\textsuperscript{26}Carers SA Australia May 2019, Carers Guide: Psychosocial Disability and the NDIS
support where there is a high risk for clients of relapse of their illness or to their safety due to other psychosocial factors. This is variable across NGOs, and depends on funding arrangements.

“People with co-morbidity [e.g. physical and psychosocial disabilities are now] having their physical needs met as well” (NGO workshop)

Carers reported increased self-confidence for clients as a result of core supports provided within NDIS Plans.

“[With NDIS support there has been] improvements in personal hygiene, self-care, keeping a tidy house and engaging with community activities” (Carer focus group)

4. NDIS Plans with greater flexibility are more likely to meet client need.
Workshop participants concur that NDIA managed plans reduce the choice of service options for Participants. The preference is for Plan managed which offers greater flexibility with support to manage the NDIS Plan.

“[Plan] and Self-managed [NDIS] plans have greater choice in spending of [funds that is not] available to consumers who are [with Agency managed plans]” (NGO workshop)

“This is] a human rights issue – people who are agency [NDIA Agency] managed should have the same rights as people who are [plan] or self-managed” (NGO workshop)

5. There is a greater likelihood of service continuity for people with psychosocial disability if there is a close service partnership approach between providers of State psychosocial programs and NDIS Support Coordinators.
Workshop participants indicated the importance of State psychosocial support workers working closely with NDIS Support Coordinators to facilitate a successful transition to the NDIS.

“The [IPRSS support worker] and the [NDIS Support Coordinator] worked together to help my son and were very helpful. The planning meeting was very open and there was good communication [which] all helped. I am very happy and my son’s confidence has improved. He is doing much more” (Carer comment)

Frequently implementation of NDIS Plans requires a slow transition from State psychosocial programs.

“We have had issues reducing our involvement with some consumers who have larger plans, (often more complex)……we have been working with NDIS providers….to ensure the consumers’ needs are being met……this takes time and is part of our exit planning” (IPRSS NGO senior support worker)
“[In a number of cases State] NGO programs have known clients for so many years and are knowledgeable in [the client’s] history which helps [with the] NDIS process [especially] when there is a longer transition period with all [stakeholder] networks involved” (NGO workshop)

6. **NGO psychosocial support workers and NDIS Providers need to work side by side when NDIS Plans do not meet all consumer need or if NDIS Plans do not have providers to service the plans.**

NGO workshop participants indicate the need for NDIS providers and NGO psychosocial services to work in a collaborative service partnership when there is:

- Complexity for clients
- And/or risk for clients
- And/or where there are challenging behaviours
- And/or the client is experiencing escalation in their mental ill health
- And/or where NDIS Plans cannot be implemented due to unavailable resources (especially evident in Country)

“[NDIS] Support Coordinators are asking us to stay involved as NDIS Plans are not meeting the client’s needs” (IPRSS NGO manager)

“Ideally NDIS could provide core supports while State funded programs continue with recovery work [meeting] all consumer’s needs [with] oversight of risk and complexity” (NGO workshop)

“[When the client is becoming unwell they] can decline in function and that is when NDIS is not enough [and] state-based services need to be able to step in” (NGO workshop)

7. **Where carers/family are involved and have good advocacy skills there is a greater likelihood of successful outcomes.**

“If family are able to advocate clients receive good packages” (MHS Clinician focus group)

“Family/Carers who are good advocates and [when able to] put time in are happy with their [NDIS] plans and the supports [provided]” (NGO workshop)

“Without the exceptional involvement and commitment of the carer we would not have a [NDIS] Plan in place and [the transition process] would not have gone so well” (IPRSS NGO manager)
In summary, carers, MHS clinicians and NGO providers described key elements of what is working best to support clients transitioning to the NDIS. They include the importance of:

- Client advocacy support to negotiate the NDIS process, supporting both carers and the client\(^{27}\)
- Involvement by NDIA and NDIS providers who understand the impact of psychosocial disability
- Building a collaborative and supportive relationship amongst stakeholders with open communication and working together with the client to develop, implement and sustain NDIS Plans.

**Challenges, Barriers and Gaps**

Many of the ‘Challenges, Barriers & Gaps’ identified through the workshops and focus groups were consistent with findings from other national reports\(^{28}\). They include issues with the complicated bureaucratic nature of NDIS access; the difficulties associated with a market based model to deliver human services; limited NDIA/NDIS workforce understanding of mental illness and psychosocial disability; lack of available NDIS providers particularly in rural areas; poor communication by the NDIA and/or NDIS with stakeholders; and poor communication options between NDIS providers and mainstream services. Findings are listed in two sections, firstly Service Providers, and secondly Carers. This is to reflect the nuance and range of experiences.

**Service Providers – Challenges, Barriers & Gaps**

The themes below reflect the discussion in workshop, focus groups and/or individual interviews with State psychosocial NGO providers, MHS clinicians and NDIS Support Coordinators.

1. **Clients of State psychosocial programs with psychosocial disability do not have the capacity to deal with the bureaucratic process of NDIS and often find it distressing.**
   
   **Determining eligibility for the NDIS and implementation of NDIS Plans is complex and often with lengthy waiting periods.**

   "It seems ridiculous to make an unwell person jump through so many hoops to be considered [eligible] for NDIS. This can result in those most in need [missing] out due to the [stressful process]" (NGO workshop)

\(^{27}\) Advocacy support is especially important when carers are not involved. Information from NGO workshops and team visits conducted by the Project team suggest up to 80% of clients receiving State psychosocial services do not have access to carer support.

“In my experience I have not worked with a single client who has the capacity to complete the process of an NDIS application by themselves” (IPRSS NGO senior support worker)

“[There] are lengthy waiting periods for planning and review meetings” (MHS focus group)
“The NDIS process is confusing with many bureaucratic procedures that create barriers to NDIS [Access and Planning]” (MHS focus group)

2. Lack of knowledge of the NDIS process by health specialists, GPs and other stakeholders makes accessing relevant reports and gathering of information to determine NDIS eligibility difficult for clients and those who are assisting with applications.

“[GPs] are not filling out access request forms properly” (NGO workshop)

“GP’s do not have time or training [to] fill out the access request form in a way that convinces the NDIS” (NGO workshop)

“[There] is a lack of support from medical and allied health staff to provide evidence to [assist with NDIS Access]” (NGO workshop)

“GPs and Psychiatrists are not on board with....providing the correct language to assist with gaining access” (NGO workshop)

3. Determining NDIS Access is more problematic when clients are unwell and requiring acute care or impacted by persistent symptoms of mental illness.

“[It is a challenge] gathering enough evidence [to assist with NDIS Access] for consumers who have been transient or have not had the same doctor” (NGO workshop)

“Clients [can have a] distrust of government implemented systems – i.e. a lack of understanding and fear” (NGO workshop)

“[Some] clients are not accepting [NDIS supports] due to their psychosocial incapacity” (MHS focus group)

4. During the NDIS Access process there are many reports of poor communication with the NDIA, inconsistent advice, unrealistic timeframes and misplaced (client has moved accommodation) or unopened (a consequence of psychosocial disability) NDIS correspondence.

“[There were] inconsistent messages conveyed by [different staff from the] NDIA when waiting between [submitting] the access request form and planning meeting’ (NGO workshop)
“[There] was a lack of communication from the NDIA during the application process” (NGO workshop)

“[At times] consumers are contacted directly by phone and decline or miss out on the access request form because they didn’t understand what [the call] is about” (NGO workshop)

“Conflicting information [was given] from the NDIA regarding ‘reapplying’ versus ‘updating application’ (NGO workshop)

“[There are] blocks in communication [with the NDIS and] information [is] not accurate [or] timely” (MHS focus group)

5. Establishing consent for release of an applicant’s NDIS information to State funded support workers has been difficult and places clients at a disadvantage to establish eligibility especially when there is not a carer or another advocate involved.

“[Cannot work] collaboratively when unable to be added as a contact [during] the time to gain access” (NGO workshop)

“[There is] difficulty communicating with NDIS/NDIA by clinicians [especially around] consent for release of information and [NDIS] nominee” (MHS focus group)

6. Language required in NDIS applications focuses on functional impairment and tends to be deficit based. This is in contrast to the strengths-based approach used within mental health services and by State psychosocial providers. This is confusing and distressing for clients.

“Switching from recovery oriented language to deficit based [is] a traumatising process [for the client]” (NGO workshop)

“It is challenging using] deficit...language when explaining a recovery journey” (NGO workshop)

“NDIS reports from specialists need to be deficit based to meet [NDIS eligibility criteria]. This is difficult for the [client] to understand and impacts on the therapeutic alliance” (MHS clinician)

“[There is] a negative impact on clients when deemed ineligible [for NDIS]” (NGO workshop)
7. In some situations, clients were not wanting to transition to the NDIS and preferred to remain with State psychosocial programs. This contributes to client distress.

“Clients fear [losing] their current State program service” (NGO workshop)

“[Clients are] feeling they [do not] have a choice [and feel] compelled to apply [to NDIS] because they are in a state-based program” (NGO workshop)

“[The client stated] I do not want change, I never felt so out of control” (NGO Workshop)

“Explaining to a client what the NDIS is and why they need to apply [is difficult as the NDIS] process keeps changing [and] clients are not wanting to lose the current [state] service” (NGO Workshop)

“Clients [are] reluctant to [apply to the NDIS] due to [misunderstanding] the word insurance” (NGO workshop)

8. The NDIS workforce lacks training/skills/knowledge in mental illness and the impact of psychosocial disability.

“NDIA assessors do not have mental health training [and] do not understand the recovery approach” (MHS focus group)

“[There is] lack of a recovery approach [and] understanding of [mental health] rehabilitation [from NDIS] (MHS focus group)

“NDIS qualifications [are] at a low level compared with [NGOs from] State programs” (MHS focus group)

9. Poor communication between MHS/NGO and the NDIS contributes to poor NDIS Planning. The Project found that NDIS internal processes are not conducive to service collaboration. Relevant MHS clinical information and/or NGO psychosocial information is either ignored or not adequately reflected in NDIS Plans.

“To contact anyone within the NDIS is a difficult process, just like Centrelink one is left waiting on the phone usually for an hour or more” (NGO Team Manager)

“The Local Area Coordinator’s plan does not reflect information given [from the State NGO provider] or the NDIS planning [meeting] discussion” (NGO workshop)
"NGOs are completely left out [of the NDIA planning process] or ignored [increasing the] risk that the consumer will not get [an] appropriate [NDIS] Plan” (NGO workshop)

"[Clinicians from Mental Health] services who know the client...are often not involved [in a] consultation” (MHS focus group)

"[When] mental health services are not involved in [NDIS] Access and Planning [this] results in poor [NDIS] Plans“ (MHS focus group)

10. NDIS Plans are inconsistent.

"Accessing NDIS support seems to be more dependent on the skills of the support letter writers and the NDIS assessor than the impact of disability on the client” (NGO workshop)

"Many plans exclude support coordination when it is needed, and there is inequity with some people receiving large plans and others hardly anything when they need substantial plans. The NGOs have had to advocate strongly, and where there are carers with the ability to advocate there is more likely to be a better plan, but the responsibility falls on those advocating, there is no responsibility on the NDIS plan approver to ensure the consumer gets what they need.” (NGO Team Manager)

11. The NDIS online portal system requires computer literacy and is not a realistic communication option for most clients of State psychosocial program.

"[The] online portal expectation [as a communication option] is unrealistic for clients” (MHS focus group)

12. Streamlined access to the NDIS is not working.

"Streamlined Access as an improvement doesn’t really work [and] is null and void” (NGO workshop)

"Streamlined Access Program [is] not helpful as questions over the phone [are] confusing to clients” (NGO workshop)

13. NDIS Plans do not have the capacity to provide support to participants when they are in crisis, experiencing mental ill health or there is difficulty with engagement.

"The [client] has an NDIS Plan but does not want the service because it is by appointment only. The NDIS price guide restricts flexible use of NDIS funds. The client is [mentally] unwell and will remain in homeless services but needs a service like IHBSS [Intensive Home-Based Support Services]” (NDIS Support Coordinator)
“[Where] clients lack insight [and/ or] do not trust services there is lack of engagement [with NDIS]” (NDIS Support Coordinator)

“NDIS Support Coordination is not the same as case management offered through [State psychosocial programs]. There are gaps in service when a person is in crisis or acutely [mentally] unwell” (NDIS Support Coordinator)

14. NDIS Plans are restricted by the terms of the respective plans and do not account for a number of services required by clients.

“The NDIS cleaning providers did not get it. [They do not] recognise presenting symptoms of [mental illness] and when [people with psychosocial disability] are becoming unwell and vulnerable” (NDIS Support Coordinator)

“A KPI [key performance indicator] for Support Coordination is to calculate every minute of the NDIS Plan, documenting and invoicing [accordingly]. It is very stressful. It is a business model not a human model” (NDIS Support Coordinator)

“NDIS Plans do not follow up on dental services and other physical health problems. It is not part of NDIS practice. Who will follow up?” (IPRSS manager)

15. NDIS Support Coordinators work outside the boundaries of their role which is not sustainable.

“Support Coordinators have to provide services that are not billable or do work they cannot charge for otherwise [payment for the extra work] will eat into the participant’s Plan. This is not sustainable” (Joint State psychosocial/NDIS Support Coordination focus group)

“If the client is in a state of wellness [and their NDIS Plan is being implemented] the psychosocial NGO provider [needs] to remain involved until the NDIS Support Coordinator is involved and services are settled” (Joint State psychosocial/NDIS Support Coordination focus group)

“NDIS support coordination is bookended, anything outside of the role is [undertaken knowing that it is] above and beyond [what is in the Plan]. [NDIS Planning] does not take into account the episodic [nature of mental illness]” (NDIS Support Coordinator)

“[Positive outcomes occurred when] other sustainable supports existed [for clients] to complement the NDIS process; [for example] a family member, carer or other support agency” (Local Area Coordinator in reference to NDIS Access and Planning for clients of State funded psychosocial programs)
16. NDIS Plans are not able to be implemented due to lack of resources.

An inability to locate NDIS providers with the capacity to be involved in NDIS Plans is especially relevant for rural areas where there is a lack of resources due to isolation.

“We have limited services ….. We have one agency that is disability focused not mental health, and limited individuals supplying other services, makes it ‘tricky’ to supply ‘choice and control’ for consumers to maintain safety, not be exploited, and have support persons understand their needs.” (Rural NGO support worker)

“There are no choices of services providers in this catchment area, there is one agency that provides services. There have been other agencies in the past and continue to provide FIFO but that is usual short lived as the cost of travel is deemed too expensive and not able to provide a consistent service. There are private service providers, offering domestic assistance, gardening services. Most plan members do not know how to utilise these services, do not understand how to spend the plan money nor how to utilise a service provider.” (Rural NGO support worker)

Specialist services are not available in this region to [implement] the support coordination required in the NDIS plan (NGO Workshop)

Carers Consultation – Challenges, Barriers & Gaps

The points below are the result of consultation with carers either through a carer focus group or individual carer meetings:

1. Dealing with the MHS system is already a confusing process often for carers, and the NDIS is an additional complex process. There is confusion amongst carers about what NDIS can offer and how it is relevant to their family members with psychosocial disability.

“Families are often not aware of what mental health services are available including NDIS” (Carer consultant)

“Translating the functional impact of psychosocial disability into NDIS domains and then identifying the support required is a complicated process” (Carer focus group)

“[People with a] Culturally and Linguistically Diverse background [have] increased difficulty with [NDIS Access]” (Carer focus group)
2. Whilst NDIS information sessions and online support are helpful there is a lack of assistance for carers with NDIS applications.

“Partners in Recovery (PIR) has had funding cuts and now [reduced] capacity to assist with NDIS Access...who can help families prepare and send an adequate application [to ensure] all appropriate information is [available for NDIS Access]?” (Carer focus group)

“[During inpatient admissions] it is not clear who is responsible for assisting families/individuals with NDIS applications. Is this the hospital’s responsibility or could [someone] be referred to IHBSS (Intensive Home Based Support Service)?” (Carer consultant)

“[People] need to have computer literacy [to get NDIS information but] many people do not have this” (Carer focus group)

“Do not go into a meeting with NDIS expecting to be helped [the onus is on you] to prove eligibility” (Carer comment)

“[There is] no service or individuals being paid to case manage the [NDIS] application process in a quality manner” (Carer focus group)

3. When a person’s illness is acute and psychosocial disability is severe it is difficult to collect the information necessary for NDIS Access.

“[When the person’s] capacity and understanding is limited due to psychosocial disability there is a barrier [to achieving NDIS] access” (Carer focus group)

“It is difficult to gather information and adequate evidence for Access when the individual is unwell” (Carer focus group)

“What happens when the client does not have capacity to understand process [and/or] judgement around health management is poor?” (Carer consultant)

4. The lack of flexibility to transfer funds between types of support within NDIS Plans results in an under-utilisation of the plan and in participants not being able to access supports needed.

“There is a lack of flexibility to transfer NDIS funds between support categories. An individual may have funds left in their NDIS Plan but in an unused category and not able to transfer the funds for support to another more relevant category” (Carer focus group minutes)

“There is a lack of choice when using a NDIA managed plan...a person who was regularly participating in an exercise class with positive benefits could not continue utilising their funds to pay for attendance as the gym was not NDIS approved. An alternative NDIS approved gym was offered however the person did not attend due to difficulty accessing the gym through public transport and not being confident to attend a new gym. NDIA managed plans are limited to NDIA approved services” (Carer focus group minutes)
5. When there is no support coordination or specialist support coordination carers can become de facto Support Coordinators placing increased stress on carers and the relationship with their family members experiencing psychosocial disability.

“At times MHS and/ or NGOs step in to assist with supporting NDIS Plans but this is outside their role” (Carer focus group)

“The NDIA planner asked me to do the support coordination.” (Carer comment)

“NDIS assess carers into informal support roles so reducing the allocation of support coordination [in NDIS Plans]” (Carer consultant)

6. Advice from the NDIS can be inconsistent and communication poor with carers not being invited to Planning meetings.

“A single point of contact for NDIS information and assistance is lacking. It is very confusing knowing if you are speaking to a Local Area Coordinator (LAC), NDIA or the 1800 call centre and getting inconsistent information” (Carer focus group)

“Carers are not receiving important information [and/ or] letters are going to the incorrect address because of confusion specifying the communication nominee” (Carer focus group)

“I was not invited to the Planning Meeting” (Carer comment)

7. There is inconsistency with the resourcing of NDIS Plans causing inequity – NDIS Plans are dependent on the type of advocacy, the knowledge and skill of the NDIS planner, and the nature of the participant’s illness and social situation.

“Why are some people getting plans that meet needs and others not? What factors influence this? Is it a lack of consistency with NDIA assessors/ planners and their training in psychosocial disability?” (Carer focus group minutes)

“Plans are more effective with increased funding when the participant identifies the need to live independently. This is not necessarily well known and assessments can overlook this especially when a person is living at home” (Carer focus group minutes)

8. Since the introduction of the NDIS some previous respite services available to carers now have a prohibitive cost attached.

“The respite option I previously used for my mother is now unaffordable. It was a free service but I cannot use it because it is too expensive” (Carer comment)
Service Improvements
During the consultation process stakeholders were asked:
- What improvements they would like to see?
- How might services work together more effectively?

Key Priorities
Stakeholders identified the following as main areas for service improvement:

1. Establish guidelines and protocols for NDIS providers, State psychosocial services and MHS clinicians to assist people transition from State psychosocial programs to the NDIS. This includes:
   - Developing business rules governing the transition process
   - Clarifying the role and function of State service providers
   - Detailing State NGO psychosocial provider service responsibilities and duty of care during handover periods
   - Specifying eligibility criteria for people with NDIS Access requiring involvement from both State psychosocial programs and NDIS providers to mitigate gaps in service

2. Develop consistent and timely communication and collaboration with NDIA and NDIS providers.
Stakeholders often experienced difficulty gaining information from the NDIA and NDIS. This created uncertainty and contributed to client distress and was counterproductive to client care. In particular the following areas need improvement to ensure effective NDIS planning and continuity of service:
   - Establish a single point of contact where approved people (service providers and carers) can make phone contact to gain an update on the progress/status of NDIS applications
   - Ensure all stakeholders inclusive of carers have the opportunity to attend NDIS planning meetings
   - Identify key NDIS liaison staff who can provide accurate information about respective NDIS participants to State NGO psychosocial providers and MHS clinicians to assist with care planning.

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29 This was the highest rated theme from both State psychosocial NGO providers and Mental Health clinicians and is complemented by carers who highly rated the need for advocacy support through NDIS Access, Planning and Implementation.
30 Clarification is required for when people receive both State psychosocial services and the NDIS. Some mental health clinicians raised concerns that this has the potential for ‘double-dipping’ and not an equitable use of resources.
31 The recently appointed NDIS Health Liaison role is an example of improved communication with State psychosocial providers and mental health services. The role is currently restricted to inpatient services.
3. Provide a streamlined NDIS pathway\(^{32}\) with capacity to assist clients of State psychosocial programs through NDIS Access and Planning.

The pathway should:

- Have NDIS staff with an understanding of mental illness and the impact of psychosocial disability, and
- Utilise mental health ‘strengths based’ language and be compatible with a ‘recovery oriented’ approach.

4. Establish a process for escalating system issues and reporting inconsistent or poor practice during the transition process.

Both State psychosocial NGO providers and MHS clinicians raised concerns about their ‘duty of care’ to clients and accountability for NDIS providers to meet the requirements of individual NDIS service agreement. Examples of issues requiring escalation were situations where:

- Relevant client information being ignored or not communicated during transition creating risk of gap in service for clients
- NDIS providers are not engaging with participants
- Service agreements not being adhered to in a consistent fashion.

Stakeholders acknowledged the role of the Quality & Safeguarding Commission but noted that the process for reporting is restrictive and did not consider it the most appropriate escalation point for all service issues\(^{33}\) identified during transition.

5. Improved equity/consistency with NDIS Planning.\(^{34}\) Stakeholders gave contrasting examples of NDIS Plans that were well resourced but then others with inadequate plans not commensurate with a person’s psychosocial disability.

The inconsistency could be addressed by:

- Ensuring NDIA planners and assessors are trained in psychosocial disability and the impact of mental illness on people’s lives
- All relevant State psychosocial NGO provider and MHS clinical information is available for NDIS planning
- State psychosocial NGO providers/ MHS clinicians and carers have the opportunity to be present at NDIS planning meetings

\(^{32}\) Stakeholder consultation noted that streamlined access for clients of State psychosocial programs was not working. Carers highlighted the complex needs pathway as being effective but with limited capacity.

\(^{33}\) The Quality and Safeguarding Commission “is the only consumer pathway into NDIS to report issues with NDIS service provision. Advocates are not allowed to report on behalf of consumers and this does not take into account the functional capacity and barriers consumers may have to access complaint processes. Service providers and carers do not have a pathway to make complaints for themselves either” (focus group comment).

\(^{34}\) Stakeholders highlighted NDIS Plans are dependent on the type of advocacy, the knowledge and skill of the NDIS planner, and the nature of the participant’s illness and social situation.
6. Greater access to information about what services the NDIS can provide, who is likely to be eligible for NDIS and procedures for determining and gaining NDIS Access

Stakeholders often commented on the changing NDIS environment. Carers valued forums and online information about NDIS whilst noting that many carers do not have an understanding of NDIS. MHS clinicians expressed the need for a greater understanding of NDIS eligibility criteria and service provision. MHS clinicians and managers suggested the following:
- NDIS in-service training
- Greater communication with NDIA staff at local levels (e.g. establish regular contact between NDIS Local Area Coordinators and community mental health services).

NDIS and State Psychosocial Program Differences

1. At a systemic level one of the most striking findings from stakeholder consultations were the workforce and service model differences between State psychosocial programs and the NDIS.

“[NDIS] funding doesn’t allow for changes to meet [client] need in crisis” (NGO workshop)

“Consumers are being referred to IHBSS, or IPRSS or HASP because their NDIS plans are delayed in implementation or are inadequate” (NGO Workshop)

“NDIS providers [are] not able to manage behaviour that may be challenging...” (NGO workshop)

“The NDIS workforce does not have the equivalent mental health training or skill to that of the NGO State program workforce” (MHS focus group)

“[The NDIS] does not have the same flexibility as [State psychosocial programs]. If a [client] does not want to see their [NDIS provider] that day they lose the service and get billed...[State psychosocial providers] will come back and see the [client] the next day” (MHS clinician)

NGO and MHS stakeholders concurred that the State psychosocial workforce is trained and experienced in:
- The Recovery Approach in delivering services
- Trauma informed care
- Understanding risk management
- Working with people experiencing persistent mental ill health symptoms

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35 Refer to carer focus group – challenges, barriers and gaps.
36 State NGO psychosocial providers were very active with support and advocacy around the NDIS process compared with public MHS. By virtue of the service partnership this maximised advocacy support for clients.
• Working with people where there is complexity or challenging behaviours
• Providing a responsive, individualised and continuous service
• Delivering service models underpinned by collaborative service partnerships within a memorandum of understanding that is closely linked with MHS treatment and rehabilitation
• Providing support that is flexible with the option to increase service intensity should clients experience a relapse in mental ill health symptoms or require increased psychosocial needs related support

2. NDIS Support Coordinators identified that it was either difficult or impossible to replicate the same level of service intensity within NDIS Plans as occurs with State NGO psychosocial support.

In many instances NDIS Support Coordinators are going “above and beyond” their role to meet consumer need. NDIS Support Coordinators consulted during the Project expressed concern that Support Coordination is not adequately funded within NDIS plans and therefore implementation of plans is compromised. NDIS Support Coordinators find themselves stretching their role to avoid billing individual participants so as not to impact on participant’s NDIS funds.

“I had to spend two days helping [the client] with accommodation...they were not coping and getting [mentally unwell]...I cannot charge for that...the [organisation] supported me doing this [but it is not] sustainable” NDIS Support Coordinator

“Organisations need to quantify how much NDIS support services are actually costing them to provide, and feed this back to the NDIS” (Joint State NGO psychosocial provider and NDIS Support Coordinators focus group)

3. Often expectations of NDIS Support Coordination by other stakeholders was found to be unrealistic and outside the boundaries of the role.

“Clinical guidelines [for] LHN (Local Health Network)/NDIS need to be developed as LHNs have very different approaches to exit of clients. For some, the practice is to exit [the] client from the LHN to the GP when NDIS services come on board. This leaves consumers without clinical support and Support Coordinators have nowhere to go for help when [the client’s] mental health declines. Support Coordinators are being put in the position of managing clients through psychotic episodes and crisis” (Joint State NGO psychosocial provider and NDIS Support Coordinators focus group)

37 “above and beyond” was a term commonly used during stakeholder consultation and attributed to NDIS Support Coordinators who would provide support to NDIS participants when that support was not billable and/or outside the bounds of the NDIS service agreement and no other supports available.
During the course of the Project the terms ‘support coordination’ and ‘case management’ were often used by service providers – at times interchangeably. There is a sense of confusion about the nature of the NDIS Support Coordinator role that is possibly contributing to unrealistic expectations about what the NDIS can offer clients.

“[Our role] is to coordinate services rather than case manage...a competent Support Coordinator [understands] the NDIA funding catalogue and maximises a person’s [NDIS] plan”
NDIS Support Coordinator

“So many aspects of Support Coordination and core supports are not funded to liaise with other services such as mental health. Support Coordinators are having to do more than they are funded for” NDIS Support Coordinator

As part of transition planning for people from State psychosocial programs to the NDIS the boundaries of the NDIS Support Coordination role need to be taken into account to maximise service continuity. This might result in State psychosocial and NDIS providers working collaboratively.

Service Collaboration for Effective Transition Planning

Project findings highlighted the importance for State psychosocial programs to work in collaboration with NDIS providers to ensure minimal gaps in service for clients as part of the transition process.

A joint State NGO psychosocial provider and NDIS Support Coordinator focus group met to consider some of the key service elements contributing to a safe and seamless transfer of care (i.e. handover period) from State programs to the NDIS. Some of the elements suggested by the focus group included the following:

Preparation

- Hold a care planning meeting with the client, client’s guardian if a guardian is required, carer where a carer is supporting the client their State psychosocial support worker, and NDIS Support Coordinator to:
  - Develop an individual transition plan identifying a pathway for the implementation of the NDIS Plan
  - Share (with the client’s consent or the client’s guardian’s consent where a guardian is required) important information around client goals, the impact of psychosocial disability and how the NDIS can best be of assistance. Information should include relevant risk assessments and identification of other supports to meet client need
  - Implement a regular review process for the transition plan
 Specify service provider roles and responsibilities should the client experience an exacerbation of acute mental health symptoms
 Identify whether the NDIS Plan is meeting the client’s needs and if not arranging jointly where possible for review of the Plan

- In planning for exit from State psychosocial programs the NDIS Support Coordinator needs to understand support from the NGO State psychosocial program will no longer apply and therefore the service consequences must be factored into ongoing NDIS planning. In particular, sufficient planning needs to address:
  - Transport arrangements (i.e. transport is not a given within NDIS Plans which can impact negatively on the client’s mobility and finances)
  - Attention to physical health issues, particularly given the higher morbidity and co-morbidity rates associated with people living with severe and persistent mental illness (e.g. dentistry, diabetes or any other chronic or intermittent health management)

**Engaging with NDIS providers**
- Face to face meetings should occur between the State psychosocial services and NDIS providers with the client, and more than once if required
- If a client is in a state of wellness the State psychosocial support worker needs to remain involved until the NDIS Support Coordinator is involved and the service agreement is operational
- State psychosocial services to work closely with NDIS providers to establish engagement with the NDIS. At times this will involve State psychosocial support workers coaching and mentoring the NDIS providers, with NDIS providers shadowing the support workers during scheduled visits. This process will allow the opportunity for NDIS providers to develop rapport and an adequate understanding of the client’s need

**Structuring the handover period**
- Ensure handover periods and processes reflect client need. The focus group agreed on the following:
  - Handover periods can be variable
  - Where there is little or no complexity a formal review period of three months would facilitate the progression of transition
  - Where there is complexity, acute mental ill health and challenging behaviours, the transition period will, in all likelihood take much longer, anywhere from six months to two years
  - Where there is a risk to service continuity during the handover period State psychosocial programs remain involved to meet client need
Maintaining transition continuity when people are unwell

- Should a client become unwell during the transition process the State psychosocial service is to remain involved and increase the intensity of service to meet client need.
- Once a person returns to their usual wellness state there is re-engagement with the NDIS transition plan.
- In situations where a client is due to leave hospital and has a new NDIS Plan in place, a referral to either IHBSS or IPRSS (State psychosocial program) should be considered to assist with NDIS implementation process.
- People with NDIS Plans can still access State psychosocial programs if they have needs that are not being met within their existing NDIS Plans.

Reviewing Plans

- If the NDIS plan is not adequate the State psychosocial service works with the NDIS Support Coordinator where there is support coordination within the plan, carers or guardian if a carer or guardian is involved, and if not, works alone to problem solve and/or support the client to appeal.
- State psychosocial support remains involved during NDIS appeal/review processes. This includes continuing with:
  - Medication prompting
  - Day to day problem solving
  - Assertive outreach where psychosocial support needs are high
  - Where relevant liaison with carers, guardians and the Public Trustee.

Exiting State psychosocial programs

- Continued access to State psychosocial programs should apply where NDIS Plans are not meeting client need and/or where there are no NDIS providers available to implement NDIS plans.
- Once exited from State psychosocial programs NDIS providers should have the opportunity to consult with State psychosocial services or refer back to State psychosocial services should there be any disruption to service continuity.
- A three monthly review involving all stakeholders could be a considered part of the exit process once clients have exited State psychosocial programs, particularly in situations where there is severe mental illness and/or complex needs and/or, challenging behaviours.

The State psychosocial support workers and NDIS Support Coordination focus group consultation confirmed the importance of collaborative transition planning as part of the

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38 This is particularly relevant for long stay mental health inpatient clients, for clients who have been supported by State psychosocial services prior to entering hospital, and for clients with complexities regarding their mental health and/or co-morbidities and/or difficult behaviours.
interface between State psychosocial programs and the NDIS. Guidelines and protocols around transition planning would reduce the risk of gaps in service continuity for clients.
FINDINGS – LIVED EXPERIENCE VIGNETTES

The Project requested State NGO psychosocial support workers to provide examples of the NDIS transition process describing individual client experiences. Forty-one lived experience vignettes were received, highlighting service and system difficulties clients of State psychosocial programs experienced from the process of NDIS application, through to the planning and implementation phases. A small number of vignettes were also received from MHS clinicians and NDIS Support Coordinators.

Themes

The following are some of the themes common to the majority of the vignettes:

1. **Poor communication, lost NDIS application forms, difficulty getting reports to establish NDIS eligibility.**

   Scenario: State psychosocial support worker assisting the client and his family with NDIS Access:

   “The most stressful part of the process was waiting to hear back from NDIA as to the approval of [the carer’s son]...This has taken 13 months. During this time the carer has contacted the NDIA as to the progress of their son’s applications and were told that some paperwork had been lost by the NDIA and the carers will need to resubmit some more information”

2. **Long waiting periods from application to NDIS Plan activation.**

   Scenario: State psychosocial support worker advocating for the client during NDIS planning

   “[There was extensive] delays in access and planning – the LAC [Local Area Coordinator] who attended the initial planning meeting....left the service (NDIA). No follow up was actioned by NDIA and the consumer told to wait until contacted when phoning the NDIA to ask for progress” (there was a 12 month period from NDIS application to the NDIS Plan activation)

3. **The need for advocacy and support when dealing with NDIA staff and/ or NDIS providers who do not understand mental illness and/ or psychosocial disability.**

   Scenario: Traumatic meeting experience with Local Area Coordinator

   “An assumption was made by the LAC the consumer’s current services would remain in place, not allowing the consumer to explore all her options. Choice and control was not provided, the consumer was not given the time, information or support to make any informed choices, as she was provided with limited information during the meeting regarding the planning of her NDIS funds. She was placed in a pressured situation to make decisions with an inadequate

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39 All vignettes have been de-identified.
explanation of the different ways NDIS funds can be managed. She was advised if she did not make a decision now, her package would be put on hold. The LAC was quick to decline what was put forward by the consumer, with decisions and recommendations made by the LAC for the consumer irrespective of the information provided or requested…as the consumer was departing, the LAC provided NDIS brochures for her to read having been informed of her illiteracy.”

Scenario: Client is transitioning to the NDIS and becomes unwell
“A significant decrease in his stability and escalation of his mental illness has occurred since having NDIS supports. He had his first hospitalisation in over 18 months. Since the NDIS package he presents as more isolated and withdrawn as his NDIS providers lack coaching skills, have not worked to build rapport with him that would be the basis for coaching him to make more positive choices. They do not know how to provide assertive support underpinned by a strength-based approach, and do not follow up regarding risks. He is now having his medication delivered to him daily by the clinical team where before he was managing his medication independently with some coaching from the HASP support worker.”

4. Respecting consumer choice when clients with NDIS Plans do not want to transition to the NDIS.

Scenario: Clients prefer to remain with State psychosocial programs
“The [NDIS Support Coordinator] received many phone calls from the client at the start of the [NDIS] service…Within the first month of receiving [NDIS] support coordination he contacted reception [state psychosocial service] and asked to end his [NDIS] contract. When this was discussed with [the client] he stated that he did not want to [have NDIS supports as he] found it too confusing”

“[The client] received a letter and three message bank voice messages over the last 3 days regarding his transition to the [NDIS] and has not responded. He stated [to the State psychosocial support worker] that he does not want to change anything if [he does not] have to...[the client was very worried about the implications of this decision]”

5. Inadequate NDIS Plans – either with very little or, in some cases, no NDIS Support Coordination.

Scenario: State psychosocial worker assisting the client and his father to appeal
“There is no [NDIS] support coordination [in the NDIS Plan] ...the father would be considered an informal support through the NDIS and a significant amount of responsibility may be placed on him to provide support. There may be no room to build the client’s capacity further if capacity building supports are not put in place to develop [the client’s] ability to self-
manage...responsibility for [coordinating NDIS Plan] has fallen onto [the State psychosocial support worker] and the father”

6. Providing trauma informed care to support people deemed ineligible for NDIS and assisting with the appeal process

Scenario: State psychosocial support worker assisting client to deal with impact of being found ineligible for the NDIS
“[The client] has initially been declined from receiving an NDIS package due to their disability being deemed ‘not lifelong’ and because they ‘have not tried all treatment options’. The [client’s State psychosocial support worker] has requested a review of this decision and is providing further documentation...despite this rejection [the client] has significantly high needs”

7. Lack of flexibility for NDIS providers to manage risk. This reduces the capacity for NDIS providers to meet client need.

Scenario: NDIS providers attempting to engage with a client in a challenging situation
“A call was made [by the NDIS service provider] to the Quality Safeguarding Commission to ask if there was scope for a two person visit [by NDIS providers due to safety issues]...the Commission said they were not concerned with worker safety and only client’s safety”

Risk to Gaps in Service and Loss of Service Continuity

While clients of State psychosocial programs required advocacy support through NDIS assessment and planning phases, the greatest risk to loss of service continuity occurred when:
- People with NDIS Plans were at the stage of NDIS Implementation
- People had exited State psychosocial programs, transitioned to the NDIS but engagement with the NDIS was not sustained.

The majority of lived experience vignettes from NGO psychosocial support workers were focused on client experience of the NDIS Implementation phase and the service difficulties associated with full transition to the NDIS. Clients with approved NDIS Plans were likely to be in one of the following situations:
- The NDIS Plan is in place and awaiting a suitable NDIS provider. In some cases, (particularly in remote country) NDIS providers do not exist or there is a protracted waiting period
- The NDIS provider is in place, however there is a disruption to NDIS Implementation due to the NDIS participant experiencing an acute phase of illness requiring intensive
treatment support and/or hospitalisation. As a result the NDIS Plan is placed on hold whilst the NDIS participant receives mental health treatment.

- The NDIS provider is engaged with the participant’s NDIS plan and there is the need for an extensive service handover process between State psychosocial support workers and NDIS providers.
- The NDIS Plan is implemented however the State psychosocial service needs to remain involved to meet client need and mitigate service gaps.

A small sample of lived experience vignettes were provided by MHS clinicians highlighting risk to service continuity for clients who had exited State psychosocial programs. They included situations where:

- Clients with NDIS Access were determined ineligible for State psychosocial programs however there was no clear indication when NDIS services would commence. This left lengthy periods where clients did not have access to much needed psychosocial support.
- Client rehabilitation and treatment needs were compromised as the NDIS provider did not have the skill base or relevant mental health knowledge to work effectively with the client and the public MHS.
- Clients had exited State psychosocial programs and transitioned to the NDIS only to have the NDIS provider withdraw from the service agreement.
- NDIS Plans were found to not adequately meet client need.

In some instances people experienced a relapse of acute mental health symptoms and/or were at risk of hospitalisation as a result of the disruption in service continuity.

Vignettes

The following lived experience vignettes represent some of the issues facing clients. They are indicative of the difficulty and complexity associated with the transition from State psychosocial programs to the NDIS.

**Vignette 1. Client requires advocacy support to negotiate NDIS Access and deal with the distress experienced during the application process.**

Client of State NGO psychosocial support program was assisted to submit an Access Request Form. The client found the process quite confusing and distressing and requested the NGO support worker to manage the process and consult with the client as required. The support worker experienced a number of difficulties, such as; obtaining relevant reports; being confirmed as the NDIS contact person; and receiving conflicting information from the NDIA. The support worker managed the NDIS application process keeping the client informed of progress and liaising with other support services including MHS. The client stated that the NDIS application process would have been extremely difficult without the support received.
The support worker noted even though the client labelled the additional support as invaluable he still experienced a high level of stress and anxiety throughout the process. The client stated that without the support received from his NGO support worker he would not have been able to submit all of the evidence, and attend the appointments required to transition to the NDIS. The client’s NDIS Access was successful and he reports a sense of relief and a burden lifted from his shoulders since his acceptance letter was received. The client now awaits a planning meeting.

**Vignette 2. Collecting information to apply for NDIS is difficult when a person’s psychosocial support needs are high and they are experiencing mental ill health requiring periods of hospitalisation.**

The client is in their late 30s and has been involved with mental health services since their early teens. They are diagnosed with a serious mental illness, have a cognitive impairment and comorbid drug use. They experienced homelessness for some years prior to receiving support through a State psychosocial NGO program, during which time they were assisted to secure stable accommodation.

The client first applied (through an NGO support worker) to the NDIS 18 months ago. During this period the client experienced a number of stressful situations resulting in psychiatric hospitalisation. The client’s initial application was dismissed as a result of not being able to provide enough supporting information. This was during a period that the client experienced a relapse in mental health symptoms and was very disorganised. The client had to reapply to the NDIS with the assistance of the NGO support worker and the Mental Health Service clinician. Apart from personal health issues there have been a number of systemic issues contributing to the disruption in their NDIS application including:

- Risk of homelessness
- Difficulty with getting relevant reports
- Incorrect information given to the support worker about the status of the client’s NDIS application

The process has been slow and stressful for the client who already has a significant amount of stress in their life. With significant advocacy and support through the State psychosocial program an updated request form with support letters and evidence has been submitted. This is over a period of 18 months and the client is awaiting a decision on their eligibility for the NDIS.

**Vignette 3. Clients require continued State psychosocial support when NDIS Plans are not adequate and need to be reviewed.**

Client is in her early 20s and has been diagnosed with a serious mental illness. There is also complex comorbid health issues. The client is currently in hospital due to mental ill health and the State NGO psychosocial support worker is assisting her to find new accommodation. The client has NDIS Access however the NDIS Plan is not significant enough to meet her needs (accommodation and therapy). The implementation of the plan was lengthy with minimal
funding around the areas of concern for the client. Delays to NDIS Implementation were a result of difficulty accessing funds (locked to in-kind services for support coordination) and then there was a change in NDIS provider causing further delays.

The client requires a high level of psychosocial disability support (6 to 8 hours per day) to sustain community living but the NDIS Plan does not reflect this level of need. The funds for NDIS support coordination cannot be released because the client is in hospital with no planned discharge date. The State psychosocial support worker remains involved with the client to:

- Provide advocacy support for a review of the client’s NDIS Plan as it is not adequate
- Liaise with other services and at times provide case coordination (e.g. with housing providers)
- Support the client to navigate the health system – trauma informed care
- Work closely with mental health services to support the client’s treatment and rehabilitation.

**Vignette 4. Where there is complexity, mental ill health and challenging behaviours State psychosocial support workers need to remain involved until NDIS Plans are adequate to meet client need and safe transition to the NDIS can occur.**

Client is a male in his 50’s who has received State psychosocial rehabilitation support through the HASP program. There was a nine month period from when the client’s application for the NDIS was lodged and his NDIS Plan activated. The client is diagnosed with severe mental illness and is under Guardianship and Administration Orders.

The client had lived in a house with support through HASP, but acute and chronic mental illness led to him being unable to carry out basic activities of daily living (ADLs), leading to a long hospital stay and then to a Supported Residential Facility (SRF).

Due to complexities and challenging behaviours one to one support, multiple times a day, is required to maintain his tenancy. The State NGO service provider had advocated to utilise extra program funding as brokerage for support until the client’s Plan was activated.

This required high level organisation intervention at a policy level to ensure appropriate levels of support were available to meet client need. The State NGO support workers regularly advocated with the SRF to keep the one to one supports running smoothly.

When the client finally received an approved NDIS Plan it was not sufficient to meet his care needs and so for some months the State NGO support worker advocated for the Plan to be reviewed.

Following the approved NDIS Plan the client decided to choose an NDIS provider outside of the SRF to provide his core supports. The HASP support workers and managers had to negotiate this arrangement with the SRF management. The housing situation became increasingly tenuous and required continuous advocacy support through the State psychosocial NGO service.
It took over 14 months from NDIS application until the NDIS Plan was sorted and until Housing through a Supported Independent Living (SIL) option was organised. The core supports provided by the NDIS have been invaluable to the client. Full transition to the NDIS is expected once the SIL House is ready and the client has moved into the house.

Advocacy and support from the State psychosocial and rehabilitation programs during the 14-month period was extremely important to facilitate transition to the NDIS. This included:

- Collaboration and advocacy with multiple stakeholders to ensure stable housing
- Supportive trauma informed care to facilitate the client’s capacity to deal with the stress of change and transition to the NDIS
- Regular attendance at case meetings and dealing with conflict between stakeholders.

**Vignette 5. Gaps in service where there is social and health complexity and NDIS Plans are not adequate.**

Client is currently experiencing homelessness and residing in hospital due to difficulties finding suitable accommodation. This is the result of many social and health complexities. The client was accepted to the NDIS however the Plan was not significant enough to meet the client’s needs. The experience of homelessness had a significant impact on the client’s life, making it difficult to access appropriate supports and limiting their support networks. The NDIS Plan was financially inadequate and therefore the client was unable to access or sustain suitable accommodation. There were also issues with identifying suitable NDIS providers and accessing clinical support letters to advocate for increased funding. During this period the SA Civil and Administrative tribunal awarded full guardianship orders for the client. Once a Guardian is allocated decisions can be made on the client’s behalf. The client currently requires 6-8 hours per day to live in the community, however NDIS funding does not cover these costs.

**Vignette 6. Implementation of the initial NDIS Plan was challenging resulting in risk to the client’s mental and physical health.**

Client lives alone in a 2-bedroom unit and has a serious mental illness with coexisting physical health issues. The client is extremely vulnerable and needs assistance with domestic cleaning, house maintenance, self-care and decision making. A Housing and Accommodation Support Partnership (HASP) referral was made by the MHS clinician to support the client in the community however this was not prioritised on the basis an NDIS Plan was ready for implementation. The MHS clinician liaised with the NDIS Support Coordinator and a care plan incorporating the services of the NDIS Provider was implemented. The NDIS supports were focused on domestic assistance (including shopping) and self-care. In a short period of time the MHS clinician found the NDIS services were not meeting the needs of the client. The NDIS Provider did not keep with the agreed visits and the MHS clinician found the NDIS staff did not have an adequate understanding of the client’s needs placing the client at risk. The client

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40 State based NGO psychosocial and rehabilitation program
experienced a serious decline in mental state (resulting in risk of hospitalisation) and deterioration in physical health as a result of poor nutrition and self-care. The community mental health team increased supports daily and the MHS clinician advocated for changes to the provision of core supports through the NDIS Support Coordinator. The MHS clinician also applied for the involvement of a guardian through SACAT (South Australian Civil and Administrative Tribunal). The client’s NDIS Plan was eventually reviewed with a substantial increase in core supports. This occurred over an eight month period. Supporting the client during this period was problematic due to the lack of appropriate psychosocial supports and resulted in a relapse of acute mental health symptoms for the client with the potential need for hospitalisation.

Vignette 7. When a person is at their usual state of mental health and their psychosocial support needs are either stable or predictable, transition to the NDIS with advocacy support is more likely.

The client is a male in his early 30’s who has a serious mental health condition and has been registered with community Mental Health Services for over a decade. In the last three years the client has shifted from the family home and has moved into a unit in close proximity to his mother. Initially he struggled with the move and just after moving became very disorganised and unwell. The client was in hospital for two months and when discharged was registered with the IPRSS program. The IPRSS support worker has assisted the client with confidence and capacity in community living. The client’s mother regularly visited her son to make sure he was ok. The IPRSS support worker helped the client apply for the NDIS and NDIS Access was reasonably prompt. The mother worked very closely with the IPRSS worker and the NDIA planner to negotiate the client’s NDIS Plan. The Plan was approved with a good combination of support coordination and core supports. The Support Coordinator worked closely with the IPRSS support worker, the client and the mother to facilitate the client’s transition to the NDIS. The working relationship between the IPRSS support worker and the NDIS Support Coordinator facilitated a smooth transition.

Summary

The lived experience vignettes brought to life the system issues confronting people from State psychosocial programs. They were compelling and highlight the many difficulties that exist for people with serious mental illness and other health conditions when transitioning to the NDIS.

The vignettes reinforced findings from the consumer survey and the stakeholder consultation. In particular they demonstrated that transition to the NDIS does require advocacy and support and is often a complicated process especially when there is a disruption to a person’s life as a result of mental ill health and challenging personal and social situations.
The vignettes highlighted the importance of State psychosocial programs not only as a pathway to the NDIS but also to provide services in collaboration with the NDIS to mitigate the risk of gaps in service for clients.
LIMITATIONS TO INFORMATION COLLECTION METHODS

Target Population
The Project targeted people currently receiving State funded psychosocial rehabilitation services however two other groups were identified by NGO providers and also MHS clinicians for consideration.

- The NGO Survey Working Group was keen to survey people who had exited State funded psychosocial programs and transitioned to the NDIS. Unfortunately to meet Project timelines there was not the scope to extend a consumer survey to this group. A longitudinal study of this cohort incorporating an evaluation of physical and mental health outcomes is included in the recommendations.

- The Mental Health Service focus group raised concern for the client cohort who receive mental health services and may be eligible for NDIS and/ or State psychosocial programs but are not registered with either. This group is difficult to quantify but is considered significant by MHS and often impacted by episodic symptoms of mental distress and mental illness along with significant social and economic disadvantage. This includes at risk of homelessness, drug use, domestic violence, vulnerable to exploitation and contact with the emergency services and the justice system. The MHS focus group strongly advocated for this cohort to be part of a separate needs analysis survey and/ or service evaluation.

Consumer Survey
The consumer survey was limited by the need to double-handle information. The majority of participants were assisted by their NGO support worker to complete a hard copy of the questionnaire and then information from the hard copy uploaded by the support worker to the SurveyMonkey platform. Whilst acknowledging the need for double-handling data the priority was to ensure participants were supported and comfortable to participate.

When compared with State psychosocial client numbers the total number of participant respondents was approximately 26% which is a reasonable representation in the context of the groups’ psychosocial needs. Managers of non-government services report response rates of between 15 and 25 percent to satisfaction surveys conducted with similar groups. Findings from the consumer survey align with the information from case studies and workshop/ focus groups – there was no evidence of skewed results.

Aboriginal and Torres Strait Islander People
Six people identified as Aboriginal, 1 person as both Aboriginal and Torres Strait Islander and five people preferring not to say. This representation is not commensurate with the challenges and barriers Aboriginal and Torres Strait Islander people experience in negotiating the NDIS, particular in remote country regions.
SUMMARY

The Project found many challenges to NDIS access and planning for clients of State psychosocial programs including; dealing with the bureaucratic nature of the NDIS to determine eligibility; limited National Disability Insurance Agency (NDIA)/NDIS workforce understanding of mental illness and psychosocial disability; poor communication and collaboration with the NDIA and NDIS; and inconsistency and inequity with NDIS Plans.

To manage the access, planning and implementation phases of the NDIS, clients of State funded psychosocial mental health programs required advocacy support from NGO psychosocial support workers, public mental health service (MHS) clinicians and carers.

“I don’t know what’s going on. My worker is helping me. I have no idea what NDIS does even though my worker has tried to explain it to me. I don’t get it” (Consumer survey participant)

State funded psychosocial mental health programs were found to be a supportive pathway for people transitioning to the NDIS. Assisting clients through the confusion, frustration and uncertainty associated with applying for the NDIS was a significant NGO psychosocial service activity.

“I would not have been able to apply [to the NDIS] by myself. I would not have even known that I was eligible. I am worried this new system won’t suit me. I am quite anxious about the change and sad to lose my current [State based] support worker” (Consumer survey participant)

NDIS planning was most effective when meaningful sharing of information and collaboration existed between NGO support workers, MHS clinicians and carers, with NDIA planners. Face to face stakeholder contact during the NDIS planning process allowed for a more informed understanding of the client’s situation, the type of supports required and any associated risks.

“[NDIS Planning works well] when there is good communication with Mental Health teams, GPs and any other party involved in the client’s care [and] when stakeholders are working collaboratively” (NGO workshop)

Consumer survey participants felt supported by their respective State psychosocial support worker during NDIS planning reporting high levels of satisfaction with their planning meetings.

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41 Up to eighty-nine percent of consumer survey participants report assistance from psychosocial support workers with NDIS applications.
42 IPRSS Team Managers report a minimum of twenty-five percent of support worker activity involves the NDIS. This can be up to fifty percent for some support workers.
“I didn’t know what support coordination was but the lady was really helpful and worked with me and my mental health support worker in getting the right supports for me” – (Consumer survey participant)

Survey participants also reported high levels of satisfaction with their initial NDIS Plan\textsuperscript{43}, however on further investigation the level of support or specialist support coordination in NDIS Plans was on average less than two and a half hours per month. When cross referenced with stakeholder consultation this would be deemed inadequate.

NDIS Plans required a balance of adequate NDIS Support Coordination or Specialist Support Coordination and core support to be effective. If Support Coordination did not exist, Plans had the potential to be under-utilised. Consumers and carers highly valued core supports in assisting with self-care, home maintenance, pursuing personal interests and attending community groups. In some NDIS Plans participants received psychosocial disability support not previously available in State programs.

“[The NDIS Plan works well] with the right package [and the] right service [especially if it] includes support coordination and practical supports such as cleaning and gardening” (NGO workshop)

There was a greater likelihood of service continuity for people with psychosocial disability if there was a close service partnership approach between providers of State psychosocial programs, NDIA planners and NDIS Support Coordinators inclusive of carers.

“The [Individual Psychosocial Rehabilitation Support Service (IPRSS) support worker] and the [NDIS Support Coordinator] worked together to help my son....the planning meeting was very open and there was good communication [which] all helped. I am very happy and my son’s confidence has improved. He is doing much more” (Carer individual interview)

There was a low risk to gaps in service continuity for clients exiting State psychosocial programs to the NDIS when:

- NDIS participants’ psychosocial support and mental health treatment needs were stable and/ or predictable
- NDIS Plans included adequate Support Coordination (capacity building) and core supports
- Service agreements involved NDIS providers with the capacity to understand the impact of mental illness and psychosocial disability
- There was stability in housing

\textsuperscript{43} Up to seventy percent (70\%) of consumer survey participants who had attended a NDIS planning meeting reported being satisfied or very satisfied with the meeting and sixty-eight percent (68\%) satisfied or very satisfied with their initial NDIS Plan – Consumer Survey
Carer or other supports were involved in shared decision making.

“[Positive outcomes occur when] other sustainable supports exist [for clients] to complement the NDIS process; [for example] a family member, carer or other support agency” (Local Area Coordinator in reference to NDIS Access, Planning and Implementation for clients of State funded psychosocial programs)

Higher levels of risk to gaps in service for people transitioning to the NDIS from State psychosocial programs occurred when:

- There was complexity, challenging behaviour or threats to personal safety requiring intensive psychosocial support linked to mental health treatment services.
- The participant is experienced mental ill health necessitating treatment and/or hospital care.
- The participant was reluctant or refused to engage with services and there were Guardianship orders in place requiring adherence to treatment and/or the Public Trustee.
- The participant had severe psychosocial disability and comorbid health conditions requiring a multi-agency approach.
- There was homelessness or risk of homelessness.
- NDIS Plans could not be fully implemented due to NDIS providers either not available or who have decided to withdraw from NDIS service agreements with short notice.
- NDIA Planners and NDIS providers had little understanding of mental illness and psychosocial disability.

“Many NDIS providers are not willing or not equipped to work with challenging behaviours” (IPRSS team manager)

The Project found that underpinning risks to service continuity were inherent model and workforce differences between State psychosocial programs and the NDIS. Clients of State psychosocial programs experience ‘complex health, lifestyle and behavioural support service needs related to their mental health’ and require care coordination and one to one advocacy and support across a range of life domains. State psychosocial models provide a responsive, flexible, individualised and persistent service closely linked to mental health treatment and rehabilitation. State psychosocial providers are trained in the application of psychosocial rehabilitation principles such as the least restrictive environment, strength based approaches to care and support, and dignity of risk.

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44 Consumer Characteristics IPRSS Service Model
“NDIS Support Coordination is not the same as case management offered through [State psychosocial programs]. There are gaps in service when a person is in crisis or acutely [mentally] unwell” (NDIS Support Coordinator)

By comparison the NDIS Support Coordination role operates within the boundaries of NDIS service agreements focussed on psychosocial disability support. Typically, NDIS Plans are prescriptive and closely linked to a billing schedule involving the selection of providers. This can only be altered by a time consuming review process.

“The [client] has an NDIS Plan but does not want the service because it is by appointment only. The NDIS price guide restricts flexible use of NDIS funds. The client is [mentally] unwell and will remain in homeless services but needs a service like IHBSS [Intensive Home Based Support Services]” (NDIS Support Coordinator).

Especially in situations where there is complexity, acute mental ill health requiring hospital care, and challenging behaviours, NDIS Plans with Support Coordination were found to not have the flexibility or capacity of State psychosocial services to meet client need. There were examples of people having been discharged from a State psychosocial program once NDIS Plans were in place only to find the NDIS Plan is not suitable and/ or the respective NDIS provider has withdrawn from the service agreement.

“[NDIS] Support Coordinators are stepping outside their role to help clients through a psychotic episode or crisis. This work cannot be billed and is not sustainable for the organisation” (NDIS Support Coordinator)

Recruitment of disability staff with an understanding of psychosocial disability to provide core supports was difficult and variable. Case examples highlighted a number of instances, where NDIS staff providing core supports found it difficult to engage with participants, did not understand or were not interested in the nature of a participant’s psychosocial disability or did not follow through on the NDIS service agreement.

“[Getting] a good core support provider is key. There is a variation between providers” (NDIS Support Coordinator)

Gaps in service were reduced when there were effective handover processes between State psychosocial providers and mental health clinicians with NDIS Support Coordinators inclusive of carers. In some situations, joint service partnership approaches were the only option to avoid gaps in service continuity. Best outcomes were achieved when NGO psychosocial support workers and NDIS Support Coordinators worked side by side during handover periods. NGO psychosocial staff conducted joint visits with NDIS providers as a way of training and modelling relationship
building with clients. This would give time for clients to develop confidence with the NDIS providers and to address areas of unmet need.

“We have had issues reducing our involvement with some consumers who have larger plans (often more complex)......we have been working with NDIS providers.....to ensure the consumers’ needs are being met......this takes time and is part of our exit planning” (IPRSS NGO senior support worker).

In a number of situations NGO psychosocial providers have remained involved in a person’s care when NDIS Plans cannot be actioned due to lack of resources (common in country regions) and/ or a persons’ needs are best supported by the respective State psychosocial program.

Risk mitigation practices by service providers were usually individual and/ or organization specific responses to client need rather than a systemically governed process. Consultation with service providers concluded guidelines and systems clarifying the role and functions of service stakeholders (specifically, MHS, State NGO psychosocial and NDIS providers, inclusive of lived experience) would provide greater consistency and safety for people transitioning from State psychosocial programs to the NDIS.

“Guidelines are needed to clarify stakeholder role and function” (NDIS support coordination/ State psychosocial provider focus group)

“Create business rules governing the interface between State programs and NDIS” (MHS focus group)

Project findings highlight the urgent need for state wide procedures to be implemented to guide the interface between State psychosocial programs and the NDIS to mitigate risk of gaps in service. Guidelines need to be applied at a local level to address the following:

- Recognise NDIS activity as core business within State psychosocial models building on psychosocial programs as a pathway to the NDIS
- Reinforce the principle of informed choice (National Standards for Mental Health Services) assisting clients with decision making and if required applying to the South Australian Civil and Administrative Tribunal (SACAT) for the appropriate orders to protect consumer rights
- Apply the SA Health Partnering with Carers Policy Directive, maximising carer involvement
- Promote collaboration between service stakeholders inclusive of lived experience with the NDIA and NDIS to guide effective NDIS Planning and Implementation
- Ensure attendance by NGO psychosocial providers, and/ or MHS clinicians inclusive of carers at NDIS Planning Meetings
• Ensure comprehensive face to face handover procedures maximising consumer engagement with NDIS plans and ensuring service continuity
• Facilitate joint NDIS State psychosocial working arrangements with NDIS providers where psychosocial care coordination is required to meet client need
• Establish formal service partnership agreements between the NDIA and State psychosocial programs inclusive of lived experience to improve service systems.
• Include quality assurance pathways for escalation of poor practice and/or system issues.
• Facilitate streamlined access pathways to the NDIS.

Reduced Federal funding whilst not in scope for this Project was observed by many to reduce psychosocial support services and pathway options to the NDIS. This is a subject of other reports and reinforces the importance of State psychosocial programs as a supportive pathway to the NDIS.

“Partners in Recovery (PIR) have had funding cuts and now [reduced] capacity to assist with NDIS Access...who can help families prepare and send an adequate application [to ensure] all appropriate information is [available for NDIS Access]?” (Carer focus group)

Despite improvements to NDIS processes such as online information, request for service (RFS) forms and introduction of the NDIA Health Liaison positions, the Project findings indicate the need for a targeted NDIS access approach supportive of people receiving State psychosocial programs. Greater availability of streamlined processes involving NDIA staff with knowledge of the impact of mental illness and psychosocial disability is required to reduce client distress and involve family and other stakeholders in determining NDIS eligibility.

A common thread throughout the Project were service differences between a ‘market-style disability services system’ and a public funded mental health service system with NGO psychosocial support linked to treatment and rehabilitation. In some situations, this can result in high risk to gaps in service.

“The NDIS [provider] withdrew their services without notice...we were not advised....the client relapsed and was hospitalised...they [client] were with HASP (Housing and Accommodation Support Partnership) but exited very quickly when NDIS came on board” (Mental Health clinician – case illustration)

45 National Disability Insurance Scheme: Psychosocial Disability Pathway, May 2018, Mental Health Australia; Mind the Gap: The National Disability Insurance Scheme and psychosocial disability Final Report Stakeholder identified gaps and solutions, January 30th, 2018, Sydney University;
46 Battams, S., Emerging issues for the NDIS, Health Outcomes International, (June 2017) p3.
State psychosocial providers reported increasing difficulty finding NDIS providers with the willingness and/or skill base to engage with people at the implementation stage. There is a trend that NDIS market responsiveness\textsuperscript{47} is not keeping pace with consumer demand.

“I try to make sure [clients with NDIS Plans] are connected with NDIS Support Coordinators who understand mental illness…but this is getting more difficult as the good [NDIS providers] now have waiting lists” (NGO IPRSS/ HASP support worker)

While the NDIA is developing the Complex Needs Pathway and plan to implement recovery coaches, this will take time, and it is not clear what the potential will be for the NDIS to increase its capacity to provide broader psychosocial support coordination.

Ongoing evaluation of the interface between State psychosocial programs and the NDIS will be an important part of service development and accountability. The following recommendations reflect the Project findings on mitigation of risk to gaps in service continuity\textsuperscript{48}. They are designed to reinforce what was found to ‘work best’ for people transitioning from State psychosocial programs to the NDIS.

\textsuperscript{47} Battams, S., Emerging issues for the NDIS, Health Outcomes International, (June 2017) pp 2-5
\textsuperscript{48} Ibid, p 12
RECOMMENDATIONS

Recommendation 1

People with National Disability Insurance Scheme (NDIS) Access continue to receive services from their respective State psychosocial program to:

- Ensure continuous service during handover periods from NDIS Planning to Implementation
- Mitigate gaps in service when both State non-government organisation (NGO) psychosocial support and NDIS provision is required to reduce the risk of unmet need

Rationale

- Lived experience vignettes highlighted that NDIS and State providers working side by side mitigate gaps in service continuity where there is complexity, acute mental ill health, challenging behaviours and co-morbidity needs not being met within NDIS Plans
- NDIS and State psychosocial services and are not ‘like for like’:
  - State NGO psychosocial services provided responsive, flexible, individualised, assertive and persistent services closely linked with mental health treatment and rehabilitation
  - NDIS Plans offer core supports with the sole focus on ‘doing for’ and were able to provide ongoing
  - Psychosocial disability support not possible in State psychosocial programs
  - Whilst the NDIA is developing the complex needs pathway and plan to implement recovery coaches it is not clear what the potential will be for the NDIS to increase its capacity to provide broader psychosocial support coordination for people with very complex needs
  - In a number of case illustrations NDIS Plans were complementary to the psychosocial support from State programs.

Recommendation 2

Review State psychosocial rehabilitation service models to incorporate the Project findings in relation to practices and processes that are working well. This includes:

- Recognition of formal collaboration with the NDIS as part of core business
- A service description of the Mental Health Service (MHS) and NGO role and function in supporting clients to apply for and transition to the NDIS
- Specific service responsibilities that mitigate risk of service gaps during handover periods or when working jointly with NDIS providers
Rationale

- State psychosocial programs were found to be a supportive pathway for clients through NDIS Access, Planning and Implementation
- Consumer survey participants reinforced the importance of advocacy support from psychosocial support workers to deal with the NDIS process.
- Service collaboration with NDIA staff and NDIS providers to support clients through the NDIS process has become a significant activity of State based psychosocial support workers.
- Public Mental Health Service (MHS) clinicians and NGO service providers are seeking clarification around their role and function and the interface with NDIS – service approaches between State psychosocial programs and the NDIS vary across Local Health Networks (LHNs).
- Protocols and guidelines supporting a service partnership approach between NDIS Support Coordination and State NGO psychosocial support was found to mitigate the risk of gaps in service continuity
- Clarification of State psychosocial providers’ role in NDIS activity will assist with handover and joint NDIS/ State psychosocial provider working arrangements.

Recommendation 3

Develop state-wide policies and procedures in line with the Project findings to guide the interface between State psychosocial programs and the NDIS. Ensure governance is representative of key stakeholders and with jointly created systems and agreements promoting service continuity.

Build on existing State psychosocial allocation committee processes to develop state-wide procedures, in collaboration with stakeholders and Lived Experience representation. Procedures would be implemented in local and regional governance structures and would formalise service collaboration between LACs, NDIS Support Coordinators, Local Health Network MHS and NGO psychosocial rehabilitation support providers

Establish an ongoing partnership quality assurance process with regular reviews and reports on service development and client mental and physical health outcomes. Ensure this process includes the capacity for all stakeholders to escalate system and service issues and report on inconsistent practice.

Rationale

- Establishing a governing body representative of key stakeholders including Lived Experience that aligns with the work of the Taskforce and could build on existing State government psychosocial program governance and operational processes.
- Development of NDIS Plans is most effective when there is meaningful sharing of information and collaboration between key stakeholders (i.e. client, MHS, NGOs, GPs,
carers, NDIA Planners and NDIS providers) – formal collaboration with agreed
protocols provides a service partnership approach mitigating risk of gaps in service.

- State NGO psychosocial providers and MHS clinicians highlight the need for
  operational guidelines/ business rules to govern their practice.
- Development of protocols and systems promoting ‘best practice’ requires ongoing
  quality assurance especially given the changing service environment.

**Recommendation 4**

**Improve pathways to the NDIS for all people receiving State psychosocial support services**

**by ensuring access to skilled and knowledgeable NDIA staff in psychosocial disability and**

**with service systems modelled on the NDIS complex needs pathway.**

**Rationale**

- Clients report wanting to choose services from State psychosocial services but feeling
  pressured to apply for the NDIS, causing distress.
- Whilst there have been improvements to NDIS processes such as online information,
  request for service (RFS) forms and introduction of the NDIA Health Liaison positions
  Project findings indicate the need for a more targeted approach supportive of people
  receiving State psychosocial programs.
- Access to a streamlined process such as the NDIS complex needs pathway will reduce
  client distress by the involvement of NDIA staff with skill and knowledge of the impact
  of mental illness and psychosocial disability.
- Carer reports indicate the NDIS complex needs pathway to have very positive
  outcomes however access to this pathway is limited.
- An improved NDIS access pathway for clients of State psychosocial programs is likely
  to result in greater use of ‘strengths based’ language congruent with a recovery
  approach, less reliance on the need for advocacy outside of the NDIA, and improved
  consistency in determining NDIS eligibility
- NGOs report the streamlined access process outcomes for clients to be variable

**Recommendation 5**

**Implement a longitudinal study to assess the impact of the NDIS on the lives of people who**

**have transitioned from State psychosocial programs to the NDIS. In the short term collect**

**information on the consumer and carer experience of NDIS reviews noting service**

**outcomes.**

**Rationale**

- People who have already transitioned to the NDIS from State psychosocial programs
  were not in scope for the consumer survey.
• Evaluation of the longer term outcomes for this cohort is part of a monitoring process addressing accountability. Information on the following would guide service development:
  ➢ The extent of improved psychosocial disability support
  ➢ Any gaps in service relating to mental and physical health outcomes
  ➢ Improvement in quality of life including social connectedness, housing, employment and education outcomes
• Service issues that may arise due to a change in service orientation – i.e. comparison of the NDIS focus on disability support ‘doing for’ with the strengths based approach of State psychosocial services focusing on skill development ‘doing with’.

Recommendation 6

Develop key performance indicators and systems for carer participation in NDIS Access, Planning Implementation & Review – ensure the SA Health Partnering with Carers Policy Directive⁴⁹ is a standard applied when clients are transitioning between State psychosocial programs and the NDIS.

Rationale

• Carers are not always informed of NDIS progress and/ or invited to participate in NDIS Planning meetings resulting in loss of information and support for clients
• Where carers/ family are involved in transition there is a greater likelihood of successful outcome
• Information and participation by carers mitigates the risk of gaps in service

Recommendation 7

Ensure the principle of ‘informed choice’ (National Standards for Mental Health Services)⁵⁰ applies to people who are either making decisions about applying to the NDIS or have NDIS Access and are, or will be, involved in NDIS Planning and Review.

Rationale

• The NDIS interpretation of ‘choice and control’ does not necessarily equate to the mental health principle of ‘informed choice’ especially as many people with psychosocial disability find it difficult to understand the potential service implication of the NDIS.

Case studies describe many scenarios where the involvement of the Office of the Public Advocate is required to assist with decision making for people impacted by psychosocial disability.

Clients from State psychosocial programs report feeling pressured to apply to the NDIS when their preference is to remain with the respective State program.

Clients from State psychosocial programs with NDIS Plans are involved in service agreements in the context of selecting and billing NDIS providers. Given the extent of psychosocial disability many people experience this is complicated and time consuming and has the potential to leave participants vulnerable to ineffective NDIS Plans unless there is high quality NDIS service coordination.

**Recommendation 8**

As part of the Taskforce unmet needs project consider a needs analysis survey and service evaluation for Local Health Network MHS clients who are not registered with State psychosocial programs or the NDIS, but who experience episodic symptoms of mental illness and psychosocial disability.

**Rationale**

- This group was out of scope for the Project but were identified by MHS clinicians as a significant cohort with many identified as needing NDIS disability support, but not in a position to manage the NDIS application process due to some or all, of the following:
  - the impact of persistent and/ or acute mental illness symptoms
  - at risk of homelessness, drug use, or domestic violence
  - contact with the justice system
  - vulnerable to exploitation
  - presenting to emergency services.

Whilst not in the Project scope reduced commonwealth funding to programs outside of the NDIS such as Partners in Recovery (PIR) was observed by many to not only create gaps in service for this group but reduce pathway options to the NDIS. This is a subject of other reports\(^{51}\) including the Mental Health Australia

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\(^{51}\) NDIS: Psychosocial Disability Pathway May 2018, Mental Health Australia; Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, January 30\(^{th}\), 108, Sydney University.
# APPENDIX 1

## National Disability Insurance Scheme Transition Pilot Project

### Project Partners Group

### Terms of Reference

#### Background
SA Health has commissioned the Mental Health Coalition of South Australia (MHCSA) to undertake the National Disability Insurance Scheme (NDIS) Transition Pilot Project to report on the consumer and carer experience of transition between State based psychosocial rehabilitation programs and the NDIS. The Project will highlight positive outcomes, challenges to engagement with NDIS, any gaps in services and make recommendations on service improvement. The Project Partners Group is representative of MHCSA, SA Health, Non Government Organisations, Consumer and Carer Lived Experience, National Disability insurance Agency (NDIA).

Programs in scope include Individual Psychosocial Rehabilitation Support Service (IPRSS), Housing and Accommodation Support Partnership (HASP), GP Access and Intensive Home Based Support Services (IHBSS).

#### Role/ Purpose
- Provide advice and feedback on the Project Plan and Design that is congruent with the Project Aim.
- Assist with Project Methodology to ensure the collection of information and data complies with National Standards for Service Evaluation and Improvement.
- Promote the Project amongst key partners within State funded programs.
- Assist with one off consultation when/ if required.
- Highlight the outcomes and recommendations of the Final Report to the NDIS Task Force.
- Distribute the Final Report to consumer and carer groups, service partners within State based programs and the NDIA.

#### Membership

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<th>SA Health and MHCSA</th>
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<td>OCP LERG – Consumer Representation</td>
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<td>Uniting SA</td>
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#### Other
Meeting to be held at CitiCentre, 1500 to 1630
- 3rd October, 2019
- 7th November 2019
- 5th December 2019
### Background
SA Health has commissioned the Mental Health Coalition of South Australia (MHCSA) to undertake the National Disability Insurance Scheme (NDIS) Transition Pilot Project to report on the consumer and carer experience of transition between State based psychosocial rehabilitation programs and the NDIS. The Project will highlight positive outcomes, challenges to engagement with NDIS, any gaps in services. The NGO Survey Working Group will assist with governance for the collection of information and data. Programs in scope include the Individual Psychosocial Rehabilitation Support Service (IPRSS), Housing and Accommodation Support Partnership (HASP), GP Access and Intensive Home Based Support Services (IHBSS).

### Role/ Purpose
- Assist with the collection of information and data via individual surveys, de-identified case studies and NGO workshops.
- Ensure survey activity complies with National Standards for Service Evaluation and Improvement.
- Co-design survey templates and nominate survey participants.
- Deliver survey questionnaires in a manner that is independent of bias, confidential and with informed consent and supportive of any client distress.
- Facilitate and participate in service provider workshops.

### Membership
- Centacare
- Life Without Barriers
- Mental Health Coalition of SA
- Mind
- Uniting SA
- Neami

### Other
- Meetings will be monthly unless otherwise agreed with ongoing business to be conducted out of session.
- A minimum representation of three NGOs is required for a quorum.
- Agenda items to be forwarded to Mark Doyle (mark.doyle@mhcsa.org.au)
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