



QUEENSLAND TRANSITION to NDIS FOR MENTAL HEALTH (QTN Forum)

COMMUNIQUE – OCTOBER 2016

The Queensland Transition to NDIS for Mental Health Strategic Forum (QTN Forum) provides a mechanism to discuss the specific issues for people who live with a mental illness, mental health service providers, representative bodies and state and commonwealth governments in the plans to roll-out the National Disability Insurance Scheme (NDIS) in Queensland.

The role of the Forum is to develop a shared vision for a future service system once the NDIS is implemented. The members will work together to consider issues and plan for the implementation of NDIS in Queensland.

The purpose of this Communique is to provide the key outcomes of the full working group meeting of the QTN Forum, held on 31 October 2016. The QTN Forum is chaired by Queensland Alliance for Mental Health (QAMH) CEO Kris Trott and attended by representatives from the Queensland and Australian governments, and the Queensland and National sectors. The following members were in attendance at this meeting:

Present- Full Working Group

- Kris Trott, Chair, Queensland Alliance for Mental Health
- Jeremy Audas, SOLAS / MIFNQ
- Kingsley Bedwell, Richmond Fellowship Queensland
- Melissa Borzellega for Meg Quinn, Department of Education & Training
- Sue Charnley, Department of Social Services – Multicultural
- Pauline Coffey, Brisbane North Primary Health Network
- Josh Fear, Mental Health Australia
- Kate Hamilton, Department of Health (Brisbane)
- Michelle McAllister for Pattie Hudson, Central Queensland, Wide Bay, Sunshine Coast Primary Health Network
- David Meldrum, Mental Illness Fellowship of Australia
- Anthony Millgate, Department of Health
- Richard Nelson, National Disability Service
- Laura Barnes, Queensland Council of Social Services (QCROSS)
- Steven O'Reilly, Queensland Department of Aboriginal and Torres Strait Islander Partnerships
- Jennifer Pouver, Mental Fellowship of Queensland
- Deborah Pratt, Queensland Mental Health Commission
- John Riley, Department of Social Services – Disability, Employment & Carers Group
- Eddie Bartnik, National Disability Insurance Scheme
- Jo Sheppard, Toowoomba Clubhouse
- Sandra Eyre, Mental Health, Alcohol and Other Drugs Branch, Queensland Health
- Marie Skinner, Mental Health, Alcohol and Other Drugs Branch, Queensland Health
- Craig Stanley-Jones, Aftercare
- Trish Woolley for Christine Castley, Department of Housing and Public Works
- Tracy Worrall, Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- Tony Hayes, Department of Communities, Child Safety and Disability Services
- Geraldine Woods, Department of Communities, Child Safety and Disability Services

Invitees

- Julia Riordan, Queensland Alliance for Mental Health (Secretariat)
- Sue Pope, Queensland Alliance for Mental Health

Apologies

- Christine Castley, Department of Housing and Public Works
- Jennifer Cullen, Synapse
- Rebecca MacBean, Queensland Network of Alcohol and other Drug Agencies
- Alistair Macdonald, Queensland Aboriginal & Islander Health Council
- Noel Muller, Queensland Voice for Mental Health
- Meg Quinn, Department of Education & Training

Summary of the First Meeting of the Full Working Group

The chair welcomed participants and explained the intention and focus of the Strategic Forum. Acknowledgement of, and respect was paid to, the traditional owners past and present of the land.

Update on Early Launch Site – Townsville, Charters Towers & Palm Island

The following experiences, including the challenges being faced in the region were presented including:

- Sometimes long waiting times for letters of diagnosis from the hospital are experienced which impacts on the timeliness of the NDIS application.
- Transport is often not included in the NDIS plan.
- Local Area Coordinator (LAC) in some regions often defers to the hospital for decisions where these would be better made 'on the ground'.
- There have been low levels of interest in NDIS packages in some regional locations.
- Low numbers of planners can slow down the process in some locations.
- Some assessments are being done over the phone.
- Office of the Adult Guardian often supports people through the assessment process but is sometimes unsure on the level of psychosocial needs required.
- Approximately 50-90% of Day to Day Living (D2DL) participants currently receiving support from one service provider are ineligible for NDIS. This service provider is unsure and concerned how these people will be supported.
- Concerns around redundancies needing to be offered to staff due to insufficient funding to support organisations appropriately throughout the transition period. There is much instability in the sector for staff.
- The level of involvement in the NDIS has been underestimated by the teams in the hospital.
- Anecdotal evidence that people are declining the offer of an assessment when contacted via telephone.

For further information please contact:

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Transition of Existing Commonwealth Programs

In terms of a national picture, the following points were noted:

- At the end of June 2016, there were 101 service providers, 82 providing PHaMS.
- The three-year funding agreements take into account the staggered transitions.
- DSS invites people to come forward and discuss the issues as they arise.
- They have undertaken modelling region by region that can assist with the funding arrangements in terms of the number of NDIS participants.
- Everyone has either signed their agreement, or is in the process of doing so.
- The most significant funding has been transferred to the trial sites – service providers will receive 60% of their funding.

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- Broadly speaking, in relation to the number of eligible clients, the overall estimate from NDIS clients track closely to the predictions from the Productivity Commission.
 - There have been reports of organisations successfully transitioning their clients to NDIS.
 - A percentage of funding has been left with the providers to assist with continuity of support until end of 2017.
 - The health system will be responsible for the treatment of a mental illness. The NDIS is responsible for those living with a psychosocial disability, however the two will work together.
 - 9.2% of total funding has transferred nationally to the NDIS which is a reduction of \$4.1M.
 - In terms of transition support, DSS continues to work with QLD Health and NDIA to assess transitional requirements.
 - Organisations should go through the NDIS Readiness Tools to see what their particular needs are and then consider how they should be engaged within their organisation.
 - The policy is tighter on who is believed to be eligible – DSS is working with the NDIA for capacity building, including LAC partners which is an important focus of the future.

Comments post presentation:

- Concerns were raised over continuity of care due to various issues including redundancies, timing of portal payment and timing of people transitioning to NDIS packages.
- There is a phasing schedule in each of the bilateral agreements – all clients Commonwealth are in the ‘other’ category. Funding reductions are not supposed to happen until the end of the transition phase.
- For PIR and D2DL, there is no step down in funding as they are ‘in-kind’ contributions to the NDIS.

For further information please contact:

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NDIS Mental Health HHS Readiness Activities: Transition of Queensland Community Mental Health Programs & Update on Tender Parameters (Commissioning Framework)

A handout was distributed on the presentation from Sandra Eyre, Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health.

An overview of the Mental Health, Alcohol and Other Drugs Branch (MHAODB) response to the roll out of the NDIS and the support currently being provided by MHAODB to Hospital and Health Services was provided. MHAODB are working closely with the Community Services Funding branch to coordinate support to the Hospital and Health Services (HHS) and the community organisations who provide support to the mental health clients in the community.

The focus of the MHAODB support is to resolve uncertainty and provide a clearer pathway for clinicians to navigate and to identify what is required to help the HHS and their clients to access the NDIS.

The following points were noted:

- Readiness activities are available for HHSs and NGOs and include support for mental health clinicians to understand the NDIS participant’s pathway.
- MHAODB has visited and will continue visiting HHSs as regions transition to the NDIS.
- HASP and some Community Managed Mental Health (CMMH) programs have been cashed out. Queensland Health will be required to maintain continuity of support for >65’s and for eligible NDIS clients until they transition.
- Transition of HASP clients: the majority of State and all of the ex-HASP clients are likely to transition to the NDIS. A very small number of State HASP clients will be 65 or older at the commencement of transition in their region. Support services will be maintained to clients aged over 65 unless their needs shift to be predominately aged care.

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- Key psychosocial messages with regards to the access request – clinicians need to shift their focus from mental health diagnosis and symptoms to functional impairments and related NDIS supports.
 - Messages to clinicians: disability focus and recovery oriented supports are compatible with the NDIS supports; the recovery focus maximises people’s potential to participate in the community and supports NDIS responses to fluctuations in mental health.
 - Likely composition of NDIS impairments in Queensland should be similar to that of earlier trial sites: Intellectual disability 30%, Autism 22%, Psychosocial 14%. Completing the access process for the NDIS: Tips for Communicating about Psychological Disability here has been developed to step through the functional impairments and assists clinicians and carers to identify likely NDIS supports.
 - Support Coordination is able to be funded as part of NDIS participants’ plans and is highly likely to be utilised in plans for clients who have a mental health issue.

The ongoing involvement of the MHAODB will be to monitor the transition of mental health clients to the NDIS and pathways for mental health clients who are not accepted or are ineligible for the NDIS.

Due to the current uncertainty about the timing of the NDIS transitions over the next three years, Queensland Health is proposing to extend community mental health contracts. This proposal is subject to further consideration and approval and the period of extension may be sufficient to allow planning for future community based support to occur.

When an individual has HASP funding, Community Funding Branch is currently working on changes to funding arrangements after the individual transitions to an NDIS package.

For further information please contact:
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Transition issues, pricing, areas of low eligibility – What is keeping the NDIA awake at night?

An overview of current comments and issues identified by NDIA are included are below:

- Further details regarding the phasing of mental health programs for each jurisdiction containing timeframes is to be released shortly, once agreed by governments.
- There is some flexibility around the first plan process and telephone interviews. Experience and learnings from trials were that the first plan was a big event for people and the new process for transition are designed to make this a smoother process.
- The NDIS is designed so that outreach strategies are built into the work of the Local Area Coordinators and Information Linkages and Capacity Building strategies. Further work on the Rural and Remote Strategy and Market Positioning Statements, such as the Northern Territory (East Arnhem), is being progressed.
- In terms of workforce, the NDIA is working to actively engage the mental health sector in the transition and build on the existing workforce numbers and capability,
- The QTN Forum is a unique forum across the country and is a good collaborative environment, where everyone is working jointly to try to find the best solution to challenges as they emerge.
- Based on the current round of Strategic Mental Health Roundtables, the NDIA is conducting around the country, there are some general themes emerging, such as: concern for a wider group of people who will not access the NDIS, capacity issues, rural and remote, NDIS’ role when people are in hospital and more details around the phasing schedule. Some examples of specific issues in some jurisdictions include:
 - SA: interest in having a forum such as Queensland. They have rolled out support for the children’s population, and due to the age groups, the mental health rollout for adults is not as advanced.
 - WA: role of GPs and primary care / PHNs is a focus.

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- NSW: focus on people with complex needs / forensic interface and the specific legislation around that.
 - NT: Market Position Statement for NT is in development – the NDIA Market Division has been working closely with NT organisations to develop this by the end of the year.
 - National Mental Health Sector Reference Group meeting from the 28th October – there will be some communication on that meeting soon, including all key project reports and feature presentations on the NDIA Aboriginal and Torres Strait Islander Engagement Strategy ([see link](#)).
 - Participant Pathway, hearing concerns from some people – need to have options for people with psychosocial disability and need to factor this in at every step of the pathway.
 - June 2016 NDIS Scheme and mental health data out shortly – all objective measures are going in the right direction. Communique will be available in a couple of weeks with a data report attached, which now includes an increased level of public data ([see link](#)).
 - Further to discussion on the recent situation in the ACT, it was clarified there is no cap – everyone who meets the access criteria will receive a plan as defined in the legislation.
 - Further to the joint work between the NDIA and Mental Health Australia on the recently completed Psychosocial Support Design project, the NDIA Markets Division is working on benchmarking studies and is also considering enhanced Market Positioning Statements for psychosocial disability. The issues of pricing, funding levels and service mix are being further considered.

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CALD Community and NDIS

A presentation on culturally and linguistically diverse (CALD) communities, the NDIS and mental health was included which raised concerns that people from culturally diverse backgrounds may struggle to access the NDIS.

The following points were raised:

- The NDIS is committed to a CALD strategy, however this has not yet been finalised and at present it is unclear whether this will include a mental health perspective.
- Currently only 4% of approved plans are for people from CALD backgrounds (compared with 27.7% of the population being born overseas and approximately 20% of population from not otherwise specified countries).
- Funding needs to be made available for community conversations around what is mental health, not just about the NDIS.
- Trust needs to be built or alternative processes need to be designed – this is particularly important for survivors of torture / trauma.
- Families need to be a part of any planning process – not just an individual.
- Reconsideration of language used when working with CALD communities.
- If the point of the NDIS is to enable the system to respond to individual needs, then the system needs to be flexible enough to do this.

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Primary Health Networks – Update on Mental Health Reforms

The following points were noted with regards to the current Primary Health Network (PHN) environment. The key questions for PHNs are: How do people with psychosocial disability transition to the NDIS? What is it that the PHN has been tasked to do?

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- The PHNs are responding to the federal government's response to the National Mental Health Commissions' review. PHNs are required to commission services against a stepped care model for mental health i.e. low intensity / mild moderate through to severe.
 - Transition Plan – July 2016 to June 2018 – the first task that PHNs have primarily achieved is to ensure that the contracts passed over to them, such as Headspace and Suicide Prevention, are continuing. In each region, it matters depending on what the region looks like i.e. getting services on the ground within X months and having a fully flexible funding pool – how do we make the best use of small resources that PHNs have? The commissioning process for the future is the PHNs design process.
 - PHNs have to commission primary clinical mental health care services. The federal Department of Health's (DOH) guidelines state PHNs cannot commission psychosocial disability support services.
 - PHN Priorities – needs assessments and annual activity workplans. Funding agreement commences on 15 June 2017. Recruitment of specialist staffing. Contracts for continuing services. Consultation and co-design for new services across seven Queensland PHNs. Engagement with the sector / consultation. Procurement of new services – how do we plan for primary mental healthcare into the future?
 - All Queensland PHNs have agreed to the same commissioning framework (see [link](#)). Review / Assess / Deliver / Co-design.
 - PHNs make up one cog in the wheel of mental health systems. There is a need to work with primary care: hospitals, Disability Services / NDIS and Human Services. PHNs are required by DOH to produce, in consultation with the HHSs, a regional mental health and suicide prevention plan by mid next year.
 - PHN and Queensland Health: Co-Commissioning is pursued as an opportunity in this space. Co-plan, co-design, co-invest for long-term co-commissioning -to produce better health outcomes for people.

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Operational Plan Update (Bilateral Agreement) & Division of Duties

The Bilateral Agreement is the key document signed by Commonwealth and State Governments for financial and high level phasing of NDIS into Queensland. The Bilateral Agreement can be downloaded [here](#).

The following points were noted:

- Bilateral Agreement – it allows for the expected numbers of people transitioning to the NDIS each year to match the funding made available by the Commonwealth Government in each of those years. 15,000 people will enter the scheme in year one, 16,000 in year two and 60,000 in year three. Ongoing negotiation is occurring regarding the funding transfer process.
- Continuity of Support applies to anyone who is currently receiving disability services from any Queensland Government agency, but is not eligible for the NDIS.
- A range of disability services currently provided by Queensland Government agencies will now be provided for under the NDIS, and funding for these services will be transitioned to the NDIS.
- Phasing Arrangements are a key element of the Bilateral Agreement and the Queensland Operational Plan.
- How people enter the scheme is governed by NDIS rules – *Facilitating the Preparation of Participants' Plans Queensland Rules 2016*. The Rules set out the key things the NDIA will consider in terms of priority for people to access the scheme, e.g. youngest to oldest, people leaving school. The Operational Plan also sets out agreed actions to facilitate access to the Scheme for participants and cohorts of participants with specific or complex requirements. Each area has an intake plan.
- Existing clients are those people who are currently receiving services from the Queensland Government and are known to agencies. 'Other' participants are not currently receiving services from the Queensland Government.
- North Queensland launch included children and young people under 18 years in Townsville and Charters Towers and all eligible people with disability on Palm Island.

For further information please contact:

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Panel Discussion: Collaboration Between Departments - Funding Phasing Out – Transitioning to NDIS or Not Eligible - Impact Upon the Sector

A facilitated panel question and answer session was held and the following questions and answers were noted:

In terms of people with severe and persistent mental illness, what is classified as Queensland Health clinical work for the HHS and what is the role of the PHN? How will this work?

Discussions are still happening around the role of the PHN. HHSs deliver clinical mental health treatment and this role won't change. The HHS has a clear idea of the services that they provide e.g. acute, treatment, rehabilitation and extended care and this won't change. With NDIS, if clients do get a plan, they may have NDIS take some of the HHS role away so that clinicians can focus on the acute clinical role. This may make the roles between QH and NDIS clearer.

PHNs focus on the primary care role and do not cross over into state delivered services. There are interactions between both, and both work together so that the best outcomes for clients can be achieved.

\$9M has been cashed out from community mental health but there will still be community mental health funding for those people in the community who require short term community mental health support. Contracts have just been extended for 12 months for now and then will be aligned to a new plan after that.

There are currently strong partnerships between NGOs and HHSs that possibly won't exist under the NDIS due to the change to an entitlement model which has not been built and funded in a way that would enable integrated systems. The importance of partnerships is currently a focus but this will change and impact on high risk clients.

What about carers – if they are not identified by a participant in or out of scheme – how do/will they get support?

The challenge is that people can go through an NDIS assessment and planning and not disclose that they have natural carer supports in place. NDIA has a set of things in place to tease this out of participants. For example, outcomes statements for under 25s ensure that they ask about their carer. In the current situation at the moment the carer accesses some supports via the carer gateway to see what kind of supports will be provided. In-home support would also be looked at. This is a respite component. This is not currently in place but the Department is trying to minimise the number of times that carers will be missed and then look at the carer gateway to assisting with this.

In 2020 when Partners in Recovery (PiR) will no longer exist, where will the systems for assertive outreach and intensive engagement be? Where will they occur – in NDIS? PHNs? QH? Where in the system?

PIR funding goes to the NDIS. There will still need to be a business model for providers to undertake outreach services as part of their business model.

How will a model which is market driven make sure that the useful addition of peer workers will continue to be encouraged by NDIS/A?

Some experience in the Hunter region is that those organisations that commit to peer support have grown exponentially. Where this is part of organisations' core strategy, there is great opportunity for this. The

dynamic that will happen is that people will get information about the effectiveness of peer workers from different sources such as their Local Area Coordinator (LAC) or planner or from their networks. Word gets around pretty quickly and people will take up peer support workers as part of their own decision. LACs and others who are assisting people with planning will provide information from a wide variety of sources. An LAC might provide some information and then they might connect people with other families and people to get access to information, and some information can only come from people with a lived experience. This goes to the heart of the values and practice framework that sits behind the thinking of the NDIS. Peer support is highly desirable and DSS has provided funding to stimulate peer support networks. There is need to do a lot more than that type of work and to train and support peer workers through organisations providing support, and to ensure that they see this as their core mission.

How do we keep a track on whether the mental health spend is getting better or worse? Not sure if the resources going into people with mental health issues and their families is getting better or worse.

Victoria and New South Wales have had significant reinvestment. Queensland's investment in the community sector has been relatively low. New South Wales is keeping its investment in community mental health despite NDIS, but a significant chunk of money has gone to support risks to individual clients coming out of secure wards that are currently well supported. Continuity with state health is going to be critical.

It is a concern that issues and problems are looked at as an individual rather than as a community problem. This individual focus takes away from the community ownership – that is the worry with NDIS.

What can we do better?

Evaluation and monitoring and embracing the opportunity to collaborate. Taking on a collective ownership around the investment and looking at who is responsible for putting that together.

Communication about spending needs to be clarified. We need to go back to budget papers and segregate community mental health spending such as PHaMS and PiR and compare this spending with what was in the forward estimates each year and then compare against actual expenditure. Capital spending on community mental health is declining. Nine State Governments agreed that the direction needs to be in the community mental health sector so the outcomes for states are very disappointing. The Queensland Mental Health Commission should be keeping track at a state level but also the National Mental Health Commission should keep track at a Commonwealth level.

Date and Time of Next Meeting

The next Core Working Group will take place on 13 February 2017 and the next Full Working Group meeting will take place on 27 March 2017.

For further information regarding the QTN MH Strategic Forum please contact:

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