A•S•U
Australian Services Union

ASU Submission

Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

Joint Standing Committee on the NDIS

Submitter: Linda White, Assistant National Secretary

Organisation: Australian Services Union

Address: 116 Queensberry Street
Carlton South, Victoria, 3053

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Table of contents

1. Introduction

The Australian Services Union (ASU) is one of Australia's largest Unions, representing approximately 135,000 members.

The ASU was created in 1993. It brought together three large unions – the Federated Clerks Union, the Municipal Officers Association and the Municipal Employees Union, as well as a number of smaller organisations representing social welfare workers, information technology workers and transport employees.

Current ASU members work in a wide variety of industries and occupations because the Union's rules traditionally and primarily cover workers in the following industries and occupations:

- Social and community services, including mental health services
- Local government
- State government
- Transport, including passenger air and rail transport, road, rail and air freight transport
- Clerical and administrative employees in commerce and industry generally
- Call centres
- Electricity generation, transmission and distribution
- Water industry
- Higher education (Queensland and SA)

The ASU has members in every State and Territory of Australia, as well as in most regional centres as well.

2. Who we represent in mental health services

The Australian Services Union represents workers across a range of diverse industries throughout Australia, including the social and community services sector. We are the union for support workers, mentors, team leaders, coordinators, social educators, case managers, advocates and managers in non-government community health in all States and Territories, and government mental health services in Queensland.

In addition the ASU is also the main NDIS union across Queensland, New South Wales, Australian Capital Territory, South Australian and Northern Territory representing disability support workers at the frontline of delivering NDIS supports.

The ASU, along with its members, are working hard to make sure the NDIS is the best it can be for everyone involved because we know that a quality, professional & sustainable workforce is essential to achieving the goal of delivering real choice and control for people with disabilities (including psychosocial disability) and respecting their rights.

3. The Inquiry

The ASU welcomes the opportunity to contribute to the Joint Standing Committee's inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

In Australia it is estimated that 1 in 5 people will experience some form of mental health issue each year.[1] The majority of people suffering from mental illness have non-enduring symptoms, which may resurface sporadically. [2]

[1] Mindframe, *Facts and stats about mental illness in Australia* [online] Accessed at: http://www.mindframe-media.info/for-mental-health-and-suicide-prevention/talking-to-media-about-mental-illness/facts-and-stats

Currently, funding from a number of state and federal programs is used to support people experiencing a psychosocial disability, but this will be rolled into the NDIS. However not everyone who is currently receiving support from these programs will be able to access the NDIS, due to NDIS eligibility requirements.

We are concerned about what will happen to those who are not eligible for NDIS funding. How will community based, recovery-oriented programs survive without ongoing secure state and federal funding?

We are concerned these questions currently remain unanswered, with the potential risk of these services ceasing to exist due to defunding or underfunding.

We are also concerned about the NDIS pricing model for various types of mental health supports. The inclusion into the NDIS of people with disabilities related to mental health issues occurred after the initial Scheme design and as such allowed less time for consultation and experience to inform how it should be integrated. It is important to remember there are key differences between the requisite supports required for mental health clients compared to those with a physical disability.

Mental health supports include outreach and crisis work which is often less predictable, is based on a recovery model with the need for greater training, supervision, debriefing, advocacy and case management focus. Feedback from our members indicates these type of mental health supports are not adequately provided for in NDIS pricing, and as such are at threat of being either reduced or eliminated entirely.

Failure to adjust the NDIS pricing model for people experiencing a psychosocial disability will have a significant impact on service viability, workforce quality and retention and the level and quality of service provided.

Recommendation: The sector, workforce and mental health consumers with lived experience be consulted in the ongoing review of funding, how best to ensure no gap emerges and that services remain properly funded.

4. Summary of ASU recommendations

The ASU makes the following recommendations to the inquiry:

Recommendation: The sector, workforce and mental health consumers with lived experience be consulted in the ongoing review of funding and how best to ensure no gap emerges and that services remain properly funded.

Recommendation: The State and Federal Governments enter into an intergovernmental agreement (e.g. COAG) to ensure there will be no gap in services and ongoing mental health funding will remain for non-NDIS eligible participants.

Recommendation: NDIS funding needs separate line items for psychosocial disability reflecting the actual costs of ongoing quality mental health supports.

Recommendation: Mental health programs like PHaMs and PIR should continue to be fully funded and separate from the NDIS to provide appropriate supports to people with mental health issues who are not eligible for the NDIS.

Recommendation: Training and development funding must be guaranteed under both mental health and NDIS systems to ensure ongoing skill development and quality of services. This could be via a portable training subsidy for workers for formal qualifications and direct funding to providers for ongoing clinical supervision and peer support.

[2] Ibid.

5. ASU issues of concern

The ASU's primary concerns relating to mental health and the NDIS are as follows:

1. Gaps in mental health service provision that may arise as a consequence of NDIS eligibility rules; and
2. For those people living with mental health issues who do qualify for support under the NDIS, the funding available for mental health supports is inadequate.

Gaps in mental health service provision due to NDIS eligibility rules

Under the NDIS eligibility rules, people with a psychosocial disability related to a mental health issue, are eligible for support under the scheme as long as they meet the access requirements. Becoming a participant of the scheme will depend on a number of factors, including, relevantly for this inquiry, a determination that your impairment is likely to be permanent.

The ASU is concerned people living with a psychosocial disability may not be eligible for NDIS funding, as their mental health issues are not "permanent". Most people experiencing mental health illnesses will not qualify as they live with a moderate and/or episodic mental illness and rely upon support programs that may not meet the eligibility criteria for the NDIS.[3] Many people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly.[4] Further, supporting people experiencing mental health issues often focusses on 'recovery', rather than on the condition or disability itself. The very notion of people with mental health issues needing to go through a process to demonstrate that they are in fact effectively permanently disabled in order to be eligible for NDIS funding is at odds with the approach adopted by support services.

People who do not qualify for the NDIS access requirements will need to rely on existing support services, however the funding for these very same support services are, in many cases, being subsumed into the NDIS. There is currently no commitment from government to continue to fund these services.

Accordingly, the ASU is gravely concerned that people living with mental health issues could be left entirely without access to adequate support to support their recovery.

Case Study - A mental health workers experience

The experience of clients in mental health who attend our service looking for assistance and not able to understand why they haven't qualified for NDIS or able to navigate how to get feedback, when a line in the letter refers to a section of an Act they have never heard of let alone read means little. Their experience was likened to dealing with Centrelink. As rollout progresses the services won't be accessible to allow someone to walk in and ask for help.

If the community mental health services either federally or state and territory cease being funded at the rollout of NDIS in their area there will be no service to specifically assist these participants. GP's, Emergency Departments and other charities/ non-government organisations that may have a shop front will see our participants without the expertise, or time, or resources to meet their needs that will result in a potential decline for this populations mental health.

[3] Probono Australia, *Concerns people with mental illness could fall through gap of NDIS* [online] Accessed at: https://probonoaustralia.com.au/news/2017/01/concerns-people-mental-illness-fall-gap-ndis/
[4] Mental Health Australia, *Getting the NDIS right for people with psychosocial disability* [online] Accessed at: https://mhaustralia.org/general/getting-ndis-right-people-psychosocial-disability

Further, there is a currently a lot of confusion surrounding who is and isn't qualified for NDIS funding. Our members report that the process of engaging with the application system and associated bureaucracy is unfortunately exacerbating the mental health issues of those they support.

ASU MEMBER SURVEY - views on gaps in service provision that are arising

We recently conducted a survey of hundreds of ASU members who work in community mental health. Our members are gravely concerned that successful and important mental health supports that they provide will no longer be offered, as a consequence of lack of funding for services.

Our members said:

- *I have been informed that there may be no new tender for the program I work in. This is due to the company prioritising NDIS over other services.*
- *My role is being phased out with the rollout of the NDIS.*
- *The work that I do will no longer exist.*
- *Funding cuts to PHaMs program has seen a reduction in staff, a redundant regional manager, and staff now working from home instead of an office.*
- *We have already been advised that our program will close with no likelihood of alternative employment.*
- *Funding cuts to PHaMs have resulted in the loss of a large number of workers.*
- *Currently we have a number of unfunded, add-on services and programs that are unlikely to be able to be continued.*
- *My employer is looking at broadening its approach to providing service so that mental health specific services will no longer be available but rather a broader disability service.*
- *My area of concern is what will happen to all the people who are struggling with their mental health who do not meet NDIS requirements??? This will impact on families and community if no services are still available and if wages are reduced the industry will lose many valuable staff only to be replaced with people who do not have the knowledge and skills.*
- *Consumers were promised continuity of care, but under the proposed changes to community mental health, I think there will be gaps in care and provision of support. Neither workers nor consumers are able to articulate what the changes are likely to be, suggesting that the NDIA has not done enough to support and educate people during the rollout. Some consumers will not be eligible for the NDIS and it is unclear what support will be offered to them (and it appears that our organisation, at least, does not have plans to continue providing support).*

A cooperative response between governments is needed

There is still time for state and federal governments to work together to ensure existing funding levels for community mental health services are maintained and for those experiencing a psychosocial disability related to a mental health issue are supported despite the fact they are not eligible for NDIS funding.

The ASU urges the state and federal governments to formally commit to maintaining existing funding and service levels for current and future consumers.

To adequately address these issues it is vital that governments, both state and federal, have close and meaningful engagement and consultation with stakeholders from the non-government mental health sector.

Recommendation: State and Federal Governments enter into an intergovernmental agreement (e.g. COAG) to ensure there are no gaps in services and ongoing mental health funding will remain for non-NDIS eligible participants.

NDIS mental health supports – pricing to be aligned with quality

We are also concerned about the adequacy of funding for consumers who are eligible for NDIS funding. The delivery of quality outcomes for mental health service users is dependent on providers being able to invest in activities such as performance monitoring, quality assurance, continuous improvement and workforce training, development and planning.[5]

The NDIS has not been designed to accommodate and support the bulk of mental health sufferers. This is due to the fact the NDIS is a disability program and not a mental health program, and the needs of clients are very different.

Prices for some key NDIS supports are too low and do not include these critical activities and overlooks the diverse circumstances in which support is provided. Mental health support differs from other disability support in that it is primarily focussed on recovery. Further, the nature of mental health issues means that a consumer's needs for support may vary widely over time. Consumers may have periods where they require intensive or crisis support, and other periods where they require less intensive support. The NDIS packages don't adequately take into account these fluctuating needs.

Further, mental health support work is complex. Entry level employees in mental health tend to perform work that aligns with level 3 in the SCHADS Award, but NDIS pricing assumes support workers are employed at level 2.3 of the SCHADS Award.

Uncertain funding arrangements, and fears associated with the transition to the NDIS are jeopardising the quality of service provision.

Many service providers are already, under the guise of 'preparing for the NDIS' using less staff, lower classified staff, and staff working fewer hours in order to reduce their costs. We are seeing reductions in service levels.

Case Study – Me Well

Recently Neami, a leading community mental health service provider, created a subsidiary called Me Well in order to provide NDIS services. Me Well will provide services where Neami would have previously as the NDIS rolls out.

Neami's justification is that the NDIS is too poorly paid and too risky to have it near the Neami brand. They want to make Neami a specialist, clinical mental health provider and have Me Well do what they see as the low-skilled work that the NDIS demands of mental health support. They plan for it to be award based and will have people on individual contracts.

Neami have said that there will be less supervision and training given to Direct Support Workers at Me Well (SCHCADS Level 2) than Neami would have previously provided. Support Co-ordinators will be paid slightly more than the current Support Worker role at Neami but will have a much larger case load and less time with each client, most of which will be back-of-house stuff not face-to-face.

ASU MEMBER SURVEY - views on reductions in offerings and quality in mental health services under the NDIS

Our members told us that their employers were already reducing the services they offer or the quality of the services they offer, or that they were aware that their employer was planning to reduce services.

[5] Queensland Community Alliance submission to the Productivity Commission inquiry into Human Services [online] Accessed at: http://www.pc.gov.au/__data/assets/pdf_file/0013/214114/sub446-human-services-reform.pdf

Our members said:

- *I have gone from a team leader role and 4 days a week to a support worker on 3 days a week due to restructure directly related to getting NDIS ready.*
- *From July 2017 the employer has indicated it will not be able to provide specialist recovery outreach community mental health support as it has been doing because the line item cost under NDIS will not be sufficient. As a result it is planning on setting up a new business model with less pay and reduced conditions.*
- *My employer is looking at employing Cert III in aged care and disability rather than CertIV/ Diploma level in Mental Health.*
- *The position descriptors have reduced qualifications required to a Cert IV, therefore wages are dropping.*
- *The NDIS does not fund enough for me to retain employment at my current level or pay rate.*
- *Neami has established MeWell which will provide NDIS services using lower paid, casual workers. Recovery based support will be phased out.*
- *I think that a lot of people will be excluded from accessing a package due to their mental illness not being perceived as being 'detrimental or chronic enough' (We have already seen this happen with some of our clients who have a primary diagnosis of Bipolar Disorder). I'm really fearful for what other publicly funded options will be available for people outside of the NDIS, especially as a large amount of people living with mental illness are not in a financial position to be able to access private services. I also think that the process of excluding someone from a package, and therefor saying 'you're current health and future recovery has no value (literally no dollar value)' will be enormously damaging.*
- *Moving to a band-aid model. Providing quick intervention with no follow-up. Reducing the amount of face-to-face hours that can be applied. Tracking who has funding and who doesn't. Passing people to other providers basically if a person doesn't come with a package our wages cannot be paid. Even those with packages often don't have accurate line item number to allow for the intense support needed.*
- *We cannot offer Bush Adventure Therapy anymore, and some of our advocacy mechanisms have changed. New programs and initiatives must be financially robust, instead of person centred.*
- *We no longer receive any training to assist us to help the individuals we support.*
- *Conditions are changing and have already had a detrimental effect on work life balance and income.*
- *We have been directed to try to push everyone through to get a package. This is intense work and has, in many cases, taken precedence over the client's presenting issues. It has been made very clear to our staff that we have to get packages for our existing clients or we will not have jobs.*
- *I am concerned that uncertainty is causing staff anxiety which is being felt by consumers. Also the two program areas I am involved in are not funded, but supported by the organisation. This will not be possible under a NDIS funding arrangement.*
- *MH clients will not fit the new NDIS system. People will be unsupported in the community, they will not have a voice or an advocate (support workers). More likely to become unwell and further disadvantaged in the community leading to increase in psychiatric admissions and possibly crime.*
- *There are fewer and fewer organisations in the sector as many fold in preparation of the NDIS or merge in order to compete with the existing big agencies.*
- *Costings in NDIS are too low to support skills and experience of current workforce. Other than some specialist roles, the rest appears to only sustain personal care or certificate qualifications. This is a kick in the guts for a sector that has worked so hard to professionalise themselves. Nil costing also for supervision, risk management and infrastructure. This will put workers and clients at significant risk.*
- *There is no certainty as NDIS funding amount is unclear, which makes it difficult for organisations to plan EFT. Reduction in activities that are not funded by NDIS, which only pays for direct care, such as training, supervision, attending meetings, documentation of care plans could lead to a reduction in trained staff who receive good supervision of their work practices. Could also lead to the casualization of the workforce and the loss of hard won conditions, particularly for low paid female employees such as carers leave, domestic violence leave, leave loading, long service leave and all the benefits of being a permanent employee. The funding model does not recognise*

the complexity of many of the consumers under psychosocial disability and is trying to apply a disability care model, which may not be a good fit.

- *My main concern is for the support workers/staff working under NDIS conditions. We are expected to have 95% face to face contact with clients across our workday to ensure the employer can afford us. We will no longer have an office, only a hub. We will have very minimal contact with our colleagues and managers which reduces our support and debriefing. We will not have time for toilet breaks between clients and are advised there will be days we won't attend the "hub" as we will commence and finish work from home. As a Peer Support Worker in Australia's largest provider of mental health recovery support, my own wellbeing will be diminished as we no longer have enough time to discuss client issues with colleagues as we go through our day, or have sufficient time to collect our thoughts and reset going from one visit directly to the next. I will not have the support around me to ensure I can offer the best support to my clients. I am employed because of my skills, and my lived experience of recovery which offers hope to people living with mental illness. I do not believe I can ensure my own recovery when I am required to meet 95% face to face contact with clients who are the most unwell in the community and very taxing to work with. NDIS is promising to improve the lives of people living with mental illness, but what about the wellbeing of the people actually delivering the support?*

Impacts and uncertainty on the workforce

As a consequence of both the absence of guaranteed funding for existing community mental health services, and the inadequacy of the NDIS funding for mental health supports, there is significant uncertainty among providers and workers as to the future of the community mental health workforce.

The provision of mental health services depends on the existence on an adequate, accessible and sufficiently skilled workforce. Our members working in the mental health services sector hold a unique position in which they not only support and care for the most vulnerable members of society, but they are also key advocates for their rights and aspirations to fully participate in society.

Workforce issues including high turnover, high burn out rate and stress levels and the inability to attract suitably qualified staff to the non-government mental health sector are well documented.[6]

Workers' ability to approach work in a confident, planned, professional and organised way is undermined by a culture of constant change. Already mental health service organisations are increasingly opting for part-time, casual and less qualified staff to keep costs to a minimum in order to win contracts and stay in business.

ASU member's comment:

From July 2017 when the organisation will roll over to NDIS funding only, the employer has indicated it will employ workers under a different contract with less pay and reduced conditions because it cannot afford to pay workers due to the line item cost under NDIS being less than it was receiving under block funding from the Victorian government. This will also lead to a reduction in staff access to training previously provided and supervision, mentoring and could lead to less skilled and experienced staff working in the sector and a reduction over time of the quality of the care consumers receive.

Whilst the NDIS is still only in its infancy there has already been some evidence of a growth of more insecure employment arrangements such as the increasing number of service providers employing workers through labour hire arrangements or as 'self-employed' contractors, to increasing levels of casualisation among direct employees.

[6] Parliamentary Inquiry into workforce participation by people with a mental illness [online] Accessed at: http://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/57th/iwppmi/Submissions/S008_Geelong_Trades_Hall.pdf

Service providers are looking to restructure their organisations to create casual and short-term positions because they say they are worried the NDIS will not deliver enough funds to cover wages and leave entitlements. There is also a move in some organisations to create a "two tiered" workforce with a small number of permanent supervisors and administrators and a large group of casual, hourly paid, disability workers.

ASU member's comment:

Margins between NDIS hourly rates and skilled workers' wages are so slim, that it doesn't allow time for reflection, debriefing, research etc. that is needed to provide effective support. I believe that our current workforce, which are generally full time Grade 3 workers, will be supplemented and gradually replaced by workers on PPT contracts of, for example 15 hours per week contracts with extra hours dependent on need, and likely to be Grade 2 instead.

In the Victorian NDIS trial sites significant workforce issues were exposed:

> "(t)here have already been lots of one hour shifts, lots of travel time. We've got staff working 15 hours to get 8 hours' pay, and they're running their own vehicles. … We try and have shifts backing on to each other but it's not always do-able"[7]

Additionally, the low level of pricing of direct care and support work and lack of certainty of demand in the NDIS competitive market, made it difficult to recruit and retain workers and to provide the same level of training and supervision as prior to the NDIS.[8]

It is acknowledged widely in the sector that the disability workforce will need to double by 2020 to meet the increased demand for services under the NDIS. There needs to be consideration for how the NDIS will attract specialist mental health workers to the sector and how it will retain the current skilled and experienced workforce.

The ASU believes good quality care in mental health services requires a stable workforce with adequate staffing and an appropriate staff mix, as well as working conditions that allow workers the time to develop and maintain trusting and supportive relationships with their clients.

ASU MEMBER SURVEY - views on reductions in working conditions in community mental health

Our members reported that many employers have already taken action to employ support workers on lesser conditions or in less secure work as a consequence of funding uncertainty. Worryingly, this includes wholesale restructures, or even setting up wholly owned subsidiary organisations as a vehicle to employ support workers on significantly worse conditions than their existing workforce.

Our members said:

- *I have lost over $500 a month due to changes in the way my company has changed the service hours*
- *My role is being phased out. My employer has proposed that in its place, I can choose to apply for a role with lesser conditions (from our workplace EBA to SCHADS - which has substantially fewer entitlements), I will have to use my own car for work when previously I had access to a work car, I will no longer have access to an office environment or direct supervision, I will no longer have access to a team environment or a team approach to care, I will have less leave, I will be required to use my own phone for work and case noting.*
- *Not personally but it is now only employing people at level 2 formerly it was level 3.*

[7] Charlesworth, S. & Macdonald, F. (2016) Cash for care under the NDIS: Shaping care workers working conditions? [online] Accessed at: https://www.researchgate.net/publication/296623648_Cash_for_care_under_the_NDIS_Shaping_care_workers_working_conditions

[8] Ibid.

- *My organization has set up a sister company which will operate under the SCHADS award. Leave entitlements will be reduced and pay rates for direct work will be greatly reduced and we will need to use our own cars.*
- *They have indicated a commitment to redeployment of permanent staff but no clear indication of what roles will be available to offer redeployment to. My role has now been renegotiated to a fixed term contract and I am no longer a permanent employee.*
- *My role will no longer exist. If I choose there will be other roles available at a drastically reduced pay rate.*
- *Neami has established MeWell which will provide NDIS services using lower paid, casual workers. New workers are only being hired on short term contracts, contracts are not being renewed, and MeWell workers will be paid at a much lower wage.*
- *Change to maximum term contract meaning I can be without employment effective almost immediately.*
- *Not yet, but they are actively targeting level 4 staff and firing them for ridiculous reasons and hiring lower paid inexperienced staff to replace them.*
- *I believe our current contracts won't be renewed and we will be offered a casual position on less money.*
- *Yes, many workers have already been made redundant, and the new workers have been employed at a reduced rate of pay.*
- *I went down 8 pay points 1 1/2 years ago, my employer stated that it was due to funding pressures in the sector due to NDIS rollout. They stated that workers could no longer be paid according to their training and experience. I have worked on and off in related community mental health services for 30 years and I am leaving the sector as I am no longer being paid for my extensive skill set and expertise.*
- *We have been told there will be no Community Support Worker positions. We will be employing the lowest qualified disability workers paid $5 to $7 less. We can either take a lesser role or there could be a small handful of coordinator roles but they won't be offering everyone a position and we will have to apply for those positions. Others may be offered a package to leave.*
- *Level 4 full time SCHADS positions are being replaced with level 2 SCHADS casual positions.*
- *Reduced from SCHADS 4 to SCHADS 2.2.*
- *We have been told that our wages may decrease and conditions (hours) will change. We have been told there is likely to be a higher casual workforce and fewer full-time positions available under NDIS.*
- *Current roles will be made redundant. New roles will be stripped back in terms of scope (i.e. removal of Care Co-ordination function) and will be offered at a far lower rate of pay. A small number of Care Co-ordination roles will be created at a slightly higher rate of pay but only offered to staff with a higher qualification. Therefore, staff without a higher qualification will be paid far less than current level for essentially the same tasks that they currently perform.*
- *We have been informed of significant changes to our workplace and conditions. When I questioned the introduction of hot desks because of the detrimental affects on the mental health of staff, I was asked point blank "Do you want to keep your job?" In addition, we will lose our work cars and have to use our own vehicles. Clinical supervision has already ceased and our manager has told us that those chats with your colleague and informal debriefs are a thing of the past. There just won't be time. We are working towards the impossible target of 95% face to face work by end of 2017.*
- *Target hrs leave 6 min spare in entire day to get between multiple appointments, find parking, walk to appointment, go to toilet, catch breath. New work conditions allow no time to reflect or plan client sessions, no contact with any colleagues each day - just straight from home to clients to home, no time to debrief with colleagues which is vital for sustainability of working all day everyday with people in v difficult circumstances, huge emotional distress, often with very challenging behaviours to manage. This leads to sense of isolation & emotional burden. Furthermore there will be next to no opportunity to learn from colleagues about how to do job or manage new challenges - especially when starting out. Having no time to recoup alone between appointments also a recipe for burnout. Have been advised future employees will be largely employed on part time and casual basis, unlike current contracts renewed annually. Safety systems e.g. pre appointment call check to clients for purposes of checking client is not in psychotic state or under influence of drugs and alcohol before arriving at their home will be cut as won't be funded - this increases risk & stress for workers entering unknown environment.*

- *Casualisation of the workforce, deskilling of the workforce due to lower conditions. Skilled workers leaving the sector due to lack of employment security and conditions. Gap in service provision to consumers who do not meet eligibility for NDIS.*
- *My main concern is we currently work in a sector that has block funding, with the NDIS that will cease, we will be providing services before getting paid and we have to rely on clients choosing our organisation there is no guarantee this will be ongoing, the future is very uncertain I don't know if it's in my best interest to stay in community mental health or look for other more secure employment, we are all feeling quite anxious about what the NDIS will look like and how it will impact us.*
- *That we will move to a casualised workforce and forced to work across 7 days. If you cannot bring your wages plus costs and profit you won't be needed. A lot of goodwill support is provided by agencies, that will have to stop. Maybe we will all have an ABN, work alone, no supervision and no support I can already see worker stress and hours increasing with no recognition and no pay. Community service workers don't like to do things half-heartedly so the put in the work and do notes in time they are no paid for. We are also seeing an increase in 1 worker models. Unsafe for all.*
- *The NDIA has set pricing at a level whereby mental health organisations cannot match the existing conditions. The work is grossly undervalued. The work that is currently being performed will not be able to be done in the NDIS environment. One of the great risks is staff welfare; staff will no longer enjoy the informal but vital support they currently receive from workmates when they need to debrief following challenging situations with consumers. Also the level of support they'll receive from line management will also be heavily reduced. The risk of burnout will be higher than ever. This can only mean a drop in quality of services and a drop in staff morale and retention. Community mental health workers were already earning below average wages but doing priceless work. The new environment can only result in a de-professionalisation of the work force.*

The ASU is campaigning for the NDIS to take the high road of secure jobs providing continuity of care, not the low road of cost cutting which means workforce churn through casualisation, and the resulting reduction of service delivery standards.

The NDIS pricing model needs to properly reflect the real cost of quality mental health support, including:

- Appropriate wages and conditions for the workforce and that reflects the complexity of the work they perform
- Secure jobs, not just short term casual work
- Career paths for mental health workers
- Team approaches and good quality supervision, including clinical supervision
- Specific mental health service provisions such as: case management, training, debriefing, documentation of care plans, etc.
- Stability of the workforce to ensure consistency for people experiencing psychosocial disability

As the mental health sector continues to transform we cannot ignore the views and voices of the workforce. Creating a safe, secure and sustainable sector that promotes consultation and collaboration between workers, rehabilitation and psychosocial support services, all the while trying to meet the unique needs of individuals and families will provide a strong foundation for the growth and development of our industry.

Recommendation: NDIS funding needs separate line items for psychosocial disability reflecting the actual costs of ongoing quality mental health supports.

Personal Helpers and Mentors services and Partners in Recovery Programs

The Personal Helpers and Mentors Services (PHaMS) is an Australian Government initiative delivered through non-government organisations to support people with a severe mental illness to manage their daily activities and live independently in the community with coordinated, integrated access to community services.

The Partners in Recovery (PIR) program aims to support people living with severe and persistent mental illness by providing a more coordinated system response to their mental health needs.

Both the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) program are set to transition over the next three years to the NDIS. This will mean a gradual reduction in programme funding as more clients become participants of the NDIS. But not all clients will be NDIS eligible, meaning there will be gaps in service provision.

Our members provide vital work in PHaMs and PIR programmes and are concerned about the potential impacts of program defunding and what this will mean in terms of job losses and the impact of the transition on the local community.

PHaMs was originally designed to fill a gap, to support people in the community who may not have a diagnosis or even a GP. It was designed as a 'soft entry' into mental health services to provide the right supports at the right time. PHaMs is very flexible and responsive to people's needs and keeps people out of hospital by providing a consistent support to people who have often been alienated or burnt out by family and friends. Our members working with clients are often the only people who never give up on them, and this has an effect on confidence and social skills.

Case Study

Kay (not her real name) has been with PHaMs for six years. When we first met her she was unidentifiable as either male or female, hidden under a beanie and a hat, sunglasses, overalls, work boots and headphones playing very loud white noise to block out the world. She had lived on the streets as a young person, has used drugs, suffered serious abuses from her family and a religious cult. Trauma affected everything about her.

With consistent support and lots of work on establishing boundaries in relationships, she has come a long way. Kay has not been admitted to hospital in the time she has been with PHaMs. She has completed two TAFE courses in a male dominated area gaining a Cert II and a Cert III with 100% attendance via public transport at night. Kay is now in a stable relationship, has a carer and is doing a wonderful job of mothering her two young children. She has had consistent support to manage her own decisions and navigate her way through divorce, property settlement and the mental health system in a rural area.

PHaMs has helped her to connect with other services and to develop trust in treating health professionals. The biggest factor contributing to her success has been that she has been consistently supported by every member of our PHaMs team over this time. She knows that people believe in her.

Already our members working in PHaMs are seeing a change in the way they approach new clients or "walk-ins" as the primary focus must be on getting them an NDIS package. This is taking a toll on the morale of our members as in the past they would have been able to assist the person straight away. The quality or face to face work is declining as reporting and logging of services increase. Our members are also worried about existing clients and how they might miss out on supports they need if they are not successful in getting a package.

Our members have reported they are currently being quoted a six week wait by NDIA staff before an NDIS application may be approved or rejected, and then a six month wait before an individual may have a planning meeting. They will not have funding to support those people in that time, nor to help them establish how their mental health issues may affect their lives and to convey this in an NDIS application.

A PHaMs worker's concern

An obvious concern is that the hours an individual may need are far from predictable. Some clients require regular touching base, and have predictable needs, but many do not. Clients overwhelmingly appreciate our consistent ability to respond to need, to be flexible, to help them address hurdles in their lives. As one client said, "I don't plan on getting unwell, or having things go wrong". These hurdles are rarely predictable, and the beauty of how "block funded" programs like PHaMs have worked is that we have strived to provide regular support but to also be flexible and be able to respond to people's needs when they arise. While we can also increase support for an individual when needed, we can decrease when needed, allowing people more independence and the opportunity to put into practice things they have learnt in their time with us.

Experience in pilot sites seem to suggest that only 20% of people who currently receive a service through PHaMS programs will qualify for the NDIS. This leaves 80% at risk of losing access to any Commonwealth funded service.[9]

Both PHaMs and PIR are very successful recovery services which must continue to be funded by the Commonwealth. Reducing funding to these services will result in poor mental health outcomes for people with severe illness and may increase the need for crisis and acute care services provided by the State.[10]

A PHaMs worker's concern

We have gone from a model of having a team with a team leader, in PHaMs at least one of the team members had to have a lived experience of mental illness, and as a team we would work out the best courses of action for particular clients. This collegial approach, which meant that each client benefitted from a team of workers, also benefitted us as workers too, as these discussions were opportunities to debrief and to support one another. Generally Team Leaders had the flexibility to be there for their staff, and had an extra level of expertise in mental health to provide appropriate support informally. We also had clinical supervision, conducted by a clinical psychologist, to support us in the work we do. Under NDIS we don't have time for any of this support, and Clinical Supervision was cut at the beginning of 2017 due to both the cost of it, and the hours lost under NDIS modelling. As workers, we are finding that we will call each other on the way home to debrief as we are not getting that support through the day, to avoid feeling stressed and isolated in our work. This of course has an effect on our quality of work, our wellbeing, and impacts on our families as we come home from work unsupported.

Furthermore to restore services in the future, will be more expensive, more time consuming, with the potential threat of the current qualified and experienced workforce having moved on.

Recommendation: Mental health programs like PHaMs and PIR should continue to be fully funded and separate from the NDIS to provide appropriate supports to people with mental health issues who are not eligible for the NDIS.

[9] The Schizophrenia Fellowship of NSW, 2017-18 Pre-Budget Submission [online] Accessed at: https://www.sfnsw.org.au/ArticleDocuments/1773/SFNSW%2520pre-budget%25202017-18.pdf.aspx+&cd=12&hl=en&ct=clnk&gl=au

[10] Mental Health Coalition of South Australia, *Discussion Paper: Community-based Psychosocial Rehabilitation: A Casualty of the NDIS?*.

6. ASU Survey of mental health workers

As we have noted earlier in this submission the ASU recently undertook a survey of our members who work in community mental health. It is apparent that ASU members working in community mental health are extremely concerned about the impact of the NDIS roll-out on the people they support and the removal of funding for key psychosocial programs. Our members are experienced professionals with more than 52% respondents having worked in the mental health sector between 5 to 15 years.

Sadly, more than 47% of survey respondents reported that they were looking to leave the community mental health sector within the next five years. The main reason they indicated they intend to leave are the changes to funding (such as the NDIS), with many citing they are able to get better pay and conditions working elsewhere.

Over 77% of survey respondents felt the NDIS will not make things better for people living with mental health issues. A significant concern of our is that the process of transition to the NDIS has become the sole focus of almost all client contacts, regardless of the other issues which many be affecting their lives.

ASU MEMBER SURVEY – Concerns for mental health service consumers

Our members told us they are concerned for the clients they currently support. When asked if the NDIS will make things better for people living with mental health issues they told us:

- *NDIS is a disability model. Recovery is the field I work in. Recovery happens over time over a lot of incidental day to day activities / functions. It is not something that can always be planned or put under a NDIS line item. We are now being geared up to be taxi drivers and shopping support and won't have the capacity to support people in crisis because it doesn't fit under a line item.*
- *Less flexibility of service. Transactional approach to non-concrete tasks (i.e., getting someone out of bed and getting them a meal is measurable, people without a diagnosis will fall through the gaps. No way of offering immediate support to someone who comes needing immediate assistance. Clients are being "locked in" to appointments of a set amount of time as the business cannot function with the margins associated with NDIS funding. Support cannot be tailored to meet needs of clients, does not allow for a worker's professional judgement or duty of care. Large gaps will form as programs like PHaMs and PIR are defunded.*
- *Some people will do very well out of it but many appear likely to lose the support they currently receive. The user-pays model of the NDIS also opens the door to reduce services in future and to fully privatise the sector, which would be catastrophic.*
- *The support we currently offer is flexible and responsive. As a worker, I am able to adjust my schedule to match the needs of my consumers (e.g.: if a consumer presents in crisis, I am able to quickly respond and can reschedule other appointments accordingly). I have the flexibility to liaise with other services, to provide direct support and to increase and decrease the level of support I provide as necessary. Most of the consumers I support do not understand that they will no longer be receiving the close support of a single worker who is able to provide a broad range of assistance. They also do not understand that, as workers, we will no longer have access to the same level of infrastructure and internal support that allows us to provide a high level of care.*
- *For the majority they will no longer benefit from a rehab/recovery model. NDIS appears to foster dependence rather than encourage recovery. The model also only supports some purchase of skilled qualified workers. For most the cost line items are too low and will only cover personal care or mental health cert. Clients will therefore no longer benefit from the expertise of different disciplines and skilled workers.*
- *How do you place a monetary value on someone's mental health recovery journey? It depends on what you mean by "better". If you mean, will people be treated as though they can't do things for themselves and have menial support with daily tasks, then yes. But if you are implying that they will be able to work towards a recovery where they are moving towards a meaningful and fulfilling life, then no.*

- *The NDIS is a fee for service structure; one of the defining aspects of mental illness is that it does not classically work within rigid structures- people may need really intensive support one year, and none the next- it is also possible that what is 'reasonable and necessary' to one will not be to another, and computer generated plans are already coming out with obvious and devastating holes in them. It is also very likely that people with mental health issues may not be able to consistently and accurately advocate for themselves, so if your yearly funding depends on you being competent and capable on the day of the review meeting, chances are a percentage of people will not get what they need. Workers are having to say no or think carefully about taking on new NDIS participants because they may not be able to deliver what they need with the funding available; we need to be able to work to the need, not the dollar, and it will be only at this point that the NDIS will fulfil its potential and provide a platform for equity.*
- *So far uncertainties and issues arising in first roll out are making supported people anxious about whether they will be able to obtain services in future. That is, the vision of the NDIS has the capacity to improve client outcomes, but so far the vision looks far from being realized.*
- *The NDIS is unsuitable for people with mental health illnesses. It doesn't have the necessary framework for best service delivery.*
- *I am a community mental health outreach worker - under the NDIS, this role will no longer be funded. The work that we do is very broad and intensive. We do everything from crisis management to navigating the housing system, legal matters, transport training, emotional support. We work very closely with our clients and have extensive training to be able to support them through all manner of situations. Training includes LGBTI, ESL, Advocacy, Drug and Alcohol, etc. No one service provider under the NDIS will be able to do what we do - providers will have very specific roles with limited training and support. Those with more expertise won't have the ability to do the regular direct contact work that we do, as a consequence of this they won't be able to develop the rapport that we do. All this means that, I believe, it will be inevitable that more of our clients will be presenting at emergency departments, coming to the attention of police and or homeless.*
- *We're having a challenging time educating GP's, specialists who haven't been through the NDIA process that clients with mental health conditions need support. The public view of disability as it appears in the media is of someone living with a physical disability. As a mental health support worker we are caught between the flexible, strength based PHaMS approach and adopting a more rigid bureaucratic approach that looks for evidence of permanent disability. It is causing our clients more anxiety and stigma. We're not even sure whether the road we're leading them down will result in a NDIS package.*

7. Conclusion

The funding uncertainty surrounding the mental health sector is compounding an already difficult situation with mental health services experiencing job losses and service cutbacks.

Our survey results demonstrate the very real impact that funding uncertainty is currently having on the community mental health workforce and underscores the need for the government to clarify funding arrangements immediately. There is an urgent need for the government to clarify what supports will be available to clients who do not qualify for support under the NDIS.

Failure to adjust the current NDIS pricing model for people experiencing a psychosocial disability will have a significant impact on the delivery of quality outcomes for mental health service users.

Currently the NDIS pricing model does not properly address the real cost of providing mental health support, with some organisations restructuring to create a “two tiered” workforce to employ workers on lesser pay and conditions. We call for a review the NDIS pricing model for mental health supports to ensure the NDIS will not only maintain but attract specialist mental health workers to the sector.

Finally, the ASU wishes to appear before the Committee to give additional evidence and to represent the arguments more fully, on behalf of our members.