NATIONAL DISABILITY INSURANCE SCHEME (NDIS) INFORMATION, LINKAGES AND CAPACITY BUILDING (ILC)
CO-DESIGN PROGRAM CONSULTATIONS

The timeframe for conducting the ILC consultations was extremely short with the National Disability Insurance Agency (NDIA) requiring the consultation workshops to be conducted and the online survey completed by 30 September, 2015

The Northern Territory Mental Health Coalition (NTMHC) was keen to ensure a 'voice' in the co-design of the ILC for Northern Territory mental health service providers and undertook to run workshops and capture feedback for the survey within the restrictive timeframe. Jennifer Upton was contracted by NTMHC and two workshops were held in the Northern Territory - one in Darwin on 27 October, 2015 and one in Alice Springs on 28 October, 2015.

Organisations represented at the two workshops were:

- ➢ Northern Territory Mental Health Coalition
- ➢ TEAMhealth
- ➢ Mental Health Directorate – Northern Territory Department of Health
- ➢ Darwin Community Legal Service
- ➢ Salvation Army
- ➢ Northern Territory Primary Health Network
- ➢ Golden Glow Nursing
- ➢ Mental Health Association of Central Australia
- ➢ Mission Australia
- ➢ Lifeline

Nine people attended the Darwin workshop and ten people attended the Alice Springs workshop.

1. THE CONSULTATION WORKSHOPS:

The National Disability Insurance Agency (NDIA) had prepared workshop materials for the consultation workshops and facilitators were requested to focus on specific areas for feedback into the survey. The following section is a summary of the information captured at the two workshops, which was subsequently loaded into the survey tool by the required deadline.

1.1 PRELIMINARY COMMENTARY BY WORKSHOP PARTICIPANTS

The lack of more detailed information regarding the transition, or not, of existing services and the eligibility criteria for individuals proved to be a source of frustration for participants of both workshops. Participants were keen for more information on

the implementation of ILC. *'We need more information about who can access ILC and what's in and what's out with regard to current services'.*

Participants expressed a high level of concern regarding the possible demise of existing services that are currently working well within the 'ILC space', particularly in regard to smaller organisations that have for many years provided a grass roots/community response to people with mental illness. Strong community connections alongside informal and formal networks that have been built over many years were described as the foundation stones for much of this work. *'Informal networking is the glue that brings it all together'.*

Participants identified the need for the NDIA to engage with those services that are working within the 'ILC space' to fully understand the breadth and complexity of what is currently being provided. *'There is a need to look at what services are in place and what's working well before making judgements around eligibility of service types'. 'Don't try and fix what isn't broken'.*

Participants discussed examples of where their organisations are providing additional ILC type services from within their own limited and stretched resources, often as an adjunct to funded services. The question was posed: *'Is the introduction of ILC an opportunity to access additional funding to meet that additional support'?*

1.2   PRIORITISATION OF FUNDING AREAS

Participants were asked to prioritise the pre-determined funding areas outlined below.

While all funding areas were viewed as a priority by workshop participants – with a degree of reluctance/scepticism the participants undertook the consultation activity of 'dollar locations'.

Funding Area A – Specialist or Expert Delivery

Participants discussed the need for more specialist/expert service delivery particularly in remote areas where services are either 'thin on the ground' or non-existent. Examples were given of where people 'come into town' from community for assistance but there is no continuation of specialist support once they return to community and they are then forced to come back into town. *'It's like a revolving door'.*

Funding Area B – Cohort Focused Delivery

Participants identified this funding area as a high priority because of the high level of Indigenous people that access services. Participants discussed the importance of meeting specific cultural requirements and ensuring that language barriers are addressed through appropriate responses. Participants cautioned against the use of a broad ATSI grouping in the development of service types. Rural and remote requirements in terms of culture and language are far different from urban settings - and even within rural and remote regions, there is a diversity of cultural and

language differences that need to be carefully considered in the development and implementation of services.

Funding Area C – Multi-regional Supports

Participants thought this area was important for regional consistency. However, they expressed concern that local solutions could be lost in an effort to save money through national-centric activity.

Funding Area D – Remote/Rural Solutions

Rural and remote regions are where the majority of workshop participants operate their services. They have extensive knowledge on the need to deliver services that can meet the needs of people residing in rural and remote regions. Climate, culture and the tyranny of distance all need to be addressed in the delivery of mental health services across the Territory.

Funding Area E – Delivery by People with a Disability for People with Disability

Participants stated that the inclusion of people with a disability in service provision is an important feature of service delivery that is underestimated.

- Votes (dollars) were allocated in the following manner:
- ➢ Funding Area A: 16%
- ➢ Funding Area B: 27%
- ➢ Funding Area C: 12%
- ➢ Funding Area D: 26%
- ➢ Funding Area E: 19%

1.3   ADDITIONAL FUNDING AREAS RECOMMENDED BY PARTICIPANTS

Carer Support: Participants identified a critical need for increased support for carers and carer networks. They provided examples of where increased funding and support in this area would result in increased social benefits for individuals, their families and carers, as well as economic benefits for government in the reduction of acute care admissions.

Training and Professional Support: The consultation materials focussed on the role of LACs and the professional and personal attributes required of people recruited to those positions. However, participants commented that the LAC would be ineffectual if the service system isn't supported to increase the knowledge and skills of staff 'at the coalface'. Success of the ILC will be 'reliant on a skilled and knowledgeable workforce'.

Independent Advocacy: Access to independent advocacy services did not appear to fit within any of the funding areas. Participants stated that the loss of independent advocacy services would seriously compromise the rights of people with mental illness.

1.4   RETENTION OF BLOCK FUNDING MODELS

Participants strongly advocated for the use of block funding to continue, and increase, flexible and responsive community based service delivery to meet the needs of people with mental illness. Case based or individualised funding models cannot work where services need to be fully operational - 52 weeks of the year - to meet the needs of people whose support requirements are so often intermittent and variable. *'You can't structure a person's mental health* (and support needs)'. Participants also recognised the value of one off or medium term project funding to research and trial specific areas of concern (for example forensic mental health), and undertake projects in the areas of community education and awareness.

Participants requested the NDIA to engage further with the mental health sector to investigate current areas of good practice and use case studies as a means to more fully inform the sector of how ILC may be allocated. Participants described the examples used in the consultation as 'fluffy' and 'irritating'.

1.5   IDENTIFICATION OF OUTCOMES THAT WOULD BENEFIT BOTH INDIVIDUALS AND COMMUNITY

Participants identified that these outcomes were both positive for individuals and the broader community:

- an increase in the diversity and range of quality services available for people with mental illness living in the Northern Territory – with a focus on accessible and flexible responses
- reduced admissions to acute care settings
- a reduction in discrimination through greater community awareness and understanding of mental health
- increased involvement for people with mental illness within their community of choice
- for some people, part-time or permanent employment opportunities
- Indigenous people with mental illness being able to live 'on community' with the appropriate supports.

1.6   MEASUREMENT OF OUTCOMES

The measurement of change and outcomes are complex areas and given the short timeframe for consultation it was not possible for participants to fully respond to this question.   Given the high priority placed on the measurement of outcomes by the NDIA (which was viewed as very positive), participants believe that contractual arrangements for all services, with the exception of specific short term project type work, should be long term i.e., up to 5 years. This view was supported by discussion on the nature of mental illness and the time people may take to engage with service providers, as well as the intermittent nature of some mental illness. It is was acknowledged that longer term contracts, where 'real' outcomes can be effectively

measured, would be required to be well managed through the introduction of supportive quality management systems; regular monitoring of services; and a strong emphasis on sector development support for service providers.

Participants strongly recommended the engagement by the NDIA of experts in the field of data measurement - particularly the determination of community and individual outcomes. Outcomes should be linked to appropriate national strategies relating to mental health and Indigenous health.

ADDITIONAL CONCERNS/COMMENTS DISCUSSED BY WORKSHOP PARTICIPANTS

ILC becoming **an overly bureaucratic system** that compromises the funding available by the introduction of administrative burdens at both the funder and provider levels, thereby reducing the dollars available for direct services.

Concern was expressed around the possible **diversion of ILC funding to building the capacity of mainstream services where those organisations had a social and/or legislative obligation for inclusiveness strategies and action plans.** *'This would reduce the pie - the dollars available for other purposes under the ILC'.*

Participants cautioned against **an over reliance on IT solutions**, particularly with client groups who may not have access or know how to use computer technology.

The role of the LACs was discussed at length. **Participants mentioned duplication of effort in terms of the current work being undertaken by Support Facilitators in the Partners in Recovery Program.** Participants were keen to know how LACs would interact with Support Facilitators. Also, who would employ the LACs - the NDIA or community organisations? The notion of placing LACs with community organisations raised some concerns around conflict of interest where the placement organisation was also providing direct services. On the other hand, the migration of skilled workers to more lucrative positions within a government structure was viewed as detrimental to the sector.

Eligibility of people who are undiagnosed. Participants gave examples of high numbers of undiagnosed people with mental illness that currently access services. Will people be able to access ILC services without a clinical diagnosis? Participants explained that if there is a requirement for clinical diagnosis many people will 'fall through the cracks' resulting in high levels of acute care admissions. Another concern expressed around people with mental illness moving in and out of services - would there be the requirement for re-assessment of eligibility after a lengthy absence as is the case in some other Commonwealth programs?

Participants requested the NDIA to ensure that **the ILC application process is transparent** and that information is publicly available on approved applications and the services to be provided.

2. ADDITIONAL INPUT BY NTMHC INTO THE ILC CO-DESIGN:

In addition to the information forwarded through the NDIA survey, a paper was prepared for National Disability Services for incorporation of relevant information from the NTMHC workshops into its national submission on ILC.