



**Community Mental Health Australia**  
**National NDIS Mental Health Conference**  
Sydney, 16 - 17 November 2017  
SMC Conference & Function Centre, 66 Goulburn  
Street, Sydney

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## CONFERENCE REPORT

### 'Towards a Good Life'

The theme of the inaugural 2017 National NDIS Mental Health Conference on 16-17 November was 'Towards a Good Life'. 489 people from community-based organisations, and government services and agencies gathered at the Sydney Masonic Centre together with consumer and carer representatives.

Organised by Community Mental Health Australia (CMHA) in association with Mental Health Coordinating Council (MHCC) and Western Australian Association for Mental Health (WAAMH) conference delegates heard from a diverse range of people with lived experience, consumer and carer advocates, parliamentarians, Indigenous leaders, as well as community and public health providers. The overarching theme set the tone for recognising the significant opportunity the NDIS presents, whilst bringing stakeholders together to discuss concerns and work towards solutions.

A key point raised was the need to ensure continuity of service throughout transition to the NDIS, and while some organisations reported impacts of reduced support, some positive outcomes have emerged in relation to the individual focus each package has created.

Many speakers raised concerns about the availability of services in regional areas and the additional education required to enable health care providers, government agencies and community mental health workers to assist people requiring psychosocial support to access the NDIS. Recommendations were also made for proactive outreach by NDIS services to people experiencing complex and diverse health and social needs including psychosocial disability - particularly in relation to Aboriginal and Torres Strait islander and CALD communities as well as homeless people.

In his opening address **Ivan Frkovic, Qld Mental Health Commissioner** urged service providers to hang onto their core values, whilst remaining open to new ideas, and to work collaboratively rather than perpetuating silos. A recurring point made was that organisations should consider staff as a key asset in the transition process when considering workforce restructures, and that they have the potential to become 'agents of change' in delivering the cultural shift required by the roll out of the NDIS.

Consumer advocates spoke of their experience of the NDIS and encouraged services to ensure face-to-face support, alongside a collaborative planning process over which they exercised control. Peer support was widely promoted as a demonstrated strength of the community sector which requires particular attention as a development focus.

The conference heard that support for early intervention and prevention was critical for effective NDIS delivery. Discussions further highlighted to switch the discourse to '**Intervene Early**' and focus on novel and innovative ideas as to how to connect people with their neighbourhoods and communities. Indigenous leaders spoke of ways of connecting by using community networks as well as individual or small group discussion.

**Aunty Donna Ingram** opened the conference with a welcome to country on behalf of the Gadigal people of the Eora nation and spoke about the transformational opportunities of the NDIS.

In her official opening presentation **Elizabeth Crowther, CMHA President**, acknowledged the lived experience of people affected by mental health conditions. She discussed the significant opportunity and potential of the NDIS and urged that implementation increasingly occur in partnership with the community managed mental health sector. She shared concern about gaps that are beginning to arise within the States and Territories.

The Dignitary Address was provided by the **Hon Jane Prentice, Assistant Minister for Social Services and Disability Services**, who reiterated that the NDIS is not about diagnosis but functioning, and is not about welfare but opportunities for social and economic participation. She also spoke about the NDIS Implementation of the Participant and Provider Pathway Review.

**Debbie Hamilton, Mental Health Advocate & NDIS participant** provided a keynote address in which she humorously described the NDIS as 'Now Delivering Inequitable Services' and questioned the varied access experiences that people with similar levels of need are having. She suggested that the access assessment process is not asking the right questions of people living with psychosocial disability related to a mental health condition. Having been an NDIS participant for more than three years Debbie said it has changed her life. The main theme of Debbie's presentation was that people with disabilities need to be included and not just integrated into society and supports a separate access and planning pathway for people with psychosocial disability but emphasised that the NDIA must do it right.

**Ralph Broad, Director of Inclusive Neighbourhoods/Local Area Coordination in England - The Centre for Welfare Reform** also provided a keynote in which he outlined the similarities and differences between the UK and the Australian NDIS experience, and reflected on the history, context, policy drivers and dollars for health. He proposed that human rights, contributing citizenship, and risk barriers were common to both; that consumer stories lead to change which must be community lead and that a long-term evidence based approach is key. He said that it is vital that people remain strong contributors to community - it is about not paying lip service to the concepts of social inclusion, human rights and citizenship.

Ralph suggested that you do not need to be an expert to support people with disability, but it is important to recognise that those living the experience hold expertise. Moving forward takes a policy shift with an increasing focus on capacity building, rather than waiting for people to fall into crisis. In the UK, Local Area Coordination (LAC) is helping both consumers and carers people with budgets. Ralph advocated for health, wellbeing, choice and control –

an integrated personal commissioning approach for people with enduring mental health issues, with a focus on a good life with natural supports; it is not just about needs.

Ralph said that people must connect to the services that they are most comfortable in, develop circles of support – this is an intentional effort that creates the conditions in which people can exert choice and control. LAC provides a positive vision for the future we can celebrate. This is about giving just enough support for people to do what they need to do. LAC develops communities that are more accessible where people nurture community resources. There must be access to the right people, in the right place, at the right time. It is important that eligibility is not an issue, where anyone can see a LAC, but are not obligated to. This encourages different ways of working collaboratively, having time to get to know a person, giving time to tell stories, acknowledge strengths, support a journey, and change culture.

Keys to success were identified as including a strong national framework underpinned by values and practice that recruits the right people, at the right salary. He suggested that we “think big, start small, get it right and grow!”

**Lisa Brophy, Academic, Melbourne School of Population & Global Health, University of Melbourne** provided an overview of the literature review [“Effective, evidence-based Psycho-social interventions suitable for early intervention in the National Disability Insurance Scheme \(NDIS\): promoting psychosocial functioning and recovery”](#)

Lisa described this work and why notions of intervening early for people with, or at risk of developing psychosocial disability is important. When the authors undertook the literature review they thought there would be an early intervention pathway into the NDIS; as the legislation made this a possibility. The NDIA have since clarified that this is not the case. Lisa says that we still need to understand the distinct needs of the 64,000 adult Australians with very high levels of psychosocial disability that will receive NDIS individually funded packages.

Lisa talked about the opportunities that arise with the NDIS to intervene early and promote psychosocial function and recovery. She spoke of the literature review conducted that set out to develop a stronger evidence base for effective interventions in responding to psychosocial disability and identify the interventions that demonstrate effectiveness for early intervention in the Scheme – either through the early intervention pathway or “early in plan”

The aims of early intervention in the NDIS are to “reduce the participant’s future need for supports”, including the “mitigation and alleviation of impairment” (Commonwealth Government of Australia, 2013). This meant alleviating the types of psychosocial disabilities experienced by people living with mental health conditions who may experience difficulties with e.g. cognitive and emotional functions; energy and drive; sleep; global activities and participation, such as: relationships with others; employment; personal health and self-care; as well as quality of life, wellbeing, satisfaction; activities of daily living.

The project sought to establish the elements for early intervention and the strongest to weakest evidence base. Lisa reflected on the fact that there are many contested ideas about what constitutes good evidence. However, both the emerging and supported empirical evidence suggests that pro-recovery interventions that particularly centre on peer support workers; advance directives and Joint Crisis Planning are of particular importance.

Lisa reported that the NDIS Independent Advisory Council, 2013, said that three interventions ‘tick all the boxes’: evidence-based practice that lines up with personal

choice/consumer preferences; that achieves recovery focused outcomes and are likely to reduce future support needs.

The study also identified the importance of working at the interface. This includes understanding physical health and the gap in life expectancy as obvious impediments to recovery and social inclusion; where loneliness has serious consequences and evidence regarding how to respond is limited. There must also be a focus on the social determinants of disability being viewed as a function of how the community responds to mental ill-health. The NDIS has the potential to bring people with psychosocial disability “in from the cold”.

Lisa suggested that it's time to challenge mediocre expectations, improve the uptake of social interventions and enhance capacity building supports to be the norm, whilst also co-ordinating and linking supports and interventions.

In conclusion, Lisa suggested that future research programs will need to be more cognisant of interventions that meet participant needs and also take into account their preferences for support. However we also need to set a baseline in regard to functioning levels and then track and analyse the impacts of supports and interventions.

On the second day, **Kerry Hawkins, Carer and President WAAMH** provided a keynote entitled “The Great Narrative Wars 2012-2017”. This was about making sense of the disability and mental health worlds colliding. She talked about the recent passing of National Mental Health Commissioner Jackie Crowe who said: “ Despite the work of well-intentioned providers, organisations and government entities, our fragmented mental health ‘system of care’ is struggling with increasing costs, uneven quality, human rights issues, rising suicide rates and people who are unable to live a full, contributing life of their choosing. Given the entrenched interests and practices of many decades, expecting mental health transformation that only comes from within (reform) is unrealistic.”

Kerry said there is hope for the 64,000 individual package recipients promised a revolution from without when they had given up on reform from within. Where they can access needs-adapted supports rather than (service) needs-adapted rationed resources; where there is promise of inclusion, citizenship, person-centred, individualised, recovery-oriented supports and an understanding of social role valorisation impacts and a new workforce to support trauma-informed psychosocial disability needs. However, Kerry reflected that for people ineligible for the individual packages there is despair and fear about falling through the gaps. Psychosocial disability is still contested space in the mental health sector, and the rush to roll the scheme out has further sacrificed and compromised implementation of key internal capacity building initiatives. There has been inadequate recognition of capacity building required for community managed mental health sector to transition towards individual packages, work required to support people into the scheme. There has been a “Plug and play approach – shoehorning mental health into the social model of disability doesn't work”.

In his keynote, **Damian Griffis, CEO, First Peoples Disability Network** asked for ‘a Call to Action’ to meet the needs of people with psychosocial disability. He noted that a lot of Aboriginal and Torres Strait Islander disability was psychosocial. He described the First People's Disability Network (FPDN) and noted that many board members have a disability. Aboriginal people established the FPDN in 1999, and in the ‘Telling it Like It Is’ report launched 13 years ago they set out to raise the profile of the high prevalence people with disability within indigenous communities. The prevalence is even higher for indigenous people in prison. FPDN has since written about the risks of market failure for indigenous people and a ten-point plan to help reduce the likelihood of this. They have been very engaged since the Productivity Commission Commenced their NDIS work in 2011.

FPDN have worked with NDIS directions but are still not seeing NDIS related changes for indigenous people. Damien said that the medical model of disability needs to evolve to the social model. Colonisation, transgenerational trauma and alcohol use are all linked to psychosocial disability. Poor access to information is a major barrier and FPDN questions whether a market-based approach to human service provision will work. If this approach is used then it should have a substantial research and development strategy associated with it. The NDIS will likely need to use cooperative based approaches for rural and remote areas.

In his presentation **Ivan Frkovic, Queensland Mental Health Commissioner** focused on NDIS individual funded packages, and changes to the community managed mental health sector through NDIS implementation. His key message was “do not panic”. He said that the NDIS brings both great opportunities and major challenges and the discourse is becoming more positive over time. Ivan questioned if we need to rush the implementation and wondered about slowing down the closure of the Commonwealth mental health programs.

Ivan said that some public mental health services still think the NDIS won't impact them as it won't change their budgets. However, it will change their practice and may see an increase in the time people spend in hospital while awaiting NDIS funded supports. He discussed the gap that is and will emerge as some other state/territory and Commonwealth governments' continue to close down or 'cash out' programs. He also expressed concerns about people choosing not to apply or withdrawing their applications.

**Gerry Naughtin, CEO Mind/NDIS Independent Advisory Council Member and NDIA Mental Health Sector Reference Group** provided a snapshot of the NDIS and psychosocial disability. He stated that mental health was the late starter to the concept of the NDIS which was designed around the needs of 400,000 people with physical and sensory disabilities estimated to be part of the Scheme and not around the needs of estimated 64,000 people with psychosocial disability.

Gerry said that in 2014, NDIA recognised that there were a range of design and implementation issues for people with disabilities related to a mental health condition and the Independent Advisory Council (IAC) produced a major report on these issues and the Board adopted a strategy plan for psychosocial disability. Design and implementation issues have been a strong focus of the IAC and the Agency since 2014.

He said that the Disability Reform Council expects that the NDIA will deliver access assessment and plans for 64,000 people with psychosocial disability by July 2019 and that reviews will be undertaken every 12 months. There are also expectations that as participants get to know and become more confident with the NDIS this will drive further change, and that continuing stories will prove to be evidence that people's lives are being changed in more significant ways than was being achieved by historical approaches. There are signs that transformation is occurring.

Gerry reported that consumers, families and carers, service providers and mental health professionals are all learning to understand how to work, receive and deliver services in a changing environment. A major sector restructure of unprecedented proportions is occurring and we are in the eye of a transformational storm. NDIA carries the expectations of the nation about improving the lives of people with disabilities in this country and change is occurring in an environment in which governments expect the Agency to deliver on a generational shift in policy and funding.

Community inclusion underpins the NDIS, consistent with recovery. Both are consistent with the insurance principles of the Scheme. Gerry said that it is important not to confuse the principles of social insurance with the delivery of supports through a market. The NDIA has a strategy, infrastructure and the people to guide and steer through the storm of transformation

that it and we are all involved in. It continues to be committed to working with consumers, families and carers and the mental health sector in improving the responsiveness of the Scheme, listening to what happening and working towards improvements.

The key elements of the work plan moving forward centres on developing client pathways for psychosocial disability with the mental health sector providing opportunities to contribute. This is as well as considering and responding to the recommendations of the Joint Standing Committee, PC and McKinsey Report on pricing. There is also the work of managing a major work plan implementing the Scheme for psychosocial disability. There is a need to build a better evidence base of what works at what cost in assisting people with psychosocial disability to have a better life.

Gerry echoed the sentiments of others during the two days, saying that the NDIS represents the most significant reform of psychosocial supports services since deinstitutionalisation and delivers significant new dollars for psychosocial disability. The challenge is to get the dollars to work in ways that meet consumer expectations and supports industry development and restructure. The major challenge for the Scheme is that good psychosocial outcomes also relies on adequate clinical mental health, housing and employment support services, which the Scheme does not control. Change of this scale will take time and the Agency is committed to listening and continual improvement. However, the government will need to build the policy, funding and practice architecture for reform over the next two decades.

During the course of the conference a number of symposia streams included presentations and panel discussions including:

- Information, Linkages and Capacity Building (ILC), mental health & the NDIS

**Chair: Eddie Bartnik, Strategic Adviser for Mental Health, Local Area Coordination and Community Capacity Building – NDIA; Mandy Baxter, Director, Information, Linkages and Capacity Building (ILC) – NDIA; Kim Rowe, Acting Branch Manager – Community Partners (ECEI & LAC Services) NDIA; Ralph Broad, Director of Inclusive Neighbourhoods / Local Area Coordination in England - The Centre for Welfare Reform; Kerry Hawkins, President – WAAMH & Ben Matthews - Peer Services Manager, Wellways Being Better Together**

**Eddie** acknowledged lived experience and went on to say how important the NDIS and mainstream services interface is. The ILC will help the NDIS and mainstream interface strengthen both for people with and without NDIS individual funded packages.

**Mandy** spoke about how the ILC is an integral part of the NDIS and our community. Mandy is a 44 year old woman living with mild cerebral palsy. The ILC is for all people with a disability and has two goals: building personal capacity and building community/mainstream capacity. The role is important to her as the ILC is all about community inclusion. She says we have to change the environment and not the person as we all have assets. ILC was not part of the NDIS trial but developing ILC policy, commissioning and outcomes frameworks was. The ILC wants to see outcomes and not just outputs. The ILC began issuing grants this year (\$120M for around 500 projects by 2019/20) and there are current state based grants underway for \$80M (New South Wales, South Australia and the Australian Capital Territory). It is important to acknowledge their collective impact and measure outcomes.

**Kim** shared that she had a brother living with schizophrenia and wondered if he might still be alive if the NDIS existed in the past.

**Ralph** spoke about key LAC lessons of the past ten years and summarised that it is all about community. He posed the question “If there were no money what would you do” (i.e., to address individual and social issues)? He advised not to do community mapping saying that you end up with service listings but not the true community. LAC work within and get to know their local community and so help to build social capital naturally and informally. He shared stories of how LAC works. He made mention of the importance of ‘Circles of Support’ to build real relationships in people’s lives.

**Kerry** stated that lived experience must inform every aspect of our conversations. Her husband is a person with psychosocial disability that now has an NDIS package. Negotiating the package has not been easy. She described having an NDIS package as being like having a ‘Porche on a sand-dune’ (i.e., lack of quality services and inclusive communities).

**Kerry** believes the ILC is where the real value of the NDIS lies as the ILC is about self-agency and social networks, particularly as we have lost ‘community’ in this society.. Addressing isolation and loneliness is the key to fixing broken communities, not broken brains. Most people need help with loneliness, money (employment) and housing.

**Ben** shared that Wellways has two ILC funded programs. The Building Belonging national project (\$397,284) creates welcoming communities through community education and engagement packages delivered by people with lived experience of psychosocial disability. A smaller project in the ACT (\$138,204.00) trains volunteers to work alongside people with psychosocial disability and assist them in building a strong network, increase community participation and to develop a sense of belonging within their community. Ben states that by driving health communities we will have health people.

- Health, Mental Health & the NDIS

**Chair: Lisa Brophy, Academic, Melbourne School of Population and Global Health - University of Melbourne; Kim Ryan, CEO - Australian College of Mental Health Nurses; Malitha Perera, Senior Local Area Coordinator - Brotherhood of St Laurence; Julie Borninkhof, Deputy CEO North Western Melbourne PHN; Amanda Bresnan - Executive Director, CMHA and Elena Sutcliffe, Being - Mental Health and Wellbeing Consumer Advisory Group**

The panel presented their perspectives on working in the NDIS environment. This included providing the opportunity for clinical mental health practitioners to have conversations about choice and control, and have a new focus that was different to the medical model. They talked about this cultural shift and the tensions that arose because of the differing cultures and language surrounding disability in contrast to mental health and recovery. Panel members also talked about the need for more cross-portfolio collaboration and conversations; they still struggle with the silos. It was suggested that now pathways can be very isolated, e.g. to see the GP, to access the NDIS, to visit a service, to see housing etc.

The panel also identified the poor understanding of what the NDIS is about in the community, by GPs, and those trapped between two systems. The importance of transparency and the need for frankness about the gaps is vitally important. There was some confusion about where forensic patients sit in relation to the NDIS, although the NSW government is working with the NDIA to address this issue.

The panel identified the need for the NDIS to hear the voices of individuals as well as look at systemic issues raised by sector. The panel also identified co-design as a critical component, so that people can meaningfully participate in policy development.

A subject also raised was the intersection across many areas e.g. disability/mental illness; co-existing mental illness/substance misuse; housing/employment. The issues of Commonwealth services transitioning to the NDIS, and states and territories not recognising the gaps in service delivery for those assessed as ineligible for the NDIS was also highlighted. Some states and territories are withdrawing supports and they should not be; all governments need to understand NDIS intersections with mainstream services.

**Executive Director CMHA, Amanda Bresnan**, spoke about CMHA's work in this space. This includes their numerous submissions to the Joint Standing Committee and responses to the numerous reviews concerning, NDIS Rule, Quality and Safeguards, Code of Conduct, Registration and Behaviour Support etc. It was also suggested that the NDIS Act (currently under review to be amended) should not occur until we have clarity, and that participants should have ongoing access to support coordination as part of their package – this seems to be happening in some areas but not others.

From a PHN perspective, we heard that there is still a problem with silos of care, and the need to upskill the workforce quickly about the NDIS. **Julie Borninkhof** reported that they have 1000 GPs in North Western Melbourne PHN and the government does not fund PHN to train GPs, but are doing it anyway because it is vital. They must support those across the continuum and this includes those not eligible for a package. She suggested that there was a real opportunity to work collaboratively, provide wrap around services and make sure people are accessing the NDIS. Clinical teams must work together and support transitions to the NDIS.

One question asked was: If we were to adopt an Intervene Early and not an Early Intervention approach, what would that look like? Responses to this were:

- Destigmatise and enable conversations about what people need so that people engage rather than disengage and isolate
- Support families to have conversations with family and friends
- Skilled people across services that can build trusting relationships
- EI stream under the NDIS but not applied to people with psychosocial disability
- NDIS is an opportunity to address silos through co-ordination
- Intervene Early for any age
- Build communities of care
- Upskill clinician in recovery model
- Peer workers key to IE

In an update on progress: NDIA and Psychosocial Disability, **Deborah Roberts, Director, National Mental Health Team, NDIA** announced that Gerry Naughtin would be the new NDIA Strategic Advisor replacing Eddie Bartnik. She expressed concern that some people continue to misrepresent the statistics about NDIS access for people with psychosocial disability as being lower than they actually are.

She also reported that the NDIA is developing new training for NDIA staff and co-designing it with people with lived experience of a mental health condition. The National Access Team (NAT) are developing a functional assessment tool and related reference package. The NDIA's National Mental Health Sector Reference Group have developed fact sheets and an access guideline for the NAT. They are also involved in the development of the Reference Package.

Deborah further discussed the Participant and Provider Pathway Review indicating that a trial of the recommendations would start by the end of this year and the NDIA will make an



announcement about this soon. The NDIA Mental Health Team will lead variation of the access pathway into the NDIS for people with psychosocial disability. They will soon be consulting and piloting to develop the pathway.

- Mental Health Practice, Organisational Change & the NDIS

**Chair: Amanda Bresnan, Executive Director, CMHA; Gerry Naughtin, CEO - Mind / National Mental Health Sector Reference Group; Ivan Frkovic Queensland Mental Health; Commissioner; Mark Orr, Chief Information Officer, Flourish Australia; Kerry Stopher, Director Stakeholder Relations NDIA; and Suzy Berry, General Manager Service Delivery Selectability**

The panel spoke about sustainability and viability. Kerry spoke about the Framework and Corporate Plan that presents current and future directions. Following consultation they identified four key aspirations clearly outlined by six stakeholder groups including: participants; NDIS providers; ILC access; State and Territory government mainstream services; DSS/ NDIA policy body: and the Safety and Quality Commission (by 2020). The Corporate Plan acknowledges listening; learning and co-design as critical elements. The mantra is Listen/Learn/Build/Develop and match staff with expertise to projects that are intentional and emphasise the four directions whilst collaborating across all levels.

The four aspirations are:

- Better participant outcomes – choice and inclusion, a reform of the participant pathway, tailored specifically to psychosocial disability and the development of an Access Team.
- A growing market review by McKinnley is a critical piece on how to develop innovation support services.
- The insurance scheme that invests in early and ongoing wellness and links to community and friends utilising CMOs.
- High quality staff and system that maintains trust and nurtures people and that supports staff to provide best quality recovery oriented practice culture and fosters co-design as usual practice.

**Gerry** raised two specific issues that come from the MIND experience. The first relates to workforce; the question being: as we continue to focus on peer workers, we need to consider how to continue funding for this. There are signs that the general workforce does not understand the peer experience and it's right to be there, proposing that their role is merely to talk to people. He also stressed the importance, in relation to choice and control, of the ongoing need to train staff in supported decision-making. He asked how we do this and how do we continue to understand good practice?

The second issue he raised concerned financial sustainability. There is a necessity to rethink service models and develop a suite of them. He asked how we take stock of and design what works for people with psychosocial disability, which is not the same as in disability. Organisations need to establish smart financial models to ensure financial sustainability but the question is, "what is the level of investment required to overcome risk"? How do we live with financial risk? Outsourcing is now a reality as this is how governments are increasingly doing business. How do we assist Boards to deal with this? Gerry proposed that we need to understand the NDIS financial arrangements as sustainable – a pricing review is an area that needs to be looked at especially surrounding support co-ordination.

**Ivan** suggested that currently people have to fit into a box and that the NDIS is an opportunity to consider different options. At a practice level – integration with public services

has been very difficult. There is now greater recognition of the importance of the CMO sector, and attitudes are changing. The clear message is that quality of life is improving for people with packages, and the language in the physical healthcare space is changing.

The NDIS is providing opportunity for innovation and to reshape the system so that people get the services and supports they want. However, can we be financially viable? Over the years organisations are burning up their resources, so the question often is can we afford to restructure and how can we use our resources. Whilst committing to our values we need to be realistic about what is possible.

Financial risk is important for Boards. Organisations have traditionally dealt with internal modelling but NDIS implementation exposes them to external forces over which they have no control. We also have to keep in mind who will not get an NDIS package and what we can collectively do in this context. Public services need to work better with the NDIS to make this possible.

**Suzy** provided three tips for transitions:

1. The number of people who will want to access your service will increase. The increase will include many people you have not worked with before. This is a huge organisational challenge. How to maintain quality supports in those circumstances where previously you worked for a rate that is now 40% lower exacerbates the problem. Suzy says her organisation really looked at their award to understand the skills they could deliver and ensuring that they have the right people to do the right jobs. There are things you can do other than get rid of staff.
2. Think about who may be eligible, who can't be assessed, and who wants to work.
3. Understand the chance to support people who don't enter the scheme.

Suzy also talked about the importance of continuity of supports, technology and transport.

**Mark** talked about Flourish's experience of the NDIS since 2014 in the Hunter. They have tried hard to make it work, capture the data and get dollars back. Flourish is supporting 650 NDIS participants. They jumped in feet first so that they could be part of the development of the NDIS. They have been able to shape how the Agency works by being there first up. The three key elements are service, workforce, and organisational elements.

He said that choice and control is the panacea - we question what we are doing and make sure we are giving people what they want and not replicating what they had. Flourish is a major employer of the peer workforce, who are mostly previous clients of the service. He reiterated Flourish's support for the participation of Peer Workers as integral to what they do - Integration is vital and Peer Workers are not add-ons. What the NDIS pays for services does not influence what Flourish pays Peer Workers. Mark said - staffing is both our greatest resource and greatest challenge, we ask whether what Peer Workers do is billable and support them through transition. Mark stated the Board are very conscious of the finances and keep a watchful eye over them. It is about insurance principles and the question is regarding the outcomes we are measuring, whether the investment is making a real difference. We are putting our minds to giving the Agency feedback on what works and what does not work.

To the question – What areas have worked and have not? The panel responded:

- A critical difference has been effected by co-ordination of supports
- The integrity of the service
- Having a support coordinator as part of the package

- Forming relationships of trust that supports participants make decisions
- Formed a Community of Practice (CoP)
- Reflective practice
- Peer support price not appropriate
- Where a LAC in place – Support Connection removed
- Palm Island no Support Coordination

- Diversity, Mental Health & the NDIS

**Chair: Damian Griffis, CEO - First Peoples Disability Network; Helen Egan, CEO TeamHEALTH; Stella Topaz, QLife National Project Manager - National LGBTI Alliance; Dwayne Cranfield, CEO, - National Ethnic Disability Alliance; Margherita Coppolino, President - National Ethnic Disability Alliance Community**

**Helen**, who is from the Northern Territory, spoke about the challenges for people living in rural or remote areas for successful NDIS implementation. The Rural and Remote Nation Health Alliance website informs us that the prevalence of mental health conditions amongst people in these communities is the same as the national rates, but that they have more difficulty accessing treatment and support services. NDIS implementation experiences are more likely to be community based and the NDIA's rural and remote market strategy supports this approach.

**Stella's** key messages related to the importance of learning about diverse communities including the languages used by them. In response to Helen's presentation, she noted that people in rural and remote communities seem to prefer web chat over phone. She noted that is disrespectful to make fun of LGBTI language as it the best of what they have to work with now. She also discussed aspects of the LGBTI experience noting that LGBTI people have higher rates of mental health conditions including depression, anxiety and psychological distress; especially for young people.

**Dwayne** shared that the NDIS is not reaching enough Culturally and Linguistically Diverse (CALD) people from non-English speaking backgrounds. He highlighted that CALD people are 20% of our population and not a minority group. Individual funded packages will not cover all people with disabilities. It was also mentioned that NDIS plans seem to be adverse to positive risk taking which is not supportive of notions of choice and control. He said we need to be more mindful of capacity, that is, where people are at on any single day and across their days. Many disabilities can have variable and fluctuating presentations, not just psychosocial disability. We need to understand and make reasonable accommodations for capacity. The NDIA are developing a CALD engagement strategy.

**Margherita**, who is a short statured person, did an exercise to demonstrate how height can alter interactions between people. She noted that while the NDIA has or is developing a range of diversity strategies, that there is no accommodation for diversity in their planning process. Margherita said the NDIA is telling some people in the adult short statured community that they are not disabled enough to get an individual funded package but are finding their children eligible. The NDIA are only looking at disability not diversity. A person can be part of many communities at once with Margherita illustrating that she identifies as a short statured person who is also a lesbian and of CALD background and these are very real and important elements in our lives.

Some other key issues and messages that emerged from these sessions were:

- The central role that peer workers can play in the NDIS across all population groups, and the impact that the NDIS pricing model is having on the workforce through casualisation, low pay and instability.
- Provider struggles with the NDIS price structure and the impact this may have on the safety and quality of services.
- The problematic relationship between the recovery model of mental health and the deficit model of the NDIS. There are issues with the language used by the sector and how this works with and is understood within the NDIS context.
- That the sector must educate itself on service provision to diverse populations including Aboriginal and Torres Strait Islander peoples, Culturally and Linguistically Diverse groups and the LGBTQI community, and the ways social disadvantage affects these communities
- Importance of providers being in a community early to establish a presence and gain trust – one of the key lessons from implementing Local Area Coordination in the UK

At the end of the conference there was a Forum summation: Where to from here...? This panel included: **Chair: Elizabeth Crowther, President, CMHA; Ivan Frkovic Queensland Mental Health Commissioner; Frank Quinlan, CEO Mental Health Australia; Eddie Bartnik, Strategic Adviser for Mental Health, Local Area Coordination and Community Capacity Building NDIA and Debbie Hamilton, Mental Health Advocate and NDIS participant.**

**Ivan** noted that answers to resolving the complexities of the NDIS and mental health space are starting to emerge but still have some way to go. He said that people are still missing out, including people that are 'hard to reach'. He encouraged us to seek out examples of where CMOs, PHNs and the NDIS are working together like envisioned.

**Frank** humorously shared photographs from a recent holiday to the NT where his trip did not go as planned and made comparisons to NDIS implementation in the mental health space. He urged us to work together to fix mental health and said that we are treating people's symptoms but not addressing the social determinants of their health and wellbeing.

**Eddie** spoke about the need to pursue the vision of the NDIS, to capacity-build its' possibilities while also pursuing the opportunities it presents. He said this was difficult to balance. He spoke about how safe and inclusive the conference had been. He supports future conferences and encouraged greater participation by other stakeholders including workers from NDIA/LACs, LHNs and PHNs. Eddie noted that the ILC is a 'slow-burn' strategy with greater potential for making a difference in the lives of people with disability than individual funded packages and said that people need to understand this better. He encouraged Mental Health Australia to envision a development plan for the sector that was not just short term but ten years out. Eddie noted that his current passion relates to notions of integrated commissioning of services and supports for people affected by mental health conditions. He said we must make NDIS processes work or we will be repeating repair work continuously. Eddie said the NDIA must better understand the mental health sector and that the sector needs to better understand the pressures experienced by the NDIA if we are to achieve optimal co-design work.

**Debbie** also provided a humorous presentation which reflected upon the highlights of the conference. She spoke about the importance in getting the right balance of duty of care and dignity of risk in an individual choice and control world. She said that as an NDIS participant who is also a former GP she concluded by stating that it was her duty of care to provide

advice on how the NDIS could work better for people with psychosocial disability and did so. Debbie said the focus of the NDIA should be on making the portal and processes related to access and planning right for people with psychosocial disability. For services, she encouraged them to focus on values over funding, to respond better to diversity, and to be more relevant to people's needs and choices. Debbie shared her belief that people be both paid and supported to attend conferences such as this as their lived experience contributions were important.

In the closing address: **Prof Allan Fels AO, National Mental Health Commission**, said that gains from investment in mental health would far exceed that for investment in any other area. He also noted that the various national and state Mental Health Commission's frameworks for a contributing life for people living with mental health conditions are relevant to NDIS implementation, in that they are person-centred and regionally based. He congratulated CMHA for hosting the event and noted its' relevance to populating the community mental health space. He said that housing was a key variable to making NDIS implementation and mental health reform work, and that mental health was especially responsive to an insurance approach and that an investment in people with mental health conditions pays social and economic dividends.

Alan said that achieving an NDIS fit in the mental health space is a big challenge but that the Mental Health Commissions are more concerned about the gap that is arising (i.e., people ineligible for individual funded services). He provided a range of statistics, including from the yet to be made public National Mental Health Service Planning Framework, arguing conservatively that some 190,000 to 350,000 Australians living with psychosocial disability are in need of services and supports. He further commented that people not included in the 64,000 to access NDIS individual funded supports would have a big impact on both health and social services.

Alan said that that the ILC is not sufficiently funded to fulfil its remit. The Commonwealth's proposed \$80M for psychosocial support services will help to bridge the gap, but this is not sufficient and still needs to be matched by the states and territories. He reflected on the problems of variable eligibility and outcomes for people with similar needs. He cautioned development of the proposed NDIS psychosocial disability access pathway in that this group of people could end up becoming a 'poor second cousin' (i.e., not receiving services and supports that are reasonable and necessary or aligned to their rights under the United National Convention of the Rights of People with Disabilities).

Alan articulated some of the Productivity Commission's concerns and recommendations including the serious problem of an inadequate workforce to deliver the NDIS. He reflected on a key theme arising from across the conference that many people living with mental health conditions are lonely and encouraged thinking about ways that we can help people with this problem.

The conference ended with [NDIS the Musical](#), performed by a group of young actors and musicians with lived experience from the Victorian Mental Illness Awareness Council (VMIAC). This is a hilarious take on many aspects of the NDIS from the perspective of the participant.

#### **Recommendations for future conferences included:**

- Further affirmative action to ensure engagement, participation and co-design by people with lived experience and their families

- That CMHA (and other peaks) continue to advocate for proactive outreach by NDIS registered and other service providers to people with complex and diverse health and social needs including psychosocial disability - particularly in relation to Aboriginal Torres Strait Islander communities, people from non-English speaking backgrounds within Culturally and Linguistically Diverse (CALD) communities and for homeless people
- That CMHA convene a National NDIS Mental Health Conference annually (i.e., with acknowledgement of a commitment to 2018)
- Encourage attendance of NDIA staff along with their Local Area Coordination (LAC) community partners and also Local Health Network (LHN) and Primary Health Network (PHN) staff in future conferences
- CMHA (and other peaks) to advocate for governments and the NDIA to include an accommodation for diversity in the individual funded package planning process
- CMHA follow up with the First Peoples Disability Network, on future opportunities to work together given the high rates of prevalence of psychosocial disability amongst Aboriginal Torres Strait Islander people.
- Further explore reasons for people with lived experience not applying for scholarships.