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RURAL Workforce AGENCY NT

NORTHERN TERRITORY MENTAL HEALTH COALITION

SUBMISSION TO THE NDIS REVIEW

BACKGROUND AND CONTEXT TO THE SUBMISSION

This submission is written on behalf of NT Mental Health Coalition (NTMHC) members and stakeholders and the Mental Health, Alcohol and other Drugs branch of the NT government Department of Health and the NT Primary Health Network. NT Mental Health Coalition writes submissions in line with our policy position statements and in consultation with our membership. We advocate locally and nationally for effective public policy on mental health issues.

The Northern Territory Mental Health Coalition (NTMHC) is the peak body for community managed mental health services across the Northern Territory. We work in collaboration with a wide network of community mental health organisations, people with lived experience, and their families and supporters. We work at the local and national level to improve mental health and wellbeing for all Territorians.

We welcome the opportunity to make this submission. The submission focuses on Psychosocial disability in the Northern Territory of Australia. The issues have been clearly described in submissions, evidence and recommendations from NTMHC, other advocacy bodies and peaks. The NDIS Review panel have identified the following themes:

1. Equity of access and navigation
2. Supply of services, service models and workforce
3. Tier 2 supports outside of the NDIS
4. Intersection with social determinants

The NDIS review panel have posed specific questions relating to the themes above to consider as part of the submission:

- How do we clarify eligibility in relation to psychosocial disability?
- What are examples of successful models that would constitute Tier 2 supports?
- How can psychosocial supports align with existing initiatives addressing social determinants?

NTMHC conducted consultations with members and stakeholders in the second quarter of 2023 culminating in a workshop on 30 June 2023. Recommendations have been drafted below from previous submissions and feedback collected and categorised against the same themes above.

For further information or clarification, please contact Geoff Radford, Chief Executive Officer on 08 8948 2246 or ceo@ntmhc.org.au

RECOMMENDATIONS:

EQUITY OF ACCESS AND NAVIGATION

1. Incorporate greater familial and communal roles of caring into the plans of Aboriginal and Torres Strait Islander participants.
2. The right to culture should be embedded within the Principles of Section 17A of the Act.
3. Implement the psychosocial recovery-oriented framework; develop guidelines for practice and implement free cyclical training for providers and NDIA staff.
4. Flexibility in support coordination and an expectation that participants may trial and change services frequently in the first 12 months.
5. Access to recovery coaching should be available to participants even if psychosocial disability is not primary diagnosis.
6. Provide procedural clarity and consistency in decision making for people with a psychosocial disability seeking to become a participant.
7. Where thin markets exist, implement frameworks surrounding conflicts of interest to increase service access with existing providers.
8. Participants should recover the cost of NDIS assessments to prove eligibility for the scheme as soon as they are approved.
9. Return to country should be explicit in participants' plans and include funding for accommodation supports including those of support workers so as to not be reliant on family carers.

SUPPLY OF SERVICES, QUALITY, SERVICE MODELS AND WORKFORCE

1. Value and remunerate traditional caring roles such as healers and extended family providing support to people with psychosocial needs.
2. Implement minimum standards of accreditation and competency-based training for unregistered providers.
3. Integrate the use of videoconferencing for assessment and therapeutic interventions with people based in the NT who understand the context.
4. Targets for Aboriginal and Torres Strait Islander workforce for the NDIA in the NT and NDIS providers that aligns with the percentage of participants.
5. Models of cultural supervision, not just localised cultural training embedded in NDIA and NDIS service provision.
6. Acknowledge that while place-based service delivery is best practice, fly in fly out (FIFO) or drive in drive out (DIDO) models of service delivery are also required to meet unmet need. Supports of this nature are high cost and should be funded at a level that also includes high level of support for this workforce and localised capacity building.
7. Implement targets for support coordination that ensures a timely response to participants and active work to ensure plans can continue to be accessed.
8. Include a weighting or loading to fees that reflect the true cost of providing services
    i. Where there are multiple risk factors and complexity
    ii. In remote areas
9. Provide capital grants in tandem with Tier 2 supports to ensure the necessary accommodation, office space and infrastructure are available, especially in rural and remote.

10. Incorporate long-term capacity building plans for the workforce in rural and remote settings that link with targeted vocational pathways.

TIER 2 SUPPORTS OUTSIDE OF THE NDIS

1. All funded supports to be formally evaluated, incorporate action research and relational contracting.
2. Prioritise funding community-led approaches aligning with the APONT Partnership Principles that incorporate Aboriginal and Torres Strait Islander perspectives of social and emotional wellbeing and healing; based on country.
3. Prioritise models of care that are led by accredited Peer Workers.
4. Include whole of family and capacity building in supports that can be accessed in Tier 2.
5. Assertive outreach models to be a crucial component of Tier 2 supports.
6. Provide group short term therapies delivered from core funding that does not require draw down from participants' NDIS funds, or for participants to have or be applying for an NDIS plan.
7. Participants need continual access to their regular groups and hubs as they step up and step down through levels of support.
8. Value models that demonstrate dual competencies of clinical and cultural supports working in tandem.
9. Aboriginal and Torres Strait Islander Healing groups facilitated by Healers to be fundamental in Aboriginal and Torres Strait Islander communities.
10. Hubs in rural and remote settings to be governed by community controlled organisations in collaboration with local Aboriginal leadership and Elders.
11. Long term funding arrangements (5-7 years) with indexation built in; and staffing models that include professional development and capacity building.

Quality community-trusted service providers commissioned by community and evaluated in conjunction with community.

INTERSECTION WITH SOCIAL DETERMINANTS

1. Expand the number of justice liaison roles to streamline assessment and access to NDIS in the justice system and include access to the justice liaison while on remand.
2. Fund co-located Tier 2 supports that provide wrap around trauma informed case management and family supports that are addressing immediately familial needs such as food security, domestic and family violence, housing and education.
3. Invest NDIS? resources at an executive decision-making level in existing community development approaches in the NT such as Strong Places, Strong People, justice reinvestment initiatives and Closing the Gap; and through consultation with the Tripartite Forum and Local Decision Making authorities.
4. Co-work with NIAA and Department of Employment and Workplace Relations on the replacement of the Community Development Program to capacity build social enterprises providing psychosocial supports and care.
5. Appropriately remunerate and offer long term grant funding agreements to address the practical challenges of the mental health workforce in rural and remote communities such as the lack of housing and broader infrastructure of service delivery.

CASE STUDIES

The following case studies are presented by members and stakeholders of the NTMHC. They highlight particular systemic issues experienced by NDIS participants and organisations and make recommendations.

1. ***Infrastructure and flexibility needed to support participants to return to Country.***

- Participant has an NDIS plan; funding does not cover all the costs (participant has to pay for flights) and funding only supports participant to travel to community once per year.
- Returning to Country and time with family improves their mental wellbeing
- Requires two support workers to travel with them
- Participants preference is to return to country at least three times per year
- There is no appropriate accommodation to support himself and two support workers in the community
- Unable to be supported in the family home
- Unable to access wheelchair accessible vehicle on country
- The planner does not have local knowledge of the NT service provision landscape, cultural knowledge and knowledge of psychosocial disability and the delegation to make decisions that could result in a positive outcome for the participant.

Recommendations:

i. Adequate and flexible funding to allow participants to direct funds to cover the true cost of returning to Country, cover the necessary costs and to travel more frequently.
ii. It is crucial that NDIS planners supporting participants in the NT are located physically in the NT and are trained in the NT service provision landscape, cultural knowledge and knowledge of psychosocial disability.

2. Long term funding and flexibility for participants with psychosocial disability

- Participant has long term psychosocial disability and an NDIS plan
- Participant remained well and NDIS plan was cut when reviewed at 12 months
- Participant uses all the NDIS funding in the first quarter of the following year
- Service provider advocates for an increase in funding however the process is very slow
- The participant is unable to access NDIS funding with existing provider whom they have a long-term relationship with; becomes increasingly unwell and cyclically presents for service and 'shops around' for support at Head to Health centre, emergency department at the hospital and community mental health providers in order to access support.

Recommendations:

i. Adequate funding for clients with psychosocial disability (primary diagnosis or not) that remains stable for several years to monitor patterns of behaviour
ii. Flags in NDIS plans when remaining funding drops below 10% that triggers an immediate review (<2 weeks)
iii. Flexibility for NDIS participants to use their funding over several years as the cycle of their psychosocial disability may be longer than 12 months; or their circumstances may change over a longer period.

3. Implement appropriate response processes and flexibility for plan review and home and living applications

- Participant has long term psychosocial disability; is placed in medium-term supported accommodation; has an NDIS plan; participant's plan is NDIA managed
- Participant is applying for Home and Living supports (H&L) and requires allied health reports to support their application
- Due to the extremely limited number of NDIA registered allied health providers in the NT, wait times for assessment and supporting documentation is extensive, often taking longer than six months.
- After waiting six months for the above report, an application for H&L is submitted. Participant waits three to four months for a response from the NDIS planner.
- Planner requests additional supporting documentation before they can proceed with application. Participant must return to waitlist for additional Allied Health assessment before continuing with H&L application.
- Support Coordinator and participant request that plan be changed to plan managed to allow faster access to an unregistered Allied Health, solely to speed up the process. To switch to plan managed, this requires a plan review which takes three to four months to occur.
- Application is then re-submitted, and participant waits up to four months for another response from planner
- Due to limitations in registered allied health providers in the NT, and extensive wait times for H&L applications/decisions, participant has remained unsupported for over two years and experiences further decline in their mental health and wellbeing.
- In the interim, pressure is placed on the community mental health organisation to discharge the participant.

Process step	Wait time	Total wait time
To submit a H&L application	6 months +	
Response to H&L application	4 months +	
Obtain additional evidence and resubmit	4 months +	
Waitlist for registered provider	4 months +	18 months
Change to plan managed	3 months +	17 months

The table above summarises the steps and demonstrates a typical waiting period for a bureaucratic process for assessment. This significant length of time consistently results in disengagement by the participant and their family; systemic trauma; and a further decline in their mental wellbeing.

Recommendations:

- Flexibility for NDIA managed plans to access Allied Health supports that are not NDIA registered where none are available within six weeks.
- Implement the following response times for plan review and home & living application requests:
    - Plan review six weeks
    - H&L requests six weeks

EXAMPLES OF SUCCESSFUL INNOVATIVE PROGRAMS MEETING THE NEEDS OF PEOPLE WITH PSYCHOSOCIAL DISABILITY OUTSIDE OF THE NDIS

Below are examples of innovative programs and practices that meet the needs of specific groups or communities with psychosocial needs from members and stakeholders located in the Northern Territory.

1. Creation of culturally informed resources promoting access to and awareness of the NDIS

Menzies School of Health research received an Information, Linkages and Capacity Building (ILC) grant to evaluate the engagement process of Aboriginal Family Support Services (AFSS) within the Iron Triangle First Nation communities, and the development of resources, for improvement of access to the NDIS. The resources provide a culturally appropriate set of tools to enable better understanding of, and to improve engagement with, the NDIS. The resources are available on the Menzies website. The resources were codesigned with Elders on the APY Lands with a number of videos available in Pitjantjatjara language. The resources have received extremely positive feedback.

Recommendations: The evaluation also makes a number of recommendations including

i. recognising the need for and adequately resourcing Aboriginal Interpreters
ii. increasing the understanding of the complexities that using an interpreter adds to assessment process;
iii. how crucial interpreters are to providing culturally safe care

2. Co-delivered Mental Health First Aid with trainer and Aboriginal consultant targeted at NDIS workforce

A community controlled mental health training provider located in the Northern Territory co-delivered Aboriginal Mental Health First Aid in collaboration with an Aboriginal consultant to the NDIS workforce in a regional community. The provider received extremely positive feedback, noting the cultural brokerage of the Aboriginal consultant, the content tailored to the audience and its value to the NDIS workforce.

3. Adequate funding and flexibility to re-engage participants

Catholic Care NT deliver a program in Central Australia that includes flexibility in their funding model for assertive outreach. The organisation can draw 5 hours/week from participants' plans for this work.

Case Study: Young person has an NDIS plan but is totally disengaged, not receiving any allied health or community access services at all; feels debilitating shame about their disability

- Aboriginal Support Workers worked in an assertive outreach model with a long-term view to develop a relationship with the participant. For six months, the participant remained disengaged; the Aboriginal Support Workers sustained their outreach for a further six months to progress enegagement with the services.
- As a result, the participants' hygiene has improved, they attend the access hub regularly and are achieving work ready goals
- The alternative to this program would have been long-term cancellations and potentially a significant cut of their plan funding.

Recommendations:

i. Sustain participants' funding when they are disengaged and initiate a trigger for assertive outreach from a culturally informed organisation
ii. Expand the footprint of the program outlined above
iii. Increase the training, support and remuneration of Aboriginal Support Workers, valuing the cultural brokerage and engagement skills