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Council to Homeless Persons (CHP) Submission to the Joint Inquiry into and report on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

Table of Contents

Contents

Introduction

Council to Homeless Persons (CHP) is the peak body for the homelessness sector in Victoria. Our vision is to end homelessness in Victoria, and therefore we represent organisations and people who are also working towards this goal.

CHP welcomes the opportunity to contribute to the inquiry into and report on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. CHP is very supportive of the NDIS and its intention to provide access to life-long disability support for those who need it. Through the NDIS, CHP sees the great potential to assist the many people with a disability who are experiencing housing instability and homelessness, providing a pathway out of homelessness, and an opportunity for a more contributing life.

CHP undertook a piece of work in mid-2016 to explore the potential opportunities and impacts of the NDIS for people who are experiencing homelessness and utilising Specialist Homelessness Support (SHS) services. We looked at rates of disability and support needs as recorded in the SHS data collection, other population level data and reports from the NDIS pilot sites. This submission is based on this piece of work.

CHP is concerned that the NDIS is yet to fully understand and respond to the needs of people with a disability, and particularly those with a psychosocial disability, who are also experiencing homelessness. There are inadvertent barriers to accessing the NDIS, which will prevent it from realising its potential. The lack of alternative psychosocial and disability support programs for those that are ineligible for individual funded support packages is also a concern, including the impact on both the demand and role of homelessness services.

1. Eligibility criteria for the NDIS for people with a psychosocial disability

Key points:

- *People who have a psychosocial disability and are experiencing homelessness are likely to experience difficulty in proving that they meet the NDIS access requirements.*
- *In 2015-16 between 1.4% and 2% of the Victorian Specialist Homelessness Support (SHS) service users aged 0 - 64 years (between 1340 and 1900 people) are likely to have had a mental illness and experienced severe levels of disability. This group may be eligible for the NDIS. This is an eligibility rate four to six times higher than would be expected in the general population[1].*
- *In 2015-16 Victorian SHS services were unable to provide assistance to fully meet the mental health and disability support needs of just over 5000 of its clients with mental health issues. SHS's successfully referred around 55% of these clients to mental health/disability specialist services; and 45% appeared to fall through the service gap. While the majority of these clients are unlikely to be eligible for the NDIS (at least 62%), they will require alternate community based mental health and disability support. With the loss of Victoria's psychosocial disability support services, this gap is widening.*

CHP's concerns about the eligibility criteria relate to the significant barriers that people who are experiencing homelessness are likely to face in proving that they meet the NDIS requirements (as well their capacity and willingness to participate – see later discussion in following sections); and the lack of alternative services and supports for people who do not meet them and/or do not get access.

For many people with a psychosocial disability who are experiencing homelessness, completing the documentation required for the access request and participating in the scheme will be a challenge. Key issues include a lack of any ongoing relationship with a health provider who will be willing or able to complete proof of condition or disability documentation, the possibility that they will have such severe functional limitations that it will be difficult to obtain or provide the "label" necessary to gain access to the NDIS and a lack of resources to engage in and with the system – such as finances to obtain medical assessments, a secure mail box or reliable phone and/or changing contact details.

[1] The NDIA identifies that 2.2% of the population under 65 years will be eligible to receive an individual funding support package. The Productivity Commission modelling identifies that amongst those eligible for such a package, 14% will have a significant and enduring psychiatric disability (which equates to 0.3% of the population)

The 2015 – 16 Specialist Homelessness Services (SHS) data collection identifies 22,154 Victorians (or 23% of the SHS population) as having a diagnosed mental health issue[2]. Of these, 1340 also needed assistance in a core activity area of self-care, mobility and communication- (indicating a severe to profound level of disability[3]). The higher level of need amongst the group identified as requiring assistance with core activities is evident by their experience of higher levels of repeat homelessness and longer support periods than those who did not need assistance with core activities. We believe this is likely to be an underestimate of people experiencing homelessness with severe levels of psychosocial disability as the SHS data collection does not ask if disability is restricting everyday activities in the domain of self-management (the life area in which many people with are a psychiatric disability are likely to experience the most limitation). We estimate that the proportion of people with a severe and enduring mental illness who are likely to access a Victorian homelessness service in a year to be closer to 1900.[4]

The SHS data collection also identifies that there are already high rates of need for specialist and mental health and disability assistance amongst the SHS population. Of those needing mental health assistance (7858 people), data suggests that SHS services were able to fully respond to 34% (2693 people), and partially to another 19% (1549 people). Of the 5,165 people for whom SHS were unable to fully meet their support needs, 2845 people (55%) were successfully referred to a specialist service. The remaining 45% appear to have fallen through the gap as a referral was not successfully made - including because the person refused the referral or the referral was not accepted by the service. These numbers suggest that within the SHS service system there will be around 3000 people with mental health support needs who will not be eligible for the NDIS.

Unfortunately the data does not differentiate between the need for treatment and disability/ psychosocial support, although, it is highly likely that many of the SHS clients, by the nature of homelessness, are likely to require both. However, it does highlight an existing gap between those needing assistance and receiving mental health support, and an ongoing demand for mental health support for which around two thirds of SHS clients are unlikely to be eligible for the NDIS.

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[2] This could be an underestimate as for 52% of the cases it was not known if there was a mental health diagnosis (there are an additional 1277 people with an unknown diagnosed and needing assistance with core activities).

[3] It is understood that the question used to obtain this information is conceptually comparable with "severe and profound core activity limitation" in the ABS Survey of Disability, Ageing and Carers (SDAC) see http://aihw.gov.au/homelessness/specialist-homelessness-services-2014-15/technical-information-glossary

[4] The second national survey of people living with psychosis identifies that they are 10 times more likely to experience homelessness than the general population. Using accepted prevalence rates of mental illness, we estimate that the proportion of people with a severe and enduring mental illness who are likely to access an SHS service to be around 1900 (or around 600 more than identified in the SHS data collection as having a diagnosed mental health issue and needing assistance with core activities).

2. Transition to the NDIS of :

- **all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular, whether these services will continue to be provided for people deemed ineligible for the NDIS**
- **of all current long and short term mental health state and territory government funded services, and in particular, whether these services will continue to be provided for people deemed ineligible for the NDIS;**

Key points:

- *Victoria will have very few (or no) alternative community based mental health supports when the NDIS is fully rolled out for those who are ineligible but still require disability and psychosocial support, including recovery and rehabilitation programs.*
- *Housing and homelessness programs funded through the National Partnership Agreement Supporting Mental Health Reform also cease in June 2017 – this funding enabled a range of specialist mental health programs within the homelessness sector. Clients of these programs are having to transition into other community mental health programs (including the NDIS where it is available) reducing the capacity of the homelessness service system to provide a specialist response.*
- *The homelessness sector is already the "last resort" or "catch all" for people who are significantly marginalised and not linked into the mainstream community support sector. The NDIA needs to work with homelessness services to better manage the risk associated with the inevitable and inadvertent consequences from such significant change, including recognition of the broader service system impacts.*

CHP is very concerned about the ceasing of existing Commonwealth and State programs and the roll up of this funding into the NDIS both in terms of the changes to the type and nature of the support[5] and because of the lack of access to psychosocial support programs for those who are not NDIS eligible. For the SHS sector, it is particularly an issue given the high proportion of current SHS clients who require assistance which cannot be met from within the SHS program, and because we expect that as a replacement the NDIS (at least in its current form) will be less accessible and less responsive to this client group.

The issue is intensified with the cessation of the National Partnership Agreement supporting mental health reform in June 2017 which has included a range of housing

[5] The Victorian MHCSS provided a broader range of support than is available through the NDIS, including rehabilitation and a support model which can respond to fluctuating mental health needs.

and homelessness programs. Many of the programs funded through this partnership were situated in homelessness services and focused on providing high levels of support to people with severe and persistent mental illness, addressing important service gaps. As such they also improved the capacity of SHS overall to respond to this client group. In addition, unlike other State and Commonwealth programs which are receiving support and have a timetable for transitioning clients, these programs are needing to identify alternative supports for their clients now. It is expected that a proportion of clients will move into the NDIS where available but the capacity of the NDIS to respond and manage this group is yet to be tested.

3. Scope and level of funding for mental health services under the Information, Linkages and Capacity building framework

Key points:

- *Homelessness will be a barrier to accessing the NDIS and individual and service capacity building needs to address this (see also comments under 4 below).*
- *"Homelessness" should be defined as one of the "hard to reach" populations for cohort related service delivery within the ILC framework.*
- *The specialist homelessness support sector can be a key partner in facilitating access to the NDIS for people with psychosocial disability.*

CHP applauds the individual choice and control aspects of the NDIS, however we are concerned how this dimension manifests in the access requirements which rely on an individual having both the willingness and capacity to participate. This inevitably creates challenges and barriers for people who are experiencing homelessness and severe social marginalisation who may not have capacity or the social cultural literacy required to understand and make systems like the NDIS work for them – this lack of capacity contributing to the ongoing perpetuation of their social disadvantage and exclusion[6].

CHP recognises that the implementation of ILC is in its infancy and its roll out in Victoria is far from complete. However, to date it would appear that individual capacity building for people with mental health issues to access the NDIS and/or identify alternative service options is low. In particular, we note that addressing homelessness as a barrier to accessing the NDIS does not appear to be at the forefront of considerations. We understand that people who are experiencing homelessness could potentially fall into the category of a "hard to reach" cohort in the context of the ILC Framework but unlike specifically defined cohorts such as culturally and linguistically diverse or Aboriginal and Torres Strait Islander communities, they are not identified.

We also note that the current funding round for ILC grants only includes community awareness and capacity building with a focus on improving inclusiveness for people with a disability within the mainstream service environment. Homelessness services are already providing support and access to people with a disability, and would benefit more from support to assist people to link with the NDIS and the provision of information, linkages and referrals to alternative services which can provide specialist psychosocial and disability support.

Improving ILC to be more responsive to people with psychosocial disability and who experience homelessness could include:

[6] K Soldatic, G can Toorn, L Dowse, K Muir (2014). Intellectual Disability and Complex Intersections: Marginalisation under the National Disability Insurance Scheme. *Research and Practice in Intellectual and Developmental Disabilities*, 6 - 16.

- Further discussion with the homelessness sector to better define roles and responsibilities, including developing best practice examples of how the NDIS may be able to offer support (in conjunction with homelessness services) to create pathways for people out of homelessness.
- Creating links and pathways between homelessness service system entry points and the NDIA.
- Recognition within the assessment and planning process that relationships are important – with allocations of appropriate time, flexibility and personnel resources.
- Practical assistance to support making an access request, including financial support for medical assessments and making and attending medical appointments to gain relevant documentation.
- Information about the NDIS utilising language and examples which are relevant for people who are experiencing homelessness.

4. The role and extent of outreach services to identify potential NDIS participants with a psychosocial disability

Key points:

- *Assertive outreach and relationship based engagement is effective in engaging people with psychosocial disabilities who are experiencing homelessness (are severely marginalised) in support and treatment. This is a deliberate and specific evidence-based approach which is both broader and deeper than delivering a service outside an office environment.*
- *Consideration should be given to developing a partnership with homelessness services to identify and connect with those experiencing homelessness who have a psychosocial disability, and to assist them through the application and planning processes.*

There is a strong evidence base for assertive outreach practice and its capacity to engage people in treatment and support[7] and is used by the Homeless Outreach Psychiatric Services in Victoria and many homelessness services. It is a deliberate and specific approach which is broader and deeper than providing a service outside an office environment. Key features include that it is flexible and responsive, and builds rapport and trust through first meeting people's presenting and/or basic needs and through creating a bridge to accepting the service or support on offer.

Facilitating access to the NDIS for people who are severely socially marginalised can only be credibly achieved if resources are applied to actively pursue, encourage and support these people into and through the process.

The NDIA, perhaps through developing capacity within the Local Area Coordination (LAC), could look to working in partnership with homelessness services to assertively identify and connect with people with a disability who are experiencing homelessness and assist them through the application and planning processes. This would also provide an opportunity to identify and respond to the barriers that may occur.

[7] See de Vet, R (2013). Effectiveness of Case ManagEment for Homeless Persons: A systematic review. *American Journal of Public Health*, e13 - e26.

5. Any other comments

The homelessness sector is currently the “last resort” or “catch all” for people who are significantly marginalised and not linked into the mainstream community and service sector. With fewer service options for people with psychosocial disability, the homelessness service system is at risk of becoming the default provider for people who disengage from or do not engage with the NDIS and/or who do not meet eligibility criteria (despite having very high needs). This is likely to be particularly so for people with psychosocial disability.

While we understand that some of this responsibility lies with State and Territory Governments, we would like to see more leadership and direction from the NDIA to manage the risks associated with the inevitable and inadvertent consequences from such significant change, including recognition of the broader service system impacts. At a minimum, homelessness services should be part of the change process with resources to increase awareness of the NDIS and to support clients through the transition phases.

CHP is also concerned that even if people with a psychosocial disability experiencing homelessness gain access to the NDIS that there will not be providers who are ready, willing and able to deliver the services and support that they may require. This would include being flexible and accommodating to someone without secure accommodation, or living in insecure accommodation and who may find it difficult to keep appointments (for both social and structural reasons). Further market development in this area is required.