Office of the Public Advocate

OPA Submission to the Joint Standing Committee on the NDIS – Mental Health

Submission to the Joint Standing Committee on the NDIS: The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

February 2017

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Office of the Public Advocate

Background

The Office of the Public Advocate (OPA) is an independent statutory office of government that works to safeguard the rights, interests and dignity of people with disabilities in Victoria. The experience of the office in mental health derives from the Public Advocate's role in advocacy, investigation and guardianship services to people with cognitive impairment and mental illness. Last financial year, OPA undertook 1645 guardianship matters and completed 494 investigations into the need for guardianship. The office also runs a volunteer program supporting people with a disability or mental illness in interviews with police. Last year, volunteer Independent Third Persons (ITPs) attended 2831 police interviews supporting people with cognitive impairment and mental illness to understand their rights and communicate with police.

OPA also supports the volunteer Community Visitors Program. In Victoria, under the *Mental Health Act 2014,* Community Visitors visit people in 24-hour mental health settings including acute units, community care units, secure extended care units and Prevention and Recovery Care (PARCs) units. Last year, 76 Community Visitors conducted 1562 visits to mental health facilities and identified 1452 issues relating to residents there. The Program is a notable safeguard for people with mental illness.

OPA welcomes the opportunity to contribute a submission to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) concerning the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. Recommendations will draw on its previous submissions and will address the terms of reference that relate to the work of OPA.

Summary of recommendations

OPA's recommendations are:

Recommendation 1: The NDIA should clarify its operational definition of 'psychosocial disability'.

Recommendation 2: The NDIA should publish further documentation regarding the access criteria for the NDIS for people with a psychosocial disability arising from mental illness.

Recommendation 3: The NDIA and Victorian Government should collaborate on the consistent collection of data for all mental health consumers being assessed against the NDIS psychosocial disability access criteria.

Recommendation 4: The Victorian Government should include a map of NDIS and non-NDIS mental health programs and populations in its annual mental health report and evaluate the impact of the NDIS on the mental health landscape.

Recommendation 5: The Victorian Government should report on mental health access and outcomes for all mental health consumers – including NDIS participants – in its annual mental health report.

Recommendation 6: The NIDA should communicate the extent to which LACs are expected to support people with mental illness who are not eligible for the NDIS.

Recommendation 7: The NDIA should clarify which existing Australian Government-funded mental health services will continue to be accessible to individuals who are not NDIS participants.

Recommendation 8: The Victorian Government should publicly report which state-based programs have been transferred to the NDIS and which ones remain available to Victorian mental health consumers (who may not be NDIS participants).

Recommendation 9: The NDIA and the Victorian Government should acknowledge the importance of individual and systemic advocacy to support people with a severe mental illness through NDIS access and service provision. Advocacy services should be funded independently from NDIS service provision.

Recommendation 10: The NDIA should dedicate efforts to ensure that NDIS plans of individuals with a psychosocial disability align with recovery principles.

Recommendation 11: NDIS planners assisting individuals with a primary psychosocial disability should be trained mental health professionals.

Recommendation 12: Support coordinators assisting a participant with a primary psychosocial disability should be required to hold professional certifications in mental health.

Recommendation 13: The NDIA should ensure appointed guardians can access the NDIS portal and NDIS plans in their professional capacity, ie. without having to access via the mygov citizen access pathway.

Recommendation 14: The NDIA should allow Community Visitors to access to all documents relevant to the care of a person with a disability, including NDIS plans.

Recommendation 15: The NDIA should, during and beyond the roll-out, develop "an outreach advocacy component (…) to ensure that people who are currently not in funded services and who are not scheduled to be transferred to the NDIS, get access to information and advocacy".[1]

Recommendation 16: The Victorian government should continue to invest in community-based rehabilitation to provide "outreach for people needing support to access community based services and/or the NDIS".[2]

Recommendation 17: Individuals with psychosocial disability who are in receipt of forensic disability services should be assessed for eligibility for the NDIS prior to their release from custody and should be provided with supports to make necessary arrangements should they return into custody.

Recommendation 18: The NDIA and the Victorian Government should each publicly identify exactly which mental health services will be available to people involved in the justice system, including post-release services.

[1] Office of the Public Advocate. (2016). Submission to Information, Linkages, and Capacity-Building Framework consultation draft.
[2] Page 3. VICSERV. (2016). State Budget Submission 2017-18: Towards a responsive mental health system in Victoria.

a. The eligibility criteria for the NDIS for people with a psychosocial disability

Defining 'psychosocial disability'

The disability requirements provided in the *NDIS Act 2013* are difficult to interpret when they apply to psychosocial disability related to a mental illness. Notions that are particularly abstract in this context are those of 'permanency' and 'functional impact', which the National Disability Insurance Agency (NDIA) does not further qualify.[3] Consequently, questions are being raised within the mental health sector regarding the operational definition of 'permanent psychosocial disability' applied by the NDIA in determining eligibility for participants enrolling into the scheme on this basis. The NDIA is presumably aware of this issue, as it is explicitly presented in the Psychosocial Support Designs Project Final Report – authored by the NDIA and Mental Health Australia. The lack of clarity has prompted Mental Health Australia and the National Mental Health Commission[4] to request clarification of the NDIS access criteria for individuals with a primary psychosocial disability. OPA endorses their recommendation:

Recommendation 1: The NDIA should clarify its operational definition of 'psychosocial disability'.

Recommendation 2: The NDIA should publish further documentation regarding the access criteria for the NDIS for people with a psychosocial disability arising from mental illness.

Ineligible individuals

Victoria's 10-year Mental Health Plan commits to ensuring "our continuing system is responsive to the particular needs of people living with mental illness"[5] throughout and following the changes originated by the NDIS. A similar but more precise iteration of this commitment is articulated in Agreed Action 5.1 of the *Operational Plan Commitment between the NDIA, State Government of Victoria and Commonwealth Government for transition to the NDIS* as follows:

[3] National Disability Insurance Agency (August 2016). Completing the access process for the NDIS: tips for Communicating about Psychosocial Disability.
[4] National Mental Health Commission (2014). Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services.
[5] Page 8. State of Victoria. (2015). Victoria 10-year Mental Health Plan.

> "The Victorian Government and the Commonwealth will identify cohorts or individuals in Victoria for whom they have administrative responsibility that do not meet the access requirements for NDIS and identify the number of people and programs where this may apply".

Agreed Action 5.1 firstly concerns the *cohorts and individuals* who are not eligible for the NDIS; in the context of mental health, this will represent the majority of consumers. OPA understands that the NDIS will only respond to a specific proportion of individuals with mental illness: those with a permanent psychosocial disability who require ongoing supports, which according to NDIA projections, represents approximately 64 000 Australians. The figure indicates that less than 10 percent of the 690 000 Australians with *severe* mental illness and an even smaller proportion of the 3 million Australians with mental illness will meet the psychosocial disability access criteria for the NDIS. Evidently, the majority of individuals with mental illness will require mental health services outside the scheme. Reports from the NDIS roll-out in Victoria show that the commitment towards identifying individuals who are not be eligible for the NDIS has not been prioritised: there remains "a large group of clients where it is unclear to the agency why the clients were deemed ineligible".[6] In the case of psychosocial disability, the gap is likely influenced by the unclear access criteria, but OPA stresses the importance for governments and the NDIA to fulfil Agreed Action 5.1. This can only be possible through the collection of reliable data on the characteristics of mental health consumers who are and are not eligible for the NDIS.

Recommendation 3: The NDIA and Victorian Government should collaborate on the consistent collection of data for all mental health consumers being assessed against the NDIS psychosocial disability access criteria.

Agreed Action 5.1 of the Victorian Operational Plan also speaks of the responsibility of both parties to deliver targeted mental health *programs*; governments and the NDIA should identify which programs and activities will be required for mental health consumers who are not eligible for the NDIS. The mental health landscape will undoubtedly continue to change, a shift that risks being quite stark in Victoria with the reallocation of community mental health funding. During and beyond the various reforms, the Victorian Government retains the responsibility of ensuring no individual 'falls through the cracks' or gets left behind. In 2013, the Mental Health Council of Australia recommended that governments produce an exhaustive map of mental health programs alongside their targeted populations. Cohorts who

[6] Page 11. VICSERV. (2015). Learn and Build in Barwon.

enrol in the NDIS could have been integrated into the map throughout the roll-out. The proposed objective was to "identify areas of need that will not be addressed through NDIS-funded services and would provide a much clearer picture of what is likely to eventuate should such programs be subsumed by the NDIS".[7] OPA notes that Victoria's *Mental Health Services Annual Report* lacked data of this nature and fears that, without this level of reporting, many mental health consumers will 'fall through the cracks' as the NDIS rolls out.

Recommendation 4: The Victorian Government should include a map of NDIS and non-NDIS mental health programs and populations in its annual mental health report and evaluate the impact of the NDIS on the mental health landscape.

The final component of Agreed Action 5.1 concerns government's *administrative responsibility* towards *all* individuals with mental illness. OPA repeats that this responsibility extends to those who are and who are not eligible for the NDIS, those who decline the NDIS or those who drop out of the NDIS after their initial engagement. The Victorian Government will need to fund and provide mental health services in both the clinical and the community mental health sectors, as the Council of Australian Government principles (COAG principles) clearly illustrate that the NDIS is designed as a complement to state-operated mental health services. The COAG principles stipulate that health systems remain responsible for the treatment of mental health, the operation of mental health facilities, early intervention services, and intensive case coordination when it is "related to mental illness".[8] Given that only a small proportion of individuals with mental illness will be eligible for the NDIS, the provision of mental health care remains the obligation of state governments. As outlined in Victoria's 10-year Mental Health Plan, the Victorian Government is accountable for engendering positive outcomes for *all* individuals with mental illness, and particularly those who are most vulnerable to abuse and exploitation. Consequently, OPA requests accountability and urges for improvements in the level of reporting on mental health outcomes in Victoria's *Mental Health Services Annual Report*. In this year's report – the first to be published since the implementation of the new Mental Health Act – the figures were scarce. For example, the total number of clients accessing mental health community support services was provided, with no further outcomes associated to this group. Furthermore, no NDIS-related data was published in the report. OPA expands on the recommendation it made in its submission to Victoria's 10-year Mental Health Plan:

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[7] Page 5. Mental Health Council of Australia. (November 2013). Mental Health and the National Disability Insurance Scheme: Position Paper.
[8] Council of Australian Governments. (2015). Principles to determine the responsibilities of the NDIS and other service systems.

Recommendation 5: The Victorian Government should report on mental health access and outcomes for all mental health consumers – including NDIS participants – in its annual mental health report.

Finally, OPA is concerned about the lack of support provided to individuals once they are determined to be ineligible for the NDIS. This issue appeared in the Barwon trial site report, and OPA notes ongoing confusion with regards to determining which service provider is liable once access to the scheme is denied. The Information, Linkages and Capacity Building (ILC) framework suggests this responsibility should fall on Local Area Coordinators (LAC): to "provide short term assistance to people who do not have an NDIS plan to connect them into mainstream services and community activities".[9] Anecdotally, OPA found evidence of instances in which individuals were left unassisted.

Recommendation 6: The NIDA should communicate the extent to which LACs are expected to support individuals with mental illness who are not eligible for the NDIS.

b. The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services

OPA is concerned about funding reallocation in the NDIS context and expects that the Australian Government will call on states and territories to account for how they will provide high-quality, coordinated treatment to individuals with mental illness who are not eligible for the NDIS. Funding needs to be clearly delineated to ensure the needs of these individuals are adequately met.

Recommendation 7: The NDIA should clarify which existing Australian Government-funded mental health services will continue to be accessible to individuals who are not NDIS participants.

c. The transition to the NDIS of all current long and short term mental health state and territory funded services

OPA understands that the transition to the NDIS of mental health state-funded services in Victoria is unique in comparison to other states and territories. There has been a lack of

[9] National Disability Insurance Agency. (November 2016). Information, Linkages and Capacity Building Commissioning Framework.

transparency about the redistribution of funds between both levels of governments, the NDIA, and the mental health sector, which has generated confusion and worry. To OPA's understanding, the Victorian Government has reallocated the majority of the Community Mental Health Support Services (CMHSS) funding to the NDIS. OPA is seriously concerned, as it has doubts that the NDIS can effectively replace the service components that are currently delivered by community mental health services. In fact, the COAG principles clearly determine that the NDIS is designed to complement state-funded mental health services. In Victoria, the CMHSS assist more than 12 000 individuals[10] with mental illness who do not require the intensive support provided by clinical mental health services and who do not necessarily meet the eligibility criteria for the NDIS. This funding arrangement risks fragmenting a robust and effective sector. It will create a significant dearth of services within the community sector, and is likely to increase the burden placed on clinical services that do not have the capacity to support this cohort.

Recommendation 8: The Victorian Government should publicly report which state-based programs have been transferred to the NDIS and which ones remain available to Victorian mental health consumers (who may not be NDIS participants).

d. The scope and level of funding for mental health services under the Information, Linkages and Capacity Building Framework

OPA welcomes the ILC Framework while being aware that the bulk of the ILC will be targeted towards what are currently known as 'disability services'. OPA expects the overlap between the ILC and the mental health sector will be minimal. OPA repeats that the Victorian Government is, and will continue to be, accountable for the provision of comprehensive mental health services.

Local Area Coordinators

OPA recognises the role played by LACs; they represent a much-needed support for the successful implementation of the NDIS. OPA is pleased to see the continuation of the LAC role in the NDIS Quality and Safeguarding Framework; LACs will continue to be required once the roll-out is complete in order to support new mental health consumers who will access the scheme.

[10] State of Victoria. (October 2016). Victoria's Annual Mental Health Services Annual Report.

Advocacy

In its submission to the ILC Framework, OPA elaborated on advocacy models that can be useful to individuals with disability. Among others, individual and representative advocacy along with the implementation of robust safeguards are known to comprehensively protect the rights of people with disability. Meanwhile, the ILC framework maintains that individual and systemic advocacy will not be funded under the NDIS. At present, individual advocacy for mental health consumers is largely provided within the community sector. While OPA appreciates the importance accorded to peer advocacy in the ILC, it also maintains the necessity to retain a range of complementary advocacy models. Specialist models, such as individual and systems advocacy add value because of the particular knowledge and expertise acquired by their proponents. They can deploy this knowledge and expertise more effectively than can generalist organisations that may lose focus if they are not guided by consumer experiences.[11] OPA is seriously concerned that the rights of people with mental illness will not be safely upheld and protected in service provision under the NDIS.

In practice, OPA has witnessed the need for NDIS-related advocacy for individuals with psychosocial disability resulting from mental illness. OPA's clients are individuals with severe mental illness; they rarely have the capacity to advocate for themselves and often have limited social supports. OPA notes an obvious discrepancy in outcomes between those clients who can self-advocate or who have advocacy supports and those clients who have no capacity for advocacy. For example, some OPA clients who cannot clearly articulate their needs were allocated supports under the NDIS that are insufficient or inappropriate. Others obtained more accurate NDIS plans, only to then experience unreasonable delays in receiving services. In these cases, OPA can provide advocacy or guardianship but does not have the resources or mandate to maintain these roles for the duration of their NDIS plans. While OPA welcomes the NDIS Quality and Safeguards Framework, it recognises that the complaint mechanisms require participants to have the ability to self-advocate. If individual advocacy is not funded through NDIS plans and if this service is no longer funded in the community mental health sector, some of the most vulnerable mental health consumers will see their wellbeing compromised. OPA reiterates a recommendation made previously:

Recommendation 9: The NDIA and the Victorian Government should acknowledge the importance of individual and systemic advocacy to support people with a severe mental

[11] OPA. (June 2016). Submission to the National Disability Advocacy Program Review.

illness through NDIS access and service provision. Advocacy services should be funded independently from NDIS service provision.

e. The planning process for people with a psychosocial disability and the role of primary health networks in that process

In its 2014-2015 annual report, OPA described how "the NDIS planning process is extremely difficult to navigate for people with cognitive impairment, unless they have either advocacy or guardianship support".[12] In the case of individuals with mental illness, NDIS plans have to consider the episodic nature of mental illness as well as overarching recovery goals. OPA encourages planners to support individuals with mental illness to develop plans that are holistic and can provide for wrap-around care that aligns with the Recovery Framework, but is concerned as to how harmoniously the two models can be merged.

Recommendation 10: The NDIA should dedicate efforts to ensure that NDIS plans of individuals with a psychosocial disability align with recovery principles.

Mental health consumers work with trained case managers/coordinators to define, implement, and monitor their recovery goals. The capabilities required to deliver high-quality, recovery-oriented care include an understanding of the "core principles, values, knowledge, attitudes and behaviours, skills and abilities"[13] of the framework. Case coordinators within the sector receive training about the framework and possess the capacities required to adapt each plan to their client's unique 'social determinants of health'. They understand that the relationship with a client is a pillar of effective service delivery; in fact, empirical evidence has consistently demonstrated the significance of a trusting, persistent, and unconditional relationship in creating positive mental health outcomes.

Recommendation 11: NDIS planners assisting individuals with a primary psychosocial disability should be trained mental health professionals.

In the provision of services for individuals with psychosocial disability under the NDIS, OPA observes that there is no equivalent to case coordination in the NDIS. In other words, the role as it exists within the mental health sector is not funded in the NDIS. The COAG principles attribute the following responsibility to the health care system: "intensive case coordination

[12] Page 10. Office of the Public Advocate. (2015). Annual Report 2014-2015.
[13] Page 15. Commonwealth of Australia. (2013). A national framework for recovery-oriented mental health services.

(…) where a significant component of care coordination is related to the mental illness". However, OPA is aware that in most cases there is no clear delineation between the aspects of case coordination that relate to mental illness and the ones that relate to broader psychosocial disability. To divide the role in this way across sectors would hinder recovery.

In its current form, the NDIS service model creates a further chasm; the responsibilities of the case coordinator are diffused across the LAC and support coordination roles, at the expense of key components:

Local Area Coordinators "work directly with people who have an NDIS plan to connect into mainstream services and community activities and get their plan into action".[14]

Support coordinators provide "assistance to strengthen participants' abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community."[15]

Case coordination does include most components from LAC and support coordination roles, but incorporates additional evidence-based practices that contribute to the achievement of positive outcomes. These skills and practices are acquired through appropriate training and certification. The NDIS Quality and Safeguarding Framework confirms that there will be no certification requirements for workers in LAC and support coordination positions. In other words, workers with little to no mental health training will be supporting mental health consumers in their recovery journey. NDIS participants risk missing out on key elements of recovery-oriented care, which are known to be associated with improved outcomes, such as meaningful engagement and holistic care.

Recommendation 12: Support coordinators assisting a participant with a primary psychosocial disability should be required to hold professional certifications in mental health.

Confidentiality of participant plans

The NDIS portal through which participants access their plan is subject to strict confidentiality; only participants or their appointed plan nominee receive the permission to log

[14] Page 12. National Disability Insurance Agency. (November 2016). Information, Linkages and Capacity Building Commissioning Framework.
[15] Page 24. National Disability Insurance Agency and Mental Health Australia. (April 2016). Psychosocial Supports Design Project: Final Report.

on to the online system. OPA welcomes the importance accorded to privacy in the *NDIS Act 2013*, but, in some instances, the provisions result in delays that are unmanageable for OPA guardians to efficiently assist their clients. Guardians are court appointed to act on behalf of individuals with regards to specific matters. Without access to clients' NDIS plans, guardians face delays in decision-making, often leaving individuals without the services or supports they require.

Recommendation 13: The NDIA should ensure appointed guardians can access the NDIS portal and NDIS plans in their professional capacity, ie. without having to access via the mygov citizen access pathway.

Legislative provisions around confidentiality have also impacted the work of Community Visitors, a program that continues to operate during the NDIS roll-out. In Victoria, section 217.1.c of the *Mental Health Act 2014* prescribes the authority to Community Visitors to "inspect any document, other than a clinical record, relating to a person receiving mental health services at the prescribed premises or any other record which is required to be kept under this Act or the regulations". Section 217.1.d of the same Act prescribes that Community Visitors can access clinical records with the consent of the consumer. Among other things, this enables them to inquire about and monitor current and future plans for residents in the provision of care, support and community inclusion.

In practice, Community Visitors have faced resistance in consulting NDIS plans. The NDIA has advised OPA that Community Visitors can only view participant plans with the consent of the concerned individual. Many, if not most, of the people visited by Community Visitors have significant disabilities and are unable to give such consent. As a consequence, the NDIS planning process and resultant plans - the core mechanisms by which the NDIS is delivered - are unable to be reviewed and monitored by one of the key existing disability safeguarding programs. OPA fears this issue will be exacerbated as the roll-out continues. OPA recommends that:

Recommendation 14: The NDIA should allow Community Visitors to access to all documents relevant to the care of a person with a disability, including NDIS plans.

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

OPA's clients are among the most vulnerable members of the community, isolated and often disengaged from services. For OPA's cohort, service engagement can be challenging and thus, outreach is an essential component in the maintenance of supports. Outreach is an exercise in persistency and trust building. Most importantly, providers must be creative in adapting to the different conditions and circumstances they may come across. For instance, an individual who refuses to answer the phone because of their mental illness may need to be communicated with in other ways.

Over the years, OPA's Community Visitors annual reports have recorded the prevalence of individuals with complex mental illness residing in Supported Residential Services (SRS). In pension-level SRS, supports are seldom comprehensive enough to provide holistic care. Through its Community Visitors Program, OPA congratulated proprietors who assisted residents to enrol in to the NDIS in the Barwon region. Despite their efforts, some proprietors report that their efforts were met with bureaucratic hurdles, such as being asked to make individual phone calls to register a group of individuals with the NDIA, rather than being able to complete all registrations in one conversation. It is not within an SRS' mandate to provide this level of support and some proprietors – often in pension-level SRS – did not engage with the NDIS. Yet, this is a sector that houses individuals with severe psychosocial disability who are likely to be eligible for the scheme. To provide outreach services into sectors such as SRS is necessary in making the NDIS accessible to isolated cohorts.

Recommendation 15: The NDIA should, during and beyond the roll-out, develop "an outreach advocacy component (…) to ensure that people who are currently not in funded services and who are not scheduled to be transferred to the NDIS, get access to information and advocacy".[16]

During the NDIS roll-out, existing mental health services are being asked to create the bridge between mental health consumers and the NDIA. OPA stresses the importance of outreach and repeats the recommendation made by VICSERV to the 2017-18 state budget:

[16] Office of the Public Advocate. (2016). Submission to Information, Linkages, and Capacity-Building Framework consultation draft.

Recommendation 16: The Victorian government should continue to invest in community-based rehabilitation to provide "outreach for people needing support to access community based services and/or the NDIS".[17]

h. The provision, and continuation of services for NDIS participants in receipt of forensic disability services

OPA maintains the recommendations made in this submission on the need for outreach services, responsive planners, and advocacy services, with special attention paid to the unique needs of the forensic cohort. OPA adds the following recommendation:

Recommendation 17: Individuals with psychosocial disability who are in receipt of forensic disability services should be assessed for eligibility for the NDIS prior to their release from custody and should be provided with supports to make necessary arrangements should they return into custody.

Given the relatively early stages of the NDIS roll-out in the metropolitan region in Melbourne, it is difficult to comment on the operations of the scheme in relation to forensic services and their patients. At this stage, it is impossible to evaluate the impact of the scheme on this cohort. Nonetheless, the COAG principles pertaining to the justice system are likely to cause gaps in services. The principles outline that the NDIS "will continue to fund the reasonable and necessary supports"; a statement that is subject to differing interpretations. Moreover, some of the responsibilities accorded to the justice system in the COAG principles are seldom available; for example, 'specific interventions to reduce criminal behaviours' and intensive case coordination are not currently provided by the justice system and there are doubts that they will be under the NDIS. For instance, in its current form, the COAG principles attribute the "management of offenders to ensure compliance with supervised orders and conditions" to the justice system, when, in practice, this is not offered by corrections officers. For individuals who have mental illness and who are involved with the criminal justice system, the impact of disability can be complex. In the case of individuals with psychosocial disability, it is easy to conflate which supports address disability and which target criminal behaviour.

The Victorian justice system is currently experiencing considerable pressures; it does not have the capacity to provide adequate care for prisoners with mental illness. The 2016

[17] Page 3. VICSERV. (2016). State Budget Submission 2017-18: Towards a responsive mental health system in Victoria.

Report of the Review of Hospital Safety and Quality Assurance in Victoria reveals that "the threshold for certifying prisoners for compulsory treatment [is] driven by availability of beds, not just a prisoner's mental health needs" (pg.140). The report estimates that in 2013-2014 the average wait time between certification and admission to Forensicare's Thomas Embling Hospital was 22.2 days, a figure that is likely to be higher at present. The report also states that fewer than 40 per cent of certified prisoners are transferred within 28 days. The under-capacity of forensic mental health facilities in Victoria is a long-standing issue, being first raised in 2003 and since repeated in reports by the Ombudsman, the Chief Psychiatrist, the Auditor-General, and Forensicare. It contributes to lesser outcomes for prisoners and increases the likelihood that they will require high-level post-custody community supports to manage psychosocial disability. It is evident that the justice system does not have the capacity to provide this support during custody or following release. OPA is concerned that the COAG principles causes the most vulnerable individuals to be 'abandoned' by both the NDIS and forensic services.

Recommendation 18: The NDIA and the Victorian Government should each publicly identify exactly which mental health services will be available to people involved in the justice system, including post-release services.