



Australian Government

Department of Social Services

27 February 2017

Mr Gerry McInally  
Committee Secretary  
Joint Standing Committee on the National Disability Insurance Scheme  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600  
By email: [ndis.sen@aph.gov.au](mailto:ndis.sen@aph.gov.au)

**National Disability Insurance Scheme (NDIS) inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition**

Dear Mr McInally

Thank you for the opportunity for the Department of Social Services (DSS) to respond to the *Parliamentary Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*.

NDIS is delivering a new system of individually tailored support for people with disability, based on need, where funding is provided in the form of an individualised funding package. People with significant and permanent psychosocial conditions who meet NDIS eligibility criteria will be able to participate in the same way as people with other severe and permanent disabilities.

In March 2013, the previous Government agreed funding for 17 Commonwealth programs would transition, in full or in part, to the NDIS. That means some or all of their funding will cease and be redirected to the NDIS, as the clients of these programs are expected to join the NDIS.

Four of the 17 Commonwealth programs with funding transitioning to the NDIS provide services and supports to people with psychosocial disability. Two are administered by DSS and two by the Department of Health (Health).

The DSS submission reports on experiences to date in relation to people with psychosocial disability accessing the NDIS, and the experiences of Commonwealth-funded mental health providers as they move to a market-based NDIS model, with a range of initiatives to support transition, including through the NDIS Sector Development Fund.

The submission also reiterates the Commonwealth's commitment to providing continuity of support for clients who are deemed ineligible for the NDIS.

The Commonwealth is monitoring closely provider, consumer and carer experiences as the NDIS transition continues to full scheme.

Please find enclosed the DSS submission, with input from Health, responding to the Inquiry's specific terms of reference.

Regards

Ms Felicity Hand  
Deputy Secretary  
Department of Social Services

## Background / Context

The National Disability Insurance Scheme (NDIS) will transform the lives of people with disability, providing them with greater choice and control over the supports they need, and over who provides those supports.

There are 17 Commonwealth programs transferring funds (in full or in part) to the NDIS. At full-scheme implementation, the funds from these programs are expected to contribute approximately 10 per cent of the Commonwealth's total contribution to the NDIS (approximately \$1.1 billion per year). The funds are being transitioned in the form of cash paid to the National Disability Insurance Agency (NDIA), or through in-kind services delivered to NDIS participants during the period of transition to full scheme.

Within the programs with funds transferring, the Departments of Social Services and Health are supporting Commonwealth disability and mental health providers to transition their businesses to operate in a competitive NDIS market place, to help their current service users access NDIS, and to ensure providers are well positioned to provide choice to NDIS participants in the future.

DSS acknowledges the wide consultation the Productivity Commission (PC) undertook in 2011 on the best way to support people with a psychosocial disability and, in particular, which system was best placed to meet the non-clinical support needs of individuals. The PC found the dominant view was the NDIS should meet the disability support needs of individuals with a psychosocial disability.

The PC stated people with a psychosocial disability have similar day-to-day functional support needs to other likely NDIS participants. These supports may include assistance with planning, decision-making, scheduling, personal hygiene and some communication tasks.

The PC's recommendation to include psychosocial supports in the NDIS was based on a key assumption that existing supports outside the NDIS would be largely maintained. The PC noted the NDIS would not displace mainstream services, and the assessment and planning process would be "layered", by providing assistance to determine which mainstream supports outside the NDIS people should be referred to, such as clinical mental health services.

The PC also noted the Commonwealth's contribution to the NDIS for psychosocial disability would be offset by rolling in funding from Commonwealth programs.

Funding for four Commonwealth community-based mental health programs is transferring to the NDIS because of the close program alignment to the Scheme's goals of supporting people severely impacted by mental illness or psychosocial disability to have a chance at living an ordinary life, by removing the functional barriers to achieving those goals.

These programs were previously established to deliver supports and services to individuals with severe mental illness, or severely impacted by mental illness, and their carers and families. Prior to the NDIS, and noting clients may be receiving services from more than one of the programs, direct Commonwealth-funded community mental health support was provided to approximately 40,000 people annually.

These programs were capped and limited, whereas the NDIS is uncapped. If someone is eligible for the NDIS, they will gain access to, and establish a lifelong relationship with the NDIS. As noted by the PC, the NDIS is replacing an unfair and inefficient system with a more equitable and sustainable system.

Descriptions of the community mental health programs with funding transitioning to the NDIS are at **Attachment A**.

Descriptions of the community mental health programs remaining in DSS are at **Attachment B**.

## Statements addressing terms of reference

**1. That the joint committee inquire into and report on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, with particular reference to:**

**(a) The eligibility criteria for the NDIS for people with a psychosocial disability**

People with psychosocial conditions who meet the NDIS eligibility criteria will be able to participate in the Scheme in the same way as people with other types of disability.

To be eligible for entry into the NDIS, a person needs to meet the criteria specified in the *National Disability Insurance Scheme Act 2013*.

A person will gain access to the NDIS if the CEO of the NDIA is satisfied the person meets the age, residency and disability requirements.

Accessing the Scheme requires a person to have a permanent disability or a disability that is likely to be permanent (one or more impairments attributable to a psychiatric condition), the disability must have a significant impact on day-to-day life and on the person's ability to participate in the community, and the person will likely need supports for the rest of his/her life.

The NDIS supports a recovery-oriented approach, a concept recognised in the mental health profession, through maximising the potential of individuals with a psychosocial disability to participate in the community. Recovery approaches acknowledge the effects of mental illness and subsequent psychosocial disability which may or may not diminish over time. This means that while some people may recover to the point they do not require any mental health or disability supports, others will always require supports to assist and maintain their recovery, and to ensure their ongoing community participation and social inclusion.

An impairment like psychosocial disability that varies in intensity - e.g. because the impairment is of a chronic, episodic nature - may still be permanent, and may require support under the NDIS for a person's lifetime.

It is likely some program clients will be ineligible for the NDIS, but will be eligible for Continuity of Support outside the Scheme. The needs of this group will be monitored throughout the transition phase of the NDIS.

In November 2016, following feedback from the sector on the need to further clarify eligibility for psychosocial disability, DSS held a workshop with a number of peak bodies and providers from across the country. As a result of this workshop, DSS is developing a better-practice guide, or similar document, for organisations, focusing on supporting their clients to access the NDIS.

This guide might include:

- characteristics of package costs and types of supports being provided
- understanding NDIS access requirements and key processes
- guidance to help providers support clients to access the NDIS, and gather evidence to meet eligibility requirements
- guidance to help providers make their services more accessible for NDIS participants
- case studies, proformas and lessons learned from providers from the trial period on how they are supporting clients to access the NDIS
- information to support/engage hard-to-reach clients.

**(b) the 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**

Evidence of overall transition to date

Based on the PC's initial modelling, it is projected that at full scheme, there will be approximately 64,000 (13.9 per cent) NDIS participants with a primary psychosocial disability. This group comprises those who have a severe mental illness that is likely to result in psychosocial disability that is permanent, or likely to be permanent, and requires intensive individualised supports.

The PC characterised this group as individuals who:

- have severe and enduring mental illness
- have significant impairments in social, personal and occupational functioning that require intensive, ongoing support
- require extensive health and community supports to maintain their lives outside institutional care.

The overall estimates of the percentage of NDIS clients with psychosocial disability is tracking close to the PC forecast, at around 13.0 per cent and 14.1 per cent respectively in New South Wales (Hunter) and Victoria (Barwon). Hunter and Barwon commenced the trial on 1 July 2013 for all eligible NDIS participants aged 0–64 years. These two trial sites, demonstrating higher proportions of participants with psychosocial and degenerative disability, reflect the adult cohort in the trial population.

Across Australia and all NDIS trial sites, as at 31 December 2016<sup>1</sup>, 81 per cent (up from 78 per cent in June 2016) of participants with a psychosocial disability who submitted access requests were eligible for the Scheme. Considering trial sites only, the proportion of participants with a primary psychosocial disability in each trial site has increased over time, bringing it closer to the projected PC estimate.

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<sup>1</sup> 31 December 2016 *Key Data on Psychosocial Disability and the NDIS* published by the NDIA

All governments know mental health service delivery is a highly challenging area, and will continue to work with organisations, the sector and the NDIA to monitor the transition of mental health programs to the NDIS, and to understand the experiences of people with psychosocial disability, their families and carers.

### Transition of Commonwealth-funded mental health services

DSS and Health continue to support providers to transition to a competitive market ahead of full-scheme implementation, through a range of funding flexibility and supports.

All transitioning Commonwealth-funded community mental health services have been offered grant agreements to 30 June 2019, or have been advised of pending extensions to ensure service continuity during the transition period.

Grant agreements include a range of flexible approaches, including the ability to carry forward unused funds to following financial years, allowing organisations operating in multiple sites to manage funds flexibly, removing prescriptive practices such as caseload requirements, and providing capacity to review funding levels if NDIS roll out plans change.

Nationally, as at December 2016, of the community mental health programs transferring to the NDIS, there are:

- 82 providers that deliver Personal Helpers and Mentors (PHaMs) services, and 57 of these have registered to provide supports under the NDIS
- 108 providers that deliver Mental Health Respite: Carer Support (MHR:CS) services, and 76 of these have registered to provide supports under the NDIS
- 38 providers that deliver Day to Day Living (D2DL) services, 17 of which have registered to provide supports under the NDIS, and
- 37 providers that deliver Partners In Recovery (PIR) services, 23 of which have registered to provide supports under the NDIS.

While some organisations are facing challenges, many view the transition as a business opportunity, and are reporting positive outcomes:

- a Tasmanian MHR:CS provider carefully considered the need to take up the DSS three-year grant offer as it was doing very well under the NDIS
- a Western Australian PHaMs provider advised it has doubled its workforce and transitioned all eligible clients to NDIS
- an Australian Capital Territory D2DL organisation is broadening its service mix to expand into broader core and capacity building activities, to provide a broader range of supports to NDIS participants
- a New South Wales PIR organisation is increasing its communications materials and events to encourage potential clients to utilise the organisation in the delivery of their NDIS plans, and
- a Western Australian PIR organisation is collaborating with a range of sectors to improve and enhance the system response to the transition of clients to the NDIS.

There will be significant changes and opportunities for new and existing service providers. The amount of funding for disability services across the country will double. The amount a service provider will source through the NDIS will depend on the quality and cost of the services it provides, and the consequent number of people who choose to access its services.

In exercising choice and control, NDIS participants will be looking for quality providers that deliver the services they want, and in a format that best meets their needs. To accommodate the needs and desires of the market, service providers may need to diversify their service offers to provide choice for NDIS participants.

### Transition support

Since transition began, DSS, in collaboration with Health and the NDIA, has undertaken targeted engagement with service providers of transitioning Commonwealth community mental health and carer programs.

In 2016, DSS and Health held a range of fora with provider CEOs, and team leaders currently delivering Commonwealth mental health and carer programs transitioning to the NDIS.

The fora were designed to deliver information directly related to the business and operational changes required for service providers to successfully transition from block-funding arrangements to the NDIS individualised-funding model.

Sessions covered the changes to business practices required to operate in an open market environment, the types of opportunities the NDIS can present to providers, and opportunities for team leaders to share strategies for assisting clients to access the NDIS. Organisations also had the opportunity to hear, and learn from, providers who had been operating in NDIS trial sites, and from business advisers and peak bodies.

Separate workshops focusing on NDIS access and eligibility for people with psychosocial disability clarified how “recovery” and “the episodic nature of mental illness” is accommodated within the Scheme.

### NDIS Sector Development Fund

The NDIS Sector Development Fund (SDF) is a Commonwealth fund to support people with disability, and the disability services sector and its workforce, with the transition to the NDIS. The SDF has commissioned projects to specifically support transition across the mental health and carer sectors.

Mental Health Australia (funded \$1.5 million) delivered a SDF capacity-building project that worked with mental health service providers to assist transition to the NDIS, and with people with psychosocial disability and their families and carers, to raise awareness and understanding of the NDIS.

Carers Australia (funded \$1.68 million) has undertaken capacity building to support carers in the transition to NDIS. It has developed information resources and a range of ways of providing information to meet carers' needs. This included developing resources for carers of people with psychosocial disability.

A \$3 million assistance package has been funded through the SDF to support mental health providers' transition readiness to the NDIS. This was in recognition that PHaMs and MHR:CS providers face additional challenges supporting people with psychosocial disability to transition to the NDIS.

Mental health and carer providers can also benefit from National Disability Services' two SDF projects, CareCareers and ProjectABLE. These projects aim to raise awareness of career opportunities in the disability sector (funded \$4.25 million), and provider readiness capacity building to prepare providers for transition to a NDIS environment (funded \$3.05 million).

The NDIS SDF webpage has a summary of individual projects, together with resources that can be used by all providers, including those occurring in each state.

### Health programs

PIR and D2DL organisations continue to be supported through the transition phase with the extension of program funding. Health is also funding a transition support project for PIR and D2DL organisations.

#### **(b)**

##### **i) whether these services will continue to be provided for people deemed ineligible for the NDIS**

The Council of Australian Governments (COAG) committed to provide *continuity of support* to people with disability currently receiving government-funded services, to ensure they are not disadvantaged in the transition to NDIS.

For people with disability who are already receiving government specialist community mental health services, but are not eligible for NDIS, all governments have committed to deliver continuity of support.

This means if an individual is already a client of a state or Commonwealth disability service, he/she will be supported to achieve similar outcomes, even if the name of the program changes, or the support is provided through a different arrangement.

For Commonwealth-funded providers of community mental health services, funding has been allocated to providers for this purpose, while longer-term arrangements are being developed.

The NDIA can assist people with psychosocial disability, ineligible for the NDIS and who were not clients of Commonwealth funded services, to obtain information about relevant services in their community. A Partner in the Community delivering Local Area Coordination services may be able to link people to appropriate services within their community, where required.

It is important to note community-based mental health services are primarily the responsibility of state and territory governments. In 2014–15, of the \$8.5 billion spent nationally on clinical and community mental health support services, 59.6 per cent (\$5.1 billion, including \$1.9 billion on community mental health) was funded by state and territory governments, 35.7 per cent (\$3.0 billion, including \$0.4 billion on community-based mental health) by the Australian Government, and 4.8 per cent (\$0.4 billion) by private health insurance funds.<sup>2</sup>

NDIS will complement mainstream and specialist services provided by the health system. The health system will continue to be responsible for treatment of mental illness, and the NDIS will be responsible for ongoing psychosocial recovery supports that focus on a person's functional ability, including enabling people with a psychosocial disability to undertake activities of daily living, and participate in the community and in social and economic life.

As set out in the COAG-endorsed *Principles to Determine the Responsibilities of the NDIS and other Service Systems*, NDIS and the mental health system will operate together at the local level to plan and coordinate streamlined care and support for individuals requiring both mental health and disability services.

**(c) the transition to the NDIS of all current long- and short-term mental health state and territory government funded services, and in particular;**

**i) whether these services will continue to be provided for people deemed ineligible for the NDIS**

As noted above, through COAG, all governments have committed to provide continuity of support to people with disability currently receiving services to ensure that they are not disadvantaged in the transition to the NDIS.

It is a matter for state and territory governments how they provide continuity of support to their program participants not eligible for the NDIS.

**(d) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework**

Information, Linkages and Capacity Building (ILC) is an important part of the NDIS, because it can enable greater access to the social and economic life of the community for people with disability, their families and carers.

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<sup>2</sup> AIHW data published February 2017 <https://mhsa.aihw.gov.au/resources/expenditure/>

In July 2015, COAG agreed to the ILC Policy Framework, and the NDIA is implementing the ILC Policy through the ILC Commissioning Framework.

The focus of ILC is on community inclusion – making sure people with disability are connected into their communities, and making sure communities become more accessible and inclusive of people with disability, as well as their families and carers. The ILC is expected to fund activities that assist people who do not have an individually funded NDIS plan, and to assist families and carers.

NDIA recently released the Community Inclusion and Capacity Development (CICD) Program Guidelines – Implementing Information, Linkages and Capacity Building. Along with the ILC Commissioning Framework, the Guidelines explain how the NDIA will implement ILC across the country over the next few years. The objective of the CICD Program is to build innovative ways to increase the independence, social and community participation of people with a disability.

The scope and level of potential funding for mental health services under ILC is a matter for the NDIA. Any identified service gaps will be assessed year-by-year. The ILC commissioning process will then aim to fill those gaps with ILC activities delivered by existing or new providers selected through funding rounds.

#### **(e) the planning process for people with a psychosocial disability, and the role of primary health networks in that process**

As noted above, NDIA, DSS and Health are assisting providers with practical information to support their clients to access the NDIS, including pre-planning and planning processes. Providers are currently funded to assist their clients through the process of testing eligibility and preparing for planning sessions.

Primary Health Networks (PHNs) have been established across Australia to increase the efficiency and effectiveness of health services for patients, and to improve coordination of care to ensure patients receive the right care, in the right place, at the right time. They are regionally based primary health care organisations funded to commission services to meet the needs of their regions. PHNs receiving funding through the PIR program at present, are engaged in the transition process.

The health system will continue to be responsible for clinical treatment, and the NDIS will be responsible for ongoing psychosocial recovery that focuses on a person's functional ability, including supports that enable people with a psychiatric condition to cope with the daily tasks of living, overcome barriers to economic and community participation, and access opportunities for greater social inclusion (Rule 7.6 'Mental Health' of the Supports for Participants Rules [www.legislation.gov.au/Details/F2013L01063](http://www.legislation.gov.au/Details/F2013L01063)).

On 21 October 2016, a draft of the 5th National Mental Health Plan was released for consultation. This Plan will guide Commonwealth, state and territory governments on addressing the needs of people with mental illness, including through provision of clinical and non-clinical services and supports. It will be important for effective interface issues to be addressed in partnership with the NDIA.

Further information on the planning process for people with a psychosocial disability and the role of primary health networks is a matter for the NDIA.

**(f) whether spending on services for people with a psychosocial disability is in line with projections**

The PC made funding projections for people with psychosocial disability entering the Scheme, based on severity and high-support needs (day-to-day or weekly). Despite some variations in the distribution of actual versus expected supports, the total cost is in line with the PC estimates.

As at December 2016<sup>3</sup> a total of 3,720 NDIS participants, with an approved plan, had a primary psychosocial disability. Participants with a primary psychosocial disability have a range of package values, with most participants receiving between \$20,000 and \$50,000. The average annual cost of a PHaMs service per participant in 2015–16 was approximately \$6,500.

The NDIA is best placed to advise on any further analysis of NDIS statistics.

**(g) the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability**

In mental health programs, funding is currently provided directly to PHaMs, PIR and D2DL service providers to deliver services, and inherently include funds for client intake processes. In mental health service delivery, encouraging hard-to-reach clients to access a service can be quite intensive, as well as being a regular component of service delivery, customer focus and clinical judgment. It will be critical the NDIS has this capability.

NDIS capacity in this area will be complemented by the role of registered providers in marketing themselves to attract new clients, including those hard-to-reach or hard-to-engage clients.

An emerging maturity issue from provider consultation is the focus of services on promoting themselves in a competitive market place, including focusing on an intake role for those consumers who typically do not respond to advertising, utilising a mix of customer focus and clinical judgment.

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<sup>3</sup> 31 December 2016 *Key Data on Psychosocial Disability and the NDIS* published by the NDIA

SDF projects are occurring in states and territories to build the capacity of extremely vulnerable people with disability, such as those who are at risk of falling through the gaps because their needs are complex, challenging and they themselves may be resistant to support. This is in addition to capacity building projects in rural and remote, culturally and linguistically diverse and Indigenous communities.

In South Australia, the ‘Preparing participants who are difficult to engage’ project will undertake early preparation with very vulnerable people with disability who are disengaged from current disability and welfare services generally, and present with a high likelihood that they will not engage with the NDIS; for example, homeless people, people with mental health issues, or people with drug or alcohol dependency.

In Tasmania, the ‘Assisting hard-to-engage individuals in Tasmania to engage with NDIS’ project will identify, support and assist people with disability, who have specific and complex needs, to engage with the NDIS. These people may not be current users of disability services and may be resistant, or unable, to engage with existing support services.

In New South Wales, the ‘Enablement support model’ project will pilot a model to transition people not eligible for the NDIS to mainstream services, and move continuity of support clients off funded supports without affecting their outcomes. It fosters greater independence and increases access to mainstream alternatives by utilising time-limited, enablement-focused supports.

#### **(h) the provision and continuation of services for NDIS participants in receipt of forensic disability services**

Offenders in the criminal justice system can access some services related to reduced functional capacities through the Behaviour Support NDIS support cluster. These supports are aimed at limiting the likelihood of behaviours of concern developing and increasing, and allow for positive behaviour supports to be funded. Other supports include access to aids and equipment and therapeutic supports.

Additionally, all governments agreed to the *Applied Principles to Determine the Responsibilities of the NDIS and Other Service Systems* and ‘tables of supports’ that outlines the funding and delivery responsibilities of NDIS and state governments in relation to the justice system.

Further information on the provision and continuation of services for NDIS participants in receipt of forensic disability services is a matter for the NDIA.

## **Attachment A**

### **DSS and Health Community Mental Health programs transferring to the National Disability Insurance Scheme (NDIS)**

Funding for these programs will transition to the NDIS, and the programs will cease.

#### **Personal Helpers and Mentors (PHaMs) (administered by DSS)**

PHaMs provides increased opportunities for recovery for people aged 16 years and over who have a severe mental illness, by helping them to overcome social isolation and increase their connections to the community. PHaMs participants are supported through a recovery-focused and strengths-based approach that recognises recovery as a personal journey driven by the PHaMs participant.

PHaMs workers provide practical assistance to people with severe mental illness to help them achieve their personal goals, develop better relationships with family and friends and manage their everyday tasks.

#### **Mental Health Respite: Carer Support (MHR:CS) (administered by DSS)**

Mental Health Respite: Carer Support (MHR:CS) provides relief from the caring role, through in-home or out-of-home respite or social and recreational activities; carer support, including counselling, practical assistance, social inclusion activities, case management; and education, information and access, including community mental health promotion.

MHR:CS supports carers of people with mental illness, whose health and wellbeing, or other impediments, are negatively impacting their ability to provide care. The highest priority is given to carers without access to similar respite or carer support through other government funded services.

#### **Partners in Recovery (PIR) (administered by Health)**

PIR supports people with severe and persistent mental illness with complex needs, and their carers and families, by getting multiple sectors, services and supports to work in a more collaborative, coordinated and integrated way.

Individuals generally have persistent symptoms (although symptoms may be episodic) and may have become disconnected from social or family support networks leading to extensive reliance on multiple health and community services.

PIR Support Facilitators work together with multiple sectors to ensure appropriate services and supports are in place to improve the immediate quality of life for the client. The PIR Support Facilitator may organise emergency housing (where required), access to a GP and / or specialist, as well as the transport to and from appointments, and training to improve quality of life, from managing budgets to seeking employment.

### **Support of Day-to-Day Living in the Community (D2DL) (administered by Health)**

D2DL provides funding to improve the quality of life for individuals with severe and persistent mental illness by offering structured and socially based activities. D2DL workers deliver activities that may include centre-based activities supporting program clients to better achieve their goals, develop better relationships with friends and family, and build confidence.

It is expected the recipients are accessing clinical services for the treatment of their mental health issues. However, some recipients may be homeless, have comorbid conditions (i.e. dual diagnosis) and may not be accessing clinical supports.

## **Attachment B**

### **DSS Community Mental Health Programs remaining in DSS**

DSS will continue to administer the following community mental health programs outside the NDIS:

#### **Family Mental Health Support Services (FMHSS)**

FMHSS supports children and young people who are showing early signs of, or are at risk of developing, mental illness. FMHSS providers work with children and young people, with the support of their families and carers, to deliver a range of non-clinical services to address risk factors, and strengthen protective factors. There are currently 52 organisations delivering services in 100 locations across Australia.

#### **A Better Life (ABLE)**

ABLE services support the Cashless Debit Card Trial in the Ceduna region in South Australia, and the East Kimberley region in Western Australia. These services provide assistance to people with mental illness that includes drug, alcohol and/or gambling dependency, to assist their recovery.

ABLE services are designed to complement existing services in the community. In addition to assistance to access alcohol, drug and/or problem gambling support services, ABLe workers help individuals achieve their personal goals, develop better relationships and manage their everyday tasks.

#### **Carers and Work**

Carers and Work aims to assist carers of people with mental illness to gain employment, while maintaining, or transitioning from, their caring roles.

#### **Individual Placement and Support (IPS) Trial**

The Australian Government has committed funding for a three-year national trial of the Individual Placement and Support (IPS) model of employment support, as part of a broader strategy aimed at tackling high youth unemployment.

The trial will target vulnerable young people with mental illness, up to the age of 25 years, who are at risk of disengaging from education and employment and who are at risk of long-term welfare dependency. There are 14 trial sites across Australia.

The IPS model integrates employment and vocational support with clinical mental health and non-vocational support, and focuses on the needs of people with mental illness seeking to remain in education and/or employment. Professional employment specialists located in headspace sites provide vocational and employment assistance, in tandem with clinical supports.

The mental health programs remaining with Health relate to clinical services rather than psychosocial supports.