POSITION STATEMENT

(DRAFT)

Mental Health Australia

Key actions to ensure continued access to community support for people affected by severe mental illness during NDIS transition and beyond

Mental health stakeholders have for some time raised concerns about the unintended consequences of transferring funding for existing community mental health programs into the National Disability Insurance Scheme (NDIS). With transition now underway, anecdotal evidence is accumulating of negative impacts on service access, continuity of support and the ability of consumers, carers and providers to navigate the system. To alleviate the situation, a series of actions are proposed below.

Confirming eligibility criteria

Clarification of the eligibility criteria for the NDIS re psychosocial disability (currently accepted prevalence figure is 64,000 people at Full Scheme) is the essential starting point. This was made clear in the National Mental Health Commission's (NMHC) Review, which recommended that government 'urgently clarify the eligibility criteria for access to the NDIS' (recommendation 3).

Such a definition needs to be public, with targeting under regular review in a transparent manner, and should build a definition consistent with the UN Charter on the Rights of People with a Disability and the work of the National Mental Health Consumer and Carer Forum entitled "Unravelling Psychosocial Disability". This paper assumes something like the following:

Complex, severe, ongoing disabilities resulting from severe and persistent mental illness (with recent diagnostic evidence). Additional evidence might be several of—

- *frequent hospitalisation for mental illness , or current or recent history of being on the caseload of public mental health services*[1]
- *minimal employment in recent years*
- *poor physical health*
- *insecure housing*
- *extreme social isolation*
- *insecure/non-existent informal carer support.*

[1] Lack of interaction with mental health services is not necessarily evidence of a lack of need for support. Evidence from trial sites indicates many participants with psychosocial disability were not previously known to mental health services, and indeed may actively avoid the public mental health system.

Consultation questions:
Is this definition suitable as the eligibility criteria for the NDIS?

What amendments would strengthen it?

Quarantining and monitoring mental health funding

Prevalence estimates from multiple sources (Productivity Commission, NMHC and the National Mental Health Service Planning Framework) show that up to 280,000 consumers and 89,000 carers fall outside the scope of the NDIS but will still need community-based mental health support. Governments will continue to have responsibility for meeting the needs of this larger group, so it is critical that available resources are not diminished in transition. All funding previously earmarked for mental health programs should therefore be quarantined, with spending on mental health (both allocated and actual) through the NDIS to be tracked and publicly reported. This is necessary to determine whether the overall level of psychosocial support (inside and outside the NDIS) is being increased or decreased. Such spending could include Individually Funded Packages (IFPs) for people with a primary or secondary psychosocial disability, services commissioned via Information, Linkages and Capacity Building (ILC), or specialist local area coordination with a focus on mental health (including Partners in Recovery (PIR) or PIR-like services – see below).

Figures mentioned in most discussions during the past three years and more have been around $1.8 billion to $2 billion. Transparent processes to keep track of this amount will help calm fears from those who recall the 'missing millions' problems that accompanied deinstitutionalisation.

Most of the figures above are best guesses only, so estimates of unmet need and options for appropriate responses should be re-examined as a matter of urgency to inform the Productivity Commission's review in 2017. This is likely to require a dedicated data strategy to improve the information available to policy makers and the sector.

By 2020, when the NDIS is more fully developed, we should aim to have a much better informed understanding of the scale of unmet need for low to medium supports for consumers and carers, and the models of assistance most suited to meet those needs.

Consultation questions:

Should there be a definition, to complement the eligibility criteria for the NDIS, for the people who require services that are out of scope for the NDIS?

Should the document be more specific about the spending on mental health to be tracked e.g. services, people?

Are there other issues that should be included in this section?

Transition arrangements for in-scope mental health programs

Day to Day Living, currently funded by the Department of Health (DoH), was designed as a long-term disability support, but for a wider target group than for the NDIS today. Day to Day Living, funded by DoH, is also fully 'rolled in' to the NDIS, but all evidence points to at least half of the participants not meeting the eligibility requirements for the NDIS. Programs including many centre-based programs could face closure if this funding ceased. Half of the current funding, which we believe to total around $15 million a year, should be available outside the NDIS. 50% of the current funding should transition to the NDIS by 2019/20, with the remainder retained for day programs aimed primarily at people unlikely to be eligible.

Partners in Recovery is aimed at a very similar cohort as the NDIS—perhaps a 70% to 80% overlap, but the real figure may be much lower if those on the margins of the service are accounted for. The PIR model can be operated within the NDIS, administered by the National Disability Insurance Agency (NDIA), as long as it is essential, flexible features of assertive outreach, engagement, holistic responses to achieve 'wraparound' services and complex coordination are protected. Its functions can in many ways mirror the NDIS early childhood and school leaver gateways, providing vital assistance to the NDIA in identifying and engaging its target population. This approach could also look much like the solution being developed for Youth Early Psychosis Programs (YEPPS)—administered within Headspace, but with a transparent national oversight mechanism ensuring model fidelity and no loss of funding. The program must also continue to offer a full service to those 20% to 30% who will not enter the NDIS, for whatever reason.

However, an equity problem remains with PIR, because more than 20% of Australians cannot access the program since around one fifth of regions did not have an approved PIR consortium prior to rollout being frozen in 2013 pending the outcomes of the National Mental Health Commission's Review. Full funding nation-wide was estimated to cost about $150 million in 2011 when the program was announced. $150 million should be reserved within the NDIA budget for PIR, to allow it to be made available nationally.

Consultation questions:

Are the estimates described above an accurate reflection of the services needed in the community?

What data do you have, or would be needed, to shed light on the nature and extent of the need for community-based mental health support?

Personal Helpers and Mentors (PHaMs) and **Mental Health Carers Respite** (MHC/Respite) are the key Department of Social Services-funded responses designed for the wider group of people dealing with severe mental illness who will not be eligible for the NDIS, and who need intermittent low-to-medium levels of support, from programs designed to be transitional, supporting short to medium term journey to greater independence. Some consumers and carers entering these programs have been found to need the longer term and more intensive supports offered by a

package in the NDIS, and this will continue to happen. However, with the huge unmet need for these programs, demonstrated by nation-wide waiting lists and low but steadily increasing referral rates from primary health and clinical services, they should be retained at least at the current level of access. Current funding for these programs is in the order of $200 million, which should continue, to ensure no loss of access. The source of these funds should be from outside the NDIS, to ensure adequate resources are available within the NDIS for people who need the more intensive, ongoing supports offered by an IFP.

Most providers of PHaMs and MHC/Respite have recently been re-funded for up to three years, with funding tagged to reduce progressively as the NDIS is fully implemented. Given the evidence summarised above, that there will be more unmet need than even full continuation of funding can guarantee, these scaled reductions should be removed from the contracts.

Consultation question:

Are there any other issues that should be included in the position paper?