INCOMING GOVERNMENT BRIEF

Mental Health Australia

Overview

At the time of writing, Australia's mental health sector is facing unprecedented change and uncertainty. After several years where mental health reform was effectively on hold, the Australian Government's announcements in November 2015, coupled with the roll out of the National Disability Insurance Scheme (NDIS), initiated major changes to the way mental health services are funded, planned and delivered.

Successful implementation of these well-intentioned and much needed reforms will require the mobilisation and goodwill of the whole mental health sector, including: consumers and carers, clinicians and other frontline workers, community-managed organisations and jurisdictions. Unlike other areas of substantial government reform, governments have not yet invested adequately in change management to achieve these mental health reforms – to their detriment.

Unless there is adequate investment in change management, there is a real risk of unintentionally removing access to services for some consumers and carers. The mental health sector supports reform having sought it for years, but the task of adapting to change will be much harder (and in some cases impossible) if services continue to face unsustainable pressures and uncertainties relating to funding and workforce.

This Incoming Government Brief provides a snapshot of the mental health sector's capacity to embrace reform and provides recommendations for immediate action. Our plan is drawn from Mental Health Australia's *Blueprint for Action on Mental Health*[1] and ongoing consultations with the sector. It has been prepared to assist the incoming Australian Government to understand the current mental health landscape and the factors which will contribute to the success of mental health reform in 2016 and beyond.

Context

The most recent review of Australia's mental health system, undertaken by the National Mental Health Commission (NHMC) between December 2013 and October 2014, was released publicly in April 2015. Mental Health Australia broadly supports the review's findings and recommendations.

The NMHC review identifies 'fundamental structural shortcomings' across 'a poorly planned and badly integrated system.' The overall impact 'is a massive drain on people's wellbeing and participation in the community.' This is consistent with the findings of many past reviews and inquiries into mental health.

[1] https://mhaustralia.org/submission/blueprint-action-mental-health

While the review was underway, the nationwide rollout of the NDIS has been gathering pace. Despite transition commencing on 1 July 2016, relevant data from the trial sites is very limited, and basic issues regarding eligibility and scope are still highly contestable and are likely to remain so for many months. The mental health sector has also struggled to access suitable data, with neither the Department of Social Services nor National Disability Insurance Agency (NDIA) releasing sufficient data to enable the sector to understand progress and lessons learnt from trial sites and to plan future service offerings.

The sector is simultaneously being asked to adapt to major changes announced by the Australian Government. These initiatives include:

- The transition of substantial Commonwealth and state based mental health services into the NDIS, with movement away from block funding to individual packages of support;
- Locally planned and commissioned mental health services through Primary Health Networks (PHNs) and the establishment of a flexible primary mental health care funding pool;
- A new digital mental health gateway;
- Refocusing primary mental health care programs and services to support a stepped care model, through the PHN flexible funding pool;
- Joined up support for child mental health, including a single integrated end to end school based mental health program and new pathways to services including online based support;
- An integrated and equitable approach to youth mental health, with current program funding for youth mental health services to be channelled through PHNs, which will commission appropriate services based on community need;
- Integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services. Services will be better integrated between mental health, drug and alcohol, suicide prevention and social and emotional wellbeing services at a regional level, with skilled teams providing support for Aboriginal and Torres Strait Islander people with mental illness;
- A renewed approach to suicide prevention, including:
  - » a new evidence based approach, including a systematic and planned, integrated and regional approach; and
  - » negotiations with states and territories that seek to ensure people who have self-harmed or attempted suicide will receive critical follow-up support.
- Improving services and coordination of care for people with severe and complex mental illness, including developing new innovative approaches to coordinating and packaging available services and funding to better meet their multifaceted needs; and
- National leadership in mental health reform, including promotion, prevention and stigma reduction activities, supporting consumer and carer engagement, building the evidence base and ongoing monitoring to enable continued improvements in mental health.

While the sector supports these substantial reforms, they are occurring against a backdrop of three successive years in which mental health providers have dealt with a series of short-term funding extensions and reductions in real funding, pending the outcomes of the NMHC review and NDIS rollout plans. The stop-start nature of decision-making on mental health at Commonwealth level has taken a severe toll on the sector, and is directly impacting

consumers and carers, as well as diminishing the sector's capacity to respond to rapid change.

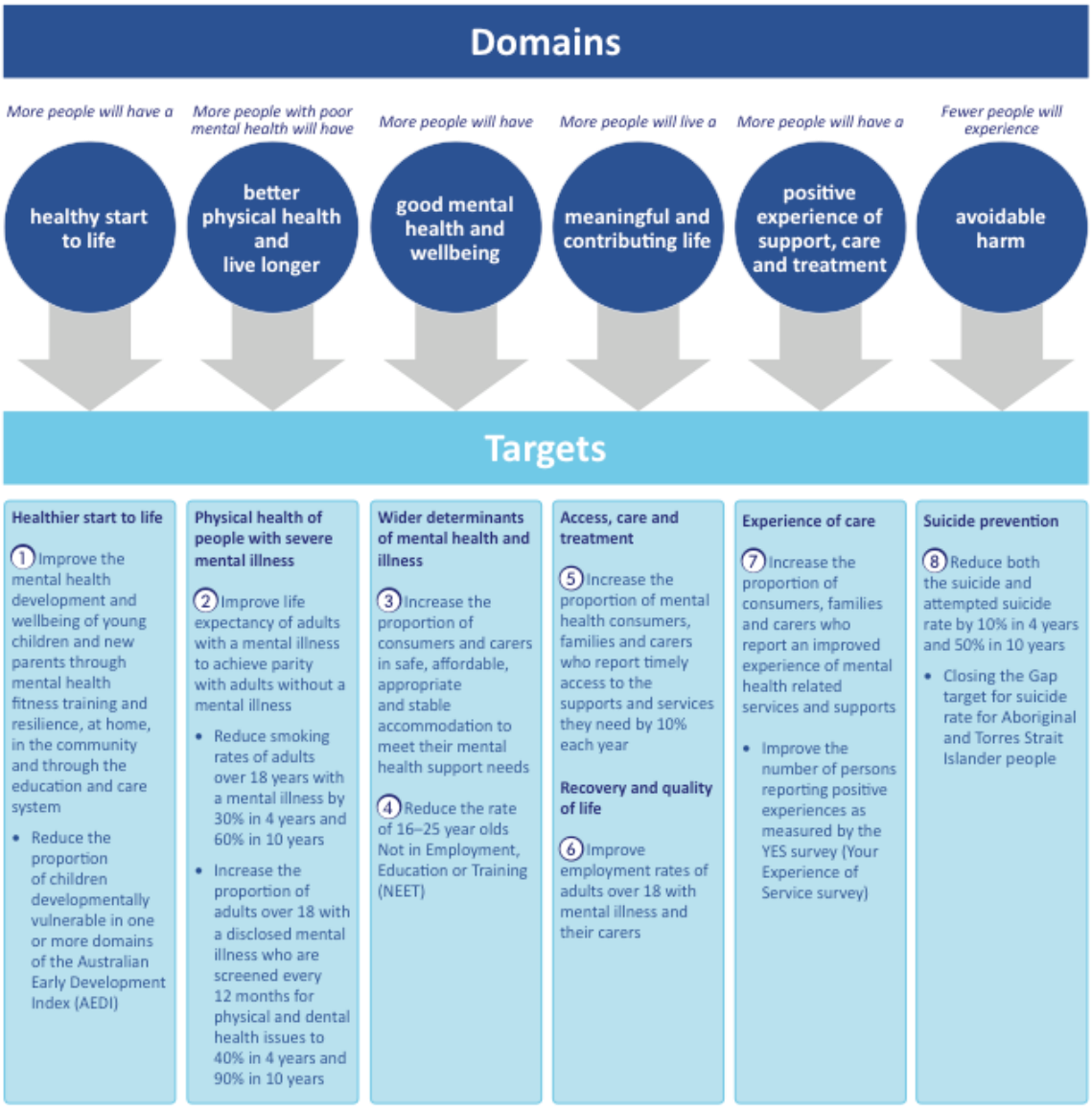
What do we want to achieve?

Implementation of Targets and Indicators

While the sector broadly welcomes these reforms outlined above, they need to be underpinned by a commitment to targets and indicators.

In 2012, the Council of Australian Governments (COAG) committed to the development of "whole-of-life and outcome-based national indicators and targets." Four years on, this still has not occurred despite extensive work being undertaken across government, by the NMHC, and by the Mental Health Information Strategy Standing Committee.

The NMHC recommended that governments "adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directors in mental health and suicide prevention." The Commission argued that targets "can be an effective lever to drive change". The Commission identified eight targets, as detailed below.



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In its response to the Commission's report the Australian Government committed to establishing: "A culture of measurement, evaluation and systematic improvement of services to achieve better consumer outcomes will be supported and encouraged to ensure meaningful feedback is available for continuous improvement and evidence based planning."

Recommendation: Immediate work should commence to implement these targets and indicators recommended by the NMHC. This would involve, at a minimum:

- harmonising data collections and requirements (for example neighbouring PHNs currently require different data from the same organisation working in both areas);
- funding, and supporting service providers to collect new data sets;
- improving timely reporting and linking of aggregated data for planning and evaluation purposes, at both national and regional levels;
- supporting and funding the development and use of IT systems within and across organisations; and
- training the existing and future workforce in the skills necessary to support a "culture of measurement, evaluation and systematic improvement".

Who is responsible for what?

According to the Federation Taskforce:

> *...Mental health is a compelling example of the challenges associated with assigning roles and responsibilities.... There is in fact no such thing as a mental health 'system'; instead, this 'system' is shorthand for the many systems and services consumers and carers may encounter. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal.*
>
> *The Commonwealth and the States and Territories both have roles [which] have evolved in piecemeal fashion and have usually not been defined with respect to an overarching vision...*
>
> *No level of government 'owns' mental health, which in turn has made it difficult to ensure accountability.... Better governance conditions would improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve outcomes.*

In December 2012, COAG agreed that a specially established COAG Mental Health Working Group would review the Fourth National Mental Health Plan and develop a 5th plan for COAG's consideration, by mid-2014. Negotiations were put on hold after the change of government in 2013, but the government re-committed to finalising the plan "in 2015-16" in its response to the NMHC's review. It also indicated that the plan will be an opportunity to develop an appropriate performance framework and national indicators for measuring progress towards reform in this context.

Now, in early 2016-17, the sector is yet to see even a draft for consultation. Notwithstanding the lengthy delay, Mental Health Australia is focussed on ensuring we get a quality plan, co-

designed by consumers and carers, and with thorough and detailed sector engagement – rather than a rushed Plan.

Recommendation: The government should urgently clarify the timing and process for the finalisation of the Fifth National Mental Health Plan, co-designed by consumers and carers, in partnership with the mental health sector. This process should describe the concrete steps needed for meaningful consultation with the range of stakeholders affected, including consumers, carers and non-government organisations and the resources that will be allocated to these processes.

How can we improve consumer and carer participation?

Consumers and carers are the experts in what services and programs work for them, and co-design with people with lived experience should be at the heart of service design, delivery and evaluation. Consumers and carers must be involved in decisions that affect them from services available locally to the development of national policy. This is especially the case for vulnerable groups such as Aboriginal and Torres Strait Islander peoples, CaLD, LGBTIQ and the intellectually disabled.

That is why all aspects of mental health policy, including the NDIS, need to increase mental health consumer and carer participation and choice in national policy design and implementation.

Recommendation: Governments should provide funding for structures that strengthen the capacity and embed the voices of people with lived experience in policy design and implementation at national and regional level. This should include arrangements to maximise the contribution that people with lived experience of mental illness can make to the ongoing work of PHNs.

Recommendation: The Australian Government should invest in the development of the mental health peer workforce. This would involve initiating the development of a mental health peer workforce development framework and providing incentives to integrate peer workers into all relevant services.

What investments are we making, and what investments are required?

Constrained by its terms of reference, the NMHC adopted a principle that there should be "no net reduction in overall investment in mental health," despite mental health attracting substantially less funding than physical health relative to the burden of disease.[2] The NMHC's response was to recommend significant increases in spending on prevention, early intervention and community-based services, with this investment leading to savings in downstream expenditures. Mental Health Australia strongly endorses this approach, along with the NMHC's identification of mental health spending across portfolios, including the welfare and justice systems.

Defining the mental health funding 'envelope' is not straightforward, since total mental health expenditure covers significantly more than standalone mental health programs. An analysis of the major sources of grants and funding received by the community mental health sector is presented in the table on the next page.

[2] http://www.huffingtonpost.com.au/2016/06/27/what-the-major-parties-have-promised-for-mental-health/?ncid=edlinkauhpmg00000001

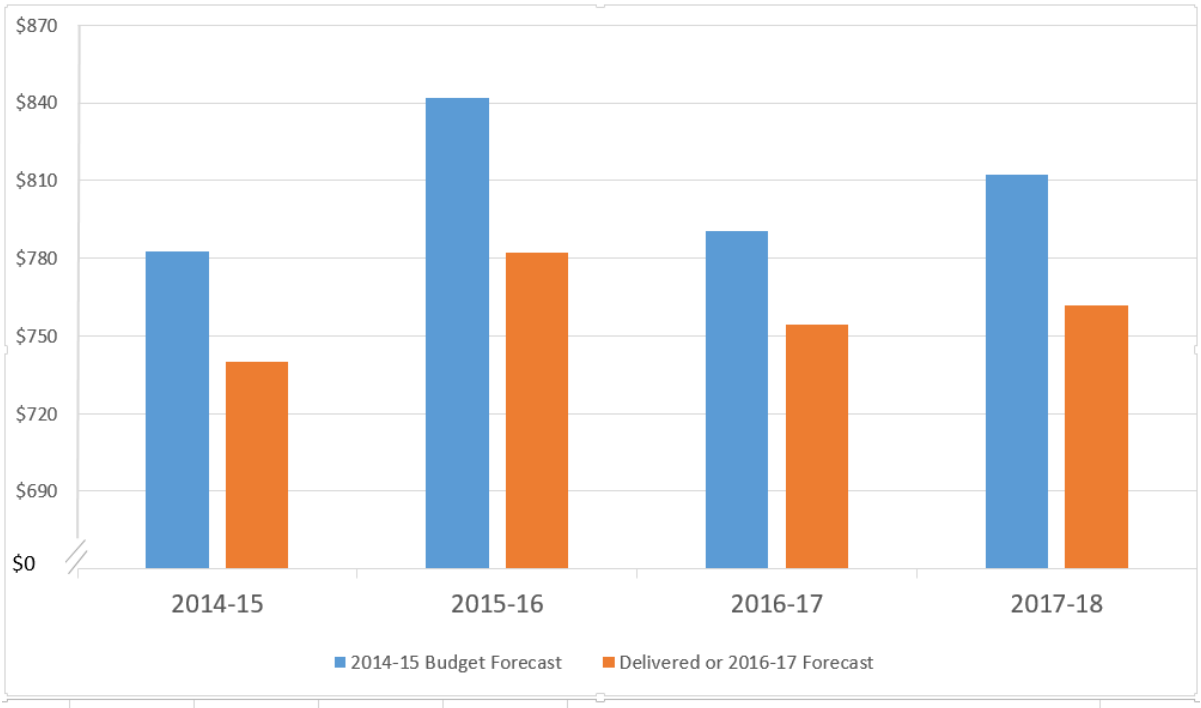
Table 1: Forecast Mental Health Expenditure in the Departments of Health and Social Services

	2013-14	2014-15	2015-16	2016-17	2017-18
2016-17 Budget Papers			$782.2m	$754.4m	$761.8m
2015-16 Budget Papers		$739.8m	$806.9m	$762.3m	$765.3m
2014-15 Budget Papers	$665m	$782.5m	$841.7m	$790.3m	$812.4m
Expenditure changes					
Compared to 2014-15 Budget (%)		-5.5%	-7.1%	-4.5%	-6.2%
Compared to 2014-15 Budget ($)		-$42.7m	-$59.5m	-$35.9m	-$50.6m
Year on year change (real)		9.4%	4%	-5.4%	-1.2%
Per capita change (real)		7.5%	2.2%	-7.1%	-2.9%
Growth 2013-14 to 2017-18 (real)					6.2%
Per capita change 2013-14 to 2017-18 (real)					-0.9%

Note: Deflated by CPI. ABS figures used until 2015-16, BP1 forecasts used for 16-17 and 17-18.
Note: the Budget Papers show a significant drop in mental health expenditure on 2018-19. This is due to the rollout of the NDIS, and therefore it is not possible to get comparable figures. Thus, 2018-19 has not been shown.

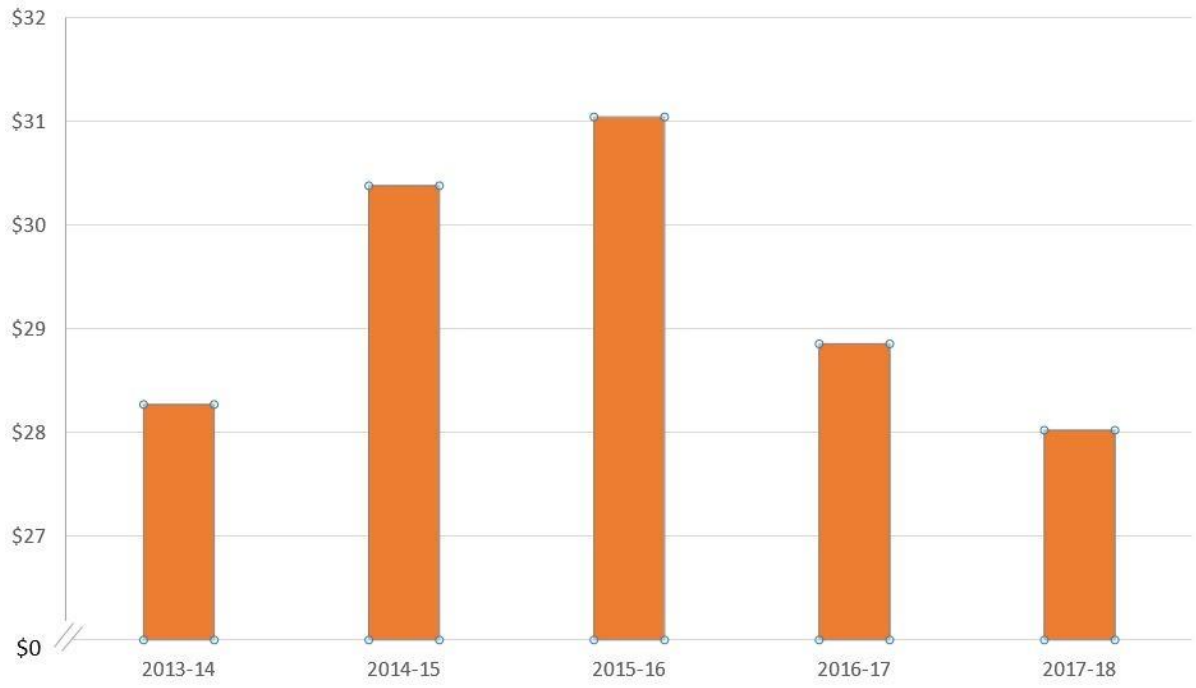
Graph 1: The Government Has Not Met its 2014-15 Budget Commitments to Community Mental Health Expenditure

2014 Federal Budget allocations for community mental health versus actual expenditure/revised forecasts ($m)



Graph 2: Per Capita Expenditure on Community Mental Health is Falling

Per capita expenditure on community mental health ($)



As a result of election commitments from the Liberal/National Coalition, we expect to see small increases in expenditure in 2016-17 and 2017-18, when updated figures are released. These increases may restore the funding that has been removed since the 2014-15 budget.

However, other election commitments may result in less investment benefiting mental health consumers and carers. These include reductions in wage subsidies available for employers,[3] and an expectation of further compliance savings from recipients of welfare payments.

When matched to population growth, the data above demonstrates a steady reduction in per capita funding for mental health and a significant decline in the percentage of that funding directed to community based programs – a trend that directly opposes the directions put forward in the NMHC review and numerous other reviews, which suggest a substantial increase is required.

In addition, based on forecasted mental health expenditure from the 2014-15 Budget papers for each year of the forward estimates (shown in Table 1, above), Australian Governments have consistently failed to deliver their promised level of expenditure, with reductions of between 4.5 per cent and 7.1 per cent for each of the four forward years. This has seen around $190 million lost to the community mental health sector over four years, because the government has not met its 2014-15 Budget commitments to community mental health.

These calculations do not assess the significant mental health expenditure within the Pharmaceutical Benefits Scheme (PBS), Medicare, hospitals, private health insurance, Centrelink, or Department of Veterans' Affairs, or by other governments. Establishing the exact amount being spent in these areas is difficult. However, there have been a range of government decisions since 2013 that reduce investment in mental carers and consumers:

[3] https://www.electioncostings.gov.au/sites/g/files/net1186/f/coa_052_-_costing_-_reduction_in_the_wage_subsidy_pool.pdf

- The 'pause' in the indexation of Medicare rebates is expected to save the government approximately $600 million per year. Given that approximately 5 per cent of Medicare expenditure is on mental health services,[4] we can estimate this will cut a further $30 million per year out of mental health services.
- Similarly, given that approximately a third of people on the Disability Support Pension (DSP) have a psychosocial disability, the review of 30,000 DSP recipients announced in the 2016-17 Budget is likely to reduce mental health expenditure by a further $20 million over five years. This is in addition to the earlier changes requiring government-employed doctors to assess DSP claimants. Based on government figures, this is estimated to have led to a $250 million a year reduction in DSP expenditure for people with a psychosocial disability, a saving that we have long argued could be re-invested in early intervention and prevention.[5]
- In both the 2014 and 2015 Budgets, the government increased co-payments and/or safety net thresholds for the PBS, which raised approximately $1.3 billion over the forward estimates. We estimate this will increase the cost of medication for people with mental illness by around $156 million over the four years from 2016.[6]
- Finally, the decision to increase the tobacco excise by 12.5 per cent per year from 2017-2020 is predicted to increase revenue by around $4.7 billion over the forward estimates. Given that approximately 42 per cent of all cigarette purchases are by people with mental illness, this is a $2 billion increase in revenue from people with mental illness, over the next four years.[7] While any reduction in smoking rates is a positive, at least some of the extra government revenue should be re-invested in specific quit-smoking initiatives for people living with mental illness.

Cumulatively, these measures are likely to have an impact of approximately $3.3 billion on the mental health sector, consumers and carers over the next four years.[8]

The only area where there has been strong growth in expenditure is hospital services – against the trend recommended by the NMHC. Recurrent expenditure on specialised mental health public hospital services has been growing at an average rate of 3.5 per cent per year, in real terms,[9] which is the fastest growing category in state and territory mental health expenditure.

The growth in hospital spending contrasts with the recommendations from the NMHC's review that future growth in mental health spending be directed towards expanding the community mental health sector and investing in prevention and early intervention.

Recommendation: The Australian Government should develop measures that support full reinvestment of cost efficiencies and savings back into community mental health programs and services, and other promotion, prevention and early intervention measures.

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[4] Australian Institute of Health and Welfare (AIHW), Mental Health Services in Australia, Expenditure on Mental Health Services, Table 16 says MBS expenditure in 2013-14 was $971m, while the 2014-15 Department of Health Portfolio Budget Statement estimated 2013-14 MBS expenditure at $19.1bn.
It is unclear if this figure includes mental health services provided by GPs under ordinary non-referred attendance items (MBS Group A1). If these attendances have not been included, the financial impact on mental health consumers is likely to be significantly larger.

[5] https://mhaustralia.org/sites/default/files/docs/submission_to_the_department_of_health_-_priorities_for_mental_health_september_2015.pdf p9

[6] Mental health related prescriptions are approximately 12 per cent of the PBS. https://mhsa.aihw.gov.au/resources/prescriptions/

[7] http://www.smh.com.au/national/health/push-for-government-to-use-tobacco-excise-dollars-to-help-mentally-ill-smokers-quit-20160515-govhv6.html#ixzz48lgaLIb1

[8] The $3.3bn is made up of $120m from MBS indexation ($30m x 4); $1.02bn from DSP ($250m x 4 + $20m); $156m from PBS; $2bn from tobacco indexation = ~$3.296bn.

[9] AIHW, Mental Health Services in Australia, Expenditure on Mental Health Services, Table 4,

Recommendation: The Australian Government should ensure its investment is consistent with the NMHC's recommendations that future growth in mental health spending be directed towards expanding the community mental health sector and investing in prevention and early intervention.

Recommendation: The government should release the National Mental Health Service Planning Framework and support its ongoing application through planning and reporting of expenditure and investment mix at national and regional levels. This Framework should provide the basis for planning services across PHNs, the NDIS, and other areas.

How do we maximise transparency and accountability?

The complexities associated with the reform processes make it vital that the NMHC take lead role in overseeing mental health reforms, keeping governments accountable and tracking mental health expenditure.

Mental Health Australia welcomes the Liberal/National Coalition election commitment to "strengthen the National Mental Health Commission, who will be charged with overseeing mental health reforms and providing direct advice to the Minister."

The NSW Mental Health Commission recently observed that:

> *Lack of accountability has the potential to undermine the reform initiatives and to compromise the impact of the additional funding. The* [NSW] *Commission will continue discussions with the Ministry of Health about improving accountability for and transparency of mental health expenditure.*[10]

With responsibility for Commonwealth service planning and delivery set to become largely the responsibility of PHNs and the NDIA, these observations about the need for accountability for mental health spending are just as relevant at the Commonwealth level. This was a key recommendation in the NMHC's first Report Card in 2012:

> *All governments must independently and transparently report each year on the actual expenditure on mental health prevention, community based, rehabilitation, recovery and acute care services and compare this with the announced expenditure. This way we will know that money committed to mental health is actually used in mental health, is used in the right areas and is not used to offset funding pressures or subsidise shortfalls in hospital or related budgets.*[11]

Recommendation: As the highest priority task in its strengthened role, the NMHC should be given responsibility for monitoring and reporting on actual expenditure for mental health programs and services, and comparing this expenditure to budget allocations. To perform this role, relevant Commonwealth agencies should be required to provide relevant data to the NMHC in a timely way.

Recommendation: All relevant Commonwealth departments (including the NDIA) should work with the NMHC to ensure that the transition to the NDIS, and to PHNs, does not result in a net reduction of funds for mental health and psychosocial supports. This monitoring should also determine whether new arrangements inadvertently result in a concentration of supports amongst some groups at the cost of gaps in services for other groups.

[10] http://nswmentalhealthcommission.com.au/sites/default/files/Report%20-%20One%20year%20on%20-%20Progress%20Report%202015%20-%208%20Feb%202016.PDF

[11] http://www.mentalhealthcommission.gov.au/media/39270/NMHC_ReportCard_Enhanced.pdf, p.7.

How can we minimise uncertainty and disruption?

Funding and policy uncertainty continues to be one of the most pressing threats services offered by the mental health sector. In recent years there have been far too many occasions where mental health services have been forced to lay off workers or even wind up programs entirely because they have been informed at late notice of funding being withdrawn or reduced.

For example, providers of the Personal Helpers and Mentors (PHAMS) and Mental Health Respite: Carer Support (MHR:CS) programs recently received contacts for 2016-17 from the Department of Social Services less than a week before their funding expired. In that case, contracts were extended by just 3 months.

The cumulative impact of short-term funding decisions was recognised late last year by the Senate Select Committee on Health, which delivered a unanimous report, *Mental Health: A Consensus for Action*. On the report's opening page, it said:

> *...Organisations providing mental health services and programmes are forced to survive on year-to-year funding. The uncertainty caused by the government's constantly delayed decision making has caused workforce instability and increasing uncertainty for mental health consumers and carers. This is an unacceptable situation.*

Within the Department of Health alone, there are around 30 vital mental health grants that expire before the end of the 2016 calendar year, including funding for Kidsmatter, MindMatters, the Royal Flying Doctor Service, Mental Health in Multicultural Australia, and various suicide prevention activities. There are a further 200 mental health grants that expire in mid-2017, and which also require urgent resolution.

Recommendation: In order to provide funding certainty, decisions regarding grants that expire in 2016 and mid-2017 need to be made, communicated and executed at least three months, and preferably six months, in advance of contracts expiring. Without urgent attention, the mental health sector will experience another last-minute funding crisis for the fourth successive year, for reasons that appear entirely avoidable.

Recommendation: To avoid further disruption and uncertainty, future contracts between government and mental health providers should last for a minimum period of 3 years, unless there is a compelling reason to opt for a shorter duration.

How can we support the transition to PHNs?

Readiness of PHNs to commission mental health services

The current mental health reform agenda challenges many PHNs to take a leadership role in the planning and commissioning of services. While some PHNs have previously been involved in the delivery of mental health programs and services, not all have the expertise required to appropriately plan and commission mental health services.

The success of these reforms will rest on three key factors. First, PHNs will need to develop a deep understanding of the kinds of evidence-based services and programs that could be offered by the non-government mental health sector, including: community based mental health organisations, clinicians, private practitioners, consumers and carers and others. Second, community-based mental health providers will need to be ready to respond as PHNs commission services in response to local need. PHNs may elect to commission innovative programs and new service models that will provide better outcomes to consumers and carers. Finally, PHNs will need to have deep engagement with well-resourced and

supported consumers and carers in order to develop service offerings that are truly co-designed.

PHNs' ability to provide high quality services has been hampered by significant delays in the finalisation of guidance material by the government, which were only released at the very end of July 2016.

Recommendation: The government should invest in capacity building activities designed to:

- Build PHN knowledge of evidence-based programs and services that could be offered by a broad range of mental health providers, including those already working in their communities
- Support PHNs in building and translating evidence where there are gaps in knowledge or insufficient evaluation
- Support structures that strengthen the capacity and embed the voices of people with lived experience in service co-design
- Build knowledge and understanding amongst existing mental health organisations and providers of the respective roles of PHNs, Local Hospital Networks and the NDIA
- Facilitate knowledge exchange between the mental health sector and PHNs by promoting best practice in a rapidly changing environment.

How can we support the transition to the NDIS?

Safeguarding access to services

The NDIS has been funded in part by moving existing mental health programs into the scheme. Evidence is now emerging that the assumptions underpinning these decisions may not be accurate, nor lead to the most effective investment of public funds. The emerging evidence reinforces concerns that mental health stakeholders have consistently raised that the NDIS could unintentionally result in a shortage of services for those people who will remain outside the NDIS.

In 2012, the Productivity Commission (PC) recommended that people with severe and persistent mental illness and associated complex disabilities should be included in the NDIS. At the time, the PC estimated that there would be approximately 57,000 people who would meet this criteria. The quantum of funds estimated as required for these psychosocial supports was around $1.8 billion per annum, based on an average package cost of about $32,000. It now appears that the actual take-up of supports by participants in trial sites has consistently averaged around $21,000 per annum.

If this take-up rate continues as expected, the estimate of $1.8 billion on which bilateral agreements were based will be considerably more than the NDIS requires to support the 57,000 people in Tier 3, in the order of hundreds of millions of dollars.

To further compound this, a significant proportion of that $1.8 billion has been achieved by 'transitioning' existing programs from all jurisdictions on the assumption that those programs mainly supported people who would get an NDIS package as a replacement. As early as 2012, the Australian Government Actuary (AGA) warned about the problems associated with this assumption.

> *if the NDIS were to be restricted to the group with complex needs [the 57,000], there would be considerable demand for the services provided by this sector from the residual 100,000 individuals with severe and persistent mental illness.*

The AGA estimates confirm that if too many programs are rolled into the NDIS, there is a real risk of a large number of people missing out on psychosocial support services.

While there is still no consistent picture of how the NDIA will define eligibility, evidence from Mental Health Australia's member organisations continues to suggest that there will be a large number of people who currently are receiving support services who will not be eligible for the NDIS. Over time, the flow-on effect will be to increase demands on the NDIS, as people who are currently receiving, or may be eligible to receive, lower-cost support services ultimately develop more severe disability because of the removal of these supports.

The Department of Social Services has previously advised that in Barwon, only 50 per cent of PHAMS clients transitioned into the scheme. Estimates by Mental Health Australia's members suggest that figure could actually be as low as 25%-30%. This outcome has been anticipated by the sector for several years now.

As Mental Health Australia indicated in a comprehensive analysis provided to the Australian and all state and territory governments more than a year ago, if these complex questions of policy and funding are not resolved quickly, service access will be reduced for thousands of people with severe mental illness. These people have already fallen through the gaps for too long. The best way to address this is may be to maintain programs like PHAMS, PIR, MHR:CS and Day to Day Living outside the NDIS, to provide services to those people who do not meet NDIS eligibility criteria. This is consistent with the recommendations made in the NMHC's review:

> *Do not cash out existing mental health and other associated programmes (e.g. carer and respite programmes) into the NDIS until there is evidence as to eligibility for people with a psychosocial disability, and clarity about ongoing support for those who are eligible for Tier 2 support.*

Recommendation: Government should immediately postpone plans to "roll in" and wind down programs which wholly or partly serve target groups ineligible for the NDIS until the full implications for individuals and families both inside and outside the scheme are known definitively.

Funding cuts to Partners in Recovery

The Partners in Recovery (PIR) program guidelines allowed for an 'innovation fund,' which allows PIR providers to explore, fund and trial innovative models of delivering services. The innovation funds are designed to promote collaborative action and encourage solutions that ensure recovery-oriented, effective and timely access to the services and supports required by people with severe and persistent mental health conditions.

The Department of Health has recently confirmed that PIR organisations have already had their funding cut in 2016-17, irrespective of when their area is transitioning into the NDIS. Mental Health Australia estimates that most PIR organisations are receiving between 8% and 10% less in 2016-17, compared to 2015-16. Across the country, this appears to be a cut of approximately $6.5 million.

The Department of Health has informed PIR organisations that this funding is being transitioned to the NDIS. As innovation funds were used for system reform and sector capacity building projects, this work will now cease. The policy rationale for halting valuable

system-level activity during NDIS transition (which is itself major system-level reform) is not clear, given that the cross-sectoral and interface challenges will only increase over the transition period.

Recommendation: The government should not reduce any funding to any funded organisations before their clients have actually transitioned into the NDIS and started receiving NDIS-funded services. Funds for system improvement that were recently reduced should be reinstated until it can be demonstrated that there is no longer a need for such activity.

NDIS pricing

Since rollout of the NDIS commenced in launch sites, mental health providers have consistently raised concerns about the match between the hourly prices paid by the NDIA for psychosocial support work and the reality of delivering that work by suitably qualified personnel. Some providers have described their work in launch sites as 'loss-leading', undertaken under the assumption that it will eventually become apparent to the NDIA that its pricing structures need revisiting, and acknowledging this is one of a myriad of implementation challenges. This means service providers are currently cross-subsidising suboptimal transition arrangements. Mental Health Australia's consultations suggest that the scale of cross-subsidisation is alarming and unsustainable.

Less optimistically than those considering "loss leader" arrangements, some mental health providers envisage a 'race to the bottom', where a less skilled workforce becomes a competitive advantage in the new "market" and choice for participants is eroded over time, as providers become unable to support more highly trained workers under the terms set by the NDIA. Concerted action is required to ensure mental health consumers and carers are not left to make choices in a marketplace denuded of high-quality options.

Consideration should be given to establishing an independent NDIS Financing Authority, based on the model of the Aged Care Financing Authority, to provide independent advice to the Government and the COAG Disability Reform Council and the NDIA on funding and financing issues, informed by consultation with consumers, carers and providers. A longer discussion of areas of concern with the current NDIA pricing regime can be found in Mental Health Australia's recent submission to the NDIA.[12]

Recommendation: The Australian Government should suspend any further step-downs in the transition price, and commission the NDIA to undertake pricing reviews on:

- how its pricing models can incorporate the costs of innovation, co-ordination with other service providers, ICT investments and other inputs that are not explicitly supported through an hourly unit price, but which nonetheless affect long-term organisational viability, service quality and participant choice in the NDIS marketplace;
- how to ensure that it is financially viable to provide supports when a participant with psychosocial disability chooses to have a range of support services delivered by the same trusted support-worker;
- the best way of ensuring participants from linguistically diverse backgrounds and other vulnerable groups such as Aboriginal and Torres Strait Islanders, the LGBTIQ community and people with comorbidities such and intellectual disability or alcohol and drug misuse are able to access culturally appropriate services; and

[12] https://mhaustralia.org/submission/submission-ndia-2016-pricing-review

- how to ensure appropriate training, supervision and support for workers.

Recommendation: The government should gather and analyse information on a range of challenges affecting mental health provider transition, including: key risks to maintaining user services and reducing the risk to users, change investment capacity, pricing, profitability, quality, workforce planning, service mix and choice, ICT capability. Based on this information, government should work with mental health stakeholders to identify potential immediate and longer term mitigation strategies to support effective and efficient transition to NDIS.

Productivity Commission review of the NDIS

The Productivity Commission (PC) is scheduled to undertake a major review of the NDIS in 2017, which will examine "the sustainability of scheme costs.... cost pressures (including wages pressures)... if efficiencies have been achieved within the scheme and whether there has been any impact on mainstream services." The precise terms of reference still need to be agreed by the COAG Disability Reform Council (DRC).

Mental Health Australia, Community Mental Health Australia, and all state and territory mental health peaks consider it vital that the PC review includes detailed terms of reference about the interaction between mental health and the NDIS. These organisations have written jointly to all 18 members of the DRC calling on them to include the following issues in the PC Review:[13]

- *Interaction with mainstream systems:* The PC should consider whether the NDIA and governments have put in place appropriate measures to meet the needs of people who will continue to require support from mainstream service systems, following the transition to the NDIS, and to consider what further actions are required in adjacent systems to meet these needs.
- *Eligibility numbers and criteria:* The PC should give further consideration to the psychosocial disability eligibility criteria and the estimate of the size of the cohort and consider the appropriate way of providing social inclusion and disability support services for people with severe and persistent mental illness, who are not eligible for the NDIS.
- *In scope programs:* The PC should consider which mental health programs and funding should be rolled into the NDIS, or retained outside the NDIS.
- *Independent Pricing Authority*: The PC should consider the benefits of establishing an independent pricing authority to provide independent advice to government.
- *Pricing for psychosocial supports:* The PC should consider whether the pricing of psychosocial supports is appropriate and sufficient to ensure the ongoing sustainability of the sector.
- *Workforce:* The PC should consider if further action is required to support the development of the mental health and psychosocial support workforce for the NDIS.
- *Transition support:* The PC should consider if any further transitional assistance for service providers is required.

The PC Review will be a major opportunity for governments to better understand how the NDIS can be optimised for people with psychosocial disability, and to adjust policy settings accordingly.

Recommendation: The government should ensure that the range of factors affecting the success of the NDIS for people with psychosocial disability and the interaction between the

[13] https://mhaustralia.org/general/letter-disability-reform-council-2017-productivity-commission-review-ndis

NDIS and other systems are appropriately captured in the terms of reference for the PC's Review of the NDIS in 2017.

How can we support digital transformation?

The government has announced that it will support the development of a new Digital Gateway to "provide consumers with the tools and information they need to successfully navigate the mental health system and make informed choices about their care." Mental Health Australia understands that the first version of the Gateway will go live before the end of 2016, with further enhancements to be made in the first quarter of 2017.

The role of e-mental health will only grow over time, and investment in this area is welcome. All mental health providers, from "traditional" face to face services to telephone services to online providers, will need to adapt the way they engage consumers and carers using technology. However, there are several aspects of the Gateway that require further work if it is to succeed.

First and foremost, further information is needed on key aspects of the Gateway's design. It is currently unclear what audience the Gateway will target so as to maximize its reach and impact. If the target audience is defined very broadly, there is a risk of duplicating offerings already well-established in the digital marketplace, without a clear rationale for doing so.

Second, the value proposition for each cohort of users needs to be spelled out clearly. The Gateway will only be of benefit to the extent that people see its benefit. The value proposition in turn depends on the features that users will find most helpful, taking into account other options that are already available.

Third, the implementation challenge continues to grow as work on the Gateway proceeds. While the Department has committed to a process of "co-design", the timeframes usually required for co-design are not consistent with release dates in late 2016 or early 2017.

Fourth, regardless of the form the Gateway ultimately takes, it must facilitate access to options that are safe, of high quality, backed by evidence, and responsive to individual need. This implies a need for robust processes to certify the content for "endorsement" on the Gateway.

Recommendation: Based on consultation with stakeholders, the government should clarify its intentions regarding the target audience, value proposition and timetable for the Digital Gateway.

Recommendation: The Department of Health should work with Mental Health Australia in developing processes relating to quality assurance and certification that will have the confidence of all stakeholders.