POLICY SUBMISION

Mental Health Australia

Draft ILC Commissioning Framework

Key points

In December 2015, the National Disability Insurance Agency (NDIA or Agency) released the draft Information, Linkages and Capacity Building (ILC) Commissioning Framework for public comment.

Mental Health Australia is confident that a well-designed system of ILC services can make a vital contribution to systems-level reforms, to optimise the interface between the NDIS and mainstream services, and in providing low-level or episodic support to people with disabilities who are not eligible for individually funded packages. It is therefore positive to see some of the priorities for ILC spelled out in the draft Commissioning Framework. In particular, Mental Health Australia welcomes:

- a priority on "delivery by people with disability for people with disability."
- a focus on outcomes based commissioning; and
- a focus on tailored approaches for indigenous people and people from culturally and linguistically diverse backgrounds.

Mental Health Australia remains concerned about the continued uncertainty in relation to how ILC will apply in practice to services for mental health consumers and carers. These concerns are very similar to those conveyed in Mental Health Australia's submission on the draft ILC Framework in March 2015, which recommended that:

> As a matter of urgency, each jurisdiction should release information from the mapping of its existing services against the ILC Framework and, wherever possible, against the target population and/or the NDIS access criteria.

It is difficult to see what progress has been made on how ILC will apply to mental health since that time. Ongoing uncertainties relate to:

- The outcomes and implications of the mapping of existing state/territory and Commonwealth services and target populations in scope for ILC.
- Any modelling undertaken to identify the size, nature and needs of those populations.
- Detailed advice regarding interactions and demarcations between activities funded by Individually Funded Packages (IFPs), ILC, Local Area Coordination (LAC) and mainstream systems.
- How outreach services will be funded and delivered, in order to identify and support people with multiple and complex needs applying for the NDIS, in particular for indigenous and culturally and linguistically diverse communities.
- How ILC could be used to improve local system integration and collaboration.
- How the continuity of support guarantee will be managed.

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We have also submitted a separate submission on outcomes measurement and data collection.

Information gaps

The Productivity Commission's (PC's) original intention for ILC was to target people with disability who:

- need one-off, low intensity or episodic supports that are better delivered and managed through funding arrangements other than through IFPs; and
- need support so that their capacity to live independently does not deteriorate to a point where they would meet the access criteria for the NDIS.[1]

While Mental Health Australia supports this intention, it is not yet clear from the draft Commissioning Framework how the PC's vision will be realised in relation to mental health. In recognising that there is still a lot of work to be done in the mental health area, the Commissioning Framework states:

> …the Agency does not consider there is sufficient clarity [in broader mental health policy] to be able to detail the exact role of ILC and the ways in which it will interact with the broader mental health system in this Consultation Draft. The Agency will continue to work closely with the Australian Government as these reforms progress.

While it is of course vital that the Agency works closely with other government agencies, the process of broader mental health reform has only just begun. The redesign of primary mental health care programs is expected to be completed in 2018, by which time NDIS transition will be almost complete. Given the important contribution that ILC can make for people with mental health issues who will not meet the NDIS access criteria, it is vital that decisions about how ILC will apply to mental health are advanced even while reforms in the mainstream primary care and mental health systems are still at an early stage.

Mental Health Australia understands an 'audit' of ILC-type services currently being provided by each jurisdiction has been undertaken but not yet released.

In the Australian Capital Territory (ACT), we understand this has led to funding cuts to Radio for the Print Handicapped and Sexual Health and Family Planning ACT. However, there has been no public announcement from either the NDIA, or the ACT Government on which services have been defunded, or on what basis these decisions were made. In addition, these cuts take effect form 1 July 2016, a full year before ILC commences in the ACT, creating further funding gaps and uncertainties for vital community services.

An ongoing lack of communication regarding the nature and rationale for such decisions can, and is likely to continue to, create significant anxiety for the people who rely on these services and for the sector. In the absence of clear, timely and well-targeted communication, stakeholder awareness may depend as much on rumour and hearsay as on fact.

Providing the sector with the outcomes of this work will assist the sector in advising government on optimal approaches to supporting the estimated 200,000 people who will need community mental health support services each year but will not meet the NDIS access criteria.

ILC will commence on 1 July 2017, in the ACT. The Commissioning Framework does not include dates for ILC commencement in the rest of the country. Further information is required about what services are currently provided in trial sites, and what will be provided

[1] National Disability Insurance Scheme – A Framework for Information, Linkages and Capacity Building, p7.

from 1 July 2016 in those parts of New South Wales, Victoria and South Australia that are rolling into the NDIS.

It is unclear what the ILC budget has been spent on since trial sites commenced in 2013. Mental Health Australia estimates the ILC budget, from July 2013 to the end of this financial year would have been approximately $22 million,[2] but is keen to see any updated information on the resources available for ILC.

Mental Health Australia recommends that the outcome of the audit ILC-type services be released, and that no existing service has their funding cut until ILC commences in their area.

Outreach Services

The Productivity Commission's report on Disability Care and Support noted that people with disability are over-represented among the homeless, in the criminal justice system, and in boarding houses. For that reason, the Productivity Commission wrote that "outreach services will still be required… the NDIS should provide homeless outreach services…. to connect people"[3] to the Agency and a broader range of services.

ABS data shows that of those who had reported being homeless at least once in their lives, more than half had experienced a mental disorder in the previous 12 months, 3 times higher than among those who had never been homeless.[4] A major Australian study found that 75 per cent of their sample of homeless people in inner Sydney had at least one mental disorder, and 93 per cent reported having at least one extreme trauma.[5]

A study of people living with psychotic illness found that 5.2 per cent of people were homeless at the time of the study and 12.8 per cent had experienced periods of homelessness over the previous year. This compares to a homelessness rate of around 0.5 per cent for the total Australian population.[6]

Similarly, we know that approximately a third to 40 per cent of people with severe mental illness do not seek help.[7] Some existing programmes, such as Partners in Recovery (PIR), have been very successful at en gaging in active outreach to identify people most in need. In North Brisbane, the PIR Organisation identified that around half of their clients had not received a public mental health service in the last 12 months, and in most cases this was because consumers had 'disengaged' due to the complexity of their needs and falling through service system gaps. As PIR funding is being transferred into the NDIS, it is vital that this capability is retained – either in ILC, or through LACs.

This means that simply relying on existing service providers to refer existing clients is will not identify everyone in need. The NDIA, LACs and its ILC partners need to undertake significantly more work to ensure that this group of people are both aware of the NDIS, and are able to participate in the NDIS.

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[2] The Productivity Commission estimated ILC would cost $200 million per year at full scheme, or 1.6% of the estimated package costs of $12.5 billion (PC Report, pgs 776-777). Applying this percentage to package costs in trial sites of $1.4bn results in $22.7m.

[3] PC Report, p233

[4] ABS, National Survey of Mental Health and Wellbeing: Summary of Results, Australia, 2007 (ABS Cat. no. 4326.0), ABS, Canberra, 2008

[5] 0 T. Hodder, M. Teesson, and N. Buhrich, Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Service Use among Homeless People in Inner Sydney, Sydney City Mission, Sydney, 1998

[6] *People living with psychotic illness 2010: Report on the second Australian national survey*. November 2011.

[7] Sources include: https://www.mja.com.au/open/2012/1/4/depression-and-anxiety and https://www.health.gov.au/internet/main/publishing.nsf/content/A24556C814804A99CA257BF0001CAC45/$File/mha23.pdf;

In addition, Mental Health Australia expects there to be a small cohort of people who are not just disengaged, but are actively resistant to engaging with any government agency (including the NDIA).

This issue was recognised by the ILC Policy Framework, which stated:

> ILC should be designed and delivered in a way that recognizes and responds to the diverse needs of individuals and considers underrepresented and hard-to-reach groups. These groups may require proactive outreach from ILC, to ensure that they are able to get the supports they need…
>
> *The role of the LAC can incorporate…. services directed to 'hard*-to-*reach' individuals or* communities[8]

However, the importance of proactive outreach is not reflected in the Commissioning Framework. The Commissioning Framework says that:

> many submissions mentioned people who require episodic supports or who belong to population groups traditionally difficul*t to engage, as people who might 'fall through the gaps'. It is important to understand that mainstream services still retain core* responsibility for supporting most of these people.

Thus, it remains unclear whether ILC will be able to provide assertive outreach services, or similar services for hard-to-reach populations, who are likely to need significant assistance before making an NDIS access request. It is also unclear whether and how the LAC stream will provide such outreach, including specialist outreach for specific population groups.

Mental Health Australia's submission on the ILC Policy Framework in March 2015 argued that that ILC and LACs should be used to access hard-to-reach groups. LACs could play a key role in providing outreach to the many people with psychosocial disabilities who are not currently connected to mental health or disability support services. Many may not be aware that they could be eligible for supports from the NDIS. In the absence of effective outreach, the NDIS will not be accessible to the population it is intended to serve – that is, those with the highest support needs.

We do not expect ILC providers, or LACs, to be duplicating the work of existing homelessness providers, drug and alcohol providers, ethnic community groups, indigenous service providers or similar providers and community groups. Rather, the NDIA, ILC providers and/or LACs need to be funded to engage in outreach activities to these community groups and NGOs that are likely to already be active in these under-served communities, and help these NGOs to support their clients who may be eligible NDIS participants.

These sorts of measures, which provide well-targeted assistance to individuals to assist them to access both mainstream services and the NDIS, will reduce overall costs to the NDIS over the life course, and therefore is highly consistent with stated insurance principles.

Mental Health Australia recommends that the NDIA amends the paragraph quoted above to reflect the important role of ILC and LACs in outreach.

Outreach Services for Indigenous Australians

The NDIA is currently developing an Indigenous Engagement Strategy, which will be a vital foundation to ensure effective engagement with the indigenous community. We also recognise the significant work that has been undertaken in the Barkly trial site in the Northern Territory to engage with local indigenous communities, and work with aboriginal community

[8] http://www.ndis.gov.au/sites/default/files/ILC-Policy-Framework.pdf pp8 & 14

controlled health centres, to identify possible NDIS participants. However, we are concerned that these worthwhile initiatives will not continue beyond the trial phase.

A recent study in Cairns, the Guddi Project, undertaken to inform the NDIA and the Queensland Government about issues facing the indigenous community to prepare for the NDIS[9] demonstrates that many potential participants are facing extreme levels of complex disablement, and often extreme mistrust of government.

> Individual disablement is further complicated by inappropriate service delivery, poor access to existing services, and poor adherence to treatment regimens due to lack of *appropriate supports and guidance….*
>
> Indigenous participants often did not identify as having a disability although their disability often leads to acute ill-health and poor quality of life. Non-Indigenous participants whilst more likely to identify as having a disability were also disengaged from disability services:
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> - People within the cohort did not want to have contact with the Department;
> - They were suspicious and mistrustful of government, seeing no positive value in referral for assessment for placement on the Department of Communities, Child *Safety and Disability Services' Register of Need;*
> - Existing services and interventions to date have been unsuccessful and programmes fail to address the needs of Indigenous people with complex disabilities.
>
> *These factors have significant implications for the NDIS's model of engagement in* relation to Indigenous and non-Indigenous people with disability who are homeless and other marginalized people. Such a model must include services and staff that are culturally appropriate and relevant to Indigenous Australians as well as trauma informed.

The Guddi Project demonstrates both the importance of working closely with traditional owners, and the very long lead times it can take for traditional owners to be willing to engage with government.

One of the major hurdles facing some indigenous Australians in accessing government services, including the NDIS, is a lack of birth certificates, or not having their birth registered at all. ABS studies indicate Australian indigenous children are particularly at risk of not having their births registered within the first year of life. In 2009 just 69 per cent of all Australian indigenous births were registered, compared with 80 per cent for the general population.[10]

Lack of proof of identity in the form of a birth certificate can have serious flow-on effects on an individual, limiting their capacity to participate in economic, cultural and social activities, including getting a drivers' licence, Medicare card or access to Centrelink benefits – all of which will hamper a person's ability to access the NDIS. Similarly, the NSW Auditor-General found that a major barrier relating to licensing and vehicle registration was the lack of birth certificates as proof of identity.

In the past, Medicare Locals and the NSW Office of Sport have recognised the importance of birth registration as a social determinant of health and Closing the Gap, and run programmes to help people without birth certificates to register their birth and obtain birth certificates.[11]

While we recognise that birth certificates, driver's licences and Medicare cards are not the responsibility of the NDIA, if a potential participant is unable to access the NDIS because of a

[9] Townsend C; White P; Cullen J; Clough A; Hammill J; and Magalhaes R, *Guddi Project*, unpublished.
[10] http://www.northerndailyleader.com.au/story/1302847/birth-certificates-a-sign-of-citizenship/
[11] http://www.futureleaders.com.au/book_chapters/pdf/Proof-of-Birth/Proof-of-Birth-Chapter2.pdf

lack of such paperwork, they should not be turned away. It is incumbent upon the NDIA (either directly, through an LAC or ILC partner) to help that individual get the necessary paperwork to become a participant – including financial support as required.

Outreach Services for people from culturally and linguistically diverse communities

As at 31 December 2015, 4 per cent of NDIS participants are from culturally and linguistically diverse backgrounds (CALD).[12] The NDIA has recognised that this is "below expected levels."[13]

CALD communities, in particular recent migrants and asylum seekers, are a particularly vulnerable part of the community, and at particular risk of 'falling through the gaps', and missing out on services that they may be entitled to. This may be because of a lack of understanding and awareness of the NDIS in these communities; stigma associated with mental health and disabilities; and lack of trust of governments. Therefore, it is incumbent upon the NDIA to undertaken outreach activities into these communities. As stated above, we do not expect the NDIA, or ILC providers, to duplicate the services of existing multicultural community groups. Rather, the NDIA and/or ILC providers should be actively engaging with settlement services providers, ethnic community groups, and other existing service providers, to ensure that these people in these communities are able to access the NDIS.

Mental Health Australia recommends that the NDIA amends the ILC Commissioning Framework to place an emphasis on identifying and supporting potential participants from Indigenous, CALD, homeless and other disadvantaged backgrounds, into the NDIS.

ILC eligibility and conflict of interest rules

Mental Health Australia is also concerned that the proposed rules on ILC funding eligibility could make outreach much harder. While NDIS registered service providers will be eligible to apply for ILC funding, registered providers will not be able to use ILC funds to assist individuals with access requests. The Commissioning Framework suggests that such work could be done "[w]ith other sources of funding or volunteer[s]."

This may create barriers for some providers, who will be able to provide information but not follow through to actively support the consumer (if they are unable to source other funding). This will also create confusion and angst for those looking for assistance in an already complex system. It is not clear who will fill the gap for consumers between accessing information and making access requests should registered providers only provide a portion of a service.

Mental Health Australia does not believe that volunteers will be able to undertake this work, which will require highly skilled and experienced staff, and is likely to take a significant amount of time. Evidence from the Hunter-New England Local Health District shows that their clinicians spend more than 50 hours per client supporting people with psychosocial disability into the NDIS; it is not possible for an NGO to undertake such work with other sources of funding or volunteers. The conflict-of-interest risk is also low, as decisions around eligibility lie with the Agency, not service providers. Therefore, Mental Health Australia recommends this restriction be removed.

Mental Health Australia is pleased that documentation relating to the tender process for LAC arrangements in Victoria (which appears to be the only detailed information publicly available to date on such matters) states that LACs "may [engage in] active outreach programs for

[12] http://www.ndis.gov.au/sites/default/files/documents/Quarterly-Reports/Report-to-the-Disability-Reform-Council-Q10-1.pdf, p21.
[13] Ibid, p32.

those people with disability less connected to existing disability supports so that they are aware of the Scheme and they experience a smooth transition to the Scheme." However, Mental Health Australia is very concerned that the NDIA requires that this activity cease after the NDIS roll out is complete in a local area.[14] This further highlights the need for ILC to support these active outreach activities on an ongoing basis, and for greater clarity on the respective roles of LAC and other ILC streams.

Continuity of Support

The draft Commissioning Framework notes that there is a "high degree of interest and concern… about the extent to which ILC will assist people who are not participants in the NDIS."

Under Annex E of the Intergovernmental Agreement on the NDIS, people who are currently receiving any form of disability support, they will continue to receive support consistent with their currently agreed arrangements (support outcomes and levels). While the details around 'continuity of support' are yet to be released, it is vital that this does not come out of the very limited ILC funding.

Mental Health Australia recommends that the Commissioning Framework clearly state that ILC funding is not to be used to meet the continuity of service requirements.

Improving local system integration and collaboration

The Partners in Recovery programme (PIR) guidelines allow 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 innovative 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 projects funded are designed to be locally focused and to:

- support collaboration between services;
- support the expansion of best practice recovery-oriented services;
- have a system improvement and recovery integration focus; and
- deliver positive outcomes for people with severe and persistent mental illness and their carers and families.

The PIR innovation fund has been used recently to fund projects like:[15]

- a trial of a family-inclusive recovery model for adults experiencing severe mental health difficulties and their families/carers;
- a trial of a holistic approach to addressing the physical health and wellbeing needs of adults with a disability;
- building the capacity of community pharmacists to support people with a mental illness living in the community and raise awareness of the role of community pharmacy among the mental health sector.

These sort of projects will play a vital role in the success of the NDIS. However, the transition of PIR into the NDIS threatens this element of PIR, as it seems clear that service providers will

[14] LAC Tender SoR p13&65.
[15] http://www.northbrisbane.pirinitiative.com.au/innovation-fund/

not have sufficient funds to undertake this type of work through the existing pricing structure. Therefore, it is vital that ILC undertakes this work. It would seem odd that arrangements would stifle innovation right at the time the Australian Government is seeking to promote it.

Unfortunately, even before the NDIS is fully rolled out, it appears funding is being cut to all PIR organisations, and they will no longer be able to undertake system reform and sector capacity building projects. This will see the immediate loss of a successful business model, with no clear plan, or timeframe, for its replacement. Mental Health Australia understands that this funding is being transitioned across to the NDIA.

Mental Health Australia recommends that until ILC is rolled out in each area, the NDIA funds PIR organisations to maintain their existing system reform and sector capacity building projects;

Mental Health Australia recommends that the NDIA analyses the recommendations of the PIR evaluation and the successes of the PIR innovation fund, and incorporate relevant learnings into the ILC Framework.

We know that co-location of services, collaboration between service providers and funders, leads to better results. The Productivity Commission said that "[t]he NDIS should put in place memoranda of understanding with the health, mental health, aged and palliative care sectors to ensure that individuals do not fall 'between the cracks' of the respective schemes, and to have effective protocols for timely and smooth referrals."

For example, within mental health, there is significant scientific evidence that shows the effectiveness of interdisciplinary teams that deliver a combination of recovery oriented clinical and psychosocial disability supports. However, because of this interdisciplinary approach, funding responsibility stretches across the NDIS, Commonwealth and state/territory health departments.

Therefore, to establish effective interdisciplinary teams, combined contracting/commissioning between the NDIA and states/territories would be required.

Mental Health Australia recommends that the NDIA explore joint contracting/commissioning models with other Commonwealth agencies and states/territories, in order to deliver the best outcomes for consumers.

Delineation between ILC and Package supports

The extent to which individuals will be able to receive low level or episodic support under ILC is uncertain. This is because the delineation between ILC- and IFP-funded services is unclear. There appears to be two potentially conflicting ways to demarcate between IFPs and ILC:

- by type of person:
  - if a person has a package, then all services they receive are funded through their package, not ILC. If they do receive a service from an ILC provider, that would be funded from their package, rather than drawing down in ILC resources.
  - if a person does not have a package, then they access ILC services.
- by type of support/activity:
  - ILC activities, and package activities, are different and identifiable, with no package-type activities available through ILC and vice-versa. Thus, someone who is receiving a package would also draw on ILC providers for ILC-type activities.

Unfortunately, the Commissioning Framework does not clearly identify which approach the Agency has adopted. In one part, the Commissioning Framework states "if a participant needs a reasonable and necessary support, then it should be funded in their NDIS plan rather than through ILC." This takes a "type of person approach". On the other hand, the Commissioning Framework also says "the focus of ILC will be the activity itself, not who will use it." This appears to take a "type of activity" approach.

Mental Health Australia supports the "type of person" approach, as any ILC resources provided to funded participants would in theory reduce the resources available to assist non-participants.

This does not mean that funded participants would be prevented from accessing ILC-type supports; rather it means that ILC providers would be paid out of participants' packages, in line with all other package supports. These services could be delivered by the same provider at the same place at the same time, to both participants and non-participants, for example through a group program which includes both participants and non-participants. The only difference in that case would be the funding mechanism for the different people accessing the service.

A "type of person" approach is also consistent with the ILC Policy Framework, which makes it clear that ILC could provide "programs for carers and counselling for [carers]," "parent breaks and programs," and "peer support groups." All of these activities would be available to participants as part of their package, so their inclusion in ILC demonstrates that these types of services should also be available to people outside of funded packages.

These kinds of supports are notably lacking in the Commissioning Framework, which focuses mainly on information and referral, rather than service delivery.

Mental Health Australia recommends that the Commissioning Framework return its focus *to the Productivity Commission's and Policy Framework's intention that many* ILC supports will be targeted at people with disability who:

- need one-off, low intensity or episodic supports that are better delivered and managed through funding arrangements other than through IFPs; and
- need support so that their capacity to live independently does not deteriorate to a point where they would meet the access criteria for the NDIS.16

How many consumers and carers will be relying on ILC?

The number of people who will be relying on ILC is of particular significance in the mental health sector, as there is a continuing concern that thousands of people with a severe mental illness will miss out on services.

In 2012, the Australian Government Actuary (AGA), split the group of Australians with mental illness into 4 categories:

Description	Care Needs	NDIS coverage
1) Episodic mental illness (est. 321,000 people)	Clinical services	Not included
	Disability support services may occasionally be	Not included

[16] National Disability Insurance Scheme – A Framework for Information, Linkages and Capacity Building, p7.

	required, particularly during a lengthy episode of illness	
2) Severe and persistent mental illness but can manage own access to support systems (est. 103,000 people)	Clinical services	Not included
	Social inclusion programs	Not included
3) Complex needs requiring co-ordinated services from multiple agencies (est. 56,000)	One on one support from a carer	Included
	Supported accommodation, where appropriate	Included
	Clinical services	Not included
	Social inclusion programs	Included
4) Institutional care (est. 2,000)	24 hr care in the mental health sector	Not included

As part of this, the AGA identified that around 103,000 people with severe and persistent mental illness (group 2), who are likely to need social inclusion/disability support programmes, will not be included in the NDIS. The AGA went on to say:

> Only those in the third subgroup (those with complex care needs) have been assumed to be eligible for supports under the NDIS. This was justified on the basis that this would be the only group with an enduring need for high level disability support services. Our reading of the PC report would not suggest that the NDIS is to be restricted to those with high level needs; rather the critical factors are the permanence and significance of the disability and the need for support….
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> The second group would appear to qualify both on the grounds of a permanent and significant disability. Indeed the mental health experts agreed that the disability support services, other than one-on-one care, required by the second and third groups would be roughly similar. Thus, on the surface, it would appear inconsistent with the PC's proposed eligibility to exclude the second group.[17]

The issue of who is not eligible for the NDIS is of great significance in mental health, as there is a real risk of people missing out on services, and a reduction in the breadth of services available. Actions by state and territory governments since the first agreements indicate substantial variation in the level of support for this population that will be available once the NDIS is at full operations. In some states, there is widespread alarm at what is expected to be a large reduction in service availability, despite governments agreeing to the principle that services should continue to be available at or above pre-scheme levels.

We are agnostic about which system, and which level of government should be responsible for providing services to this group of people. However, we are deeply concerned that it is currently unclear who, if anyone, has policy responsibility for this cohort and how these issues are going to be resolved. In particular, we are concerned that unless adequate

[17] http://www.treasury.gov.au/~/media/Treasury/Access%20to%20Information/Disclosure%20Log/2012/National%20Disability%20Insurance%20Scheme%20Costings%20Review%20by%20the%20Australian%20Government%20Actuary/Downloads/PDF/doc1.ashx

supports are provided for this cohort, it is likely to put significant long-term cost pressures onto the NDIS.

The AGA went on to raise a significant concern that if existing social inclusion or disability services for the 103,000 cohort (severe and persistent mental illness), or the 321,000 cohort (episodic mental illness) are rolled into the NDIS, there is a real risk of people missing out on services.

> The PC assumed that all current State grants to NGOs to provide support to those with mental illness would be available as offsets. Our discussions with the mental health experts made it clear that if the NDIS were to be restricted to the group with complex needs, there would be considerable demand for the services provided by this sector from the residual 100,000 individuals with severe and persistent mental illness who are able to manage their own access. Their advice was that, at present, the bulk of these services are going to those with the complex needs and that there is substantial unmet need from the larger group. They estimated a cost of $312 million to meet these needs, suggesting that none of the $262 million taken as offsets should be included. It is possible that similar issues apply to the Commonwealth-funded Support for Day to Day Living in the Community, which accounts for a further $14 million of offsets.
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> The issue of offsets is inextricably linked to the assumptions around population. If it is assumed that the population that can manage its own needs is entirely excluded from the NDIS, then the offsets would have been overstated by around $270 million.[18]

In addition, there will be a large cohort of carers who will also require services. Thus, in order for the mental health sector to be able to determine the adequacy of the ILC, it is vital that these issues be addressed urgently.

Mental Health Australia recommends that prior to the ILC Commissioning Framework being finalised, the NDIA publicly release estimates of the number of people who are likely to be reliant on services provided by ILC providers.

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18 http://www.treasury.gov.au/~/media/Treasury/Access%20to%20Information/Disclosure%20Log/2012/National%20Disability%20Insurance%20Scheme%20Costings%20Review%20by%20the%20Australian%20Government%20Actuary/Downloads/PDF/doc1.ashx