



**Submission to the Joint Standing Committee
on the NDIS Inquiry into Transitional
Arrangements for the NDIS**

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About Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Overview

Mental Health Australia welcomes the opportunity to provide a submission to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) Inquiry into Transitional Arrangements for the NDIS.

The Transition period is a unique period in the life of the NDIS. Never again will large numbers of people be required to move into the Scheme in such a short period of time. Difficulties were to be expected given the numbers of people involved and the complexity of the task at hand. However, there have been people with severe mental illness who have been seriously negatively impacted by these implementation issues. This is unacceptable and cannot be allowed to continue.

At this time, the National Disability Insurance Agency (NDIA) is being judged on volume, on time and on budget. The frequently cited estimate of 64,000 participants with psychosocial disability appears to have become a target, with an emphasis on getting the Partners in Recovery (PIR), Day to Day Living and Personal Helpers and Mentors (PhaMs) program clients into the NDIS. In the headlong rush to meet both time and volume commitments outlined in bilateral agreements, as the CEO of the NDIA recently conceded,¹ insufficient attention appears to have been paid to quality. The timetable and limited resources are dictating process, rather than the other way around. Processes that are ill-suited to people with psychosocial disability are compromising outcomes for individuals. Consequently, the vision of the Scheme and public confidence in its effectiveness are undermined.

The Scheme's success must be measured by how well it supports people with disability – not how well it serves governments.

The NDIS is an historic opportunity to improve the lives of people with psychosocial disability who have for far too long missed out on the support they need to live contributing lives in the community. The mental health sector is united in its desire to see the NDIS succeed and take its place as a key contributor to better outcomes for mental health consumers and carers.

¹ National Disability Insurance Agency. *Participants and providers work with NDIS to improve processes*. 6 June 2017



However, the transition process has been hastily planned and poorly communicated. It has already created significant gaps in psychosocial services for people with psychosocial disability who are ineligible for the NDIS and less than desirable experiences and outcomes for NDIS participants. These outcomes are a result of one or more of the following:

- The transfer of Commonwealth and state and territory government psychosocial services programs, and their funding and clients to the NDIS and very limited understanding of the implications of these arrangements both in transition and beyond for responsible government entities
- A lack of information about the number of people who need psychosocial services but who are ineligible for the NDIS, and the consequent gap between need and available services of various kinds, with little or no acknowledgement by responsible policy agencies
- Scant arrangements to support health care practitioners to facilitate access to the NDIS for people within the mental health system
- Governance arrangements that do not adequately address interface issues between mainstream services and the NDIS
- A lack of fit for purpose processes to ensure the NDIS meets the needs of participants with psychosocial disability on an equitable basis.

Without improvement, this situation has the potential to either undermine the opportunities presented by the NDIS, or worse, disrupt or remove necessary disability and capacity building supports from vulnerable people with psychosocial disability.

The recommendations set out in this submission are intended to improve the experiences and outcomes for people with psychosocial disability, their carers and families, with a focus on issues relevant to Transition, including those issues raised in the Inquiry's Terms of Reference.

The NDIS and mainstream interface

The NDIS depends on sound integration with mainstream services that:

- ensures people with psychosocial disability have access to reasonable and necessary supports in and outside the NDIS
- ensures there are efficient and effective pathways for people with psychosocial disability between the health and mental health systems and the NDIS
- clearly delineates NDIS supports from those provided by mainstream systems.

Access to mainstream psychosocial services

A foundational challenge for the NDIS, and for governments more broadly, is to close the large and persistent gap between service provision and the level of need in the community for assistance with the impacts of psychosocial disability. On our current trajectory, the NDIS will provide more public funding to address psychosocial disability, but for a smaller number of people. At worst, the Scheme will provide less public funding overall, either because resources are directed almost entirely to the severe/acute end of the psychosocial disability spectrum or are diverted to other disability types; in both of these scenarios there will be a very large group of people outside the NDIS. For this group, the NDIS may come to



seem like the only 'oasis' in the 'desert' of community mental health services in Australia, as psychosocial support programs outside the NDIS are withdrawn.

The Productivity Commission rightly identified the implications of service gaps:

The implications of gaps are significant — uncertainty about what supports will be provided is distressing for people who rely on them and places an additional call on the generosity of informal support. They can also threaten the sustainability of the scheme by encouraging scope creep, or by forcing those who are unlikely to meet eligibility requirements to test their access anyway.²

The NDIS is therefore not only relevant for those who gain access to individually funded packages of support (IFPs), but also (and perhaps even more so) for those who do not access Tier 3 of the Scheme (including because they choose not to). This is a much larger number of people with psychosocial disability than will ever be eligible for a package of supports under the Scheme. This non-NDIS group will therefore be reliant on the effectiveness of:

- the Information, Linkages and Capability building (ILC) element of the Scheme, which the Productivity Commission correctly identified as a very weak link in the NDIS as it is currently being implemented, and/or
- the potentially very threadbare patchwork of programs available (or too often not available) in the 'mainstream' mental health or disability systems, with considerable variability in coverage and quality from state to state, giving rise to the very 'postcode lottery' the NDIS is designed to overcome.

A well-functioning and effective mainstream system for providing psychosocial supports for people not eligible for the NDIS is a key factor in containing the long-term costs of the NDIS. Mainstream supports can help people with mental illness and psychosocial disability to avoid their disability deteriorating to the point where they need and qualify for high cost and long term supports under the NDIS.

Government mainstream mental health and disability systems must not only interact well with the NDIS, but provide early, flexible and responsive interventions that address individuals' clinical, non-clinical and psychosocial needs in an integrated and sustainable way, allowing consumers, their carers and families to lead fulfilling lives, contributing to their communities and the economic wellbeing of Australia.

Pathways for people with psychosocial disability from the health system to the NDIS

With the majority of future participants with psychosocial disability still outside the Scheme, there is an urgent need to identify and address the barriers to NDIS access via the health system. Access to the mental health system (including both primary care and the acute sector) offers opportunities to identify and assist people with psychosocial disability to access the NDIS.

Anecdotal reports suggest that health care practitioners are not well supported to assist people with psychosocial disability to access the NDIS. Several specific projects represent early steps to assist health care practitioners to facilitate access to the NDIS including:

² The Australian Government Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs: Productivity Commission Position Paper*, 2017, page 195



- Aftercare has recently developed some resources for GPs in relation to the NDIS and psychosocial disability
- a consortium of health services in North Eastern Melbourne are building effective models for collaboration with health services around the NDIS
- the NDIA has developed information about the NDIS for GPs and Health Professionals

While these are worthy ‘awareness raising’ projects, seamless interface between the health system and the NDIS requires collaboration with health care practitioners and community mental health providers to develop practice and business processes for enhancing clinical care with NDIS access.

Recommendation 1:

Mental Health Australia recommends that urgent analysis be undertaken of current NDIS access pathways, not only from the health system, but also by drawing on the experiences of the community managed mental health sector, consumers and carers. Lessons about best practice should then be shared across the health and community mental health sectors nationally as well as with government agencies.

Clear boundaries and effective pathways between the NDIS and relevant mainstream systems

As Transition proceeds and more participants with psychosocial disability enter the NDIS, ongoing interface issues with a range of mainstream service systems (justice, housing, workforce, education, transport) will become even more prominent. However, as the system stands, there is no effective or efficient mechanism to resolve cross portfolio issues. Mental Health Australia sees a role for the Council of Australian Governments (COAG) in this space including: monitoring, reporting and issue resolution in relation mainstream interface issues. The efficacy of the National Disability Strategy, for example, would be greatly enhanced if relevant COAG councils were explicitly responsible for monitoring and regularly and publicly reporting not only on NDIS interface issues, but also on the performance of the relevant mainstream service systems in addressing the needs of all people with disability, whether they are receiving IFP supports, supports under ILC, or neither.

In mental health, this monitoring and reporting should cover, at a national level, service systems established through Primary Health Networks. State- and territory-funded mental health services (clinical and non-clinical; acute and non-acute; residential and community-based) would also be within scope.

Key performance indicators that might be reported against should cover the full spectrum of quality, quantity and efficiency from the consumer and provider perspectives. Examples are provided at Appendix A.



Recommendation 2:

The National Mental Health Commission should monitor and report on the NDIA's performance in relation to psychosocial disability using a range of objective measures relating to quality, quantity and efficiency and the effectiveness of the NDIS and non-NDIS (mainstream) programs for psychosocial services.

Consistency of NDIS planning and service delivery

Anecdotally, there are substantial variations between NDIS plans for participants with similar psychosocial functional impairments. The reported variations relate to both the total amount of funding provided and the types of supports funded. Variations occur across locations and between first and second plans.

For example, in some locations a person with psychosocial disability is more likely to receive an appropriate level of support coordination in their NDIS package than in other locations, where they are more likely to receive time limited 'support connection' only. Now that Local Area Coordinators (LAC) are able to deliver a low level of support connection outside of an NDIS plan, some locations may be inappropriately substituting necessary support coordination in plans with LAC support connection.

With respect to second plans, providers and carers have informed Mental Health Australia that in some locations, upon review the total amount available in second plans for people with psychosocial disability is often substantially reduced. This appears to occur in the absence of any concrete evidence that the participant's functional impairment has improved significantly enough to safely decrease services, in line with what would be reasonable and necessary for the individual in question. In some cases, the rationale given by the NDIA is that reductions are based on participants not utilising the services in their first plan, without establishing why that has occurred e.g. the person had a period of wellness, services were unavailable, choice and control takes some time to adjust to etc.

Specialised planning team for psychosocial disability

One of the assumptions in the design of the NDIS is that people with disability will actively seek to participate in the NDIS. In reality, it can often take community mental health service providers anywhere between 6 and 12 months to win the trust and confidence of people with psychosocial disability and for those people to agree to engage with the planning process and then use psychosocial supports. This pre-access and pre-planning support is not currently funded by the NDIS, is not part of ILC, and LACs are yet to prove themselves capable of providing the specialist outreach services required. Psychosocial disability is sufficiently different from other types of disability. Consequently, participants with psychosocial disability, and those who struggle to navigate the Scheme, are most at risk of experiencing poor outcomes.

For example, a report from the Barwon NDIS trial site in 2015 stated that:

Consumers have consistently reported the value of having a support worker or advocate to assist them in the planning process, in trying to establish eligibility and in following up



*on plans, and that when available it contributed to the successful outcome and their positive experience of the planning process.*³

Strong anecdotal evidence indicates that consumers who are well supported by strong advocates (whether they happen to be carers, support workers, formal advocates or others) continue to receive plans which better suit their needs. Although this underscores the valuable and skilled role performed by carers and community workers, it also suggests that the NDIS is poorly equipped to ensure people who are isolated from such supports (i.e. the most vulnerable) receive an appropriate package of support. Even more concerning, Mental Health Australia understands that input from carers and support workers is not always sought as a part of the planning process. This could account for some of the discrepancies in planning outcomes.

While the NDIA's plans to improve the participant and provider experience are a welcome acknowledgement of widespread implementation problems, and may prove in time to make a difference to the experience of people with psychosocial disability in relation to a range of administrative issues; in reality the same structural barriers will remain, preventing this cohort from utilising the Scheme in ways which are responsive to their needs. Without addressing these structures, it is inevitable that the NDIA's reforms will not result in better engagement with the Scheme for people with psychosocial disability.

Therefore Mental Health Australia supports the Productivity Commission's recent recommendation regarding the establishment of a specialised planning team for psychosocial disability. This should be well supported by improved training for planners and oversight of the planning process to ensure consistency and improved outcomes.

Mental Health Australia also agrees with the Productivity Commission's recent recommendation around improving the planning processes more generally, but we suggest greater involvement of organisations in the sector with specialist expertise. Community mental health organisations specialise in psychosocial disability and have invaluable experience and expertise that currently remains under-utilised by the NDIA. At this point in time, both the NDIA and providers of psychosocial services have different perspectives on the improvements that can and should be made to the planning process and they should work together to improve the experience for NDIS participants and their outcomes.

Recommendation 3:

The NDIA should support consumers, carers and organisations with expertise in mental health and psychosocial disability to co-design improvements to the planning and pre-planning processes.

Beyond planning, this model could be invaluable in implementation issues more generally – such as the development of reference packages, in the development of guidelines for what constitutes reasonable and necessary support, and in effective communication to particular groups of participants.

³ Psychiatric Disability Services of Victoria, *Learn and Build in Barwon: The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch site*, 2015, page 16



Specialist organisations could also provide invaluable assistance with pre-planning. While we agree with the Productivity Commission that greater attention needs to be paid to pre-planning, we do not agree that having LACs on ground six months in advance will help resolve the issue completely. There also needs to be clearer communication with participants about what to expect from NDIS processes. This needs to be from trusted sources, in accessible formats and in plain language that everyone can understand. In all of these respects organisations with specialist mental health expertise could assist the NDIA to better meet the needs of participants.

The governance arrangements currently in place for the NDIS have acted as a barrier to co-design of NDIS policies and processes, and effective and timely two-way communication between specialist expertise in the sector and those responsible for implementing the NDIS. Co-design with people with disability, their families and carers and the organisations that represent them have been ad-hoc and inconsistent. While the NDIA has established some good mechanisms – such as the Mental Health Sector Reference Group – its mandate does not facilitate co-design of policies and processes.

The development of a psychosocial gateway should commence in tandem with the NDIA's reforms to the wider planning process. Early work on the key design features of a psychosocial gateway should be done with consumers and carers, providers and peak advocacy organisations. This work should include the development of metrics to assess the success of reforms to the participant pathway for this specific cohort in advance.

Recommendation 4:

The NDIA should begin working with consumers, carers, service providers and advocacy organisations on:

- The design features of a specialist psychosocial disability gateway
- Defining criteria for successful reforms to improve engagement of people with psychosocial disability.

Additional resources will be needed to meet the additional operational costs for a successful psychosocial gateway and annual measurement of the outcomes the gateway delivers, to ensure compliance with the *Principles of Recovery-Oriented Mental Health Practice* which are relevant to the *National Standards for Mental Health Services*.

On past evidence, however, it will be very difficult to tell whether the reforms are working for people with psychosocial disability unless we define in advance what success looks like, with criteria designed with their specific needs in mind, and monitor those criteria objectively and report on them publicly.

To inform the design and development of the psychosocial gateway, the NDIA should now start measuring quality outcomes for participants with psychosocial disability, and not wait for Full Scheme. A solid foundation for this work would be to adapt the *Your Experience of Service* (YES) questionnaire, which asks consumers about their experiences of mental health care. Another important dimension to measure is the impact of the NDIA and the



NDIS on carers. The Mental Health Carer Experience Survey⁴ (MHCES) could similarly be adapted for this purpose.

An adapted YES and MHCES for the NDIS would complement reports from state and territory governments. Mental Health Australia is well placed to convene relevant groups to adapt the YES and the MHCES for the NDIS and the National Mental Health Commission is the appropriate organisation to report annually on the outcomes of the survey.

Recommendation 5:

The NDIA should implement an adapted version of the *Your Experience of Service* questionnaire and the Mental Health Carer Experience Survey to measure the performance of the NDIA and the NDIS in relation to psychosocial disability.

Recommendation 6:

The National Mental Health Commission should provide independent reports annually about the *Your Experience of Service* and the Mental Health Carer Experience Survey evaluation of the NDIA and the NDIS.

These reports could be included in the National Mental Health Commission's core reporting on mental health and suicide prevention.

Information, Linkages and Capacity Building

As both the Productivity Commission and the NDIA have observed, the success of ILC and LACs depends heavily on the effectiveness of mainstream systems adjacent to the NDIS, on which both participants and non-participants will continue to rely. The success of the information and referral component of ILC, therefore, is bound up with the future quality and scale of the service systems to which individuals are referred.

Beyond information, referral and community capacity building, other ILC supports are intended for 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
- 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 and require an IFP to participate socially or economically in the community
- need low levels of support to live independently in the community, but are not receiving an IFP, where access to ILC will mean they do not have to test their eligibility for an IFP

⁴ Developed by the Australian Mental Health Outcomes and Classification Network



- would otherwise meet the access criteria for the NDIS and would therefore be eligible for an IFP, but only require low levels of support that could be provided through ILC
- access specialist supports through an IFP but also have needs that can (and should) be supported through the mainstream or community sectors, and/or ILC.⁵

These objectives are in line with insurance principles and represent a vital complement to the individualised component of the Scheme. However, we are concerned that the implementation of the ILC Policy Framework has been heavily weighted towards information, referral and community capacity building, with much less energy and funding directed to services that will reduce pressure on the scheme and help realise long-run social and economic benefits by building consumers' own capacities in dealing with the impact of their impairment. In Mental Health Australia's view, this narrow focus stems from several factors:

- A very limited ILC budget, especially in transition but even at Full Scheme, given the ambition written into the ILC Policy Framework. If ILC funding for psychosocial disability is representative of the proportion of participants in the Scheme, then some \$17.7 million would need to be spread across around 225,000 people with psychosocial disability who will not meet the access criteria. This would equate to around \$78 per person (without taking into account the fact that some people in Tier 3 would also need to access some ILC supports).
- A commissioning process marked by unrealistic deadlines, confusing and contradictory information, an inability to answer basic questions and a lack of clarity regarding policy intent. A key example is the assertion that the ILC Commissioning Framework will 'not fund activities that rightly belong in an NDIS plan or package.'⁶ To this day, despite repeated requests for clarification, it is not clear whether this means that ILC funds cannot be used for 'package-type' activities for participants, non-participants or both.
- An apparently unchallenged assumption that individualised funding is the only mechanism for achieving choice and control, yet choice and control is entirely consistent with block funding in the right circumstances. Many recovery-oriented community mental health providers have been facilitating choice and control in partnership with consumers for many years under block funding arrangements.
- A (reasonable) view within the NDIA that mainstream systems must be held to account for their obligations to people with disability (both participants and non-participants) beyond the Scheme.
- A combination of time pressure and lack of strategic planning within the NDIA.

The Productivity Commission has recommended increased funding of \$131 million per annum for ILC⁷, despite a lack of evidence regarding the benefits of investments made to date in ILC initiatives.

⁵ National Disability Insurance Agency, *A Framework for Information, Linkages and Capacity Building* (nd), pages 7-8.

⁶ National Disability Insurance Agency, *ILC Commissioning Framework*, 2016, page 21

⁷ The Australian Government Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs: Productivity Commission Position Paper*, 2017, page 191



A further alternative rationale for increasing investment in ILC is to focus on existing programs and supports that are not readily substitutable through IFPs, which currently provide a major benefit to people with disability but are in danger of not being transitioned as participants move to the NDIS. There needs to be a full assessment of the level of funding needed to cover the range of functions the ILC is intended to provide – especially capacity building and outreach – with an estimate of the funding required. Ideally, this work should be done by the Productivity Commission as part of its NDIS Costs Study.

Specialist assertive outreach

A critical area (indeed, arguably the very highest priority) for investment is specialist assertive outreach for people with psychosocial disability. This is an area where generalist LACs currently simply do not have the right skills and connections, and it is unclear whether such capability could ever exist outside the community mental health sector.

Assertive outreach takes place before someone accesses the NDIS, so NDIS registered service providers are not able to charge the NDIA for outreach services (regardless of whether a consumer ultimately becomes an NDIS participant). It may also occur once someone has become a participant – when the NDIA is at risk of losing contact with a participant experiencing an episode of high need. The very low prices for NDIS supports mean that providers of psychosocial services have no scope to cross-subsidise assertive outreach activities. Without direct funding for specialist assertive outreach, the organisations that regularly work with hard to reach people are unlikely to continue this activity. In the long term, the inevitable result will be this most vulnerable of population groups will experience higher levels of illness and disability, increasing costs to both mainstream systems and to the NDIS.

The best available example of specialist assertive outreach is the PIR program, which facilitates better coordination of and more streamlined access to the clinical and other service and support needs of people experiencing severe and persistent mental illness with complex needs requiring a multi-agency response. PIR has enabled organisations to provide assertive outreach services to locate potential clients in the community, rather than waiting for clients to approach a service. PIR organisations have specific strategies for assertive outreach which have shown impressive results in reaching and engaging hard to reach clients.⁸

With interim block funding arrangements applying during transition, there is emerging evidence that the assertive outreach that PIR was originally funded to provide is no longer being delivered – particularly for new clients not already on the books of service providers. Instead, PIR has become a ‘feeder’ program for the NDIS, even though there is not complete alignment between their objectives. In the long term, without specific new policy and funding arrangements, there is a major risk assertive outreach for people with severe mental illness and complex needs will no longer be delivered at all, either through the NDIS or elsewhere. With PIR due to wind down and (most of) the program’s current clients to transition into the NDIS, the lack of a strategy for funding specialist assertive outreach is a critical loss to the system of supports for people with psychosocial disability and a major concern for mental health stakeholders.

⁸ Urbis, *Partners in Recovery Annual Report 2014-2015*, 2015, Prepared for the Department of Health.



An alternative rationale for increasing investment in ILC (even beyond the figure proposed by the Productivity Commission), one which Mental Health Australia would strongly support, is to focus on programs which are not readily substitutable through IFPs, which currently provide a major benefit to people with disability but are in danger of being lost as an unintended consequence of transition, and which are likely to reduce long-term demand on the NDIS on a net basis.

Recommendation 7:

ILC should provide block funding for services that provide psychosocial services that are not readily substituted through Individually Funded Packages, which provided demonstrable benefit pre-NDIS, and which are likely to reduce long-term demand on the NDIS and adjacent systems.

Recommendation 8:

ILC should provide block funding for specialist assertive outreach for people with psychosocial disability. These services should not be delivered via generalist local area coordinators.

Continuity of support and transitioning programs

All governments are nominally committed to providing continuity of support to clients of programs that are being rolled into the NDIS. Implementation of that commitment is impeded by a number of factors, including:

- a failure to recognise that many existing programs do not ‘map’ to the NDIS, because they:
 - » have different objectives and eligibility criteria (e.g. not requiring the participant’s disability to be permanent), and/or
 - » provide a different range of services (e.g. providing group-based supports, direct respite for carers, or intensive capacity building – resulting in many clients who transition to the NDIS experiencing a diminution of service), and/or
 - » operate fundamentally different service models (e.g. operating assertive outreach to potential clients, building community engagement, providing one-to-one mentoring and advice, allowing clients to move in and out of the program on their self-assessed need)
- a lack of reliable and publicly available data on the number of clients affected in each program, at both levels of government (e.g. some existing programs use aggregate level data that cannot be used in transitioning clients to the NDIS, which requires individual identified data)
- a lack of transparency about funding flows as programs wind back and the NDIS (in theory) starts taking up affected clients (including very high level budgets and reporting)



- different arrangements for in-kind funding across different programs, depending on (often unannounced or poorly articulated) funding transition plans.

More fundamentally, the context in which existing programs are being defunded means that the continuity of support commitment to existing clients represents at best a temporary fix to an ongoing and major gap between community need and supply of services. The Department of Health has estimated that 90,000 to 95,000 people access Commonwealth, state and territory community mental health services for assistance with psychosocial disability.⁹ The Department of Health (and the Department of Social Services) also estimate (using the National Mental Health Service Planning Framework) that there are around 282,000 people aged 0-64 with some level of need for psychosocial supports (including around 93,000 whose condition is equivalent to the NDIS target group), implying at least 180,000 who are currently missing out on services they need.

Depending on a number of variables, Mental Health Australia estimates that the client load for continuity of support across Commonwealth, state and territory programs could range between 20,000 and 70,000 people.¹⁰

It is important to understand that several programs that are rolling into the NDIS are fundamentally different to the Scheme in ways that materially affect the continuity of support issue. For example, the Mental Health Respite: Carer Support Program (in scope for the NDIS) 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, and case management; and education, information and access including community mental health promotion. However, given the NDIS is a participant focussed scheme, it is difficult to see how this will work in practice and over the long term. In addition, the NDIS does not fund respite. Instead the supports focus on the participant while building the skills and capacity of other family members to manage the impact of a participant's disability on family life. While work is being done by the Department of Social Services on an 'Integrated Plan for Carer Support Services' and a 'Service Delivery Model', carers are reporting that they are now not receiving supports that they previously had access to. Future access to support for mental health carers must be resolved as a matter of urgency.

Existing programs (e.g. PhaMs) often have less stringent eligibility criteria than the NDIS and a significant proportion of their client base includes people who access the program intermittently, as they require support, assistance and guidance. Some clients do not wish to be 'labelled' as either mentally ill or as permanently disabled. Due to the high level of background need in the community, providers often also have 'waiting lists' of clients who have sought access but have not been able to be admitted to the program. All of these factors create classes of clients in existing programs for whom transition to the NDIS may not be possible, or delayed, or highly problematic.

There are three categories among existing program clients:

1. Clients who cannot access NDIS (assessed as ineligible)
2. Clients who choose not to access the NDIS

⁹ Department of Health, Submission to the Productivity Commission Study of NDIS Costs, 2017, page 3

¹⁰ Factors affecting the range include the number of clients in terminating programs and their rate of access to the NDIS, and the proportion of NDIS clients with psychosocial support who were not previously in a program.



3. Clients who access the NDIS but find that their package does not include supports and services they had access to before, such as capacity building.

All three groups need to be catered for in continuity of support arrangements, yet no detailed continuity of support plans have been published by the Commonwealth, state or territory governments, despite transition having commenced in mid-2016. In preparing such plans, governments need to ensure that there is a clear and transparent program of supports that cover all three circumstances, and an outline of what the wind-down arrangements will be as the numbers in receipt of continuity of support drop below a level that is sustainable in terms of program fixed costs.

There also needs to be clarity around ILC-based supports, especially capacity building, for the continuity of support cohort.

A clear illustration of the enduring issue with continuity of support is the Australian Government 2017-18 Budget measure to provide \$80 million over four years for Psychosocial Support Services. The Budget paper indicates that the money may be used for services that are already covered by the bilateral agreements and therefore should be already budgeted for:

This measure also helps continue support for existing clients of Commonwealth (and state and territory) CMH programs who are deemed not eligible for the NDIS.¹¹

In the absence of a comprehensive plan for continuity of support, it is inconceivable that this level of investment could constitute the entirety of the Commonwealth's financial commitment to continuity of support for this cohort. It would be demonstrably inadequate if this were to be the case. Even if the \$80 million were to fund new services, it will provide only \$25 million per annum over three years¹². Without specific attention and effort, it does not signal sustainable arrangements for psychosocial support for the anticipated population of people who will not benefit from the NDIS.

Mental Health Australia is also very concerned that the transition process is driving poor program design and management decisions. Departments responsible for transitioning programs appear to be increasingly taking decisions because they need to make the transition process work administratively, regardless of the potentially deleterious impact on consumers, their families, carers and providers.

For example, at the Commonwealth level, Department of Social Services PHaMs guidelines have been amended to require current program participants to actively test their NDIS eligibility in order to qualify for continuity of support arrangements. This action was presumably taken to simplify the administrative task of determining who qualifies for continuity of support, but it:

- risks placing undue pressure on highly vulnerable clients
- potentially adds an unnecessary administrative burden on the NDIA, which is already struggling to meet ambitious targets

¹¹ Department of Health, *Budget 2017-18 Prioritising Mental Health – Psychosocial Supports Services – funding*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2017-factsheet28.htm>

¹² In addition, given the funding is linked to matching commitments yet to be made by state and territory governments, there is a risk that it will be deployed in some jurisdictions but not others, potentially exacerbating geographic inequity in the distribution of these types of services.



- sets a dangerous precedent that could see people with psychosocial disability needing to test their NDIS eligibility in order to access programs outside the scheme, including potentially for the program(s) to be established with the \$80 million provided in the 2017 Federal Budget.

Similarly, Department of Health PIR providers have been advised that their client numbers are capped and that even if clients leave the program, they cannot take on new clients because of the need to transition to the NDIS. This is creating an increasingly large pool of people with psychosocial disability who have no options for addressing their needs, even though there is funded capacity within the PIR program.

Although there is less visibility in most state and territory government programs, Mental Health Australia is aware of similar or even more egregious administrative decisions in programs at that level as well. There are well documented issues in Victoria, for example.

Administrative actions, such as forcing all people to test their eligibility for the NDIS will have a detrimental effect on consumer wellbeing.

Recommendation 9:

As part of a revised implementation plan for the NDIS, governments should consider the ongoing need for complementary community mental health programs that offer more flexible eligibility and services and have a strong focus on individual capacity building. This would allow for earlier and more effective intervention for more consumers, reducing the long term pressure on the NDIS.



Examples of Mainstream Interface Key Performance Indicators

Key performance indicators that might be reported against should cover the full spectrum of quality, quantity and efficiency from the consumer and provider perspectives. For example:

Quality Measures:

- Consumer experience and satisfaction, using an instrument such as the Your Experience of Service survey
- Provider experience and satisfaction, using a simple survey, potentially mirroring the Your Experience of Service survey
- Providers' assessment of their capacity to appropriately resource the engagement of NDIS participants and potential participants from their NDIS income
- Government program managers' views, using a simple survey, potentially mirroring the Your Experience of Service survey
- Changes in composition of psychosocial packages over time (i.e. better balance of capacity building in plans)
- Reduced proportion of psychosocial access requests and planning actioned via telephone

Quantity Measures:

- Time taken, e.g. between initial contact to access request to access approval to plan initiation to plan approval to actual service delivery
- Number of clients submitting access requests (including 'new' clients, i.e. not participants in existing programs and not only programs in scope for the NDIS)
- Number of clients completing access requests

Efficiency Measures:

- Number of access request assessors with appropriate knowledge/training in dealing with mental health and psychosocial disability clients/Total number of access request assessors
- Number of access request assessors/Number of client access requests processed
- Number of access request assessments per month (or quarter).



Mental Health Australia



Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
ABN 57 600 066 635

P 02 6285 3100
F 02 6285 2166
E info@mhaustralia.org
W mhaustralia.org