



***Response to the Productivity Commission  
National Disability Insurance Scheme (NDIS)  
Costs Position Paper***

**JULY 2017**

# Contents

---

<b>About Mental Health Australia</b>	3
<b>Overview</b>	3
<b>Access to psychosocial support pre- and post-NDIS</b>	3
<b>Implementation – pace and direction</b>	6
<b>Governance</b>	8
<b>Monitoring and reporting</b>	10
<b>Continuity of support and transitioning programs</b>	13
<b>Pricing</b>	15
<b>Workforce development</b>	16
<b>Key design features of the NDIS</b>	18
<b>NDIS funding arrangements</b>	26
<b>Attachment A – Overview of Productivity Commission draft recommendations and Mental Health Australia response</b>	27
<b>Attachment B – Supplementary Submission (19 May 2017)</b>	35



## 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 congratulates the Productivity Commission (the Commission) for tackling a number of key issues and challenges in the implementation of the NDIS. The Commission has clearly taken an appropriately broad view of the concept of 'costs' in the NDIS, recognising that there can be 'false economies' if a simplistic budgetary approach is taken to the financing of the Scheme. This is crucial if the NDIS insurance approach is to succeed in reshaping the national approach to disability services.

As Mental Health Australia said in its first submission to the Commission, 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.

However, an NDIS that is poorly designed and implemented will mean people with severe mental illness and psychosocial disability will continue to miss out. This extremely vulnerable group has experienced a long history of underfunded programs, at both the state and territory level and the national level. Getting the NDIS right for this cohort is critical to avoid another devastating chapter in what is already a long story of policy hopes undermined by underfunding, poor use of data and evidence, siloed policy development and poor implementation.

The recommendations set out in this submission are intended to improve the NDIS experience and long-term outcomes for people with psychosocial disability and their carers and families.

Attachment A provides a summary of Mental Health Australia's responses to the Commission's recommendations.

## Access to psychosocial support pre- and post-NDIS

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 Commission has 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. (p. 195)

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 Commission has 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 risk 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. Our first submission to the Commission has already described how governments have wound back mainstream supports to meet their funding obligations for the NDIS.

Mental Health Australia is therefore keen to see the Commission's Final Report on NDIS Costs take a strong and clear position on the responsibility of governments to ensure that mainstream mental health and disability systems 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. This will allow consumers, their carers and families to lead fulfilling lives, contributing to their communities and the economic wellbeing of Australia.

In light of this concern, Mental Health Australia recommends the Commission undertake or recommend an urgent, detailed and transparent analysis of the community need for psychosocial services and the funding flows for psychosocial support programs as all governments continue to wind back or close existing programs to fund the NDIS. This would build on the Position Paper's Draft Recommendations 5.2 and 5.3 by providing consistent and transparent analysis of the implications of the decisions taken by all governments and jurisdictions for the population in question.

As shown at **Figure 1**, the proposed analysis would require in each state and territory:

- A. Estimates of the cohorts of need, identifying the numbers with some level of psychosocial disability support need, broken down into categories of severity and of persistence. The best source of this information is the National Mental Health Service Planning Framework (NMHSPF).
- B. Detailed analysis of the pre-NDIS supports/services available through Commonwealth and state and territory programs, including categorisation by program service offering (classified as 'core supports' and 'capacity building', where possible, so as to align with the NDIA's categorisations), numbers of clients in a year and annual funding. While some of this information is published in budget papers etc, it is likely that governments would need to provide administrative data for this analysis.
- C. Detailed analysis, at Full Scheme, of psychosocial supports/services, including NDIS and non-NDIS Commonwealth and state and territory programs, with client numbers and funding categorised by core supports, capacity building and information/linkages, where possible. The NDIA would be able to provide the NDIS information, and governments would need to provide the non-NDIS data.<sup>1</sup>

The analysis would aim to quantify and classify the coverage (client numbers) and effort (funding) in (B) and compare it to the coverage and effort in (C).

Based on information currently available, Mental Health Australia would anticipate that this analysis would show the following post-NDIS:

- an increase in net funding by some states and territories, and a decrease in net funding by the Commonwealth and some states and territories
- nationally, a net decrease in effort (especially when 'like for like' service offerings are analysed, such as capacity building, which represents only about 26 per cent of current NDIS psychosocial packages<sup>2</sup>)
- nationally, a net decrease in numbers of clients assisted
- a shift to support for people with severe and persistent mental illness and psychosocial disability and a decrease in supports for people who are not eligible for the NDIS
- an increase in the estimated numbers of the target groups not receiving any assistance, or less assistance than they need.

#### **Recommendation 1:**

The Commission should undertake or recommend an urgent detailed and transparent analysis of:

- the community need for psychosocial services within and outside the NDIS using the National Mental Health Services Planning Framework
- the flow of funding from psychosocial support programs that all governments have wound or are winding back or closed to fund the NDIS, and
- the net effect of NDIS rollout on access to psychosocial support in each state and territory.

---

<sup>1</sup> There could be some duplication in that some individuals may be clients of more than one program. It may be possible to estimate this cohort, but it would be important to recognise that they still represent a cohort of need for supports in the two or more programs in which they participate.

<sup>2</sup> NDIA, *Key data on psychosocial disability and the NDIS – as at 31 December 2016*.

**Figure 1: Psychosocial Programs - Analytical Framework**

<b>Categories of need</b>	<i>All people with some level of need for psychosocial disability supports (each state/territory)</i>				
	<i>Mild-moderate impairment</i>			<i>Severe impairment</i>	<i>Severe &amp; persistent impairment</i>
<b>Pre-NDIS</b>	State/territory government programs	Eligibility & target population	Program service offering*	Participant numbers & categories	Annual funding – total & per participant
	Commonwealth government programs	Eligibility & target population	Program service offering*	Participant numbers & categories	Annual funding – total & per participant
<b>Post-NDIS (Now &amp; at full scheme)</b>	NDIS IFPs	Core Supports: Client numbers	Core Supports: Funding	Capacity Building: Client numbers	Capacity Building: Annual funding
	NDIS ILC	Info & Linkages: Client numbers	Info & Linkages: Funding	Capacity Building: Client numbers	Capacity Building: Annual funding
	Non-NDIS – C'wealth & State/territory	Eligibility & target population	Program service offering*	Participant numbers & categories	Annual funding – total and per participant

\* Classified as 'core support' or 'capacity building' if possible

If the Commission is unable to undertake the analysis in time for its Final Report, it should recommend a process for carrying out this work as a matter of high priority. The information gleaned from such an analysis will make a vital contribution to solving the current policy impasse.

Mental Health Australia is well placed to participate in this analysis, for example to advise on the host of definitional issues that need to be resolved. To be successful, this analysis would require a high level of cooperation from Commonwealth, state and territory governments and the National Disability Insurance Agency (NDIA). This analysis would also assist governments and the NDIA in taking decisions about priorities and make such decisions more transparent for the community.

The National Mental Health Commission (NMHC) may be in a position to assist with this work, if it was appropriately funded and authorised.

## Implementation – pace and direction

In its Position Paper (Draft Finding 2.1, Request for Information 9.1 and Draft Recommendation 9.5), the Commission has posed a crucial question: Should the pace of implementation of the NDIS be slowed, and if so how should this be achieved? This is a crucial question, but it is also a question to which the answer is neither obvious nor easy. This is because the Transition phase of the Scheme is now well underway. Slowing down the rollout of the NDIS would be subject to significant renegotiation of the bilateral agreements with states and territories, including slowing down the wind-up of the programs that are transitioning to the NDIS. A triaging system would need to be developed, with rationales for which areas would be chosen for delayed rollout and why, such as priority given to areas that are already underserved. It could take just as long to renegotiate the bilateral agreements as taking positive action to overcome the problems identified in the Position Paper.

On balance, the scale and nature of problems associated with the implementation of the NDIS for people with psychosocial disability requires a systematic and logical plan for improving the quality of their NDIS experience and outcomes from their NDIS funded supports. If that plan suggests that there needs to be a delay in reaching 'Full Scheme', or that more resources need to be invested in achieving success, then that is a price well worth paying for the people with psychosocial disability who will be directly reliant on the NDIS in the future, and for all Australians who contribute to the Scheme's insurance 'pool'.

To back up Draft Finding 2.1 that the rollout to Full Scheme is highly ambitious, Mental Health Australia suggests that the Commission make an explicit recommendation for the development of a detailed work plan for making process improvements to the NDIS for people with psychosocial disability that incorporates what needs to be done and in what sequence, and for governments to agree to a changed implementation timetable, including funding adjustments as required.

The scope of the work plan for psychosocial disability should be broad, with considerable depth of analysis and information, including:

- determining, testing and deploying a specific assessment tool for psychosocial disability access
- developing and deploying reference packages for psychosocial disability
- developing and deploying planning tools for psychosocial disability supports
- specific plans of action for 'thin markets' and 'hard to reach' groups
- comprehensive and transparent data collection and analysis
- protocols for involving consumers, and their carers and families, and existing providers in the planning process
- prioritising and resourcing effective and sustained outreach and engagement with consumers, their carers and their families
- explicit and sustained mainstream interface planning and governance arrangements
- workforce development planning and contingencies
- provider support and business assistance
- clarifying performance goals and benchmarks, including establishing baselines and progress milestones
- an evaluation strategy with published independent analysis and reports, and
- commencing work on the design features of a standalone gateway for psychosocial disability (see discussion of the gateway below).

It is especially important that quality measures be introduced as soon as possible, given it has taken some time to identify the problems that people with psychosocial disability have encountered with their engagement with the NDIA and the NDIS. Performance benchmarks should focus on outcomes at the individual and system level, activity and output measures as well as providers' experiences with the business aspect of the 'system', supported by transparent publication of relevant data, information and analysis. For further discussion on these issues and specific recommendations see 'Monitoring and reporting' (below).

In response to Information Request 9.1 (which seeks views on whether and how different groups might be prioritised in a revised implementation timetable), Mental Health Australia suggests that priority in the implementation plan for psychosocial disability be given to ensuring outreach to and access for eligible clients who are not currently in existing state, territory or Commonwealth programs. The current implementation approach has been to bring into the NDIS existing program clients who are relatively easy to engage, but this is proving a poor option, because the process has not been well managed and coordinated. This cohort is already supported and can continue to be supported during the NDIS Transition phase in the existing programs, which would allow the NDIA to address the

greater unmet need, especially among those experiencing psychosocial disability. A complementary action would be to return the existing programs to full funding, pending the scheduling of their clients transfer to the NDIS, where such transfer is in the clients' best interests and the client agrees.

## Governance

### *Advocacy*

Since the inception of the NDIS, the NDIA has maintained something of a role in what it calls "market stewardship". However, it has defined this very narrowly and this poses risk to the success of the Scheme.

Historically, across a wide range of social, disability and community services, governments have deemed it necessary to fund two different, but related, kinds of advocacy, reflected in the *National Disability Strategy 2010-2020* (the NDS):

"Individual advocacy supports people with disability to understand and exercise their rights, through either one-to-one support, or by supporting people to advocate for themselves individually, or on a group basis. Systemic advocacy seeks to introduce and influence longer term changes to ensure the rights of people with disability are attained and upheld to positively affect the quality of their lives. Systemic advocates can influence positive changes to legislation, policy and service practices and work towards raising and promoting community awareness and education of disability issues". (p. 17)

Firstly, individual advocacy has allowed independent and knowledgeable third parties to negotiate better outcomes for individuals seeking to access the service system. These third parties develop expert knowledge of eligibility and service options and assist individuals to make more informed approaches to service agencies. These third parties also frequently play an important role in mediating disputes and in some cases, testing eligibility and access decisions through various forms of appeal. There are widespread concerns about the demise of individual advocacy. Without such assistance, knowledge of the key checks and balances within the system will always be limited.

Secondly, and in some but not all cases arising from this individual advocacy, governments have also seen fit to fund systemic advocates within service systems. These systemic advocates take the experience of other players in the system (service providers, consumers and carers, researchers and others) and turn this into policy advice aimed at constantly improving the overall service system. Sometimes this is with advice direct to service agencies, sometimes with advice to consumers directly, and sometimes with advice directly to governments. This advice can target legislative improvement, regulations and agency practice, service provider capacity, and consumer and carer capacity.

It appears that both these kinds of advocacy are largely missing from the ecosystem imagined by governments and by the NDIA. In work Mental Health Australia has previously conducted for the NDIA, contracts specifically precluded any opportunity to make recommendations regarding legislation and/or policy. NDIA pricing makes no allowance for advocacy, making it impossible for service providers or consumers to "self-fund" advocacy without removing funds from the service system.



An organisation like Mental Health Australia is funded by the Australian Government Department of Health, so notionally work on the NDIS would largely fall out of scope. The Department of Health currently funds Mental Health Australia to undertake the following activities (excerpts from our contract):

- Inform and support the Australian Government’s health agenda
- Effective consultation and information sharing
- Functioning as a repository and source of sector knowledge and expertise
- Provide well-informed and impartial advice to the Australian Government
- Consultation, information sharing, inquiries and investigations
- Promote best practice
- Engage with the media
- Support mental health consumers and carers

Currently it appears that this kind of advocacy is not being supported systematically in relation to the NDIS, although arguably this period of significant change and upheaval is precisely when such activities are needed most.

As the Commission’s Final Report is likely to present the last significant opportunity to consider overall system architecture, it will be important for this gap to be acknowledged and addressed if the NDIS is to realise its potential to maximise choice and control for consumers and carers.

The governance arrangements for the NDIS (Figure 9.1 in the Position Paper) do not include systemic advocacy as described in the National Disability Strategy. In particular, there is no place for non-government stakeholders in the COAG Disability Reform Council (DRC) processes. Consequently the DRC’s focus has been on financial risk for governments, and not policy risk or risk to individuals. While the National Disability and Carer Advisory Council (NDCAC) provides advice to the Minister for Social Services to help drive key government reform agendas impacting people with disability and carers, its advice may not reach the DRC. A national Scheme needs a national approach to systemic advocacy.

**Recommendation 2:**

A national expert advisory group should be established to provide direct advice to the COAG Disability Reform Council in relation to the NDIS. This group would be constituted by consumers and carers, private sector service providers, community managed organisations’ representatives, and experts in disability services.

The Commission has recommended that the NDIA needs to find a better balance between participant intake, the quality of plans, participant outcome and financial sustainability (Draft Recommendation 9.5). Mental Health Australia does not regard this as sufficiently concrete or actionable, and urges the Commission to give consideration to structures and resources to formalise the contribution of consumers and carers, providers and advocacy organisations in the development and co-design of NDIS policies and processes. The Department of Social Services should urgently re-establish and expand programs to support individual and systemic advocacy over the long term, in line with the National Disability Strategy.

**Recommendation 3:**

The Department of Social Services and the NDIA should establish permanent arrangements for supporting systemic and individual advocacy to ensure the Scheme delivers the intended outcomes for participants, carers, families and communities.

## Monitoring and reporting

Mental Health Australia shares the Commission's concerns about the efficacy of current arrangements for governing the NDIS, including monitoring and reporting on key aspects of the NDIS. We strongly support the immediate establishment of an independent pricing body for the NDIS, separate from the NDIA (Draft Recommendation 6.1). Read together with Draft Recommendations 5.2, 5.3 and 9.4, it is clear that the Commission is seeking to ensure greater transparency in the governance and monitoring of the NDIS. Mental Health Australia acknowledges that there are inevitable limitations in finding very efficient governance arrangements for large, complex social service systems that are the joint responsibility of several levels of government and across portfolio boundaries. However, some improvements can be made, beyond those in the Position Paper Draft Recommendations.

The Commission may wish to consider reinforcing the principle of separation of functions further, by recommending that there be independent monitoring and reporting on the NDIS, including individual and population level outcomes, effectiveness of access and planning processes, and coverage and effectiveness of service delivery. At the moment it is not always clear whether or how the NDIA is monitoring and auditing some key functions, such as access applications and planning. Separating performance monitoring would also free up the Agency's resources to focus more on the core issues of actuarial analysis, finance planning and risk assessment and mitigation. Alternatively, the Commission may wish to recommend that the NDIA publish more detailed and regular information from its Outcomes Framework and financial analysis of package costs and composition.

A core principle of the NDIS is that disability is an issue that concerns all Australians and therefore cuts across many social systems and structures. This philosophy also underpins the NDS. As a COAG-endorsed strategy, the NDS carries considerable moral weight, but its implementation is mostly carried out indirectly, through initiatives such as the NDIS and various government policies and programs. The efficacy of the NDS would be greatly enhanced if relevant COAG councils were explicitly responsible for monitoring and regularly and publicly reporting not only on NDIS interface issues (as per Draft Recommendation 5.3), but also on the performance of the relevant mainstream service systems in addressing the needs of all people with disability, whether they are receiving individually funded packages, 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 (PHNs). 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. 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).

#### **Recommendation 4:**

The 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 programs for psychosocial services.

Recommendation 1 of this submission proposes urgent analysis of access to psychosocial services pre- and post-NDIS. Building on and embedding that analysis in broad-based and sustained data collection, modelling and analysis would provide the NDIA and other agencies responsible for mental health service planning with crucial information. It would also encourage a culture of 'continuous improvement' through establishing baseline data points and milestone objectives that would build progressively to improve the overall system. This would be in stark contrast to the current tendency for policy and funding decisions to be made in an ad-hoc manner and based on incomplete or out of date data. The absence of such an approach has contributed substantially to the policy failures which the Commission describes in relation to psychosocial disability supports.

There is also a need for more integrated and detailed information that includes but goes beyond the NDIS, as there is a risk that a narrow focus on the NDIS and its clients could hide or obscure problems and issues outside the Scheme that could dramatically affect the Scheme's long term viability. There needs to be national and local level estimates of overall need for psychosocial supports. These estimates need to be categorised by forms and severity of disability/need, location, and population groups such as Indigenous Australians, Australians from culturally and linguistically diverse backgrounds, youth, LGBTIQ people, etc. Against the background of these estimates, there needs to be publicly transparent monitoring and reporting on the coverage and effectiveness of services within and beyond the NDIS. The National Mental Health Service Planning Framework (NMHSPF) is the tool that governments have been using to model their estimates, but the NMHSPF and governments' modelling are yet to be made public.

Analysis of supply is challenging because there is not a consistent 'lexicon' for defining and articulating types or categories of service and their relationship to each other. In the context of the NDIS, this is more than an esoteric issue. Pre-NDIS, providers geared their service provision to the almost exclusive focus on capacity building for individual consumers under those programs, such as Partners in Recovery and Personal Helpers and Mentors. There was very limited data collection that has proved useful for analysis in translation to the NDIS context.

However, based on the limited information made available by the NDIA to date, the composition of packages of support for psychosocial disability represents a considerable shift from capacity building to core supports for everyday living, around 70 per cent, which has shifted the nature and type of services now delivered by service providers.

Work to develop a data and evidence strategy requires sustainable funding and the organisation(s) entrusted with the work need to be both capable and independent of major providers or funders of service systems. The NMHC is ideally placed to carry out such a role, if jurisdictions are in support.

**Recommendation 5:**

The National Mental Health Service Planning Framework should be made publicly available to enable wider analysis of the need for psychosocial services, as a matter of urgency.

**Recommendation 6:** To help analysis of the need for and supply of psychosocial services, the NDIA should release detailed information on the types of services provided to people with psychosocial disability, in addition to the notional allocation of supports in individually funded packages.

**Recommendation 7:** The NDIA should work with the National Mental Health Commission to develop and implement a strategy for monitoring and reporting on people with psychosocial disability who are found ineligible, the reasons for the ineligibility, subsequent referrals to and use of mainstream and/or ILC services, and individual outcomes.

## 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), and
- 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.<sup>3</sup> The Department of Health (and the Department of Social Services) also estimate (using the NMHSPF) 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.<sup>4</sup>

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,

---

<sup>3</sup> Department of Health, Submission to the Productivity Commission Study of NDIS Costs (2017), p. 3.

<sup>4</sup> 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. Mental Health Australia can provide details of its estimates if required.

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 DSS 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. Personal Helpers and Mentors – 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
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. Further discussion on ILC can be found in 'Information, Linkages and Capacity Building (ILC) and Local Area Coordinators (LACs)' (below).

A clear illustration of the enduring problem is the Australian Government 2017-18 Budget measure to provide \$80 million over four years for Psychosocial Support Services, which the Commission believes "will go some way to addressing supports gaps" (p.194). 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.<sup>5</sup>

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 years<sup>6</sup>. 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.

---

<sup>5</sup> 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>

<sup>6</sup> 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.

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, DSS 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, and
- 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 2017-18 Federal Budget.

Similarly, Department of Health Partners in Recovery (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. As the Commission's Position Paper notes, the Victorian Council of Social Services has highlighted that requiring people to identify as having a permanent psychosocial disability (an essential part of testing one's NDIS access) can "create stigma, distress and limit people's hope and optimism".

**Recommendation 8:**

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.

## Pricing

The Commission's Position Paper implies that the reasonable cost model (RCM) was developed in consultation with the mental health sector. As advised in our submission to the Issues Paper, this was not the case. Mental Health Australia would like the Commission's Final Report to acknowledge that the mental health sector had no involvement in the development of the RCM and to recommend that, with proper analysis of the costs of specific types of services, particularly psychosocial services, price setting will need to be differentiated.

Having said that, Mental Health Australia wholeheartedly agrees with the Commission that independent pricing (Recommendation 6.1) is a better way to set prices.

The recommendation could be strengthened with specific references to psychosocial supports. As a priority, the independent price monitor should review the pricing for psychosocial supports. Also, to avoid repeating the 'one price fits all' approach to NDIS pricing of supports, the independent price regulator should be required to establish differentiated prices for psychosocial supports.

**Recommendation 9:**

Recommendation 6.1 should be expanded to:

- ensure the independent price monitor prioritises review of prices for psychosocial supports
- include that the body tasked with price regulation for Scheme supports should:
  - determine the differentiated prices for psychosocial supports
  - work with the new Quality and Safeguards Commission and the mental health sector to inform this work
  - consider the inclusion of a standalone item for psychosocial support services in the NDIA's pricing catalogue

## Workforce development

Mental Health Australia shares the Commission's concerns about the fragmented nature of roles and responsibilities for market stewardship and workforce development. However, Recommendation 7.1 (that roles and responsibilities for workforce development be clarified) could be strengthened through recommending specific activities to achieve workforce development. In this context, Mental Health Australia reiterates the call by National Disability Services for governments and the NDIA to "fund and assist the development of an industry plan, led by the non-government sector"<sup>7</sup>. The plan should be informed by input from people with disability, their families and carers, service providers, peak bodies, professional bodies and governments. The plan should also include actions, timeframes, accountabilities and monitoring arrangements.

The proposed NDIS industry plan should include specific actions relating to development of the psychosocial disability workforce, including actions relating to maximising the use of the peer workforce. The plan will also need to take into account broader mental health workforce strategies, which Mental Health Australia anticipates will be identified in the *Fifth National Mental Health and Suicide Prevention Plan*. This approach will ensure due consideration is given to flow on effects between sections of the mental health workforce.

---

<sup>7</sup> National Disability Services, *How the Get the NDIS on Track*, 2017, page 4



The plan should also be mindful of the distortionary effect NDIS pricing structures have already had on psychosocial disability workforce composition in NDIS Transition sites. For example, a report by Community Mental Health Australia noted:

“At least two ‘divisions’ seem to have been formed around two potentially distinct areas of work.

The first area of work largely relates to support for individual consumers that provides basic — some services and stakeholders have called it ‘core’, assistance in self-care in the home and the community...

The second area of work appears to be more in keeping with the principles of the National Framework for Recovery-Oriented Mental Health Services ... and provides psychosocial disability support and rehabilitation services to consumers individually or in groups, which is more developmental in nature”<sup>8</sup>.

The impact of this division of labour on quality, safety and effectiveness of care should be considered as a part of any NDIS industry plan and broader mental health workforce strategy. More information is provided about the division of labour and its link to NDIS pricing and package composition in ‘Monitoring and reporting’ (above).

In addition, NDIS specific psychosocial disability workforce development should be clearly and transparently monitored through the regular publication of an NDIS National Psychosocial Disability Market Position Statement, similar to the Market Position Statements currently published for each state and territory.

**Recommendation 10:**

Recommendation 7.1 should be expanded to include the development of a whole of NDIS industry plan, led by the non-government sector. The plan should include specific actions relating to development of the psychosocial disability workforce and take account of broader mental health workforce strategies, maximising the use of the peer workforce.

**Recommendation 11:**

The NDIA should regularly publish an NDIS National Psychosocial Disability Market Position Statement incorporating workforce numbers and qualifications.

---

<sup>8</sup> Community Mental Health Australia, *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. 2015, page 4

## Key design features of the NDIS

### *Permanency*

“The Commission does not support changing the eligibility criteria to relax the definition of permanency and how it relates to psychosocial disability.” (p.24)

The Commission’s Position Paper has presented no substantive analysis of how the permanency criterion is being applied in practice through the NDIS Rules, Operational Guidelines and (most importantly) by NDIA staff. For example, rule 5.4 of the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* states:

“An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.”

This Rule does not take account of the fact that people with mental illness will receive ongoing clinical, medical and other treatments and psychosocial services to aid their recovery potentially over the course of their lives. This is entirely appropriate and to be encouraged. While the Commission has found that “81 per cent of people with psychosocial disability who lodged an access request to the NDIS were eligible for the Scheme” (p.24) it does not discuss the grounds for rejecting the other applicants, nor the reasons why eligible populations may not have applied. Anecdotally, permanency has been a factor on many occasions.

Psychosocial disability service providers’ experience indicates that some people with psychosocial disability are denied access to the Scheme on the basis that their condition is not fully treated and stabilised and that not all treatment options have been tried. Providers have also reported that NDIA access decisions seem to focus on diagnosis rather than functional impairment. This may be due to a perceived treatability of certain conditions perhaps betraying a lack of expertise within the NDIA. The result is that people experiencing psychiatric conditions which are perceived to be more treatable, such as severe post-traumatic stress disorder, depression and anxiety, are less likely to be accepted as Scheme participants even if they are experiencing severe functional impairment.

Analysis of the reasons for access rejections is necessary for the Commission’s study to shed light on the extent to which the permanency requirement is being balanced with a recovery approach.

#### **Recommendation 12:**

The Commission should review access decisions to date, including the reasons for rejecting access requests from people with psychosocial disability, and the reasons why eligible populations may not have applied, to ascertain if the legal provisions are being interpreted and applied in a way that impacts negatively on access to the NDIS and if there is sufficient consistency in decisions to deny access.

For the Commission’s further consideration of the issue, Attachment B is an options paper provided to the Joint Standing Committee on the NDIS for addressing the permanency criterion for people with psychosocial disability.

### *Psychosocial gateway*

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 will 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 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. In the headlong rush to meet both time and volume commitments outlined in bilateral agreements, as the CEO of the NDIS recently conceded,<sup>9</sup> 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.

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 six 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 psychosocial 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, which the Commission's finding 2.4 attests to – that participants with psychosocial disability, and those who struggle to navigate the Scheme, are most at risk of experiencing poor outcomes.

The Commission has flagged the prospect of a specialist gateway for people with psychosocial disability:

“While a specialist gateway provides no guarantee of improved outcomes, it is something that could be explored if wider reforms to the planning process do not result in better engagement with the scheme for people with psychosocial disability.”  
(p.144)

While current 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 accessing the Scheme in ways which are responsive to their needs. Without addressing these structures it is inevitable that the wider reforms will not result in better engagement with the Scheme for people with psychosocial disability.

---

<sup>9</sup> National Disability Insurance Agency. *Participants and providers work with NDIS to improve processes*. 5 June 2017

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.

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, noting that it took some time before the NDIA that the standardised pathway is not working for participants with psychosocial disability. Mental Health Australia has suggested a series of metrics under 'Monitoring and reporting' (above).

**Recommendation 13:**

The Commission should recommend that the NDIA 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*.

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 Survey<sup>10</sup> (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 14:**

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.

---

<sup>10</sup> Developed by the Australian Mental Health Outcomes and Classification Network

**Recommendation 15:**

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.

*Early intervention*

The Commission's Position Paper states that the NDIS provides people with psychosocial disability greater access to early intervention supports. Although the NDIS legislation and rules enable access to NDIS funded early intervention psychosocial disability supports (see NDIS Act Section 25 and NDIS Operational Guideline 'Access to the NDIS'), Mental Health Australia understands that only very small numbers of NDIS participants with psychosocial disability have accessed the Scheme via the early intervention access requirements.

It would appear that a policy decision has been taken to exclude (or limit the number of) people with psychosocial disability from accessing NDIS funded early intervention supports. The Council of Australian Governments' *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* states that the health system will be responsible for "Treatment of mental illness, including acute inpatient, ambulatory, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs"<sup>11</sup> (although the principles also note that the issue will need to be considered during NDIS Transition). The NDIA has taken the position that the supports offered by the NDIS are "generally not the type of help a person requires at the first signs of a mental health issue"<sup>12</sup>. This is a very simplistic assumption, which could unnecessarily limit opportunities to mitigate the severity or longevity of functional impairments through the provision of early intervention psychosocial disability supports. For example, people at the early stages of experiencing psychosocial disability can benefit from an holistic approach to care which includes both clinical and psychosocial supports, and in fact the success of treatment and disability support can be mutually dependent.

In 2016, Mind Australia released a literature review investigating the effectiveness of early intervention strategies for people with psychosocial disability interventions and considering whether effective interventions fit in the context of the NDIS. Mind Australia's review confirmed:

"There is significant evidence that people with psychosocial disability make significant gains in their capacity to engage in social and economic participation if they are offered early intervention. Interventions identified in this review have the potential to reduce the experience of impairment and provide early assistance that maximises people with psychosocial disabilities' potential to work, improve their relationships with their families and others, gain new skills, stabilise their housing and self-manage. While the use of early intervention requires further consideration, the findings of this review do suggest that, in the NDIS context, it may enable people to

---

<sup>11</sup> Council of Australian Governments, *Principles to Determine the Responsibilities of the NDIS and Other Services Systems*, 2015, page 6

<sup>12</sup> National Disability Insurance Agency, *Mainstream Interface – Mental Health*, 2017, page 2

reduce their reliance on the Scheme into the future, hence reducing costs over time. It may also reduce pressure on other health and welfare services”<sup>13</sup>.

Considering the findings of this review, there is a strong case that funding early intervention psychosocial supports through the NDIS may help to reduce cost pressures on NDIS IFPs as well as costs in adjacent systems such as welfare and health. This approach clearly aligns with insurance principles.

If early intervention psychosocial supports were to be funded through the NDIS, Mental Health Australia anticipates that it may be difficult to differentiate immediately at the point of access between NDIS participants who require early intervention supports only and those who will go on to become lifelong Scheme participants. This lends further support to the development of a specialised psychosocial gateway, as outlined above.

**Recommendation 16:**

The NDIA should build on the findings of the Mind Australia review to further investigate the potential benefits of funding early intervention supports for people with psychosocial disability through the NDIS, in consultation with the mental health sector.

The NDIA should report on the outcomes of this work and in response determine a position in relation to early intervention for people with psychosocial disability to access support through the NDIS.

*Planning*

Mental Health Australia supports the Commission’s Recommendation 4.2 for 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 agrees with Recommendation 4.1 to improve planning processes, but with 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.

As discussed above, systemic and individual advocacy should be a key input into NDIA processes to improve the planning and pre-planning processes and to design training programs for planners.

---

<sup>13</sup> The University of Melbourne and Mind Australia, *Effective evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery*, 2016, pages 19-20

**Recommendation 17:**

Building on Draft Recommendation 4.1, specify that 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.

Specialist organisations could also provide invaluable assistance with pre-planning. While we agree with the Commission that greater attention needs to be paid to pre-planning, we do not agree that having LACs on the 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 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.

*Information, Linkages and Capacity Building (ILC) and Local Area Coordinators (LACs)*

As both the 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
- 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.<sup>14</sup>

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."<sup>15</sup> 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.

These factors are not explicitly canvassed in the Position Paper, but the Commission does point to a lack of evidence regarding the benefits of investments made to date in ILC initiatives. Given the lack of evidence, there is a risk that governments will not accept the Commission's recommendation of a significant (if temporary) increase in funding for ILC over the Transition period without clarifying the intent more clearly.

A further alternative rationale for increasing investment in ILC (including potentially beyond the figure and timeframe proposed), 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.

---

<sup>14</sup> National Disability Insurance Agency, *A Framework for Information, Linkages and Capacity Building* (nd), p. 7.

<sup>15</sup> National Disability Insurance Agency, *ILC Commissioning Framework* (2016), p. 21.



### *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 Partners in Recovery (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.<sup>16</sup>

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 that 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.

For these reasons, Mental Health Australia suggests that the Commission consider revising its recommendation in relation to ILC funding by assessing the level of funding needed to cover the range of functions the ILC is intended to provide – especially capacity building and outreach – and provide an estimate of the funding required. As it is currently drafted, there is a risk that Draft Recommendation 5.1 will be ignored because there is not a clear rationale behind it.

An alternative rationale for increasing investment in ILC (even beyond the figure proposed), 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

---

<sup>16</sup> Urbis, *Partners in Recovery Annual Report 2014-2015* (July 2015). Prepared for the Department of Health.

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 18:**

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 19:**

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.

## NDIS funding arrangements

The NDIA has already identified significant limitations in both its capability and capacity. Both need to be addressed as a matter of priority. Capping of staff numbers and maintaining unrealistic expectations regarding the operating budget seem particularly short sighted given the size and complexity of the roll out of the Scheme. It is also evident that some of the decisions made by the NDIA during Transition have been driven by resource limitations. An obvious example is the number and scale of projects commissioned by the NDIA and carried out by commercial consultants – work that would be much better carried out by NDIA staff in collaboration with organisations with specific disability expertise. It should also be expected that spending on administration might be considerably higher during establishment and Transition than during Full Scheme roll out.

These are perverse outcomes in an insurance scheme. While the bulk of the NDIS funds should deliver support for people with disability and the NDIA should be held accountable for how funds are utilised, considerable flexibility, especially in the early years of the Scheme (and during Transition in particular) would help ensure the Scheme is implemented more effectively than has occurred to date.

## Attachment A – Overview of Productivity Commission Draft Recommendations and Mental Health Australia response

Draft Recommendation	MHA response
<p><b>How is the scheme tracking?</b></p>	
<p>DRAFT FINDING 2.1</p> <p>The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.</p>	<p>Agree</p> <p>See the 'Implementation – pace and direction' section.</p>
<p>DRAFT FINDING 2.2</p> <p>While a different methodology is used, the National Disability Insurance Agency projections of scheme costs are broadly consistent with the Productivity Commission's modelling of the scheme in 2011, after accounting for sector-specific wage increases, population changes, and costs associated with participants aged over 65 years (who were not included in the Commission's estimates).</p>	<p>No position</p>
<p>DRAFT FINDING 2.3</p> <p>The National Disability Insurance Scheme, at the end of trial, came in under budget. This was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 74 per cent). Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children and higher than expected package costs) have been offset by lower than expected levels of utilisation. The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.</p>	<p>No position</p>
<p>DRAFT FINDING 2.4</p> <p>Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided. However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.</p>	<p>Agree</p> <p>See the 'Psychosocial gateway' section</p>

Draft Recommendation	MHA response
<b>Scheme eligibility</b>	
<p>DRAFT RECOMMENDATION 3.1</p> <p>When determining that an individual is eligible for individualised support through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the <i>National Disability Insurance Scheme Act 2013</i> (Cwlth) are relevant for each individual when they enter the scheme.</p>	<p>Endorse</p> <p>See additional recommendations in the 'Monitoring and reporting' section.</p>
<b>Scheme supports</b>	
<p>DRAFT RECOMMENDATION 4.1</p> <p>The National Disability Insurance Agency should:</p> <ul style="list-style-type: none"> <li>• implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review</li> <li>• review its protocols relating to how phone planning is used</li> <li>• provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options</li> <li>• ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.</li> </ul>	<p>Endorse</p> <p>See additional recommendation in the 'Psychosocial gateway' section.</p>
<p>DRAFT RECOMMENDATION 4.2</p> <p>The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.</p>	<p>Endorse</p> <p>See additional recommendation in the 'Psychosocial gateway' section.</p>
<b>Boundaries and interfaces with the NDIS</b>	
<p>DRAFT FINDING 5.1</p> <p>It is a false economy to have too few resources for Information, Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.</p>	<p>Agree</p> <p>See recommendations in the 'Information Linkages and Capacity Building and Local Area Coordinators' and 'Specialist assertive outreach' sections.</p>

Draft Recommendation	MHA response
<p><b>DRAFT RECOMMENDATION 5.1</b></p> <p>Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of \$131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach \$131 million should be made available from the National Disability Insurance Agency’s program delivery budget.</p> <p>The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of \$131 million per annum until results from this review are available.</p>	<p>Endorse</p> <p>See additional recommendations in the ‘Information Linkages and Capacity Building and Local Area Coordinators’ and ‘Specialist assertive outreach’ sections.</p>
<p><b>DRAFT RECOMMENDATION 5.2</b></p> <p>The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.</p> <p>The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.</p>	<p>Endorse</p> <p>See additional recommendations in ‘Continuity of support and transitioning programs’ section.</p>
<p><b>DRAFT RECOMMENDATION 5.3</b></p> <p>Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.</p> <p>Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.</p>	<p>Endorse</p>

Draft Recommendation	MHA response
<b>Provider readiness</b>	
<p>DRAFT RECOMMENDATION 6.1</p> <p>The Australian Government should:</p> <ul style="list-style-type: none"> <li>• immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)</li> <li>• transfer the NDIA’s power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.</li> </ul> <p>The body tasked with price regulation for scheme supports should:</p> <ul style="list-style-type: none"> <li>• collect data on providers’ characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University</li> <li>• determine transitional and efficient prices for supports at a state and territory level</li> <li>• comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives</li> <li>• assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.</li> </ul>	<p>Endorse</p> <p>See additional recommendations in the ‘Monitoring and reporting’ section</p>
<p>DRAFT FINDING 6.1</p> <p>In a market-based model for disability supports, thin markets will persist for some groups, including some participants:</p> <ul style="list-style-type: none"> <li>• living in outer regional, remote and very remote areas</li> <li>• with complex, specialised or high intensity needs, or very challenging behaviours</li> <li>• from culturally and linguistically diverse backgrounds</li> <li>• who are Aboriginal and Torres Strait Islander Australians</li> <li>• who have an acute and immediate need (crisis care and accommodation).</li> </ul> <p>In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.</p>	<p>Agree</p> <p>See ‘Access to psychosocial support pre and post NDIS’, ‘Information, Linkages and Capacity Building and Local Area Coordinators’ and ‘Specialist assertive outreach’ sections</p>
<b>Workforce readiness</b>	
<p>DRAFT FINDING 7.1</p> <p>It is unlikely that the disability care workforce will be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.</p>	<p>Agree</p> <p>See recommendations in the ‘Workforce development’ section</p>

Draft Recommendation	MHA response
<p data-bbox="229 271 603 297">DRAFT RECOMMENDATION 7.1</p> <p data-bbox="229 315 991 423">The roles and responsibilities of different parties to develop the National Disability Insurance Scheme workforce should be clarified and made public.</p> <ul data-bbox="229 441 991 1081" style="list-style-type: none"> <li data-bbox="229 441 991 580">• State and Territory Governments should make use of their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.</li> <li data-bbox="229 584 991 831">• The Australian Government should retain oversight of workforce development, including how tertiary education, immigration and aged care policy interact and affect the development of the workforce. In doing so, the Australian Government should pay particular attention to immigration policy to mitigate workforce shortages over the transition period.</li> <li data-bbox="229 835 991 974">• The National Disability Insurance Agency should provide State and Territory Governments with data held by the Agency to enable those jurisdictions to make effective workforce development policy.</li> <li data-bbox="229 978 991 1081">• Providers of disability supports should have access to a clear and consistent mechanism to alert those tasked with market development about emerging and persistent workforce gaps.</li> </ul>	<p data-bbox="1066 271 1161 297">Endorse</p> <p data-bbox="1066 315 1358 461">See additional recommendations in the 'Workforce development' section</p>
<p data-bbox="229 1104 603 1131">DRAFT RECOMMENDATION 7.2</p> <p data-bbox="229 1149 991 1339">The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.</p> <p data-bbox="229 1350 991 1541">The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.</p>	<p data-bbox="1066 1104 1161 1131">Endorse</p> <p data-bbox="1066 1149 1326 1305">See additional recommendations in the 'Workforce development' section</p>

Draft Recommendation	MHA response
<p>DRAFT RECOMMENDATION 7.3</p> <p>The National Disability Insurance Agency’s (NDIA) guidelines on paying informal carers who live at the same residence as a participant should be relaxed for core supports for the period of the National Disability Insurance Scheme (NDIS) transition. Such payments should be:</p> <ul style="list-style-type: none"> <li>• accessible under clearly defined and public guidelines, which make reference to worker shortages in the relevant market using the NDIA’s information about providers and supports in the participant’s region</li> <li>• set at a single rate determined by the NDIS price regulator in a transparent manner</li> <li>• reviewed by the NDIA as part of plan reviews.</li> </ul>	<p>Endorse</p> <p>See additional comments about carers programs in the ‘Continuity of support and transitioning programs’ section</p>
<p><b>Participant readiness</b></p>	
<p>DRAFT RECOMMENDATION 8.1</p> <p>The National Disability Insurance Agency should implement the eMarketPlace discussed in the <i>Integrated Market Sector and Workforce Strategy</i> as a matter of priority.</p>	<p>No position</p>
<p><b>Governance</b></p>	
<p>DRAFT RECOMMENDATION 9.1</p> <p>The requirement that changes to National Disability Insurance Scheme Category A Rules have unanimous agreement from the Australian Government and all host jurisdictions should be relaxed.</p>	<p>No position</p>
<p>DRAFT RECOMMENDATION 9.2</p> <p>The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.</p>	<p>No position</p>
<p>DRAFT RECOMMENDATION 9.3</p> <p>The National Disability Insurance Agency should publicly report on the number of unexpected plan reviews and reviews of decisions, review timeframes and the outcomes of reviews.</p>	<p>Endorse</p> <p>See additional recommendations in the ‘Psychosocial gateway’ section.</p>



Draft Recommendation	MHA response
<p>DRAFT RECOMMENDATION 9.4</p> <p>The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme’s objectives.</p> <p>The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).</p> <p>The <i>Integrated NDIS Performance Reporting Framework</i> should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.</p>	<p>Endorse with qualification</p> <p>See additional recommendation in the ‘Psychosocial gateway’ section</p>
<p>DRAFT RECOMMENDATION 9.5</p> <p>In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.</p>	<p>Endorse</p> <p>See ‘Implementation – pace and direction’ section</p>
<p><b>Funding arrangements</b></p>	
<p>DRAFT FINDING 10.1</p> <p>The objective of the escalation parameters is not specified in the Bilateral Agreements between the Australian Government and the State and Territory Governments at full scheme.</p> <p>The existing escalation parameters are unlikely to reflect the full increase in National Disability Insurance Scheme (NDIS) costs over time, which would result in the Australian Government bearing a higher share of NDIS costs over time.</p>	<p>No position</p>

Draft Recommendation	MHA response
<p>DRAFT RECOMMENDATION 10.1</p> <p>At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7-10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.</p> <p>The National Disability Insurance Agency should be required, in its annual report, to state reasons why it has not met this target in any given year.</p>	<p>Endorse with qualification, see 'NDIS funding arrangements' section</p>
<p>DRAFT FINDING 10.2</p> <p>Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control. The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.</p>	<p>No position</p>
<p>DRAFT RECOMMENDATION 10.2</p> <p>The Australian Government should reconsider the staffing cap on the National Disability Insurance Agency, given the importance of developing internal capability and expertise.</p>	<p>Endorse with qualification, see 'NDIS funding arrangements' section</p>
<p>DRAFT RECOMMENDATION 10.3</p> <p>In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.</p>	<p>Endorse</p> <p>See recommendations in 'Continuity of support and transitioning programs' section</p>

## Attachment B – Supplementary Submission (19 May 2017)

### Options for achieving recovery oriented psychosocial support in the NDIS

Supplementary submission to the Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

This supplementary submission has been prepared for the Joint Committee on the National Disability Insurance Scheme in response to its question on what needs to change for the Scheme to have a recovery focus for people with psychosocial disability. We believe the issue, which is the subject of widespread stakeholder concern, has arisen in part because the Scheme was initially designed for people with physical disability, with psychosocial disability a late addition.

Our recommendations are informed by the principles in the *National Framework for Recovery-Oriented Mental Health Services*, endorsed by the Australian Health Ministers' Advisory Council in 2013. A recovery-oriented approach aligns with the objective of the NDIS to maximise independence and social and economic participation at the individual level. A recovery orientation is also consistent with the Scheme's emphasis on choice and control.

The options presented are intended to clarify the original intended cohort for the Scheme – i.e. people with the greatest need for disability support – not to expand the Scheme's reach. We do not recommend a relaxation in access criteria or their application, but instead to make improvements in order to assist the right people to access the NDIS as easily as possible.

#### Legislation

We recommend the following amendments to section 24 of the *National Disability Insurance Scheme Act 2013*:

- Remove references to *psychiatric condition* and replace with *psychosocial disability*. Using a validated assessment tool, a full assessment of a person's functional capacity to undertake activities of daily living can preclude the current requirement that a *psychiatric condition* be demonstrated by medical certification.
- Replace the word *permanent* with *ongoing, enduring, or chronic*
- Consider incorporating into 24.1 (b): *the impairment or impairments are ongoing, or likely to be ongoing without the person receiving supports intended to build their capacity.*

While a change to the legislation is necessary, we believe the urgent priority is to ensure the operation of the Scheme is recovery-oriented for people with psychosocial disability.

## Regulation

Amendments to NDIS Rules will give the NDIA greater flexibility to implement the Scheme for people with psychosocial disability based on recovery principles. We recommend the following amendments to the Rules:

Amend the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* to:

- Include the principle of recovery-oriented practice for psychosocial disability.
- Remove the requirement that psychosocial disability must be, or likely to be, permanent. (Subrule 5.1.(e) requires that a person is likely to require support under the NDIS for their lifetime, which adequately covers the longevity of the impairment.)
- Clarify that Rule 5.4 does not apply to psychosocial disability, to reflect that people with mental illness will receive ongoing clinical, medical and other treatments and psychosocial services to aid their recovery.

Rule 5.4 An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.
---

- Recognise that medical evidence obtained for the purposes of gaining the Disability Support Pension is sufficient in confirming both the medical fact of and the enduring nature of a psychosocial disability.

Amend the *National Disability Insurance Scheme (Supports for Participants) Rules 2013* to:

- Recognise that a recovery-oriented approach will be taken by the NDIA in determining support needs for people with psychosocial disability.
- Require that a validated assessment tool is used for assessing reasonable and necessary supports for people with psychosocial disability, which would ensure equity for these NDIS participants while enabling the NDIS to operate according to insurance principles with timely investment to minimise lifetime costs.

## Operational processes

The universal model of the NDIS is admirable. However, unique needs can and should have tailored approaches, such as that which has already occurred with early childhood. Recovery-oriented practice can be applied to the operational aspects of the Scheme for psychosocial disability.

Given the philosophical differences between the recovery-oriented assessment of and planning processes for people with psychosocial disability and those with other disabilities, the organisational structure of the NDIA should accommodate a specific psychosocial disability stream and NDIA staff (including staff involved in assessment and planning) should have expertise in psychosocial disability.

Other options for recovery-oriented practice in NDIS processes are set out below.

#### Assessment process

- Remove the requirement for people with psychosocial disability to produce medical evidence of the psychiatric condition and a medical testament to its permanence. This administrative practice to truncate individualised assessment of functional capacity is not a recovery-oriented approach to providing psychosocial supports services for people with mental illness.
- Adopt a validated assessment tool that is fit for purpose to assess the eligibility of people with psychosocial disability that focusses on their impairment and functional capacity to undertake activities of daily living.
- Assessment of people with psychosocial disability should be undertaken by a person with the right professional expertise. This can be done within the NDIA or outsourced, noting that the professional expertise largely exists in community based mental health service provider organisations and mental health professionals working with people with psychosocial disability.

#### Planning process

- Participants' plans should be oriented to capacity building supports to aid recovery, wherever possible.
- The planning process should be based on evidence of what constitutes effective and recovery-oriented packages of support for psychosocial disability.

#### Pricing

- Prices for psychosocial supports services should reflect the costs of a recovery-oriented services, i.e. not simply assistance with activities of daily living.

Since rollout commenced, mental health providers have repeatedly highlighted that the price of supports is set well below the hourly rate for psychosocial support work currently delivered by suitably qualified people. There is no hourly price for psychosocial support services in the NDIS Price Guide, and mental health providers have had no involvement in the process to set prices for different support types.

#### Background

The *National Framework for Recovery-Oriented Mental Health Services* was developed by the Australian Health Ministers' Advisory Council in 2013 and is formal government policy. The Framework acknowledges that "Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma". This is why the use of the term "permanent" in the NDIS legislation presents such a big barrier to the cohort for whom the Scheme is intended to support. It is why so many stakeholders have made this point in their submissions to Parliamentary inquiries, review of the NDIS legislation and to the Productivity Commission.

In 2015, reporting on its review of the *National Disability Insurance Scheme Act 2013*, Ernst and Young recommended that the government conduct another review of the Act in two to three years given that the "legislative framework will be exposed to more participants, more

locations and more sources of stress”.<sup>1</sup> Ernst and Young noted that the [second] review will “help government ensure that the legislative framework is ‘fit for purpose’ for full Scheme”.

#### Eligibility assessment tool

In its advice for implementing the NDIS for people with mental health issues<sup>2</sup>, the NDIS Independent Advisory Council found there was “no commonly accepted and used instruments for assessing functional impairments and indicating support needs related to disability due to a psychiatric condition”. The Council highlighted the risk of inconsistent approaches in both eligibility and support needs being determined by the NDIA.

The issue remains unresolved and the Council has recommended, in its submission to the Parliamentary Joint Standing Committee on the NDIS, that the NDIA “invest in the development of a validated instrument for identifying an evidence-based approach to the determination of functional impairments and support needs for people with an impairment related to a psychiatric condition”. It is unclear what has prevented the NDIA from: a) developing an NDIS specific tool; b) modifying the existing assessment tool for physical disability to assess psychosocial disability; or c) purchasing the licence for an existing psychosocial assessment tool.



Frank Quinlan  
CEO  
Mental Health Australia



**Mental Health  
Australia**



Tony Stevenson  
CEO  
Mental Illness Fellowship Australia



**MENTAL ILLNESS  
FELLOWSHIP  
of Australia Inc**



Liz Crowther  
President  
Community Mental Health Australia



**CMHA**  
Community Mental Health Australia

<sup>1</sup> Ernst and Young. *Independent review of the NDIS Act*. December 2015. Page 3.

<sup>2</sup> Independent Advisory Council for the National Disability Insurance Scheme, *IAC advice on implementing the NDIS for people with mental health issues*, 2014

# 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](mailto:info@mhaustralia.org)  
**W** [mhaustralia.org](http://mhaustralia.org)