



COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY
INSURANCE SCHEME

**Services for people with psychosocial disabilities related to a mental health
condition**

(Public)

FRIDAY, 16 JUNE 2017

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JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME

Friday, 16 June 2017

Members in attendance: Senators Gallacher, Siewert and Mr Andrews, Mr Wallace.

Terms of Reference for the Inquiry:

To inquire into and report on:

The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, with particular reference to:

- a. the eligibility criteria for the NDIS for people with a psychosocial disability;
- b. the transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular;
 - i. whether these services will continue to be provided for people deemed ineligible for the NDIS;
- c. the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;
 - i. whether these services will continue to be provided for people deemed ineligible for the NDIS;
- d. the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework;
- e. the planning process for people with a psychosocial disability, and the role of primary health networks in that process;
- f. whether spending on services for people with a psychosocial disability is in line with projections;
- g. the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability; and
- h. the provision, and continuation of services for NDIS participants in receipt of forensic disability services;
- i. any related matter.

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MEAGHER, Ms Janet AM, Member, National Disability Insurance Agency Independent Advisory Council

NAUGHTIN, Dr Gerry, Council member, National Disability Insurance Agency Independent Advisory Council

Committee met at 10:51

CHAIR (Mr Andrews): I now declare open this hearing of the Joint Standing Committee on the National Disability Insurance Scheme for the inquiry into services under the NDIS for people with psychosocial disabilities related to a mental health condition. These are public proceedings, although the committee may determine or agree to request to have evidence heard in camera. Can I remind all witnesses today that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as contempt. It is also contempt to give false or misleading evidence to a committee. If a witness objects to answering a question, the witness should state upon the ground upon which the objection is taken and the committee will determine whether it will insist on an answer having regard to the ground on which it is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may be made at any other time. Could I please remind those contributing that you cannot divulge confidential, personal identifying information when you speak. If you wish to supplement your evidence with written information, please forward it to the secretariat after this hearing. We have Senator Siewert online. Can I welcome the representatives of the NDIS Independent Advisory Council. I thank you for coming along today. Can I invite you, if you would like, to make some opening remarks to the committee?

Prof. Galbally: Good morning. Thank you for the opportunity to present to your committee on behalf of the Independent Advisory Council. My role here is as principal member of the Independent Advisory Council. Since its establishment in July 2013, the council has had a strong focus in its work program on addressing the issues of the NDIS for people with disabilities related to mental health conditions. The inclusion of people with psychiatric conditions occurred later in the planning of the scheme, and the council is giving considerable attention to providing advice to the board and agency on strategies for improving the scheme's responsiveness to people with psychosocial disabilities who, the Productivity Commission projected, would constitute 14 per cent of scheme participants at full rollout.

In 2015, the 'IAC advice on implementing the NDIS for people with mental health issues' was accepted by the NDIA board and provided to the minister and Disability Reform Council. The advice was subsequently published on the website, and I have the advice to table.

The council's advice was informed by a literature review that the IAC commissioned in conjunction with Mind Australia. The literature review focused on eligibility for people with disabilities due to mental health issues, likelihood of permanence, the evidence for the nature and extent of psychosocial impairment, and its implications in terms of functional impairment and reasonable and necessary supports. The literature review is also on the NDIS website and stands as the leading published literature review on this specific subject in Australia. We believe that this document and the advice it supports will be of assistance to the JSC in its deliberation on these issues.

In considering strategies for implementing the NDIS for people with psychosocial disability arising from mental health issues, the IAC has undertaken considerable work listening to the views of consumers, family and carer advocates, and the mental health sector; proactively working with key stakeholder groups to inform and engage with the NDIS; and building an understanding of how the trial sites have responded—and are responding—to applicants and participants with disabilities arising from mental illness. On an annual basis, the IAC provides feedback on the mental health work plan and achievements to the NDIA specialist mental health consultant, and this feedback is incorporated in the report to the board.

I would now like to introduce two of my fellow expert members of the council, Dr Gerry Naughtin and Janet Meagher, and they will speak to our submission. Both Dr Naughtin and Ms Meagher bring extensive experience and expertise in psychosocial disability. Gerry Naughtin is the Chief Executive of Mind Australia, one of the leading providers of psychosocial disability services in Australia. He has an extensive background in the delivery of disability and aged-care services. He was the founder and Chief Executive of Silver Circle Home Support Services for 14 years, now Calvary Community Care. He grew this organisation from a concept to becoming a significant provider of client focused home support services. He has also held positions as associate professor at La Trobe University and with the Brotherhood of St Laurence.

Janet Meagher is a leading consumer advocate in mental health services, having lived with schizophrenia since the early 1970s. Janet was institutionalised at Sydney's notorious Gladesville psychiatric hospital for 10 years and has since advocated passionately for rights, equity, participation and respect for people living with mental health issues. Janet was director of Psychiatric Rehabilitation Australia, a foundation commissioner of the National Mental Health Commission, and former board member and secretary of the World Federation for Mental Health. Today, in addition to being an author, lecturer and leader in advocating for mental health issues, she is also a member of the IAC and has been for the past four years, as has Gerry. I would now like to hand over to Gerry to start the submission.

Dr Naughtin: Good morning. Thank you for the opportunity to present to you this morning. As Rhonda Galbally has outlined to you, this issue of the adequacy of the approach towards people with psychiatric conditions—the language we are using increasingly is 'psychosocial disability'—within the scheme has been a strong area of focus and interest of the independent advisory council.

We called these issues early in the scheme. In 2014 we did considerable work in this space and have provided, I think, consistent and strong advice to the agency. In relation to our experience as a council, I think the agency itself has taken on board our advice and has been very open. It has also put considerable effort into understanding the particular issues that confront access, eligibility, plan approval and plan implementation in regard to this cohort within the scheme which, at full rollout, will constitute approximately 14 per cent of the scheme.

For us today, one of the key themes that we want to present to you is that considerable work has been done in this space. From our perspective, some of the work that the agency is doing has been taking on the advice from the council, has been trying to apply the best technologies that we have in Australia and to be experimenting and developing a strong database in relation to those. One of the key points we want to make to you today is that substantial work has been done, but there is a need for ongoing work and an ongoing agenda. In 2015 we recommended, and the NDIA board supported this position, that we needed a mental health focus in the scheme. They agreed to our recommendation that there would be an annual mental health work plan. Since that time there has been a consistent approach where there has been a work plan each year, and that has been an important mechanism for us to provide input back into the scheme.

We note now that, clearly, through the work of this committee but also more broadly—the report from the Productivity Commission yesterday and a range of other sources—there is much focus on this issue of what is reasonable and necessary and how we understand eligibility. One of the insights we want to share with you from our work is some of the complexity. That is, when the legislation was drafted what was taken in the concept of permanence from legislation from around Australia at the time was appropriate for the broader range of disability types, but perhaps did not have the sensitivity for people with psychiatric conditions. Also, some of the work that still needed to be done in this space is cutting new ground internationally, so there is no formula that we can go to in another jurisdiction across the world where we can see a working model that is actually working in this space.

Having said that, we are suggesting there are still some issues where improvement needs to occur. One of those in particular is in relation to episodic conditions, and I wonder if this would be an appropriate point to introduce my colleague, Janet Meagher, to speak in relation to this matter.

Ms Meagher: I am also a member of the NDIS Independent Advisory Council. I have very passionate views that the council has to endure. Amongst them is the sort of confusion that arises when we need to discuss permanency, when I would dare to say all psychiatric conditions are episodic. There is an argument that all disabilities are also, to some extent, episodic. When we look at the issues of permanency, they have to be moderated by the understanding of episodic conditions, how extreme or not those episodes could be and whether as an agency we are responsive to those fluctuating needs. That would be amongst the work we need to do into the future to determine how flexible plans can be—not just for people with psychosocial disabilities arising from mental illness, but also for a range of disabilities. I think the work you are doing here has applicability in a broader sense, as well.

If I could move onto a separate issue, some of the target population for this NDIS support—those who have psychosocial disabilities—are people who are not connected to state or territory disability services and are frequently isolated and disconnected from their communities and a range of supports other than, or even, clinical. Some people have some clinical supports and others are totally isolated from most supports. I commend the agency in doing a trial of a specialist liaison person in WA whose activities are to seek out people who are in various types of non-supportive accommodation or inadequate service provision in their accommodation. If we look at people in housing situations, such as community housing and various governmental housing policies, and even below that you have formal and informal boarding houses, congregate care situations that are in many institutions, and so on, the people who are utilising those types of accommodation are generally people who may

well be totally unsupported in their disability related to their mental health condition. These people will not come forward of their own volition. They will not necessarily be able to come forward without adequate support and information. I think that is where it comes up, that many plans for people with psychosocial disabilities, if they fall into this terribly needy group of individuals, will not be implemented without specialised support to help the person to not only activate their plan, but maintain their plan and motivation to get supports. These things are really critical for ongoing success.

I will take it to another point now: the issue about who is eligible for an NDIS plan if they have a psychosocial disability. I am not going to answer all of the questions that arise from that, but I will put forward a thought that we need to need to move away from diagnostic being the primary definer in this area. We very much need to emphasise the functionality of the applicant. We very much need to understand that most mental illnesses come and go. Some leave behind terrible life consequences and inadequacies. With the right supports, quite a lot of people are able to move into a productive, contributing life. I am lucky; I am one of those people. As you have heard, I live with schizophrenia and that is still active in my life, but it does not control my life. I control my life. However, the reliance on diagnostic criteria and symptoms alone should not gain you access to NDIS. In that case, I should be receiving it, and I do not think I should—except that I am too old, but we will not tell you that. The idea that someone with schizophrenia is out there functioning—I could name you dozens who are out there doing that, yet that is regarded as the big, heavy duty diagnosis that you are mad and you are gone. That is terrible language, but anyway—when we are talking about these things, we really need to understand functionality. I have regained my functionality and, only very occasionally, when I have an episode do I lose of it. But I never lose it all, thank God. So are we enabling people to just rely on a diagnosis that is inadequate in the first place? Their symptoms are horrendous. All of our symptoms are horrendous—it is just awful—but we learn to deal with them and we get on with our lives.

Having a particular condition does not necessarily predicate eligibility, and I want to ram that down everybody's throat because I think it is a terrible mistake to just rely on anything other than a person's ability to function in the world and in the community of their choice. That to me is pivotal. When people do gain plans, I think an essential thing that we might need to work on into the future—we have suggested it—is to build support and maintain motivation to continue with people's plans. I think I should give you a break now and let you ask your questions.

CHAIR: I will lead off then. What you have just been talking about has really been at the nub of a lot of the discussion that we have had with various individuals and organisations in the course of this inquiry. It seems a common response from the mental health sector that there is potentially a conflict with the way in which we are addressing this under the NDIS versus what has developed as best practice in the mental health sector. The question is: given that there could possibly be some revision of the legislation itself in the future, but for the time being this is the legislation that we have got, do you see a way in which—working with the definitions that exist at the present time, particularly the core one about permanent impairment—this approach can be implemented from the functionality point of view, or are we always going to be reverting to the diagnosis of the symptoms? I suppose what we are looking at, given the existence of where we are at the moment, is if we are to accept what we have been told by you and by others—that this is the best practice approach in mental health and it is developed over a period of time—can that be implemented within the framework that we are working with?

Dr Naughtin: We have certainly spent a lot of time deliberating on this issue. One of the judgements that we have come to is we see a lot of commonality between the principles of recovery and recovery-orientated practice, as is understood within Australia, and, essentially, the insurance principles of the NDIS. We understand that both are committed to trying to build social and economic participation, and, ideally, independence. The choice is a really important component of that. From our perspective, we consider that the legislation itself correctly defines this notion of permanency, but recognises episodic. I think the legislation in itself is very farsighted in its understanding of that.

The practical issue we have at this point is how we understand that. From our perspective, one of the key things—for example, in terms of service planning—is to ensure that there are appropriate provisions for advanced directives so that when someone makes their plan and it is approved, they can do so providing for sufficient advanced directives—this clear direction about who they wish to act on their behalf and what may need to be done. The second question, and that would be a practical implementation, is the speed of response. One of the charters of the council is to look at national consistency. Certainly in our observations and feedback, what we are seeing in some areas of the scheme are very quick responses in the trial period when there has been an escalation of need—and so that notion of scaling up and scaling down to respond to what may be a period, rather than understanding that it is a lifelong scale of need. I think there is clearly a need to consider further how we set

guidelines about the way we are about to respond. Timelines for review can take three to 12 months, and so one of the questions for this population group is how the scheme is able, as it rolls out to full scale, to be sufficiently responsive. What we know is that if we are not able to respond quickly, we are likely to see a greater level of impact on functional impairment, and greater costs to the scheme. For us it is a problematic issue in terms of there being no simple, clear answer—there are still some important building blocks. We note, and we are very pleased about, the development that has come from the NDIA and the Department of Health with strong encouragement from the mental health reference group—the NDIS mental health reference group which is undertaking a review of assessment of functional impairment across 300 individuals who are involved in day-to-day living and the PIR program. It is an important piece of research in also trying to quantify how we do understand functional impairment, and this question of how we can link this understanding of functional needs with this notion of variation in support requirements.

CHAIR: One of the most common problems, if I can call it that, that has been raised with us, not just in relation to this issue but more broadly, is the planning process and the lack of face-to-face involvement in that. It would seem to me that it is very difficult to measure functionality unless you do have that face-to-face contact in the planning process.

Dr Naughtin: Those of us who have worked in the field for a number of years would clearly support that sort of view. I think particularly with people with psychosocial disabilities, it is not just the access and planning process, it is also the preparation for that—that is the need for that 12-month period beforehand. The scheme clearly has a strong focus on client choice and control. For many people with psychosocial disability, their contact with the health system, particularly, has been about one of compliance—you need to take your medication. So, there is this notion of how you open up the opportunities that the NDIA is presenting, and how you help people to make the most of that. It is also important, because what we, in our deliberations, are saying is that the planning process should be challenging, encouraging and supporting people to take up new opportunities for social participation, better management of their own mental health, and the last circumstance—education and employment. They are central. From our judgements individually, and our deliberations as a council, we are saying that does take more time—not just for face-to-face. It probably is a process. If you are going to get effective use out of the plans that people approve, there is a need to put greater emphasis on the pre-planning and planning stage. We recognise the enormous pressures the agency is under in meeting the bilateral targets, but our view would be that better value for money will be achieved by better investment in preparation and planning, and—particularly for the people with psychosocial disabilities—the importance of review, because there is a greater fluctuation in people's life circumstances.

CHAIR: Did you want to add something Ms Meagher?

Ms Meagher: I wanted to go back to your original question, where you were asking about whether the legislation needs revising. I would suggest, as did Gerry, that while it is probably not urgent, work needs to be done down the track. I think that initially, and one of our recommendation is, the agency should develop stronger working definitions, particularly around functionality versus symptoms and diagnosis, and that it be able to develop the elements that will constitute eligibility out of those definitions. In particular, something that does occur is that there is no acceptable definition of psychosocial disability. There is a current definition that is being used, but it is not one that is formally accepted; so that would be something I would recommend we do that would be fairly significant.

Mr WALLACE: I have a series of questions. Ms Meagher, you said that all psychiatric conditions are episodic, and you said—and if I have written this down incorrectly, I am sure that you will correct me—that all disabilities are episodic, to some extent. One of the many difficulties with the NDIS is that, as compared with people suffering from psychosocial disabilities, if you have a leg amputated then you are never going to grow that leg back. I am keen to know what you mean by saying that all disabilities are episodic. Some are not, are they?

Ms Meagher: Some are, but not to the same degree as in, say, our example here today—psychosocial disability. Professor Galbally, you live with a disability; what would you say?

Prof. Galbally: To elaborate, if you take a developmental approach to disability, which the NDIS is premised on, then you learn things. Without a leg, whether you are in a wheelchair or not, you learn things, then you put them into practice and then you can retreat from needing support because you are putting that into practice. Then something else can happen, and you need things again. It is not a linear 'here's your package and that's it,' type of thing; otherwise we lose the point of the NDIS, which is for people to develop into more independent, or as independent as possible, individuals and into the community with the stop-start. For things like epilepsy, obviously, that is episodic and there are episodic conditions, but for every disability one would hope it is a developmental thing—so more here, less here.

Also, I guess, there is throwing in the notion of the NDIS being about stretching people, which can be quite uncomfortable. It is about stretching people to do more and to be out there more, so that is the nub of the reform; that it is not a holding place where you are here, where you are going to be held for the rest of your life. It is more the risk and the stretching. In mental health that is particularly the case, but it would be so in every condition. I cannot think of one where it would not be, from my experience. Otherwise you sort of give up hope of their being a developmental life.

Mr WALLACE: Yes, I understand. You also said that for very needy people, many people will not get the proper care via their plans. Why do you think that is?

Ms Meagher: I do not think they will ever get the plans. Unless we make some concerted effort to put in specialised people or retrain our LACs, these people will be invisible to the agency. That is because, frequently when you are in service provision or consumer movement, you know these people are out there and you know how to find them. But, when you are in an agency, you do not know where to find them. In the community that is involved with people who are vulnerable due to mental health conditions, a lot of us know where to find them. That was the nature of us developing the Partners in Recovery program, because we knew where these people were likely to be and who they were likely to be. That program was built to address some of the needs of those particular groups. But there are still people out there who are in various forms of congregate housing, primarily, and community housing, secondarily. They will miss out if we do not put in a concerted effort and have specialised people involved to, firstly, cultivate their interest and, secondly, maintain that interest in order for them to get supports to have a better life—an ordinary life, not a life of deprivation.

Prof. Galbally: At the council, Janet is often referred to people under bridges and in rooming houses and boarding houses.

Dr Naughtin: One of the terrific examples of this is that the agency led a project in Western Australia called the NDIS psychiatric hostels project. About 100 people were deemed to be eligible for the scheme in Western Australia. There was a low level of take-up, so what the agency did was engage one of their staff as a project person who went into those hostels and called boarding houses in many other cities. They basically built a trusting relationship with those individuals, informed them about the scheme and helped them to understand how they could apply for that. I think the outcomes of that are very positive, but it is, again, an example of how expecting that group to actually be applying through the standard processes would mean that that is not the case. That reflects a very strong tradition within psychosocial disabilities of the need for assertive outreach, which has been—Janet would know better than I—a principle of practice for 30 years that the government has historically funded in this country. That principle really needs to be translated through into the scheme.

Mr WALLACE: This is to you, again, Ms Meagher—I am not picking on you—

Ms Meagher: I am used to people—

Mr WALLACE: You have talked, as have many people who have given evidence before the committee, about the need to move away from diagnosis to functionality. I suppose one of the concerns I have with that is: is the NDIS going to be agile enough to be able to deal with people's ups and downs and needs and wants at different times of their life? Do you have a comment on that?

Ms Meagher: I do. I believe that the NDIS has the capacity to be agile enough.

Mr WALLACE: That is refreshing.

Ms Meagher: There is a little bit of work that we really do need to enhance, but, I believe, for instance, that if I was one of the people eligible, a plan for me would include everyday supports to participate in the community, plus an add-on, like an advanced directive would be in health, only it would be part of my plan that would be able to be implemented by certain given triggers. For example, if I was to have some sort of crisis in my condition, I would probably go to hospital, if I was lucky, and maybe come out of hospital less capable than the period when I made my plan. When I am returned home, I often want to isolate myself. I would probably not go shopping, not wash and not do the usual social and expected things. At that point, I might need somebody who can come and help me get out of my comfort zone of: 'I'm sick. I can't do this. I'm sick. I can't, I can't, I can't.' Somebody needs to be able to be activated to support me to move faster back into my usual life. What we would need to work on is: how do we build in that little trigger part of the plan?

Senator SIEWERT: I have a number of questions. I want to go—since we were just there—to the issues around diagnosis versus functionality. What work has been done on a validated assessment tool for psychosocial disability? It seems to me that that is the sort of approach that we need to formalise a bit more.

Dr Naughtin: We have certainly had discussions with some of the specialists in this space in relation to WHODAS 2.0 and trying to understand what the applicability of WHODAS 2.0 has been for people with

psychosocial disability. We have in Australia some of the leading researchers in this space. The agency, as you know, is relying on WHODAS 2.0. We understand that there is a view from the academics that it is not sufficiently robust.

One of the difficulties that I think the scheme has is that, in other areas—such as spinal cord injury, for example—there clearly has been developed a set of practice guidelines, and so there is a clear set of practices that are evidence based and have some consensus amongst practitioners about what is appropriate. One of the issues in this is, as we have argued in our submission, that we believe there is a need to do further work on evidence-based and standardised instrumentation. We would suggest that that needs to be a technical instrument but also has to be formed by expert panels, experts being both professionally qualified people and then, secondly, people with lived experience contributing to that.

Our vision, I suppose, and our hope in this is that, over the next few years, we can develop such a set of guidelines. We have certainly been encouraging a range of parties across the country. We have had extensive discussions with the agency with regard to this, particularly with Eddie Bartnik and the mental health team. I think there is a great awareness of this. From our perspective, we would say—and we say it to you in our submission—that further, more focused work needs to occur to actually achieve the set of guidelines, rather than just an instrument, and that should be a priority over the next three to four years for the scheme.

Senator SIEWERT: The issue with that, of course, is that we are in the process of transitioning to full rollout, and three or four years down the track may be a bit late.

Dr Naughtin: We absolutely understand that dilemma and, in our own advocacy to the agency, have been quite forceful about that question. The practical reality of where we are at this point in time is that instrumentation does not exist internationally or in Australia at this point. What we see the agency doing is indeed using the best of breed of the current functional impairment methodologies that are available and trying to synthesise those with the other form of information and data collecting to come up with a balanced judgement that deals with the questions of equity, connecting to functional impairment and individual choice. Our observations—and certainly this is an area where we have grilled the agency staff very strongly—are that they are trying to utilise and implement what is known best practice.

The point we have been making in our advice to board and to the agency—and we would put to you—is that the technology that we would all desire in this is simply not available at this juncture. We therefore need to use what we have as best we can at this point, and we need to look at it being used in a more standardised way across the agency. We certainly make the point to you, in our submission, that there is a need to build the psychosocial disability expertise within the agency—in the access team, in LACs and in planning review processes. We have made recommendations around that that are being implemented. It is not just about instrumentation; it is also about knowledge base and capacity to deliver.

Senator SIEWERT: I want to go to the issue of permanency and recovery. I do not know if you have seen the approaches that Mental Health Australia. They recommend changes to the legislation, which will take time, and suggest changes to the rules to better accommodate psychosocial disability. Have you had a chance to look at those?

Dr Naughtin: I certainly have, yes.

Senator SIEWERT: I am probably going dangerously close to asking for an opinion, but do you think that staged approach might be a good way to go—addressing the rules now and perhaps the legislative change a bit further down the track?

Dr Naughtin: I have to start my comments by saying that this is not a matter that the IAC has considered, so any comments that we might make are not considered comments from the IAC simply because the IAC has not met since the more recent position from Mental Health Australia has come out. I can make some personal comments, but I do not think I can represent an IAC position in regard to this matter.

Senator SIEWERT: I understand that totally. Perhaps, to be fair, I should ask you to take it notice.

Dr Naughtin: We would be happy to do that.

Senator SIEWERT: That would be appreciated.

Ms Meagher: Could I make a comment?

CHAIR: Yes, Ms Meagher.

Ms Meagher: This will be personal. I think there has been a long-running argument coming from the mental health sector about the NDIS running counter to the principles of recovery, which are dominant in the mental health discourse in Australia at the moment. I put myself forward as one of the people who promoted, from the

very beginning, the concept of recovery, from way back in the early nineties. I put to you that a distorted concept has come through that now means something different to what it meant when we introduced it—and which is still owned by the consumer movement, the Lived Experience Movement: the right to maintain hope. That is our concept of recovery. Anyone that purports personally to follow a recovery strategy or ideology in their lives will acknowledge that it is not, and cannot be, a model. It is a mindset whereby I will do everything possible to maintain hope that I will have a fulfilling and contributing life. Therefore, in the context of the NDIS, I see the elements of the insurance model actually promoting my right to maintain hope, my activities to maintain my hope and my future in the community of my choice. Ideologically, I cannot see how recovery is aligned to permanency. I will always live with my illness. I do not think at this stage it is going to go away. However, I have hope and, through that hope, I am able to maintain a relatively productive and contributing life, and a lot of my peers do similarly. This is not an official view of the IAC, but it is a very personal and strong view held by me, a leader in the mental health community, that permanency has very little to do with recovery; it has everything to do with hope. Thank you.

Senator SIEWERT: Ms Meagher, I am trying to work out a way to frame this properly. The council has taken this question on notice, but, if you have any additional feedback, that would be appreciated as well.

Ms Meagher: Thank you.

CHAIR: Have you any further questions, Senator Siewert?

Senator SIEWERT: My questions on planning and outreach have been addressed.

CHAIR: Thank you. I just have one final question, and it comes back to this issue of the groups of people that are out there and potentially are not going to be identified and therefore given the opportunity to utilise the NDIS. It seems to me that there is a fundamental tension in the NDIS, and that is that the approach that we are seeking to empower the individual ultimately has some limitations to it if the individual is not in a position even to be aware, let alone to be empowered. I know this is a broad question, but how do we balance those things? Is there a need for some more of what I might regard as communal aspects of the way in which we approach this in certain areas? It is not just in relation to, say, mental health and these conditions. We are running a concurrent inquiry at the moment into hearing, in which some of these same broad issues are at stake. I am not sure whether the council has turned its attention to this, but it seems to me that this is one of the tensions in the new arrangements that somehow or another we have to work through.

Dr Naughtin: I think your point is a critical point. We have certainly discussed this in council deliberations, particularly in relation to this question of: how do we engage with participants across the scheme? Professor Galbally mentioned before this notion of: how do we stretch people? I think there is tension between what might be how we help people to take hope and active agency in their lives in relation to that, as opposed to, I suppose, the requirements of fitting into the eligibility criteria of the scheme and how they need to present themselves both to be seen to be eligible and to maximise the resources that they are able to obtain through that process.

I think we have identified in that some inherent tensions, as you have said. Certainly, for us, good information—we have certainly been arguing for a number of years for the need to empower community groups, particularly disability groups, to work within their own communities to inform, to engage and to empower so that people understand the purpose of the scheme—as opposed to the tension—so people learn how to use the scheme to get maximum government resources to assist them in their lives. This, I think, has been a strong theme for us. I think we have been disappointed that, between what we call the supply and demand parts of the equation, we have not put enough investment in that process of using disability networks, using people within those networks themselves, to be having these conversations. We would certainly have a view that not just the agency but government more broadly needs to consider, in its strategies going forward, what we call social capital—I think that is the term—within the disability community. I am not sure, Rhonda, whether you want to comment even more in relation to that.

Prof. Galbally: Thank you. I think it is a really important point. We have discussed it at length, and there are other pieces of advice that we could make available that are not specific to mental health but are around that topic of communal response and responsibility—not in the old models of the holding, where that is where you stay for the rest of your life without a developmental focus, but in the lively, dynamic peer support networks. Even when you think about the topic of outreach to people who may not be participants unless there is outreach, one pre-NDIS solution would be to assess whether there are peer support groups reaching out. If there are not, could they be established on the smell of an oily rag? Those groups are great value for money.

CHAIR: Any further advice that you have for us about that, I think, would be appreciated, because it is not an issue that pertains only to this particular subject; it really is an issue that crosses, I think, the whole future operation and effectiveness of the NDIS.

Prof. Galbally: Absolutely.

CHAIR: So I suspect we will be all ears for any practical advice in that regard. I thank Professor Galbally, Ms Meagher and Dr Naughtin for coming along this morning and for the discussion. It has been most useful and informative and, hopefully, will help us in our deliberations to make some proposals or recommendations in relation to the ongoing rollout of the NDIS. So thank you very much.

Prof. Galbally: Thank you.

COLE, Ms Natasha, First Assistant Secretary, Health Services Division, Department of Health

DAWES, Ms Anne-Louise, Branch Manager, Program Transition Branch, Department of Social Services

LLEWELLYN, Ms Joanne, Director, Carer and Mental Health Transition, Department of Social Services

MILLGATE, Dr Anthony, Assistant Secretary, Mental Health Services Branch, Health Services Division, Department of Health

RILEY, Mr John, Acting Group Manager, National Disability Insurance Scheme Market Reform Group, Department of Social Services

[11:48]

CHAIR: I welcome representatives of the Department of Health and the Department of Social Services. Would any of you like to make some opening comments?

Mr Riley: Thank you for the opportunity to address the Joint Standing Committee on the NDIS inquiry on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. The Department of Social Services has monitored the submissions to the inquiry with the NDIA and the Department of Health. We acknowledge the issues consistently raised within the context of this inquiry. For the most part, it is DSS's view that these are transitional issues we can learn from and continue to address up to full scheme and beyond. As the minister has publicly stated, none of these challenges is necessarily unexpected, and none of them is insurmountable. Rolling out the NDIS remains a key priority for government and for people with disabilities, their carers and their families.

DSS would like to begin by reiterating some of the key issues raised in the DSS submission to the inquiry. Firstly, there is now broad stakeholder support for inclusion of psychosocial disability within the NDIS, with feedback suggesting participants are receiving better and more effective support and assistance under the NDIS than was available previously. The NDIS is not a capped system. People with significant and permanent psychosocial conditions who meet the eligibility criteria will be able to participate in the same way as people with other significant and permanent disabilities. To date the number of people with psychosocial disability in the NDIS is broadly consistent with projections by the Productivity Commission. There are now nearly 5,000 people with psychosocial disability in the scheme, and the success rate of 81 per cent of people with a primary psychosocial disability being accepted into the scheme as reported by the NDIA in December 2016 is a very positive trend indicator.

For our part, many of our personal helpers and mentors and providers who began services in the NDIS trial are reporting a 95 to 100 per cent success rate for clients becoming NDIS participants. DSS's own reporting for the first half of 2016-17 is showing a similarly positive trend, noting it is early in the phasing schedule, with Commonwealth clients only just starting to phase in at that time. In more detail, 256 PHaMs participants requested access to the NDIS, 166 of those participants were deemed eligible, or 65 per cent, and 35 did not meet the access criteria. You will note that they do not tally to 256—that is due to access requests that are still in train at the point at which that data was compiled.

While we continue to expect most existing clients of Commonwealth community-based mental health programs to become NDIS participants, those ineligible for NDIS will receive continuity of support. As the committee would be aware, all governments through the Council of Australian Governments committed to providing continuity of support for existing clients who are not deemed eligible for the NDIS. For the Commonwealth, this means, where existing program funding is rolling into the NDIS, program clients who are not eligible will continue to receive supports. During NDIS transition this is being achieved through existing program structures and funding and services to June 2019. In DSS's case, we have left money with the providers for this purpose. Longer term continuity of support arrangements is being developed. It is also important for decisions about continuity of support arrangements beyond the transition to be well informed by transition outcomes, including information on the number of existing clients deemed ineligible for the NDIS and findings from key reviews and inquiries such as this inquiry and the Productivity Commission review of scheme costs.

While a huge investment and on track, the NDIS is not meant to support all people with mental illness who may need some form of community-based mental health support. Outside the NDIS it is DSS's view that community-based mental health services remain primarily a state and territory government responsibility. Issues being highlighted publicly on shortfalls in community-based mental health services are not the result of the NDIS—rather, they reflect longstanding mental health service gaps in mainstream systems.

The Commonwealth will continue working with states and territories on community mental health services being maintained outside the NDIS through a number of important avenues. There is work happening to build stronger interfaces with the existing mental health system, both through the 5th National Mental Health Plan and the National Disability Strategy 2010-2020. In September 2016 all governments agreed to reinvigorate efforts to drive progress under the National Disability Strategy. In March this year the Disability Reform Council agreed to mental health as an additional area of focus, along with the criminal justice system and the broader health system. By focusing on these areas the council will seek to ensure these systems are effectively supporting all people with disability in Australia. It is important for governments to monitor the impact of mental health reforms and implementation of the NDIS to identify and respond to issues that may emerge.

In the recent budget the Australian government announced a new \$80 million National Psychosocial Supports Program over four years to target services for people with mental illness who are not eligible for the NDIS, through the Department of Health. This funding, to be administered by our colleagues, is contingent on a commitment from states and territories to contribute to a national approach to maintaining community mental health services outside the NDIS. It is anticipated longer term continuity of support arrangements post full scheme implementation will build on this new program. States and territories will also have continuity of support obligations. There may be merit in joined-up services, but these negotiations still need to occur.

I would like to conclude this opening statement with a quick mention of how providers are transitioning to the NDIS. While some providers are facing challenges in moving from block funding to a fee-for-service, competitive NDIS environment, many view the transition as a business opportunity and are reporting positive outcomes. Providers are diversifying their businesses to deliver a broader range of services than ever before and changing their business names to be more in touch with the NDIS focus on individual choice and control. Aboriginal-controlled organisations are moving in to replace organisations that have made a business decision to not continue in more remote areas, and other providers are branching out to deliver NDIS-linked support such as information linkages and capacity building and local area coordination services. Some examples of business rebranding include One Door Mental Health, formerly the Schizophrenia Fellowship of New South Wales, Flourish Australia, formerly RichmondPRA, and LiveBetter community services from CareWest. CareWest also merged with seven similar services and now spans much of regional New South Wales and Central Queensland.

By December 2016 over 70 per cent of Commonwealth-funded providers are registered to deliver NDIS supports. Recent initiatives announced in the federal budget will also support provider transition. In particular the government announced an investment of \$33 million over three years to help service providers in the disability and aged-care sectors grow their workforce. A major focus of the package is to boost local job opportunities in care work, particularly in rural, regional and outer suburban areas.

Finally, it is important we all learn from transition experiences and continue to improve and adapt NDIS processes and outcomes for participants and providers. The NDIA issued a public statement on 6 June 2017, noting:

Detailed work is currently underway to incorporate participants' and providers' insights to ensure the NDIA delivers a high quality, outcomes focussed participant and provider experience that is simple, clear and accessible ...

Thank you.

CHAIR: Thanks, Mr Riley. Does Health wish to make an opening statement?

Ms Cole: No.

CHAIR: Good. Thank you. Mr Wallace has some questions.

Mr WALLACE: Mr Riley, I have had the opportunity to sit here and listen to and read submissions from many different groups, and the majority of people who have given evidence to the inquiry usually preface their evidence by saying that the NDIS is effectively the best thing since sliced bread but then go on to talk about the many challenges that they are encountering. I have a few concerns that I want to raise with you, and I am hoping you can help me. The first one is in relation to service providers in regional Australia.

Currently block funding is provided to service providers in the regions. When the NDIS is fully rolled out people will be given freedom of choice as to who they deal with. A scenario of concern that has been raised with us is where a big player—for want of a better term—moves into a regional area, gobbles up the market, realises there is not the money to be made that it thought there might be and then exits the market, leaving no smaller players left to provide those services. As a regional member of the House of Representatives I am very concerned about that. Is that something that you are seeing in practical reality, and, if so, what are you doing about it?

Mr Riley: I will begin with a little bit more of a general response to that before I get to more specific things. The general response would be that in our engagement with the sector, which the Department of Health, the

NDIA and DSS have done a lot of together, as well as in some things we have done as individual organisations, what we have seen is, I think it is fair to say, some trepidation around the rollout of the NDIS and the move to a market-based environment. That is not exclusive to regional providers, but it does come up. 'What if none of my clients are eligible? What if a bigger player comes in and takes all of my business?' That has not been the experience to date. That is not to say the issue is not an important consideration, but it has not been the experience to date. In fact, what we see, for the most part, particularly under the first-plan arrangements, is that people stay with their existing provider. We expect, in a market based environment like the NDIS, that that may change over time. What we have done is provide a range of support to organisations to prepare them best for that environment. That has included, in this space, both the funding of the NDIS readiness tool kit through the National Disability Services and, in multiple forums, urging our organisations to go and do that—to understand where they need to change their effort, whether that is in the areas of governance, community engagement, individualised billing or other areas of their business.

Ms Cole or Dr Millgate might like to expand on this, but I will describe in more detail what we have done. The Department of Health has a transition support project that is managed both hands-on by the Department of Health and also through Flinders University that works with their providers to prepare them to operate in this environment—and that is for providers in all sorts of different markets. In addition to the funding of the tool kit, DSS provided our organisations with \$15,000 to go and seek professional advice around NDIS readiness. We strongly encouraged them to go through the tool kit and assessment process first, and so forth.

In thin markets, it is envisaged that the quality and safeguards regulator will have a role in identifying where there are practices of concern. There could be greater levels of concentration of a provider, which I think is one of the things you have referred to. In those circumstances, it is likely that the regulator would be making recommendations to the NDIA around how it would go about its business of supporting a diversity of providers in an area. That is what will happen into the future. To date, we have not seen those problems manifest. Where we have had organisations decline to phase into the NDIS—that is probably not the right term, but you understand what I mean—we have sought alternative providers. We have not had great trouble in obtaining alternative providers. We do a lot of work through our delivery network in the states and territories to do that. To date, that has been our experience.

Mr WALLACE: One of the significant issues that we are hearing about and reading about is in relation to the plans. In a past life I was a builder, and I know that if you start with a dodgy plan you are going to end up with a dodgy building. One of the concerns that we are hearing, particularly in the psychosocial disability space, is that people are being called on the telephone and plans are being done over the phone, often with no warning and often with no support structures put around them. In some cases, people are saying that they were not even aware that the phone call they had was for a plan at all. Would you like to comment about that.

Mr Riley: Only to say that I understand our NDIA colleagues are following us in this hearing, and that would be an operational matter on which they would be best placed to comment. But, yes, we are aware of concerns that have been raised, particularly around people with psychosocial disability in the scheme, and the NDIA has taken some steps to improve the process.

Mr WALLACE: Can you advise the committee of the role of DSS. Is it as a form of oversight over the NDIA? How does that work?

Mr Riley: We are the policy agency responsible for the NDIS. We are responsible for taking the legislation through, supporting its passage through the parliament and so forth. We are working intensely with our own providers, so we have that role to prepare them for the NDIS. We also have a critical role in terms of engagement with the sector and the community around mental illness issues. DSS has an abiding interest in mental health, and of course our colleagues at the Department of Health do as well. We are part of tripartite governance arrangements in each jurisdiction to work through the bilateral arrangements.

Mr WALLACE: So you have got significant skin in the game?

Mr Riley: Yes.

Mr WALLACE: What are we doing about the complaints being made to the committee about the lack of qualifications and experience of planners?

Mr Riley: To my knowledge, those concerns have not been raised directly with DSS, but where those issues are raised by us the usual practice is that we will raise—

Mr WALLACE: Sorry, wasn't that talked about in the Productivity Commission report that was just released?

Mr Riley: I have not gone through the report in detail at this stage. That specific issue has not, until now, been raised with DSS to my knowledge. In any event, if concerns were raised round the planning process, as they have

been broadly, we would as a matter of course talk to the agency around the concerns. If it is a specific matter for which there is a concern—it might be that something has been left out of a plan despite the provision of data that would indicate that the person was already in receipt of those services—we would raise that with their national office and then the NDIA would raise it with the relevant regional area to see if the issue can be worked through.

Mr WALLACE: I think it would be fair to say that it is a fairly common complaint that the committee has heard about. There are inconsistencies in the plans that have been drafted. Some people get more than what they themselves think that they would be entitled to and others get very little. There seems to be no rhyme or reason to some of these plans that are being prepared. When you look at it from our perspective, what concerns me at least—and I will not talk for any other committee members—is that, as the scheme is being rolled out across the country, there is an intensity in the numbers of plans that are being written. We are working towards these time lines and, as identified by the Productivity Commission, what concerns me is whether these plans are being done properly in the first place. The Productivity Commission spoke about that there are many applications for reviews being made. That tends to suggest that there are many people who are thinking that they do not have the appropriate plans.

Mr Riley: I think I understand your concern a little bit more now. In DSS's case and in relation to all of the transitioning mental health programs across the two agencies, what we do in the first instance is work with the agency around the timing of their section 55 data request. When that is going to the providers, we will then put out a communication through our delivery network around providing that data, because what that says is that person X is a current Personal Helpers and Mentors service, a Partners in Recovery or a Day to Day Living client of this service. Then two things happen. Once the data is received and the rollout schedule is going ahead and there is a phasing arrangement for the clients, what happens is the person is contacted by the agency in relation to their access request. From when they go ahead with their access request, they go through into a planning discussion. The planning discussion is meant to call on the current services they are in receipt of, so that data from our providers is absolutely critical to that and to ensuring that the full gamut of existing services is included in the plan.

In the event that a person's plan is out of the ordinary, the agency has processes in place. We have a range of plan values for people with psychosocial disability. If the plan is outside of those parameters, then there is a flag in the system. The NDIA will be aware of that before the plan is finalised, and then they go back to it. That is on the financial values of the plans, but it is not necessarily about the content of those because they tend to be, as you would expect, individual to the participant. Where a participant seeks a review of the plan, the NDIA has a process in place for that to occur. It occurs in two types of circumstances. The first, which you are alluding to, is when there seems to be a gap in the plan or a failure in the process, and the other one is usually around the annual review where it is about the individual and their circumstances may have changed. That could lead again to a change in the parameters of the plan.

Mr WALLACE: An issue that people have raised in this committee is the changeover time between when their current plan expires and their review. Some people seem to be complaining that they are falling between the gaps. One thing that I would like to get a clear answer from you on—in non-public service speak, if possible—is: what are we doing about people being phoned for their plans? Is that something that DSS says is okay, or is that something that DSS says is not okay?

Mr Riley: DSS leaves that matter with the agency to decide how best placed they are to respond to the local circumstances.

Ms Llewellyn: And a client can request a face-to-face interview.

Mr WALLACE: Senator Siewert, I will let you go, and, if we have got time, I will come in after you.

Senator SIEWERT: I wanted to go back to the continuity of support with DSS. Can I go back to the issue of responsibility for community mental health. Is it not the case that the department does have responsibility for community mental health under the administrative arrangements order?

Mr Riley: That is correct. It is in the arrangements for DSS.

Senator SIEWERT: It is not the first time I have heard the department say the states and territories are largely responsible for community mental health. Can you expand on that a little bit more, when the administrative orders, as you have just articulated, clearly mean that you do have responsibility?

Mr Riley: We have lead responsibility within the Australian government. Historically, what has happened is the states have been the main provider of community mental health services.

Senator SIEWERT: Surely that is different to the actual responsibilities that you have?

Mr Riley: They are different from the responsibilities that we have, but the administrative arrangements orders only relate to the Australian government.

Senator SIEWERT: And that is what we are talking about now—your responsibilities as part of the Australian government.

Mr Riley: You are asking me about continuity of support?

Senator SIEWERT: Directly as it relates to this particular issue.

Mr Riley: We have an all-governments commitment around continuity of support. The Australian government's commitment is the same. The government will support clients deemed ineligible for the NDIS who are a current service client to achieve equivalent outcomes.

Senator SIEWERT: Can I go back to the issue of being deemed ineligible for support. I understand the guidelines came out in May, where you really focused on being deemed ineligible. The issue we have here with psychosocial disabilities—we have discussed this before—is that many people are not coming forward to test their eligibility, for a variety of reasons. I have asked both DSS and Health before how many people have already come forward. As I recollect, you have taken on notice the percentage of people, but we are certainly getting evidence from service providers to say that a number of their clients are reluctant to come forward, for a variety of reasons. Some of those are that, at the moment, they are well. What do you intend to do for these people that are not coming forward, that are not testing it?

Mr Riley: We are putting a considerable amount of effort into I guess what you would call hard-to-reach or hard-to-engage participants. In accordance with the phase-in schedule, a person can change their mind about testing their eligibility. There is an example of a provider in Victoria who had some 36 clients in their PhaMs service. Twenty-seven had gone through to the NDIS and been deemed eligible through the planning process and then into implementation. That left them with eight or nine clients whose eligibility was not known. Three of those were deemed ineligible. They would clearly trigger the continuity of support requirements. That left some six or seven clients who were almost certainly eligible, according to the service provider, and so forth. Over time, what has happened since we became aware of that is that we have been working with the provider around a plan to deal with that situation to encourage those participants to go in, and they have gradually whittled down the numbers who have not tested their eligibility, to the point where I believe there are three or four of them. But we have got work going on in four different jurisdictions, noting differences in the service system, to try to encourage people who are either hard to find or hard to engage or reluctant to engage with the NDIS to do so. In the end, if a person is likely to be eligible for the NDIS, we are putting our efforts into encouraging those people to engage with the NDIS. That is the service system for those people, and we have been working with the providers to encourage them in.

Senator SIEWERT: What you are saying is that every single person—for example, participants in PhaMs and PIR, have to test their eligibility before they can qualify for continuity of support. That is the new guideline, is it not?

Mr Riley: I would not say that that is new; that is a message that I have been personally delivering to this sector for a couple of years now—not just in relation to psychosocial disability but more broadly in relation to the NDIS.

Senator SIEWERT: When I asked, a couple of estimates ago, about continuity of support, we had a discussion about the number of people that were on the books and whether they were people that were actually accessing services or people who were not currently accessing services but were clients who had previously received services and, when they were unwell, would seek services again. We did not talk about this issue of whether or not you tested their eligibility.

Mr Riley: No, we did not. I would say to you that that is not the area of particular concern. The agency is well aware that there are people who go through periods of hospitalisation and so forth. Ms Meagher talked about that in the previous session. There are some particular challenges there about connecting people with the right support in a timely fashion. It is more about people who, because of either their circumstances or the nature of their condition, are hard to find because they are sleeping rough and so forth, or we do know about them but they are hard to engage with and do not particularly want to come forward. That is the area that we have judged as needing the most effort. There are five different projects going on nationally around that. The issue about people who, because of hospitalisation or just being unwell, are not able to go into the scheme at the time that they had intended is one that can be worked through on an individual basis.

Senator SIEWERT: That is not the point I am trying to make. What I am asking is: in order for people to access continuity of support, every single person that is currently in those services needs to apply and be knocked back for NDIS, whether or not they are obviously ineligible?

Mr Riley: Yes, that is broadly correct, but, in PHaMs at least, we are seeing upwards of 90 per cent of clients being deemed eligible.

Senator SIEWERT: Yes, but that is the people who are applying. We have been through this discussion in estimates before. We do not know how many of the people who are currently accessing supports through PHaMs and PIR—I do not want to leave health out—are applying. We have had evidence from some providers that it is certainly not all, and there is only a certain percentage of their clients who are applying, not just because they are uncontactable but for a variety of reasons.

Ms Llewellyn: You need to keep in mind that our programs under DSS are cashing out, so the funding to providers is reducing in line with the number of clients we expect to go to the NDIS. Providers need to manage within their capacity, and, as you know, our providers have always done assertive outreach. There is no reason they would not continue to do that as NDIS providers. It is a very important area, and our providers will still focus on assertive outreach to clients that are hard to engage with the NDIS.

Senator SIEWERT: Sorry, but you have not answered my question. You are expecting every single client to apply, regardless of whether they want to be part of the NDIS—some may not want to—even when they would be clearly ineligible for NDIS but obviously still in need of access to services?

Mr Riley: Yes, we do, and the service is for people that are severely affected by mental illness. The match between PHaMs eligibility and NDIS eligibility is a very strong one.

Senator SIEWERT: What about Partners in Recovery.

Dr Millgate: Partners in Recovery is very closely aligned with the NDIS eligibility criteria, other than over-65 requirements and residency. It is very closely aligned, though. We have one trial site—I guess for comparison—that we are looking at, and in excess of 90 per cent of those clients are getting in to our Partners in Recovery program.

Senator SIEWERT: I presume you mean: of those that apply?

Dr Millgate: Yes; that is correct.

Senator SIEWERT: Do you have an idea of how many clients throughout those PIR services who have not applied are applying for access?

Dr Millgate: No; I do not have an exact number. I can give you details for the ACT, which is the first full scheme, as opposed to the trial sites, which are still opening up in those regions. Partners in Recovery is being funded for the next two financial years. So we will have more time to get those clients into the scheme, and that will allow people to find those hard-to-reach people and give them more time to access the scheme. Obviously, Commonwealth clients, due to the bilateral agreements, have been some of the last ones to be entered into the scheme. At this stage we have 40 clients out of 120 for Partners in Recovery in the ACT who have entered the scheme, 40 who are still outstanding in terms of applications pending and around 40 who have yet to test the scheme. They are still in that process.

Senator SIEWERT: Did you say 120?

Dr Millgate: That is correct.

Senator SIEWERT: Out of those, we have one-third who are yet to test?

Dr Millgate: That is right. That could include people who do not want to test, but we do not have an exact number of that yet. We think that the NDIS is a good scheme and we would like our clients to get into that scheme if they are eligible. From all reports that we have had from clients who have got into the scheme so far, it has been very positive for those clients in getting more or better services than what they were getting under Partners in Recovery.

Senator SIEWERT: I am not questioning that side. My question is: what happens to those people who do not test their eligibility and then are not eligible for continuity of support?

Dr Millgate: In relation to that, we are working with the DSS on the continuity of support arrangements process. But, also, as you are probably aware and as was discussed by my deputy secretary, Mark Cormack, at Senate estimates recently, \$80 million was announced in the budget for those who do not get into the NDIS and are not eligible for the NDIS. That \$80 million over the next four years will hopefully go towards that side of the program once we work out arrangements with states and territories for that funding.

Senator SIEWERT: I am aware of the announcement you just articulated, and we did discuss that at estimates. The issue then is, if people are no longer eligible for continuity of support would they then need to go through an application process et cetera for whatever is decided for the new program? I understand the new program is still being developed.

Dr Millgate: Again, it depends on the outcomes of the programs that eventuate through the discussions with states and territories as we go forward. I cannot say with certainty there will not be an application process. I would not envisage that we would like to make it that onerous. That is not the intention at this stage.

Senator SIEWERT: Thank you. Chair, I have a series of other questions, but I also realise that we are over time. Do you want me to continue or put my other questions on notice?

CHAIR: What is your continued availability?

Senator SIEWERT: In terms of now? I can keep going for about another 15 or 20 minutes after our scheduled deadline, if that is what you are asking.

CHAIR: Senator Siewert, Mr Wallace has to leave at 1 pm. Could I suggest that, at this stage, you put your questions on notice and we move to the NDIA. Is that convenient?

Senator SIEWERT: Yes.

CHAIR: I thank both Health and Social Services for coming along for the further discussion. Mr Wallace and Senator Siewert may have some further questions. I ask them to forward their questions through the secretariat to you. Thank you for your attendance today.

BARTNIK, Mr Eddie, Expert Advisory Mental Health, National Disability Insurance Agency

GUNN, Ms Stephanie, Acting Deputy Chief Executive Officer, Participants and Planning, National Disability Insurance Agency

ROBERTS, Ms Deborah, Director, Mental Health, National Disability Insurance Agency

[12:31]

CHAIR: Welcome. Would you like to make some opening remarks?

Ms Gunn: Thank you for the opportunity to appear. The National Disability Insurance Scheme represents a transformation and an unprecedented opportunity for Australians with psychosocial disability to have choice and control over their supports. The NDIS approach is based on an individual's strengths and their goals and needs related to impairment, not a diagnosis. This means the heart of the NDIS is looking at an individual's functional capacity to firstly determine eligibility and then to put in place plans and supports to build capacity, independence and social and economic participation. There is now a growing recognition that this is very consistent with the recovery principle that underpins the psychosocial disability sector, and indeed, through the provision of individualised funding, the opportunities to pursue recovery goals that are unique to each individual is enhanced.

From the perspective of the NDIS, recovery is about achieving an optimal state of personal, social and emotional wellbeing as defined by each individual whilst living with or recovering from a mental health condition. Through the NDIS this is supported by four key principles: choice and control for participants on how they pursue their recovery goals, a commitment to individualised supports and funding to match that as and when required, a focus on increased independence and social and economic participation, and support for a partnership approach with community and treating clinicians where required.

We recognise that the change to the NDIS has generated changes, but we continue to work actively with the mental health sector and in partnership with the community and governments to get this right, and this is reflected in the acknowledgement of positive outcomes to date. We also recognise that, for people with psychosocial disability, families and carers, the NDIA is very different to the previous ways of receiving services. In particular, the choice and control of providers, of opportunities to pursue goals and to actively engage with more diverse and inclusive recovery strategies is increased. This does present some challenges, which has required shared learning and support.

Our planners work very hard to be consistent in their application of guidelines for what are reasonable and necessary supports and for plans to be always tailored to the needs of the individual. The agency and staff are committed to supporting the independence and social and economic participation of persons impacted by psychosocial disability. We have focused our efforts to ensure staff are skilled and to educate the community sector and mainstream services regarding the NDIS and psychosocial disability. We are grateful for the ongoing advice of Eddie as a strategic adviser to guide our efforts. The establishment of the national Mental Health Sector Reference Group is one example of how we engage on an ongoing basis with the sector to provide up-to-date information and provide the opportunity to discuss and resolve issues as they arise. There is always a public communicate that follows those meetings, and that includes a summary of the key data on the progress of the scheme to date. We work closely with our Commonwealth colleagues in regard to the national programs that are transitioning. We have hosted strategic round table discussions with states and territories regarding psychosocial disability and the interface with the NDIS, and we continue to collaborate with the mental health sector on a range of projects.

The data, as you have heard so far, is good. Recently released March 2017 data in the COAG quarterly report confirms that the current trend is holding and is consistent with what is expected from the scheme. The NDIS does not replace the mental health system and does not replace community based support or medical clinical care for people living with mental health conditions, but, rather, must be designed to work collaboratively with these sectors. We continue to work to do this.

We do recognise, however, there are ongoing questions about a number of facets of the NDIS and how it applies to people with psychosocial disability, and I want to quickly outline five major areas of focus that are underway to address these concerns. They are consistent with the questions that you have raised, so we certainly go into those in more detail. There is a challenge about improving a shared understanding of the access requirements. There is work underway to clarify the pathway for existing and potentially new participants, including those who are in that hard-to-reach group that we have been focusing on. We are working hard to explain the types of supports typically needed, and how these are best integrated, and the work that Dr Gerry Naughtin mentioned goes to the core of that. Importantly, we are also building our staff competencies and

understanding about the challenges and the uniqueness of psychosocial disability. Finally, we are working on the functional assessment work that, again, Dr Naughtin, mentioned.

I would like to finish by noting the concerns raised about planning, and note the participant pathway review announced last week by the NDIA. Through this review, our aim is to deliver a significantly enhanced quality of participant and provider experience in a way that is consistent with maintaining the scheme's financial sustainability. We know that many reforms will be required in the way in which we engage with individuals, and the board, management and staff of the NDIA are unequivocally committed to delivering a much better experience for our participants, based on an outcomes driven approach.

Mr WALLACE: With respect to the identification of the concerns with plans, I am pleased to hear that you acknowledge that there are concerns. Are you in a position to be able to advise the committee, at this stage, what the NDIA intend to do? What are some of the ways you are going to improve on the way the plans are prepared?

Ms Gunn: Firstly, I want to emphasise that, at this point in time, 65 per cent of all plans are developed in a face-to-face conversation, and an individual has always been given the opportunity: 'Would you like to do your planning conversation now, or would you like to book a time for a face-to-face conversation for that plan?'

Mr WALLACE: Can I just confirm—65 per cent of plans are prepared face-to-face?

Ms Gunn: That is correct. Certainly, for what we call the intensive and super intensive streams of participants—those who may need more assistance to engage and who have more complex circumstances—that percentage would be much higher. I do not have the exact split with me, but it would be much higher. Unfortunately, at this stage I am not in a position to outline the nature of the change that is currently being considered by our board. We have organised a time with the secretariat to brief you in detail about those issues.

Mr WALLACE: Good. You will have heard me ask a question earlier about concerns that have been raised with us that some people, particularly in this space, are not even aware that they have had a plan meeting over the phone. Do you want to comment on that?

Ms Gunn: It would be fair to say that that has been a common response as part of the review work that we have been undertaking. We have listened to that very seriously, and we will be addressing that concern as part of the planning review.

Mr WALLACE: From an operational perspective, I noted that in the Productivity Commission report that I read a couple of days ago there was some concern about the speed of the rollout. Are you able to make any comments on that?

Ms Gunn: That will be a decision by governments. At the moment we continue to focus on implementing the scheme as per the existing bilaterals. Our challenge, as you would expect, is to ensure that we can deliver both at a quality within the financial sustainability parameters of the scheme and within those time frames that are set for us by government.

CHAIR: What confidence do you have, then, from an operational perspective, of being able to meet those time frames?

Ms Gunn: At nearly the end of the first year we are on track for the bilateral estimates given to us by those bilateral agreements.

CHAIR: But there is a big ramp-up coming?

Ms Gunn: There is a big ramp-up. We have a ramp-up in capability, in terms of staffing and the appointment of a new range of partners to match that ramp-up of participant intake to the scheme. There are, as you would expect, many challenges, with rolling and growing and delivering that quality service at the same time. There is a big focus on our staff training, a big focus on our engagement with partners of the right culture, the right commitment, enthusiasm and capability to assist us in that delivery challenge. We are very grateful for the goodwill of providers, of participants, of the sector to assist us to deliver that goal.

Mr WALLACE: One of my concerns is that in the ramping up of the scheme are the service providers going to be able to ensure that there are enough qualified and experienced staff to fulfil their service obligations? Are you able to comment on that?

Ms Gunn: The focus on work force growth is very clearly articulated in the PC original reports as well. There is an awful lot of work underway by all governments focused on workforce and sector growth. There are a range of responsibilities at the Commonwealth and state level. The agency itself absolutely works very closely with the providers, providing advice about what it means to work within the NDIS and individualised unit price base and the facilitation of their transition. Our registration numbers are very positive at this stage—there are close to about

8,000 providers now registered with us to deliver services to participants in the scheme. That is a very positive sign.

Mr WALLACE: One issue that concerns me as a regional member of parliament is in relation to the transport allowances that are provided by the NDIA or NDIS. Some issues have been raised with us—I cannot remember the actual amount but I remember thinking to myself there would be some properties in Western Queensland where the allowance would not get you outside the farm gate, or would not get anyone far if they were going to do a home visit, for example. I think there is an allowance, it does not matter where you are in Australia, for only one hour of travel for a clinician to go out and see someone. Does that sound right?

Ms Gunn: It does vary. I do not know off the top of my head, but it does vary depending on the distance, and that is per visit. I cannot remember off the top of my head, but a recognition of travel time is certainly incorporated into the need for the delivery of that service.

Mr WALLACE: What is concerning me is that when we are talking about large distances that a clinician may have to travel, they are not going to be able to see 10 people in a day. Given the distances that they may have to travel, is there sufficient allowance provided to people who live in remote and rural Australia?

Ms Gunn: There is a real challenge in addressing the gaps that already exist in those service sectors and service opportunities for rural and remote. We are working very closely with the state governments looking at transport options—a change to transport arrangements as they transition into the scheme. There is a working group of senior officers across all state and territory governments to explore how we make it better. We also need to look at more innovative delivery of services, particularly how we might grow the capacity for localised delivery of those services. We are very keen to explore things like allied health practitioner assistants who are based in local communities and who can be supported by remote practitioners, so that we are growing the opportunity for economic development and employment within those communities as well. There are some interesting projects that we could certainly brief you on further, if that were useful.

Mr WALLACE: Is this something that is on the agency's radar—transport for rural and regional Australia?

Ms Gunn: It is part of the agreed work program for the senior officer working group.

Mr WALLACE: I do not know if that answers my question—

Ms Gunn: Sorry, the NDIA participates in that working group.

Mr WALLACE: Yes, but are the challenges that we are beginning to hear about—transport, the lack of access and the lack of money available to clinicians under the scale of fees—on the radar?

Ms Gunn: I would imagine that would be picked up as part of the independent review of pricing that we announced recently as well.

Senator SIEWERT: I want to double check: when is the participants pathway review expected to report?

Ms Gunn: It is unclear at this stage. Certainly our board will be looking at some of the first round of recommendations in July, and we will go from there.

Senator SIEWERT: So there is no fixed time line for it to report?

Ms Gunn: It has not yet been agreed, no. But, as I said, we just recently agreed via the secretariat on a date to brief the committee in detail about broader issues and the focus of the reviews to date.

CHAIR: That is 28 July, Senator Siewert.

Senator SIEWERT: I am pleased we are going to be having the update, but that does not reassure me, if there is no time line for this review.

Ms Gunn: Our objective is to make sure that with what we have identified from the review—from participants and providers—we get it right. Any change that we make will need extensive change through our systems, our processes, our training and our documentation. While there may be some quick wins in the things that we have identified, the majority of those changes will take some time to put in place, and it is important that we get those right before we jump in and try to make changes, without making sure that we have our foundations built correctly.

Senator SIEWERT: I understand where you are coming from. I would have thought you could do that by setting a timetable for when this review was going to be complete so that you could get on with the process.

Ms Gunn: Yes. The timetable will be determined by our board.

Mr WALLACE: When does the board meet next?

Ms Gunn: Mid-July.

Senator SIEWERT: Maybe I am misunderstanding. Surely you are undertaking the review first before you put in a response?

Ms Gunn: Yes. I am sorry, I had not quite understood where you were going. We have completed a number of workshops; we have had multiple participants and providers, frontline staff, involved in those workshops. I think the statement that the CEO put out identified a very large number of concepts and issues that had been raised, and we are in the process of collating and collapsing those into what might be a refined pathway, so those recommendations are evolving. We have conversed with our board representatives on a rolling basis, and they are continuing to be refined.

Senator SIEWERT: Will that process include any steps that are being taken to help people navigate the system?

Ms Gunn: Absolutely. If you look at the pathway, we recognise that that very first step of understanding and connecting to the scheme before you even start the process of access is very important—looking at how we can improve our communications and be more visible in the community prior to the scheme phasing in, as was always the intention of our LAC partners being available to explain the scheme.

Senator SIEWERT: So it will include further assisting people to navigate the scheme. Will that include people beyond the LACs doing that, or is that just enhancing the LACs?

Ms Gunn: I do not think I can say that that has been landed one way or the other. I would say, though, that that broader question about support for decision making and how we engage with peer supports, how we engage with community and trusted organisations that can work with individuals to facilitate their journey with the NDIS, is something that we have been working quite a lot on with the Independent Advisory Council and in particular through the Intellectual Disability Reference Group that works to the IAC. We are, as I say, exploring what is the range of other options we can build and think about around decision making supports.

Senator SIEWERT: Does the review involve consultations? Maybe you can explain how the mental health sector is involved in this process.

Ms Gunn: Representatives from the mental health sector have been involved in consultations with us, and we have certainly had individual participants who have identified as having psychosocial disability participate in our workshops and design processes.

Senator SIEWERT: Will there be ongoing engagement in terms of the design of the new process, or the enhancement of the old process, whatever you come up with? Will they be included as you continue to develop that?

Ms Gunn: Exactly how we will do that has not been landed. We have always tried to take very much a learn, build, refine methodology to the way we implement the scheme. We cannot do that without listening very intently. The exact focus of what we would seek and the level of detailed collaboration on a particular issue change over time, but certainly one of our core principles is that we need to make sure we do that in collaboration with our stakeholders.

Senator SIEWERT: Does that mean that you have acknowledged or you are moving away from a generalist approach that planning is the best way to go in terms of all disabilities?

Ms Gunn: One of the things we are exploring is how we make sure that, in the period of rapid growth of numbers and individuals and that whole transition challenge, we can have access to the right skills and understanding within the agency. As a national network, we focus on having national teams of experts. For example, Deb is our mental health leader. We have similarly psychosocial disability expert trained people within our technical advisory team and in our national access team who are available for staff on the ground to seek advice and guidance from. Particularly in our staff we have a very broad range of skill sets and experience. We have many people from mental health nursing backgrounds and psychology backgrounds, and I should mention that in our partners we have that same level of diversity. The benefit and strength that our partners bring is their immense connection to the local community and, in particular, their experience with some of those hard-to-reach groups that the committee was talking about earlier.

Senator SIEWERT: Thank you. You will be aware that we have had evidence that is quite critical—in fact, very critical—of planners, and the point made frequently is that they do not have that expertise. I do not know whether they have also been explaining the technical terms you have been explaining to us, but that is certainly not feedback we have been receiving in terms of the expertise of the planners.

Ms Gunn: I think that is right. As I mentioned, it is one of the five things that we are very focused on in making sure that we build the skills of our workforce further.

Mr Bartnik: In addition to the skills and capacity and resources of our own staff and also the LAC partners, we are doing another piece of work with our Commonwealth funders and their provider agencies to look at maximising the contributions of those providers and their resources and knowledge to both the access process and also the planning process. We see that enhancing this process has many layers, but also if there is really solid knowledge and information that our providers have got, we want to bring that into both the access process and the planning process, to be balanced with the participants and family and care reviews and also the information from our own staff and partners.

Senator SIEWERT: Do I presume that is going to be included as part of the participants' pathway review process?

Ms Gunn: The review has an overarching focus on how we do our work. There are many projects and improvement initiatives that underlie all of the other things that we do. That whole question about our training and our skills is a key element that we are focused on. The work that Eddie has just outlined slots into that whole focus on staff.

Senator SIEWERT: Have you done any trials looking specifically at having a dedicated mental health planning team?

Ms Gunn: We did in the very early days, when the numbers were very small and there was a relatively slow intake of participants. Certainly our Barwon trial site had a dedicated psychosocial supports team, all of whom had come from the sector, from clinical or community mental health. In most of our teams now we certainly would have people who are what we would call our subject matter experts within that site. The example that Dr Naughtin mentioned of the team working with the psychiatric hostels in WA is a really good example of how we build on and utilise those skills, and there are other similar, small examples like that across the network.

Senator SIEWERT: What was the result of the Barwon process?

Ms Gunn: The outcomes for the Barwon trial site—we referenced those and the Hunter trial site as having that zero to 65, and they are almost now all in. We are sitting at around 14 per cent of our total participants with a psychosocial disability in those trial sites. That is not to say that the providers found that journey smooth or that the participants themselves found it perfect. Everything is always subject to improvement. But it was a good example of active engagement, and we have attempted to build the core principles of that trial into the way each of our areas and regional hubs works now.

Senator SIEWERT: That is the dedicated psychosocial disability focused team?

Ms Gunn: As I said, there is a subject matter expert, and there is a national capability and a technical team. I cannot guarantee that, in every physical site that we have, there is dedicated expertise at this stage.

Senator SIEWERT: Sorry, I may have misunderstood what you said about Barwon. I was asking specifically about a dedicated mental health planning team.

Ms Gunn: Whether it was during the Barwon trial?

Senator SIEWERT: Yes.

Ms Gunn: Yes, it was, sorry. Yes.

Senator SIEWERT: That is what I was specifically asking about. I expand my question, then. Did you notice any difference between the outcomes in that trial site and how the scheme has been rolled out in other areas?

Ms Gunn: I think that might be hard to answer at this stage because the scheme was so very, very new. The understanding of how we wanted the scheme and needed the scheme to work for the psychosocial sector was very new at that time. We worked very closely with the providers during that period, and I think we got some really good outcomes. Eddie, did you want to comment on that?

Mr Bartnik: Yes, if I can. I think one of the differences between Barwon and Hunter, for example, was that Barwon did not have a Partners in Recovery program. We have had different arrangements. So the Barwon example had a bit of a vacuum because there was not a Partners in Recovery program, whereas other areas did have a PIR program, which provided a level of expertise, knowledge and coordination for people for the target group. So we just need to see the Barwon experience in the context of other locations that had other resources, and that goes back to our piece of work around how, if we have good programs on the ground now that know people, we maximise that input into our process.

Senator SIEWERT: Okay. But part of the work that you have been doing as part of that program is identifying those areas where there are good programs on the ground, and using a different approach where you identify gaps. Would that be correct?

Mr Bartnik: Well, we have been trying to understand the experience of different sites, to do with their particular characteristics, and that is why we need to be a bit careful about drawing direct comparisons. Some geographical areas, for example, have large numbers of people with quite significant disabilities; others have had those people migrate to bigger population centres. Each area is not exactly the same. So we are trying to understand best practice in a very, very broad sense, because it does need to be applied to the particular context.

Senator SIEWERT: Yes. I take your point. Thank you, Chair.

CHAIR: I thank the representatives of the NDIA for coming along today and for the discussion. We look forward, obviously, to ongoing discussions as the scheme is rolled out. Thank you very much. If there is anything you want to add, please forward it to the secretariat. I declare this public hearing closed.

Committee adjourned at 13:05