

# Submission to the Productivity Commission Issues Paper on National Disability Insurance Scheme (NDIS) Costs

National Mental Health Commission

March 2017

## Introduction

Thank you for the opportunity to comment on the Productivity Commission (PC) inquiry into National Disability Insurance Scheme (NDIS) Costs.

The purpose of the National Mental Health Commission (NMHC) is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community. The NMHC provides cross-sectoral leadership on the policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia.

The NMHC considers the NDIS to be an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability. It is a potentially very important element in addressing the long standing unmet needs of people with mental illness for effective community and disability supports. We welcome the PC's inquiry as an important step in the ongoing reform process to ensure the sustainable design and implementation of the NDIS.

The NMHC is aware of early anecdotal evidence that for many people with severe and persistent psychosocial disability, participation in the NDIS is resulting in more effective services and supports, better tailored to the diverse and specific needs of individual consumers. However, and as acknowledged by the Issues Paper, concerns have been raised regarding the interface between the NDIS and mental health services, and the implications of this reform for the mental health sector more broadly.

The principle areas of focus for this submission are:

- eligibility for individualised support for people with psychosocial disability associated with mental illness
- the scope of supports available for NDIS participants
- scheme boundaries and the interface of the NDIS with other services (including in the mainstream) for people with mental illness who are not NDIS participants
- governance and areas for overseeing the ongoing implementation and impacts of the NDIS.

## Eligibility – Psychosocial disability associated with mental illness and 'recovery'

The nature of psychosocial disability, and commonly endorsed approaches to 'recovery' in the mental health sector, can give rise to challenges in assessing eligibility for the NDIS for people with severe mental illness.

The NDIS requirement for Tier 3 participants to establish a 'permanent impairment' can appear to be somewhat at odds with the more strengths-based concept of 'recovery' used in mental health. 'Recovery' is not synonymous with the absence of illness. Rather, it means people who are living with, or have experienced, mental illness can nevertheless lead contributing and meaningful lives, in which they feel safe and secure, have connections with community and family, are engaged in social



and economic participation (whether paid or not), and are physically and mentally thriving (not just surviving).

From this perspective, recovery is not inconsistent with the philosophical underpinnings of the NDIS that aim to support people with lifelong disability to live an ordinary life so they can engage in education, employment and community activities.

A person with a severe mental illness can have periods of wellness in addition to regular severe symptoms that limit day to day functioning. This episodic nature of severe mental illness can disrupt connections to employment, family and community, and make service continuity difficult to plan and achieve. These experiences can give rise to ongoing (sometime lifelong) need for care and support that goes beyond clinical mental health treatments.

That periods of wellness can be achieved, and the impact of disability reduced, through recovery-oriented early intervention services and supports is not necessarily in conflict with the existence of a 'permanent impairment'. However, the sometimes episodic nature of severe mental illness can make it challenging to assess whether a person has a psychosocial disability that would entitle them to individualised funding under the NDIS.

Anecdotal evidence also indicates that some people are deterred from applying due to the process (e.g. lengthy applications) but more fundamentally, not wanting to be labelled as having a permanent disability. This raises challenging questions about the National Disability Insurance Agency's (NDIA's) outreach and engagement with people with mental illness – a group that is often challenging for service systems to find, reach and engage.

In addition, service providers and consumers are reporting that negotiating the access and eligibility process for the NDIS can be a significant barrier for some people experiencing mental illness, resulting in many people who might benefit very much from the NDIS not entering the scheme. The relative lack of active outreach to such clients by the NDIA risks compounding this problem.

### **Eligibility – anticipated number of NDIS participants with psychosocial disability**

As the PC would be aware, and of particular relevance to the question of NDIS costs, there is much debate around the projected numbers of people with psychosocial disability associated with mental illness who are expected to gain access to the NDIS.

Current estimates are that 64,000 people with psychosocial disability will receive Individually Funded Packages (IFPs) for a primary psychosocial disability by full rollout of the NDIS in 2019-20. To date, the proportion of people with a primary psychosocial disability who have gained an IFP under the NDIS and the average costs of their packages are broadly within the estimates in the PC's original report. However, and as discussed below, this masks a number of challenges and concerns, including:

- latent need for NDIS-type services
- unclear eligibility for people who in future would be eligible for current services that are in the process of transitioning into the NDIS
- people who are facing barriers to access or for whom active outreach may be needed to establish a connection in order to examine eligibility
- the relatively low draw down on IFP services by current participants with psychosocial disability.



The 64,000 figure is based largely on participation rates in the previous system of supports – a system known to be falling well short of the level of need in the community. This brings into question how accurate the current estimate is around the number of people living with a severe mental illness who require access to NDIS packages, and whether there is capacity within the NDIS to provide access if indeed the figure is higher.

There is a clear need for further information to help confirm estimates around the likely number of NDIS participants with psychosocial disability, as well as how many people with severe mental illness are likely to require ongoing supports in the community. The NMHC has two suggestions in this regard:

- The as yet to be released National Mental Health Service Planning Framework could provide greater clarity on the issue of unmet need, once it is made available through the Australian Department of Health.
- Further information may also be shed by reference to the rate of secondary psychosocial disability amongst people who are already accessing the NDIS on the basis of other types of disability.

The existing uncertainty around the likely number of people at full scheme with a primary psychosocial disability presents a risk of encouraging a conservative approach by the NDIA in terms of outreach and access and eligibility processes. It is important the NDIS is implemented ‘as planned’ so the ‘true’ level of need can be more clearly understood, both for those who are eligible for the NDIS and those who are not (yet) eligible.

## **Scope of supports**

### *Low draw-down on individual packages*

There is a relatively low draw down on IFP services by NDIS participants with psychosocial disability. This suggests at least some packages are not ‘fit for purpose’, or have identified support needs that the market is not responding to with accessible services. Alternatively, the packages may be suitable but not all the elements are needed all of the time by the clients (i.e. because of the often episodic nature of mental illness). This may be an area warranting further investigation.

### *Early intervention*

As resources for disability support are being refocused, it will be particularly important to ensure that access to early intervention initiatives for people with psychosocial disability is preserved. This includes early interventions for people who are deemed eligible for individualised support through the NDIS.

A recovery-oriented approach to the provision of supports for people with severe mental illness aims to ensure both preventative and treatment services are accessible in a timely way, so the person with severe mental illness is supported in managing their condition to help minimise or prevent their symptoms from escalating to more acute phases.

Enabling access to services to achieve this aim also helps to avoid larger future costs, consistent with the insurance principles that underpin the NDIS. From both a costs and recovery perspective, therefore, it is important that early interventions are taken into account in the planning and assessment processes for individualised funding packages.



### *Families and carers*

Many people with mental illness depend on the support of family and carers. The NDIS implementation to date has not adequately addressed the needs of carers, with carer respite in particular being considered merely as a by-product of individuals' packages, rather than being designed into the packages themselves. In some instances this seems to work reasonably well, but there is evidence that the NDIS does not respond well in all such circumstances, and that it can be inflexible when there is critical need for urgent respite for carers. This does not seem to be in line with the legislated intent of the NDIS and should be considered as part of the ongoing refinement of the scheme. This will inevitably have cost consequences for the scheme in the short term, but to ignore the problem now risks far greater cost impacts on the NDIS and other parts of society in the future.

The impact of the NDIS on families and carers needs to be closely monitored given their crucial role in the daily lives of people living with mental illness. It is not clear how continuity of support for carers will be addressed through the NDIS. For example, the NDIS does not include direct provision of respite support for carers. Anecdotal evidence indicates that some applicants are being encouraged not to include family support in order to enhance their chances of getting a package. Further information is required around whether the benefits of well-designed packages are reducing the need for respite as anticipated in the design of NDIS, or whether there is in fact an interim or ongoing need for formal involvement of carers and families in supporting NDIS participants.

### **Interface with mainstream services – Current context**

In considering psychosocial disability and the NDIS, the NMHC recommends the PC have regard to the current complexity of the broader mental health policy and service landscape.

As with other disability types, determining what services will be available to people with psychosocial disability – both through the NDIS and through residual (non-NDIS) services in the community – is difficult, as there are different arrangements in different jurisdictions as a result of variations in bilateral agreements between the Commonwealth and States/Territories.

In addition to the inherent complexities of NDIS design and implementation thus far, several reforms currently underway in the broader mental health service system may also have a bearing on the impact of the NDIS.

- Since June 2016, Primary Health Networks (PHNs) have been responsible for commissioning mental health services in the community and local coordination and integration to better support people with mental illness. A priority area of focus for PHNs is severe mental illness – overlapping with the cohort of people potentially eligible for individualised support under the NDIS.
  - Guidance from the Department of Health to PHNs notes that 'while psychosocial support services are not in scope [for funding by PHNs from the flexible primary mental health funding pool], holistic care requires close links', and that PHNs have a role in 'promoting links and easy to navigate referral pathways between clinical services and broader support services for people with severe mental illness, including relevant services provided by LHNs and through the NDIS'.<sup>1</sup>

---

<sup>1</sup> Department of Health, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care.



- The extent to which PHNs are able to link eligible people to the NDIS may have implications for the number of participants in the scheme and the associated costs.
- The Commonwealth's 'Health Care homes' trial will examine bundled payments and coordinated delivery of clinical care for enrolled patients with chronic and complex conditions, which may include people with psychosocial disability associated with mental illness.
- At a national level, the NDIS and severe mental illness was identified as a key priority under the draft Fifth National Mental Health Plan, which was released for consultation in October 2016.
  - The draft Fifth Plan outlines areas of work requiring collaborative action by both the Commonwealth and States/Territories. However, it did not specify which level of government will hold ultimate responsibility or alternatively, if this responsibility is to be shared, what form this will take in practice. While the NMHC understands further work is underway, the initial absence of roles and responsibilities in this area illustrates the ongoing lack of interjurisdictional clarity in this area.

The Australian Government's reforms in the mainstream mental health system – especially the new role for PHNs – are welcome, but there needs to be vigilance as these large and complex reforms unfold, especially in terms of coordination failures and cost shifting between systems.

While health services are not in scope for the NDIS, and similarly PHNs are (initially) to focus on clinical services, it is notable that there is significant overlap of clinical and non-clinical service systems for people severe mental illness. For instance, many non-clinical services that support recovery (e.g. Partners in Recovery and Day to Day Living) although now in scope for the NDIS have previously been delivered through the health system.

PHNs currently have little to no role in relation to psychosocial disability, but an individual's capacity to live a contributing life is integral to the success of their response to their illness. This means there is likely to be an increasing expectation from consumers, carers, families and service providers that PHNs incorporate access to disability and other community support services as part of their management of mental illness. If PHNs respond to this pressure by referring many clients to the NDIS for assessment – including those who are not eligible – there is a risk of consumers 'bouncing' between the two systems and not receiving the support they need.

These examples illustrate the sometimes difficult distinction in mental health between what is a disability service and what is a health service, and reinforce the critical need for close coordination between the NDIS and the health system in designing and monitoring both the costs and benefits of the NDIS.

### **Interface with mainstream supports – Impact of the NDIS for residual services**

It is generally accepted that 2-3 per cent of the population experience a severe mental illness each year, equating to roughly 600,000 people. So, regardless of how accurate the 64,000 figure is, as an indication of magnitude it clearly shows that many more people with mental illness will not be eligible for package under the scheme.

---

<http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/%24File/1PHN%20Guidance%20-%20Stepped%20Care.PDF>



Even if the 64,000 is accepted as the best available estimate for the number of people eligible for an NDIS package for a primary psychosocial disability, many among those who are experiencing severe mental illness may, without effective early interventions and supports, eventually become eligible for the NDIS.

A particular concern is that there seem to be many people in existing community mental health programs at the Commonwealth and the State and Territory level who are being found ineligible for the NDIS, and while governments' commitment to continuity of support for existing clients is welcome (subject to the details of how such support is to be provided into the future), there appears to be no clear strategy for dealing with future cohorts of people who would otherwise have accessed such programs but who are not eligible for the NDIS.

It is important that an early intervention approach that minimises disability is also available for non-participants with severe mental illness. This, in turn, will help deliver a shift in resources over time and manage the long-term cost pressures for the NDIS. This is particularly critical in the context of funding transitioning from community mental health programs to the NDIS, which will provide psychosocial disability support for people with the most disabling forms of mental illness and complex interagency needs.

Commonwealth, state and territory governments have elected to transition funding from a number of existing community mental health programs into the NDIS. This would seem to be in contrast to the PC's 2011 report on Disability Care and Support, which implies the continued need for community mental health services concurrently with the NDIS. Chapter 5 and Appendix M of the report present evidence that there are many more people with mental illness than would be eligible for the NDIS (given the NDIS 'bar' is quite high in terms of severity of functional impairment and permanence of the disability). Chapter 5 (page 188) suggests that the NDIS would 'strengthen' community mental health services, not displace them. It is therefore likely that the PC did not envisage widespread closure of existing Commonwealth, state or territory mental health programs as part of the NDIS implementation. Rather, this is a financial decision governments have subsequently taken.

Ongoing demand for services by non-participants could place significant pressure on 'Tier 2' of the NDIS – the Information, Linkages and Capacity building (ILC) element of the NDIS and on mainstream services (clinical and non-clinical). However, the NMHC is concerned that the ILC as currently envisaged will not be adequately funded to address the level of need, especially among those with psychosocial disability who do not qualify for a package under the NDIS. This could lead to increased pressure on the already stretched resources of the mainstream mental health system, especially PHNs, which have only recently been tasked with establishing a stepped care approach for people with mental illness. Hospitals are also likely to come under increased pressure as more people reach an acute level of need in the absence of effective early interventions in the community.

The ILC is not adequately resourced (with the funding level well below that recommended by the PC), with significant concerns that this may result in this tier of the NDIS not being able to provide individualised support to people with a mental illness who may not be eligible for an IFP, but who are nevertheless in need of help with their psychosocial disability. This risks adding to the risk of such people suffering necessary or avoidable deterioration in their condition and their needing to access high cost clinical and non-clinical services at a later date.

Furthermore, if non-participants' needs for early intervention services are not met – either through adequately resourced ILC arrangements or through other services in the community – it is possible





that demand and eligibility for Tier 3 supports may increase, along with the associated costs for the NDIS.

Addressing the capacity of mainstream (non-NDIS) service systems to support and complement the NDIS will be an important part of ensuring the success of the NDIS. The high number of people with severe mental illness represents a significant 'pool' of potential need for non-clinical community supports and services to help deal with the effects of psychosocial disability of varying levels of intensity and persistence. If there is not adequate investment in such services outside the NDIS there is a risk that more people will need more intensive and costly supports such as those offered by the NDIS, and/or medical interventions through the primary and acute care systems. With several such programs being closed and funding moving to the NDIS at both the Commonwealth and the state/territory level, this risk is accentuated.

### **Interface with mainstream supports – the need for cross-sector and cross-jurisdictional coordination**

There continue to be significant numbers of people with mental illness who are not receiving the supports they need, severely reducing their capacity to participate in the community and the economy.

For people living with mental illness, the service landscape is complex and fragmented, as services are both cross-sectoral (health and disability, as well as other sectors such as housing) and cross-jurisdictional (Commonwealth and state/territory). To meet the needs of people with a psychosocial disability, coordination across these sectors and jurisdictions is required to ensure no gaps in services emerge from the implementation of the NDIS. Effective coordination across the disability and mental health systems will be central to ensuring success in the reform agenda currently underway, including policy development, service coordination and program evaluation.

One area where coordination is particularly needed is in relation to accommodation support. Historically, the trend in Australia (and overseas) has been towards de-institutionalisation of mental illness and the provision of more services in a community context, including through various forms of supported housing and accommodation. In principal this is a laudatory policy; in practice there have been significant shortfalls in delivery, sometimes at catastrophic cost to those experiencing severe mental illness, their careers and their families.

The NMHC notes that there is provision in the NDIS to include funding to help individuals with the cost of supported accommodation. Welcome though this is, the NMHC is concerned that the stock of such accommodation in Australia is very low relative to community need, and it is unlikely that the funding through individual's packages of the 'user cost of capital' will be sufficient to ensure the market will respond quickly and effectively to fill the gap. The barrier to entry for potential providers that up front capital costs represent – whether equity or debt – is unlikely to be adequately addressed by the NDIS funding approach to supported accommodation.

### **Governance – Monitoring and reporting**

The challenge for governments as the managers and funders of the mental health system is to closely monitor and report on the impact of this far-reaching reform on people with a severe mental illness considered eligible for the NDIS and their families and carers, but also the impact on the many people living with mental illness who are ineligible for, or who do not seek access to, the NDIS. Based on this evidence, further consideration may be required to ensure that people living with mental illness, especially outside the NDIS, are better supported so they can and do lead contributing lives.



With the NDIS still in its early implementation phase, transparency and accountability are paramount. It is critical that timely and comprehensive information is available on the state-by-state (and local) impacts the reforms are having for people who gain access to the NDIS, as well as for those who do not. The NMHC suggests that reporting should encompass secondary as well as primary disability categories, as there are high numbers of people with physical or intellectual disabilities who also experience psychosocial disability arising from mental illness. More information about eligibility assessment tools and processes would also help with transparency.

It is important to monitor the impact of transitioning of major Commonwealth, state and territory community mental health programs into the NDIS (e.g. Personal Helpers and Mentors, Day to Day Living, Partners in Recovery and Mental Health Respite: Carer Support) to ensure no overall reduction in mental health expenditure both at a macro and individual level, and that new gaps are not emerging due to the shift from block funding to individualised packages. For example, what services will be available for those who were eligible for these programs but who are ineligible for Individually Funded Packages or for those who would have been eligible had the programs continued?

Tracking the experiences of people living with mental illness – and their families and carers – as they transition into the NDIS needs to be in the broader context of the mental health system, as all the reforms in primary health care, health and mental health impact on one another. In this context, it will be critical that the specific investments, services, impacts and outcomes for people with serious mental illness are monitored and evaluated.

A core role of the NMHC is national monitoring and reporting on Australia's mental health system and outcomes for mental health consumers and carers. As a system-changing reform with potentially significant impacts for the mental health sector, the NDIS is of key interest. The NMHC will have an ongoing role in monitoring and reporting on the mental health system and its interface with NDIS, with a focus on ensuring that – as an unintended consequence of social support programs transitioning to NDIS – a growing gap does not emerge between the lives of those eligible and not eligible for NDIS supports. In 2017, the NMHC will be considering the way in which it will report on the NDIS over the roll-out and further years to come.

The NMHC looks forward to working with governments and key stakeholders as the learnings from the current inquiries inform governments on the future design and implementation of NDIS. We would be pleased to provide any further information that may be of assistance to the PC in conducting its inquiry.

