



***Submission on the Productivity Commission
study into the National Disability Insurance
Scheme Costs***

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About Mental Health Australia

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

Overview

The National Disability Insurance Scheme (NDIS) is an historic opportunity to improve the lives of people who have for far too long missed out on the support they need to live contributing lives in the community. Mental Health Australia strongly supports the policy intent underpinning the Scheme, and hopes to work with government over the long term to maximise choice and control for people living with mental illness and psychosocial disability.

Psychosocial disability was added to the NDIS in response to vocal advocacy for its inclusion in the Scheme. While the Commission gave some consideration to the distinctive needs of this group, the nature of the existing service system was not given the same consideration as for other types of disability. As a result, implementation of the Scheme has focused on physical disability systems, with ad-hoc responses to the needs of people with mental illness. Unfortunately, a range of issues remain unresolved to this day, with little evidence available publicly that governments have strategies for resolving them. Mental Health Australia hopes the Productivity Commission's (the Commission) current Review can bring clarity to these important issues.

Anecdotally, many people with psychosocial disability who have entered the NDIS now report better access to services and better lives as a result. This is of course a pleasing development and to some extent a proof of concept. Mental Health Australia also acknowledges the efforts of the staff of the Department of Social Services and the National Disability Insurance Agency (NDIA) who, in implementing the NDIS, have sought to be faithful to the overarching design and structure proposed by the Commission.

However, feedback from many mental health consumers, carers and providers since the earliest days of Scheme rollout indicates some fundamental and ongoing problems with scheme design and implementation. These threaten both the long-term effectiveness of the Scheme and its ability to deliver greater choice and control to people with psychosocial disability.

At the broadest level, the major barriers include:

- Governance arrangements that are not fit for purpose, at least with regard to resolving issues at the boundaries of the mental health and disability systems, and between those systems and health and social services programs at Commonwealth, State and Territory and regional/local levels
- Inadequate structures and resources for formalising the contribution of consumers and carers in policy development and co-design

- Protracted delays in making decisions on key aspects of scheme design, such as the rollout of the Information, Linkages and Capacity (ILC) building initiative and in sector development
- A lack of transparency around decisions between governments on services and funding earmarked as in scope for the NDIS, and poor communication of the implications of those decisions for affected stakeholders
- Lack of capability and capacity within the NDIA to meet the twin goals of transitioning a large population of consumers into the NDIS and doing so in a person-centred fashion, coupled with a mismatch between the NDIA's task, the resources it has been allocated and the expected timelines for rollout
- An insistence that a universal approach be applied to all disability types (with the exception of the early childhood population), even where distinctive approaches might be preferable, such as in mental health
- Unintended but potentially devastating impacts on the viability and sustainability of organisations especially during, but not limited to, the Transition period. This carries the great risk of limiting the future choices of consumers and carers, as the skilled workforce is lost and organisations and communities are stripped of capacity. If, after trial, we realise that many of these organisations and skills are required, their loss during Transition would seem worse than futile.

At its best, the present system of community-based services for people with severe and persistent mental illness with complex needs (the target population for the NDIS) is built around low barriers to entry and responses that can be scaled quickly according to individual needs and circumstances. The on-the-ground reality of the NDIS as it stands today is somewhat antithetical to these principles. The access process imposes an additional administrative barrier to people receiving the right help, at the right time, on terms that make sense for those individuals. Further, the need to meet transition targets has led to planning processes (including the 'First Plan') which are formulaic and not necessarily aligned to individual needs. It is easy to see why this assists the transition by moving individuals into the scheme quickly, but it is also apparent that in many cases this is not in the interests of the individuals concerned.

The Commission's vision is predicated on the notion that the shift to individualised funding will lead inevitably to greater choice and control, given the shortcomings of legacy disability systems. Mental Health Australia does not accept a simplistic juxtaposition between, on the one hand, block grants and non-responsiveness, and, on the other hand, choice and control through transactional funding. While the mental health sector is willing to embrace the future and accept valid criticisms of past practice (practices whose root causes often lay in policy failings), it would be short-sighted to lose the gains the recovery movement has made in recent years by making best practice services unviable under an NDIS model.

For governments more broadly, there are also major uncertainties about the longer-term availability of psychosocial support services for people who do not enter the NDIS. The most optimistic scenario for the community mental health sector is that ongoing access to recovery-oriented psychosocial support for non-participants will vary greatly from jurisdiction to jurisdiction. It already appears that some jurisdictions are abandoning this responsibility. Given these uncertainties, services are struggling to plan for the future at the very time when supply needs to rise dramatically in response to increased demand through the NDIS.

Unless appropriate responses to these barriers can be identified, there will inevitably be an impact on costs to government. These costs will be in the form of poorer outcomes and lower value for money within the NDIS, along with greater pressures on crisis-driven services outside the NDIS, including hospitals, acute services, police and emergency services, and community mental health services (where they still exist).

The insurance principles on which the Scheme is based are an ideal starting point for resolving these problems. A focus on the lifetime cost of disability allows policy makers to step back and consider how the right up-front investments can help lower the overall costs of providing support to people with psychosocial disability associated with mental illness. But this calculation can only be meaningfully made if needs and effects outside the immediate remit of the NDIS are included in the calculus.

While the Productivity Commission review is largely about the costs of the NDIS, Mental Health Australia is most concerned about the extent to which the Scheme can meet the needs of people with severe mental illness and who need extensive and individualised disability support, both through the NDIS and through mainstream service systems. If there is a large drop in the support available for the ‘first people out’ compared with the ‘last ones in’, this will create incentives to join the Scheme even where an IFP is less appropriate or efficient given individual circumstances. In keeping with insurance principles, then, it is critical that the Commission takes account of the present system of services available to people with severe and complex mental illness, as well as mental health reforms being implemented in parallel in several jurisdictions, including at the Commonwealth level.

Scheme costs

Cost drivers

Price

Since rollout commenced, mental health providers have repeatedly highlighted that the price of supports is set well below the hourly rate for psychosocial support work currently delivered by suitably qualified people. This has flow on consequences for safety and quality of supports and innovation.

Mental health stakeholders had no involvement in the process to set prices for different support types, specifically through the Reasonable Cost Model (RCM). The RCM was developed jointly by the NDIA and National Disability Services with mental health pricing expressly out of scope.¹ There has been no further consultation with mental health providers or their representatives to better understand the full costs of service delivery.

The NDIS Price Guide² does not have an hourly price for psychosocial support services. Instead the prices apply to support with daily living (lower prices) and capacity building, including support coordination (higher prices at varying levels). Therefore, the relative mix of services in a participant's individually funded package (IFP) will determine the average hourly wage that a provider can offer to skilled and qualified mental health workers. IFPs that have a higher number of capacity building supports will mean providers should be able to employ staff with higher skills. It is very difficult on current evidence to determine whether the balance between ‘core’ versus ‘capacity building’ support items in plans is appropriate and well matched to individual need.

¹ National Disability Insurance Agency and National Disability Services. *Report of Pricing Joint Working Group*. p7

² National Disability Insurance Agency. *NDIS Price Guide VIC/NSW/QLD/TAS* Valid from: 1 July 2016

An objective of the *National Disability Insurance Scheme Act 2013* (the Act) is to:

promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community
(paragraph 3(1)(g))

Consequently, *quality* and *innovation* should be added to the five cost drivers listed in the issues paper – they are integral to *price* and *volume*. Higher *quality* and *innovation* should attract a higher hourly price, otherwise poor quality supports (at a lower price) and/or lack of innovation could lead to a higher overall volume of supports, potentially increasing the overall cost of support and even jeopardising the achievement of participant-driven outcomes.

Quality

The Australian Safety and Quality Framework for Health Care asks policy makers to ensure funding models are designed to support safety and quality, because funding models can be a driver for quality care.³

With the low prices for supports set by the NDIA it will be a challenge for providers to meet the National Standards for Mental Health Services 2010⁴, since low prices will incentivise business models that rely on a less skilled workforce. If this ‘race to the bottom’ is allowed to continue, choice and outcomes for participants will be eroded over time.

Innovation

The Productivity Commission recognised the challenges that individualised funding under the NDIS would present for research and innovation by service providers.⁵ Under the Partners in Recovery (PIR) program, providers of psychosocial services have been able to utilise an innovation fund to explore, fund and trial innovative models of delivering services. With Transition, these efforts have now ceased.

Unfortunately, the NDIS Innovative Workforce Fund is very small and has a narrow focus on innovation in practices relating directly to the disability workforce.

Mental Health Australia urges the Commission to investigate and recommend additional strategies for recognising quality and innovation on the part of psychosocial support providers, both through the prices set by the NDIA and other means.

Utilisation rates

Mental health consumers, carers and service providers have suggested two potential causes for low utilisation of funded supports. One concern relates to the First Plan process and in particular the transition from the planning phase to plan implementation. The NDIA states that the planning process for most First Plans is conducted over the telephone and that once plans are developed an NDIA representative will be available to assist participants to put it into action.⁶ However feedback from mental health stakeholders indicates that this may not

³ Australian Commission on Safety and Quality in Healthcare. *Australian Safety and Quality Framework for Health Care. Putting the Framework into action: getting started. Advice for policy makers.* Action 3.5.

⁴ The NDIS practice standards will reflect the National Standards for Mental Health Services for providers specialising in mental health services. Department of Social Services. *NDIS Quality and Safeguarding Framework.* December 2016. p85

⁵ Productivity Commission. *Disability Care and Support.* July 2011. p521

⁶ National Disability Insurance Agency. *Developing your first NDIS plan 2016*

be occurring in practice for every participant. In some cases participants are unsure what their plan means (due to the use of organisational jargon) or who to contact first for assistance to implement their plan. In addition, stakeholders have raised concerns that some organisations which currently deliver Local Area Coordination (LAC) functions (which can potentially assist participants with plan implementation) may not be well versed in mental health supports and programs, or may lack capacity to meet the needs of a large and growing population of new Scheme entrants.

A report prepared jointly by the NDIA and Mental Health Australia on the *Psychosocial Supports Design* Project notes that mental health stakeholders “strongly cautioned against connecting with people with serious mental health issues under an assumption of ‘readiness’ or ‘preparedness’”. They noted that “investment is required to support the person to work through a range of issues ... Only once this investment is made is it then possible to take best advantage of the NDIS by choosing the supports they need in the long term”.⁷ The concept of assisting the participant to genuinely engage with supports is as applicable to plan implementation as it is to planning. It is difficult to see how this can be achieved in practice if the majority of participants enter through the First Plan process as currently conceived.

Mental health stakeholders have also raised concerns regarding what could be termed a thin supply of community mental health services across the country. This issue is discussed under ‘Market readiness’ (below).

Scheme boundaries

The NDIS should provide a high-quality system of psychosocial supports for people with psychosocial disability who are likely to need assistance over a lifetime. However, this should not come at the expense of the much larger number of people who need individual psychosocial support, but who will not enter the NDIS for a range of reasons. These people too should be able to access a range of additional, and often time-limited or temporary, supports through mainstream systems, in part because providing these services outside the NDIS will protect the sustainability of the Scheme itself.

Mental Health Australia urges the Commission to revisit its original estimate of the size of the population of people with psychosocial disability likely to enter the NDIS, informed by analysis by the Australian Government Actuary (AGA) in response to the Commission’s estimate and with reference to modelling from the National Mental Health Service Planning Framework, the most accurate tool for assessing the size, characteristics and service needs of the population of people with mental illness.

Eligibility criteria

The National Mental Health Consumer and Carer Forum describes psychosocial disability as:

The disability experience of people with impairments and participation restrictions related to mental health conditions. These impairments and restrictions include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

⁷ National Disability Insurance Agency and Mental Health Australia, *Psychosocial supports design project – final report*, 2016, p17

Not all people with a mental health condition will experience a psychosocial disability. Many people with a mental illness will lead fulfilling and productive lives with little support. However, effects of psychosocial disability can be severe and the impact is frequently underestimated both for people with a psychosocial disability and for their carers.⁸

The legislation for the NDIS presents something of a clash in philosophies when it comes to mental health and the NDIS. The ‘permanent impairment’ requirement in section 24 of the Act may make sense with regard to certain disabilities that result from impairments such as blindness or reduced mobility, which can leave people unable to live and work without support.

The idea of permanence is more problematic for someone with mental illness. Most people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly. Some people who experience severely debilitating mental illness aren’t going to need support and be in the mental health ‘system’ for a long time – only as long as they need for their symptoms to improve. Many consumer ‘survivors’ of severe and persistent mental illness emphasise the importance of hope and a belief in their ability to grow and change for the better as keys to their recovery. On principle then it would seem unreasonable to deny hope to anyone with a severe and persistent mental illness, given the positive effects it can generate.

Further, for any two people with precisely the same diagnosis – of schizophrenia, say, or bipolar disorder – it can be impossible to predict which one might need long-term support, making the idea of a ‘permanent impairment’ difficult to fit with the realities of mental health. That said, many people with psychosocial disability will need, and should expect to receive, support over the long term, and perhaps for a lifetime. These are difficult tensions to reconcile within the policy and legislative framework currently underpinning the Scheme.

The NDIA’s mental health team has endeavoured to ensure the access process is consistent with a recovery orientation,⁹ as recognised in the NDIA’s fact sheet *Psychosocial disability, recovery and the NDIS*. However, feedback from the mental health sector indicates ongoing concerns about inconsistent outcomes of the assessment process, with confusion about whether this has to do with how the ‘permanent impairment’ requirement is being applied or other factors (or both).

Because the concept of permanency of impairment is a poor fit with respect to mental illness and psychosocial disability, there is likely to be inconsistency in the assessment of people’s eligibility for the NDIS. The risk of inconsistency may be especially high where NDIA assessors lack skills and experience in mental health.

The *Independent Review of the NDIS Act*, conducted by Ernst & Young in 2015, considered the permanency issue as it relates to mental health. It concluded:

We believe there is merit in allowing the NDIA to continue its efforts to address concerns associated with the permanency provisions from an operational perspective – and for these efforts to be exhausted before determining whether amendments to the permanency provisions are required.

⁸ National Mental Health Consumer and Carer Forum, *Unravelling Psychosocial Disability – Summary Brochure*, 2011. p1

⁹ Australian Health Ministers Advisory Council. *A National framework for recovery-oriented mental health services. Guide for Practitioners and Providers*. 2013

Noting the level of stakeholder interest in the issue, there would be value in revisiting the appropriateness and effectiveness of the permanency provisions as part of the next review of the NDIS Act.

Mental Health Australia supports the need for further examination of this issue, taking into account experiences by consumers and carers of the assessment process, the work undertaken by the NDIA to date to reconcile the concept of permanency with recovery principles, and the policy intention that the NDIS be targeted at those most in need of individualised supports over a long period.

The size of the cohort who need psychosocial support

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

Description	Care Needs	NDIS Coverage
1) Episodic mental illness (est. 321,000 people)	Clinical services	Not included
	Disability support services may occasionally be required, particularly during a lengthy episode of illness	Not included
2) Severe and persistent mental illness but can manage own access to support systems (est. 103,000 people)	Clinical services	Not included
	Social inclusion programs	Not included
3) Complex needs requiring co-ordinated services from multiple agencies (est. 56,000)	One on one support from a carer	Included
	Supported accommodation, where appropriate	Included
	Clinical services	Not included
	Social inclusion programs	Included
4) Institutional care (est. 2,000)	24 hr care in the mental health sector	Not included

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

Only those in the third subgroup (those with complex care needs) have been assumed to be eligible for supports under the NDIS. This was justified on the basis that this would be the only group with an enduring need for high level disability support services. Our reading of the PC report would not suggest that the NDIS is to be restricted to those with high level needs; rather the critical factors are the permanence and significance of the disability and the need for support.

The second group would appear to qualify both on the grounds of a permanent and significant disability. Indeed the mental health experts agreed that the disability support services, other than one-on-one care, required by the second and third

*groups would be roughly similar. Thus, on the surface, it would appear inconsistent with the PC's proposed eligibility to exclude the second group.*¹⁰

Since the AGA analysis, the Australian Government has identified that around one third of the 690,000 Australians with severe mental illness have chronic, persisting illness and that most have a need for some form of social support, ranging from low intensity or group-based activities delivered through mainstream social services to extensive and individualised disability support.¹¹

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

In 2015, Mental Health Australia provided briefings to Commonwealth, state and territory public servants on a technical paper (Attachment A) that seeks to quantify the issues around people with severe mental illness and the NDIS. The paper uses the draft Mental Health Service Planning Framework to estimate that approximately 289,000 people with a severe mental illness will need individualised, intensive "NDIS-like" community supports in any 12-month period. This is approximately 5 times the estimated number of people with a psychosocial disability that were forecasted by the Commission to be eligible for the NDIS. In addition, there are around 153,000 mental health consumers whose carers require some form of support.

Mental Health Australia does not have a firm view on which system, and which level of government should be responsible for providing services to this group of people. However, we are deeply concerned that at this very late stage it is still unclear who, if anyone, has overarching policy responsibility for this cohort and how these issues are going to be resolved. In particular, we are concerned that unless adequate supports are provided for this cohort, it is likely to put significant long-term cost pressures onto the NDIS, or otherwise on more expensive crisis-driven services, such as hospitals, homelessness accommodation, police and the justice system.

Mental Health Australia therefore recommends that the Commission give further consideration to the eligibility criteria as they apply to people with psychosocial disability, and to its estimate of the size of the population likely to enter the NDIS.

Mental Health Australia further recommends that the Commission considers appropriate mechanisms for resourcing social inclusion and disability support services for people with severe and persistent mental illness, who are not eligible for the NDIS.

¹⁰ <http://www.treasury.gov.au/Access-to-Information/DisclosureLog/2012/National-Disability-Insurance-Scheme-Costings>

¹¹ Department of Health. *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. 2015. p17

Eligibility assessment process

In its advice for implementing the NDIS for people with mental health issues¹², the NDIS Independent Advisory Council found there was “no commonly accepted and used instruments for assessing functional impairments and indicating support needs related to disability due to a psychiatric condition”. The Council highlighted the risk of inconsistent approaches in both eligibility and support needs being determined by the NDIA.

The issue remains unresolved and the Council has recommended, in its submission to the Parliamentary Joint Standing Committee on the NDIS, that the NDIA “invest in the development of a validated instrument for identifying an evidence-based approach to the determination of functional impairments and support needs for people with an impairment related to a psychiatric condition”.

Until that occurs, there is a need for greater transparency regarding the assessment mechanism used to assess people with psychosocial disability to better understand whether there are sufficient safeguards around the fair and consistent application of the *National Disability Insurance Scheme Act 2013* (the Act).

In the meantime, the only avenue available to people who have been assessed as ineligible is to seek review of the decision under section 99 of the Act that a person does not meet the access criteria. This is not an appropriate way to redress inconsistency, whether that inconsistency stems from the lack of an appropriate standardised and validated assessment tool, a capability problem within the NDIA, relative preparedness and resources of the applicant, or other factors.

Mental Health Australia recommends that as part of its review, the Commission seeks clarification from the NDIA as to whether an appropriate tool has been developed to assess the eligibility of people with psychosocial disability, and whether there are clear safeguards around the consistent interpretation of the provisions in the Act as they relate to the assessment of psychosocial disability.

Mental Health Australia also recommends that the Commission review some of the cases where administrative review has been sought by the people who have been assessed as not being eligible for Individually Funded Packages (IFPs). This would help to highlight if there are inconsistencies in the eligibility assessment and decision making processes.

In any event, the tools used by the NDIA to assess psychosocial disability for people making access requests should be publicly available, as should data regarding the results of those assessments. This would go some way to improving general understanding of, not only the assessment process, but the eligibility requirements. There should also be transparency around the safeguards the NDIA has in place for the consistent interpretation of the provisions in the Act as they relate to the assessment of psychosocial disability. This is already an obligation under section 8 of the *Freedom of Information Act 1982* for agencies to publish their operational information i.e. rules, guidelines, practices and precedents relating to decisions and recommendations affecting members of the public. It is not clear why the NDIA has not yet made these documents publicly available, given the high level of stakeholder interest in understanding the assessment process in more detail.

¹² Independent Advisory Council for the National Disability Insurance Scheme, *IAC advice on implementing the NDIS for people with mental health issues*, 2014

Intersection with mainstream services and cost shifting

The broad demarcation of responsibilities between the NDIA and mainstream systems (including the mental health system) is described in the *Council of Australian Governments Applied Principles for Determining the Responsibilities of the NDIS and Other Service Systems*, which was updated in November 2015. While the latest version of the *Applied Principles* is a marked improvement on its predecessor, there is still significant potential for ambiguity in their interpretation – not just in mental health, but also in justice, child protection and family support, and housing and community infrastructure.

In recognition of the need for greater clarity, the NDIA is working with jurisdictions to agree on *National Working Arrangements for Mainstream Interfaces*, including escalation processes to address interface issues which cannot easily be resolved. Mental Health Australia's chief concern is that these arrangements are still to be confirmed some nine months after national transition commenced, and years after stakeholders raised legitimate questions about system boundaries.

From a mental health perspective, interface issues are especially challenging in the context of major reforms in the broader health and mental health sectors. These include transferring responsibilities for commissioning many Commonwealth-funded mental health services to Primary Health Networks, and the trial of patient care plans and 'Health Care Homes' in the primary care system.

Mental Health Australia strongly supports the Commission's statement in 2011 regarding the need to avoid cost shifting and scope creep resulting from NDIS rollout:

It will be important for the NDIS not to respond to problems or shortfalls in mainstream services by providing its own substitute services. To do so would weaken the incentives of government to properly fund mainstream services for people with a disability, shifting the cost to another part of government. This 'pass the parcel' approach would undermine the sustainability of the NDIS and the capacity of people with a disability to access mainstream services.

One area where this intention appears to be at odds with the situation on the ground relates to how psychological therapy is funded. Mental Health Australia has anecdotal (but compelling) evidence from several jurisdictions that some participants with psychosocial disability have received plans that include psychological therapy. The rationale provided by the NDIA (according to consumers, carers and service providers) is that the ten sessions with a psychologist subsidised by Medicare under the *Better Access* initiative is not sufficient for those consumers. While the need for additional therapy is entirely plausible (given that people with complex needs could very well benefit from more intensive clinical intervention), it also appears to be inconsistent with the policy intent as articulated by the Commission and public messaging from the NDIA. This in turn has led to confusion in the mental health sector about what supports might legitimately be funded in IFPs and what services will remain the responsibility of mainstream systems, even where there may be insufficient or inappropriate services available.

The impact of NDIS rollout on access to mental health services

Beyond Full Scheme, there will remain a need for an effective system of community mental health services in each state and territory, and indeed in every local region. This system should provide both:

- Services for anyone (including NDIS participants) where that service remains the responsibility of the mental health system, for instance where the primary purpose is the treatment of mental illness
- Psychosocial support services for the larger population of people with mental illness who will not be eligible for the NDIS, but nonetheless require such support to lead contributing lives.

Unfortunately, it is difficult to see how a strong community mental health sector will remain in place once in-scope programs and services are fully transitioned to the NDIS. Some jurisdictions have decided to allocate all current funding for community mental health services in their financial contributions to the NDIS, meaning no funding will remain for people with a need for psychosocial support who do not enter the Scheme. As explained above (under ‘Scheme boundaries’), this population is much larger than the group expected to enter the NDIS.

At the Commonwealth level, in-scope services include the highly successful PiR program and the Personal Helpers and Mentors (PHaMs) program. Both of these programs have a strong focus on capacity building and coordination.

PiR has a strong focus on assertive outreach – that is, on engaging consumers who are out of touch with or on the margins of the service system, and who would otherwise not receive appropriate support. This is better conceived as a pre-NDIS service, and as such is more aligned with specialised LAC in the NDIS model than as a funded support in IFPs. While as yet unpublished, we understand the recent evaluation of the PiR program commissioned by the Commonwealth Department of Health identified that a large percentage of PiR participants, with high and complex needs, had been recruited via assertive outreach, rather than from existing programs. This would appear to be an outstanding success, but Mental Health Australia is not confident that the success can be replicated under the NDIS through current arrangements.

The PHaMS program was designed for people who need intensive but often time-limited support, meaning its inclusion in the NDIS is also problematic. Feedback from PHaMS providers indicates widespread confusion about whether their clients can be said to have an impairment that is ‘permanent’ or ‘likely to be permanent’.

At state/territory level, the situation is quite varied. The most pressing concern is in Victoria, where eligibility criteria for accessing state-funded community mental health services is directly aligned with the NDIS access criteria. This appears to mean there will be no state-funded community mental health services for non-participants – again, despite the population of non-participants with a need for individual psychosocial support greatly outnumbering those who will enter the Scheme.

These examples illustrate how programs and services with different target populations and different policy objectives will be wound down to fund services for NDIS participants with psychosocial disability. Providing reasonable and necessary support to those with the highest and most enduring needs should not result in reduced capacity to service the needs of people with less substantial levels of disability or less enduring conditions. Indeed, without support for the population of people with severe and complex mental illness outside the

NDIS, many people may in time develop ongoing disabilities and enter the NDIS, at greater cost to governments.

With the introduction of the NDIS, mental health services have identified a division of labour between 'capacity building' and 'core' support types.¹³ This division is well articulated by Mind Australia, which refers to the different services as 'rehabilitation services and supports' and 'disability supports' respectively.¹⁴

Rehabilitation services and supports to help people get their lives back on track after a period of illness. These do not deal with the symptoms of illness, but with its effects and impacts on people's ability to function and pursue their regular life; and

*Disability supports for those who experience significant and ongoing impairment in their ability to function following illness. Like the rehabilitation services, these do not deal with symptoms, but provide assistance to people to enable them to lead a life of reasonable quality and meaning despite the existence (or otherwise) of symptoms.*¹⁵

While 'disability supports' are clearly provided through the NDIS, mental health service providers are concerned about access to 'rehabilitation services and supports', as described above. Mental Health Australia understands that NDIS plans for people with psychosocial disability currently include an average of approximately 70% core supports (corresponding to the definition of 'disability supports' above) and 30% capacity building supports (corresponding to the definition of 'rehabilitation services and supports' above). This is concerning on face value: prior to NDIS, services provided under programs like PiR and PHaMS were 100% capacity building type supports, whereas now it represents a fraction of the support being provided to a participant. While core support will often be reasonable and necessary (and often not available under previous arrangements), Mental Health Australia is concerned that such a shift has occurred without careful examination of its impact or appropriateness. This issue warrants further investigation, especially to determine whether the capacity building support being provided to participants with psychosocial disability at least matches to the support they received pre-NDIS.

In terms of the intersection between the NDIS and mental health services outside the scheme, Mental Health Australia believes there is much work to be done to ensure that the clinical treatment of a person with mental illness and the provision of psychosocial supports to aid their recovery is seamless.

We understand that many mainstream providers of mental health services are only now becoming aware that the NDIS is for people with mental illness. The next step is to provide mainstream providers with expedient avenues to refer their consumers to the NDIS and with the ability to align the NDIS packages with their clinical treatment plans, so that the NDIS participant not only has a seamless service experience, but also has coordinated, joined-up care.

¹³ Mental Health Coordinating Council of NSW, *Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*, 2016, p5

¹⁴ Mind Australia Limited, *Response to the Joint Standing Committee inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, 2016, p4

¹⁵ Ibid.

Information, Linkages and Capacity Building

Mental Health Australia is confident that a well-designed and appropriately funded system of ILC services (including LAC) can make a vital contribution to improve the interface between the NDIS and mainstream services, help to alleviate some of the fragmentation within the disability system and assist mainstream services to be inclusive of people with disability.

However, Mental Health Australia remains concerned about how ILC could adequately fund such services within the limited budget, which has been allocated to fund multiple types of services to be accessed by people with all disability types (\$33 million in 2016-17 growing to \$131 million by 2019-20).¹⁶ Indeed, the outgoing Chair of the NDIA, Mr Bruce Bonyhady AM, acknowledged these amounts to be insufficient for ILC to reach its goals.¹⁷

The ILC objectives will also be hampered by the loss of Commonwealth, State and Territory programs for people who are ineligible for NDIS IFPs. A sudden and significant decrease in services available to this cohort would undermine ILC's effectiveness. For example, LACs and PHNs will be unable to refer people with psychosocial disability to appropriate services.

In addition, the uncertainty around availability of services for people with psychosocial disability is heightened by the lack of transparency with which additional programs have been identified as in scope for ILC. The ILC Commissioning Framework states:

*State and Territory governments will work with organisations that currently deliver activities that may fit into ILC in the future to let them know what the funding arrangements will be leading up to the start of ILC in their State.*¹⁸

Although Mental Health Australia understands the importance of ensuring funding is invested strategically and inefficiencies are avoided, a concern remains as to whether funding will be withdrawn from successful programs in advance of ILC rolling out in particular locations.

In this context of uncertainty, Mental Health Australia welcomes the Government's commitment through the ILC policy framework that ILC could fund "one-off, low level or episodic supports which focus on preventative intervention (for example counselling)."¹⁹ In particular, Mental Health Australia supports the intention to ensure people get early support which could prevent someone ultimately needing an IFP under the NDIS. However, it is unclear what types and volumes of psychosocial support services will be commissioned under ILC and for whom, particularly given that (confusingly) ILC will 'not fund activities that rightly belong in an NDIS plan or package.'²⁰

In addition, during Transition, with some interim block funding arrangements applying during that time and the scope and function of ILC funded programs still unclear, it is difficult to track where, and to what extent, key functions of currently successful programs will continue to be provided. For example Mental Health Australia has significant concerns about the availability of assertive outreach, which prior to NDIS roll-out in each area can be delivered through the PiR program.²¹

¹⁶ National Disability Insurance Agency, *Community Inclusion and Capability Development Program Guidelines: Implementing Information, Linkages and Capacity Building*. 2016. p7

¹⁷ Naomi, W, *NDIS: Outgoing chair Bruce Bonyhady pushes for independent board with disability experience*. ABC News website. 2016

¹⁸ National Disability Insurance Agency, *ILC Commissioning Framework*. 2016. p13

¹⁹ National Disability Insurance Agency, *ILC Policy Framework*. p13

²⁰ National Disability Insurance Agency, *ILC Commissioning Framework*. 2016. p21

²¹ Urbis. *Partners in Recovery Annual Report 2014-2015*. July 2015. Prepared for the Department of Health

Local Area Coordinators

Mental Health Australia welcomes the NDIA commissioning community sector organisations as LACs, given the significant knowledge already residing in the community sector about how to work effectively with people with psychosocial disability. However, Mental Health Australia is concerned that NDIS registered providers are excluded from applying for LAC funding, even in the event that they would cease provision of other NDIS services if they were successful in receiving LAC funding. Many organisations which employ a suitably trained and experienced workforce will not be able to provide LAC services, as they will already be NDIS-registered. Since LAC services were first commissioned, mental health providers have raised concerns about the lack of awareness by particular LAC providers about psychosocial disability.

Assertive community outreach

The Commission's report on Disability Care and Support noted that people with disability are over-represented among the homeless, in the criminal justice system, and in boarding houses. The Commission identified that "outreach services will still be required... the NDIS should provide homeless outreach services.... to connect people"²² to the NDIA and a broader range of services.

Assertive outreach takes place before someone accesses the NDIS, so NDIS registered service providers are not able to charge the NDIA for outreach services (regardless of whether a consumer ultimately becomes an NDIS participant). Further, the very low prices on offer for NDIS supports mean that providers of psychosocial services have no scope to cross-subsidise assertive outreach activities. Without direct funding for assertive outreach, the organisations that regularly work with hard-to-reach people are unlikely to continue this activity. Without specific policy and funding arrangements, there is a risk that assertive outreach for people with severe mental illness and complex needs will no longer be delivered, either through the NDIS or via other means. Mental Health Australia anticipates that this will result in fewer people with psychosocial disability accessing the NDIS, with those missing out likely to be those most in need of support because they are currently disconnected from services of any kind. It is worth noting that these services are required in perpetuity, not just during Transition.

In addition, outreach services are not included in the ILC Commissioning Framework or the Community Inclusion and Capacity Development Program Guidelines. Therefore, it would seem that, at this point in time, outreach services can only be delivered through the LAC function. Tender documentation for LAC arrangements in Victoria appears to confirm this, stating that LACs will "[engage in] active outreach programs for those people with disability less connected to existing disability supports so that they are aware of the Scheme and they experience a smooth transition to the Scheme".²³ Given the broad range of disabilities people may be experiencing who come into contact with LACs, stakeholder concerns about whether LACs have sufficient mental health expertise seem to be valid.

It would be appropriate that providers of psychosocial services, who have regular and direct contact with people with psychosocial disability, are also funded to undertake assertive outreach with potential NDIS participants and work with them over time until they are ready to make an NDIS access request and/or approach other mainstream services for assistance. Unfortunately, a key barrier to this at the moment is that registered providers cannot carry out (or even apply to carry out) LAC functions.

²² Productivity Commission. *Inquiry Report. Disability Care and Support*. 2011. p233

²³ National Disability Insurance Agency, Local Area Coordination Tender SoR. pp13&65

To ensure every person with severe and complex mental illness who may be eligible for the NDIS has an opportunity to access supports, governments must ensure specialised assertive outreach services are delivered throughout NDIS transition and beyond. It is important that future efforts build on the key features of the PiR program and the role of PiR support facilitators, given the success of that program and its national status.

Planning processes

Mental Health Australia acknowledges the difficult task faced by the NDIA in meeting ambitious roll-out targets established by the NDIS Intergovernmental Agreements. It appears that in establishing the “First Plan” process the NDIA has attempted to balance its swift roll out with the need to respond to lessons learnt through trial site experiences. Acknowledging the pressures on the NDIA, it is important that the pre-planning and the planning process supports mental health consumers to effectively exercise choice and control.

Participant choice and control

Feedback from mental health stakeholders indicates that key features of a planning process which facilitates authentic choice and control for people with psychosocial disability include:

- engagement with mental health consumers in a manner appropriate to their distinctive circumstances
- recovery-focussed pre-planning support
- appropriate engagement by NDIA staff and/or the LAC with the participant’s key existing supports, for example mental health carers and/or support workers in the pre-planning and planning processes
- effective outreach mechanisms including an appropriately informed network of primary health professionals
- access to appropriately skilled NDIA planners and/or commissioned LAC planners who have an understanding of mental illness and psychosocial disability.

Consultations undertaken to inform a recently released joint report by Mental Health Australia and the NDIA stressed the importance of engaging consumers and carers on their terms and in a manner appropriate to their distinctive circumstances.²⁴ The consultations highlighted that the majority of NDIS participants with psychosocial disability will have had minimal experience with exercising choice and control. Accordingly, significant support may be required to assist a participant to prepare (pre-plan) for their first planning meeting. The report noted that this process can take some months to complete.

In addition, the Interim Report from the Flinders University evaluation of NDIS Trial Sites found that people with mental illness and psychosocial disability are more likely than other participants to report having less choice and control since becoming NDIS participants. This result is reported to be a consequence of difficulties navigating the system, a lack of quality services, and a reduced ability to articulate their support needs.²⁵

Evidence emerged early in NDIS trial sites of the importance of including existing key support people in the NDIS planning process. For example, a report by Psychiatric Disability Services of Victoria stated that “consumers have consistently reported the value of having a

²⁴ National Disability Insurance Agency and Mental Health Australia, Psychosocial Supports Design Project – Final Report. 2016. p17

²⁵ K. Mavromaras, M. Moskos & S. Mahuteau, Evaluation of the NDIS: Intermediate Report. 2016

support worker or advocate to assist them in the planning process, in trying to establish eligibility and in following up on plans, and that when available it contributed to the successful outcome and their positive experience of the planning process”.²⁶ That report also observed that “trusting relationships can play a major role in helping people with psychosocial disability identify and articulate their goals”.²⁷ In addition, an issues paper developed jointly by Mental Health Australia and Carers Australia clearly outlines the benefits of including mental health carers in the NDIS planning process, which helps improve the accuracy of the needs assessment (and therefore appropriateness of the plan) and assists to keep informal care arrangements sustainable.²⁸

Providers have also observed support workers being excluded from NDIS planning meetings, even where their contributions would benefit a participant.

In recognition of the importance of trusting and ongoing relationships between participants and providers and/or carers (where these already exist), Mental Health Australia recommends that the NDIA provides guidance and resources to NDIA planners and LACs and require inclusion of support workers in preplanning and planning conversations, where potential NDIS participants agree.

Performance of planners

Mental health consumers, carers and service providers have on many occasions raised concerns about NDIA planners’ understanding of psychosocial disability. Mental Health Australia would like to recognise the efforts of the NDIA Mental Health Team’s work to address this and other important implementation issues. Initiatives such as the establishment of an internal NDIA Community of Practice on psychosocial disability and the provision of training are designed to build the understanding of NDIA staff about psychosocial disability. To ensure the planning process results in informed decisions regarding reasonable and necessary supports for people with psychosocial disability, it is imperative that work focussed on mental health continues and indeed expands to match the NDIA’s growth over transition.

Assessment tools and criteria for supports

The NDIA has released limited information in relation to the details of the assessment and planning processes. Although some brief targeted consultation occurred regarding the ‘First Plan’ process and questions proposed to be asked during the planning meeting, the final assessment tools used to decide upon supports have not been made publicly available (which is also the case with the eligibility assessment tools).

In the absence of public information regarding the assessment tools, Mental Health Australia is reliant on anecdotal evidence regarding the outcomes of planning meetings in order to form judgements in relation to whether the NDIA’s planning assessment tools and support criteria are valid, reliable and accurate and promote the efficient allocation of resources.

To date anecdotal evidence from service providers suggests that outcomes of planning meetings can vary considerably depending on several factors, for example:

- whether the NDIS planning representative is sufficiently knowledgeable about psychosocial disability and relevant supports

²⁶ Psychiatric Disability Services of Victoria, *Learn and Build in Barwon*. 2015. p16

²⁷ National Disability Insurance Agency and Mental Health Australia, *Psychosocial Supports Design Project – Final Report*. 2016. p17

²⁸ Mental Health Australia and Carers Australia, *Mental Health Carers and the National Disability Insurance Scheme*. 2016

- whether a support person or advocate is present in the meeting
- how well skilled and resourced the applicant might be
- how the consumer presents at the meeting (especially given the episodic nature of mental illness associated with psychosocial disability).

This variation in planning outcomes points to some deficiencies in the assessment tools, processes and criteria for supports, however it is not possible to point to particular solutions without greater transparency around the tools themselves. In future, in the true spirit of the Scheme, assessment tools should be co-designed with mental health consumers, carers and service providers and made publicly available.

More fundamentally, the issue of what constitutes reasonable and necessary support for people with psychosocial disability is an area of substantial uncertainty. There is little evidence available internationally to inform the NDIA's development of a reference package for psychosocial disability. At this stage, it appears that the reference package will (at least initially) be based on clinically defined and collected measures, measures which Mental Health Australia believes are not appropriate to determining reasonable and necessary supports related to functional need. This is an area that requires substantial further investigation in collaboration with consumers, carers and other experts, along with dedicated resourcing.

Market readiness

In a market as traditionally conceived, if well-informed consumers demand services that are unavailable for any reason, prices rise until the market meets demand. Under the NDIS as currently configured, prices cannot change to respond to consumer demand. Despite the frequent use of the term 'market', this is one of several ways in which the reality of NDIS rollout does not in fact correspond to the creation of a market.

Workforce

The Commission noted that the NDIS would lead to a significant increase in the demand for qualified staff. In relation to the psychosocial service workforce, the creation of the NDIS has not had the positive impact on the workforce envisaged by the Commission. The community mental health workforce has not experienced "greater pay, more jobs, better working conditions, the capacity for innovative practice, enough resources to do the job properly, recognition of the critical role of workers, more choice of employers, and greater satisfaction from working in a system that achieves better outcomes for the people they support"²⁹ predicted by the Commission.

On the contrary, feedback from the mental health sector has been that the pricing determinations by the NDIA to date have had very negative impacts on the workforce. This has included forcing service providers to reduce the quality of services they provide, hiring less skilled and less qualified staff, and increased casualisation of the workforce.

The Commission's predictions regarding the skill set and qualifications required for workers providing supports for people with psychosocial disability has not been matched by the NDIA Price Guide. Consequently, the Scheme will not generate the workforce that NDIS participants will need without further investment in workforce capacity, capability and supporting infrastructure.

²⁹ Productivity Commission. *Inquiry Report. Disability Care and Support*. July 2011. p50

At the same time the overall supply of and demand for high-quality psychosocial services is contracting, because the Australian Government's mental health reforms make no provision for psychosocial services for people who do not enter the NDIS, while some State and Territory Governments have withdrawn or plan to withdraw funding for psychosocial support services. This means investment in the growth of the psychosocial support workforce is likely to fall in large measure to the NDIS – despite the fact that most people in need of such support are unlikely to enter the Scheme.

The NDIS Integrated Market, Sector and Workforce Strategy states that the entire disability workforce will need to more than double in size by 2019-20, to 162,000 FTE.³⁰ By contrast, Professor David Gilchrist warned that 'the initial estimates of both cost and demand are significantly off target' and NDIS prices may be 'too low to ensure sustainability of the current sector.'³¹

A paper produced by Community Mental Health Australia (CMHA) scoping the impact of the NDIS on the mental health workforce highlights that 'many service providers consider the NDIS to be a 'challenging' environment, with pricing constraints and perceived rigidity in the Catalogue of Supports (now the...NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner.'³²

That report's recommendations (largely yet to be acted on) include the need for national mental health workforce planning underpinned by sound mental health sector research, support for mental health qualifications, support for effective implementation of necessary workforce flexibility, sector communications about good practice, and effective information dissemination to support organisations to engage with the NDIS.

Providers

For many years, psychosocial services have been funded by all governments under a range of programs that have shaped providers' business models. There are three material differences between the NDIS and those programs which have flow on consequences for community mental health providers, and consequently NDIS participants with psychosocial disability.

The first is that the NDIS has barriers to entry that are new (i.e. NDIS applicants need a formal clinical diagnosis of their condition or evidence of permanency of their condition, and they must complete and submit application forms). This contrasts with the approach under Commonwealth programs, whereby people presented voluntarily to service providers (usually having self-assessed) and were then supported by the provider, without the need for a formal diagnosis. This approach is much better suited to people with psychosocial disability, who can have difficulty accessing services where there are administrative barriers to doing so. The NDIS access process as it currently stands is likely to mean fewer people with psychosocial disability will enter the NDIS than projected, which in turn means fewer clients for providers.

The second is the change to the cash flow of providers of psychosocial services, who now have to wait for fee-for-service payments from the NDIA after the service has been provided to a smaller number of clients due to the NDIS entry barriers. This contrasts with the

³⁰ Department of Social Services, *Integrated Market, Sector and Workforce Strategy*. 2015. p19

³¹ Gilchrist David, *Time to Get Real on NDIS: Data and Flexibility Are Key*. Pro Bono Australia. 2015

³² Mental Health Coordinating Council of NSW on behalf of Community Mental Health Australia, *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. 2015

up-front block grants they received under Commonwealth programs. As a result, some providers may not survive this financial hiatus and may have to cease operating. Other providers may have to substantially reduce their financial commitments by putting employees off and/or replacing them with lesser trained staff, thereby reducing their service offering and/or the quality of their services. As a result, NDIS participants with psychosocial disability will have less choice of and diminished access to services.

The third difference is the mix of services in NDIS participant plans. Whereas under Commonwealth programs the service focus was on capacity building supports (which are higher priced supports under the NDIS), NDIS plans are predominantly for (lower priced) core supports. In addition, some providers are losing revenue where their previous functions are being carried out by LACs.

All governments have recognised the risk of significant fluctuations in provider income, as plans are developed and approved and therefore the importance of assisting service providers to transition programs from block funding to individualised funding.

However, for many providers, there is simply no available funding to bridge the financial hiatus created by the changed funding arrangements and adapt their service models to the new pricing structures mandated by the NDIA. This is partly because some governments, and some government programs, have not allowed block funded providers to make provision for the future by creating and reserving operating surpluses.

Alternative funding models have been proposed, such as mixed funding (part block grant, part individualised funding) or an NRMA-style membership model, in order to give organisations greater stability while retaining individual choice and control. To date there has been little indication that government has seriously considered such alternatives in the interests of maintaining and increasing the supply of high-quality services. Instead, the NDIA appears to be waiting for market failure before it intervenes, which jeopardises access to services and potentially puts participants at risk.

Further, as is the case for all disability providers, there is a cost for providers of psychosocial services to manage the change in the source and structure of their revenue. It is imperative that organisations receive funding and training to help them to adapt to the new disability market. In 2016, Mental Health Australia held 15 training workshops in NSW, QLD and NT in collaboration with National Disability Services and relevant state mental health peak bodies on the topics of costing and pricing under the NDIS, change management, marketing and flexible work practices. Over 50% of participants stated they were interested in future training on clients and market focus, people and capability and information and knowledge management, indicating an ongoing training need to assist organisations to effectively transition to NDIS arrangements.

Looking to the future, Mental Health Australia has recently submitted a proposal to the Department of Social Services to carry out work examining the supply and sustainability of community mental health services in Australia in the context of multiple streams of reform affecting non-government providers, including the NDIS. Based on this work, Mental Health Australia hopes to develop and implement strategies to assist providers to adapt to the unprecedented change facing the sector.

Pricing

To illustrate the feedback from community mental health providers that the prices determined by the NDIA do not match the reality of service delivery to people with psychosocial disability by suitably qualified personnel, Box 1 describes a typical example.

Box 1: a psychosocial service delivered as part of assistance with daily living

Assistance with self-care activities during daytime weekdays to assist with, and/or supervise, personal tasks of daily life to develop skills of the participant to live as autonomously as possible is priced at \$42.79 per hour (ref no. 01_011_0107_1_1)

While the psychosocial support worker assists the NDIS participant in their home with washing their dirty dishes, in conversation he or she is:

- identifying the person's strengths and moments of resilience to work with, emphasise and acknowledge so that the person can build on these at the right time
- using recovery-oriented and person centred perspectives and counselling skills to help the person explore their own goals, passions, desires and motivations, and when the person appears to be ready, discuss opportunities where he or she could use their strengths to work towards their goals or participate in activities that they find makes life more meaningful to them
- considering the impact that systemic discrimination and/or stigmatisation has on the person and finding ways to promote their self-empowerment
- being sensitive to past trauma, and being very careful with the conversation to avoid causing re-traumatisation for the person, while looking for symptoms that the person could be becoming unwell
- watching for early indicators that the person, the support worker or someone else's safety could be at risk
- listening for opportunities to involve the family, community, environment if possible and productive in the person's recovery journey, to ensure they have the support they need.

After the service has been provided the support worker:

- writes case notes and undertakes a self-reflective practice audit to review the quality of the service
- coordinates other services as necessary (i.e. contact their housing, transport, other workers about practical non-confidential issues) and make any necessary reports (e.g. to child protection, police).

The NDIA's process for pricing services of various kinds has been difficult for non-government stakeholders to understand or contribute to. For example, mental health providers were not invited to contribute to the detailed work and assumptions built into the NDIA's Reasonable Cost Model regarding overheads, supervision etc. Providers have also been largely unable to provide detailed advice in response to any consultations either during or subsequent to the RCM's development. To build the NDIA's evidence base for 'a market price' for psychosocial services, Mental Health Australia asked the NDIA to check the assumptions in the model with providers, but to our knowledge this did not occur. As a result, providers have described their work in Trial Sites as 'loss-leading', undertaken under the assumption that it will eventually become apparent to the NDIA that its pricing structures need revisiting, and acknowledging that this is one of a myriad of implementation challenges.

Support coordination

To put the concerns about the pricing model into perspective, the adoption of the revised Pricing Guide in August 2015, along with other changes in NDIA practice, has led to changes in the mix of support items funded at different pricing levels, including three levels of support coordination. Many activities for people with psychosocial disability undertaken on a flexible, client-directed basis can now (in theory at least) be carried out through the support coordination role. The extent to which the right balance is being achieved between core support items (funded at a lower rate) and capacity building items (including support coordination funded at higher rates) is still unclear, and appears to vary substantially. It is

difficult for non-government stakeholders to understand the drivers of such variation, and Mental Health Australia would like to see the NDIA monitor this issue closely and report on its findings. In broad terms, it would be disappointing if programs originally designed to provide capacity building supports are being absorbed into the NDIS to resource the provision of core supports.

Given the potential impact of the current prices on the availability of psychosocial support services, Mental Health Australia suggests the NDIS needs to have an 'effective' price rather than an efficient price. An effective price would enable providers to adjust their business model and their running costs in order to provide high quality services, in turn ensuring an appropriate supply of services in order to deliver on the Scheme's objectives by having the right number and diversity of providers for the range of services participants need.

Given supply and demand under the Scheme are likely to fluctuate for several years to come, coupled with economic pressures that affect the Scheme's budget, Mental Health Australia recommends the NDIA establish an ongoing arrangement for capturing and responding in good faith to provider input into deliberations regarding the pricing model. At the same time, there is a need for interim, transitional arrangements to ensure valuable skills and programs are not lost inadvertently during Transition, before key drivers of the cost of service delivery are better understood (see below).

Benchmarking

An important aspect of a high-functioning market is access to information. On the provider side, information on how a range of business costs compare with competitors can help providers determine if their target market is the right one, whether their operations are efficient, and where improvements might be made. As the NDIA has recognised, there is a strong argument for a benchmarking exercise to gather business-related information from providers and share results with individual enterprises.

While the broad intent is sound, Mental Health Australia has strong concerns about the manner in which the NDIA's benchmarking project is being implemented:

- The governance of the project does not allow for sufficient input or oversight from providers or provider representatives, meaning the sector cannot be confident the project will be of genuine benefit to providers. An actual or perceived lack of impartiality will substantially reduce the credibility of the project and therefore participation by providers.
- The project seeks to circumvent, rather than complement and build on, work already undertaken to benchmark provider financial ratios, work which was funded by the DRC and undertaken by Curtin University and which is highly regarded in the sector.
- A range of methodological flaws in the study design will mean that the data collected may not be fit for purpose. These in turn stem from a lack of genuine engagement with the sector, and the NDIA's claim that the project reflects a 'co-design' process is highly inaccurate.

Properly designed and managed work to benchmark the real costs of service delivery can contribute substantially to a helping providers adjust to the new funding environment and plan for the future. Mental Health Australia hopes to work with DSS and the NDIA to develop a more satisfactory approach to this important work.

Independent Pricing Authority

In the aged care sector, the Government established the Aged Care Financing Authority (ACFA), to provide independent advice to the Government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors.

The ACFA brings together providers, employee representatives, finance and business experts to provide advice on the impact of funding and financing arrangements on the viability and sustainability of the aged care sector, the ability of care recipients to access quality aged care, and the aged care workforce.

The ACFA was established in 2012 to monitor the introduction of the *Living Longer Living Better* reforms to aged care. At the time, the then Government noted that “as with any significant change, it is important the transition ... is managed efficiently and effectively.”

Mental Health Australia recommends the Commission consider the benefits of establishing an independent pricing authority, adopting a similar model to the ACFA, to provide independent advice to Government on pricing issues relating to disability, psychosocial and other services funded under the NDIS.

Supply

As this submission has argued, the supply and sustainability of psychosocial services is particularly vulnerable during the transition of block funded Commonwealth programs to fee for service arrangements through the NDIS.

The transition to the NDIS is happening in parallel with the implementation of other mental health reforms, most notably at the Commonwealth level, making this an even more challenging time for community mental health providers. Mental Health Australia hopes the Commission’s Review will take into account the intent and anticipated impact of all reforms affecting the sector and the implications for ongoing access to quality psychosocial support for people with severe and complex mental illness.

Governance and administration of the NDIS

The introduction of the NDIS and the transition of funding for psychosocial services from Departmental programs, along with other funding reforms associated with Primary Health Networks, has been very disruptive to the community mental health sector. Problems have gone unresolved for long periods of time. Not only has there been very real consequences for vulnerable individuals, but service providers are now in tenuous business circumstances that they may not survive.

This significant change process could have, and should have, been managed by a sound governance process that included consumers and carers, sector representatives and experts.

Instead, consumers, carers, service providers and industry groups feel distant from the current governance arrangements. This is largely because when issues have been raised with the NDIA, stakeholders are re-directed to other parts of Government, who also take little or no responsibility for them.

These arrangements have not facilitated systematic engagement or consultation with service providers and other stakeholders on key decisions. From a mental health perspective, one important contributor to this situation is that ultimate policy responsibility rests with disability

ministers, with no way to escalate critical issues to a forum also involving senior health or mental health bureaucrats. From this perspective, there is still no 'early warning system' that would allow mental health stakeholders to alert decision-makers before issues require a crisis response.

From an implementation governance perspective, feedback loops have developed slowly. It will be essential to the future success of the NDIS to put in place arrangements that allow problems and potential solutions to be identified and escalated quickly, and for decisions regarding these issues to be fed back to practitioners in a timely way. Current governance arrangements are highly government-centric, with occasional and by no means comprehensive attempts to seek advice from consumers, families and other experts.

The NDIA Mental Health Sector Reference Group (NMHSRG) has been established to develop a strong working partnership between the Mental Health sector and the NDIA. Mental Health Australia commends the NDIA for its foresight in establishing this Group. However, the NMHSRG has no mandate to consider policy issues, instead focussing on immediate matters of implementation.

Mental Health Australia hopes future governance arrangements will promote more regular and person-centred consultation regarding a wide range of issues associated with the NDIS, including aspects of Scheme design beyond the NDIA's immediate control.

Operating costs

Mental Health Australia notes that the target of 7 per cent operating costs set for the NDIA is slightly below the 8 per cent management expenses of the two private health insurers with revenue in excess of \$6 billion.

It would seem appropriate for the NDIA operating costs to in fact be higher than usual insurance scheme benchmarks because it has higher up-front operating costs associated with assessing eligibility, planning the payout of benefits for every NDIS consumer, and managing participant expectations as they enter into a lifetime of accessing support. This contrasts with the situation for other insurers, who accept premiums up-front and determine payouts if and when claims are made.

In Mental Health Australia's view, the range of issues highlighted in this submission (and doubtless many others) indicate major capability and capacity constraints within the NDIA. While the NDIA may (barely) have sufficient resourcing to meet its transition targets, it is much less clear that it can do so in a way that maximises choice and control for NDIS participants. Instead the NDIA has been forced to compromise on the integrity of the planning process and its person-centred principles to meet its challenging Transition targets. Mental Health Australia encourages the Commission to give serious consideration to the resources required to manage transition successfully (in the broadest sense), as distinct from the Scheme's ongoing operational requirements.

Mental Health Australia



Mentally healthy people,
mentally healthy communities

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

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