

**Productivity Commission Issues Paper
National Disability Insurance Scheme (NDIS) Costs**

Submission by Flourish Australia

24 March 2017



Supporting Mental Health & Wellbeing

INTRODUCTION

Flourish Australia welcomes this opportunity to submit a response to the Productivity Commission's Issues Paper 'National Disability Insurance Scheme (NDIS) Costs'

Flourish Australia, previously known as RichmondPRA, is one of Australia's largest and most experienced not-for-profit community based, mental health organizations. For over 60 years, we have worked in local communities to support people on their mental health recovery journey. We provide a range of psychosocial support programs across our metropolitan and regional, rural and remote, locations in NSW and South East Queensland - including individual support in the home and the community, group programs and activities, supported employment opportunities and assistance to find and maintain work. Our aim is to build participation pathways and support people with a mental health issue to achieve their goals and live hopeful and meaningful lives. In 2015/2016 we supported 4,723 people in this way.

Our organisational culture fosters leadership in recovery-oriented, strengths-based and person-led support. The value we place on lived experience is evidenced by 50% of our staff identifying as having a lived experience of a mental health issue, and through our peer workforce strategy. Currently 37% of our frontline staff are mental health peer workers, drawing on their own lived experience of a mental health issue and recovery journey to support others to achieve their goals.

We have significant experience providing services under the NDIS, having been part of the Hunter trial site since 2013. At the end of 2016, we were supporting over 350 people under the Scheme, 160 of whom commenced receiving services from Flourish Australia following the advent of full Scheme rollout in July 2016. Many of these 'newer' people are based in the Hunter where there is heightened awareness of, and demand for, the NDIS. Those numbers include people transitioning from other Commonwealth programs including Australian Disability Enterprise (ADE) services, Partners in Recovery (PIR) and Support for Day to Day Living in the Community programs.

Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. We are also strongly supportive of the inclusion of psychosocial disability within the Scheme's remit, and have seen firsthand the benefits of the Scheme for the people we support and their families.

However, we are also mindful that, as with any reform of such a substantial scale, there can be unintended consequences, implementation issues and uncertainty, especially during the transition phase. We are particularly mindful of the impact of this on the people we support. These are the focus of our submission.

In preparing our submission, we have drawn on our direct experience of the Scheme in the Hunter and elsewhere, and have consulted the people we support who are NDIS participants and our frontline staff to ensure their views are reflected.

ISSUES AND QUESTIONS

We have addressed those issues and questions raised that are relevant to our experience as an experienced provider of psychosocial supports who is registered with the NDIS.

1. Scheme costs

a) Are there cost drivers not identified in the paper that should be considered? If so, how do they impact costs in the short and long term; and how and to what extent can government influence them?

Studies show that there is a strong relationship between income inequality and the prevalence of mental illness in wealthier countries. Analysis of comparable data across a range of countries has highlighted that Australia rates fourth (behind the United States, United Kingdom and Italy) when it comes to income inequality, and second in terms of the percentage of the population experiencing mental illness - on a par with United Kingdom and behind only the United States. (Pickett & Wilkinson, 2010).

It is also known that stigma and discrimination concerning mental illness can exacerbate adverse outcomes, impacting on education and employment opportunities, housing stability, access to services and social connectedness. These factors can increase isolation, insecurity, poverty and a sense of hopelessness, which in turn can impact negatively a person's mental health.

Further, the lack of sufficient, effective prevention and early intervention for people with mental health issues, and historic underspending on recovery-based community support services, have also served to exacerbate people's circumstances and conditions and mean that more intensive and longer term interventions may be required at a later point (National Mental Health Commission, 2014). A joined-up government approach is required, especially between Health and Social Services/Human Services for the Scheme to operate effectively and efficiently.

Tight labour market conditions, especially in locations where the people with the skills and experience required to provide appropriate supports are less available, also drive costs up. In discussing human resources factors driving costs it is also important to note the current lack of ability within the Scheme to cater for the different support needs of people experiencing different types of disability and the consequent level of experience and training required to provide good quality supports. For example, people with a psychosocial disability arising from a significant and complex mental health issue arguably require more skilled and experienced people providing the support than some other groups. Understanding and allowing for the differential nature of the supports and one-on-one staffing costs, in excess of the standard provisions, is more consistent with the insurance principles of the NDIS. More targeted support earlier for many people may in the long-term, lead to a reduction of need for support over time as a person's confidence and capacity grows.

It is not possible to quantify the extent to which these factors are contributing to mental health issues in the Australian population, affecting their ability to participate fully and live

independently. However, we believe that they play a part in driving demand for the NDIS. Until we have an outcomes-focused, integrated mental health system that responds to whole of life needs and places people with lived experience and their families and carers at the centre – providing access in the right place at the right time – demand for more intensive psychosocial support via the NDIS may continue to grow.

b) Why are utilisation rates for plans so low? Are the supports not available for participants to purchase? Do participants not require all of the supports in their plans? Are they having difficulty implementing their plans? Are there other reasons for low utilisation rates?

A number of factors may be contributing to low utilisation rates in plans.

The planning process

In relation to mental health issues and psychosocial disability, we know that the level of understanding and the approach taken by NDIA staff can be highly variable. We have had instances of people we support being told that “mental health” is solely the concern of the health system, not the NDIS. This points to a lack of understanding of the concept of psychosocial disability that can, and does for some, arise out of a mental health issue.

We are concerned about reports that ‘diagnosis’ drives eligibility and planning processes, as opposed to an assessment of functional impact arising from a person’s psychosocial disability. Where the mental health diagnosis is seen as the primary consideration, there is the risk that the resulting plan will not be tailored to the psychosocial needs and goals of the individual, which will impact on the appropriateness of the plan and the rate at which available elements in it are used.

We also know that the planning process can be rushed, often occurring over the phone and not in person. For some people with a psychosocial disability arising from a mental health issue, this approach is less than ideal and will increase the risk of a less than optimal planning and outcomes. Difficulty to gather thoughts, to plan, to express needs and goals or have a future focus can make planning over the phone for this group extremely challenging, especially if there is not adequate preparation or support available prior to and/or during the discussion.

Where face-to-face planning meetings do occur, we have been told that they can be an overwhelming and difficult experience for participants, lessening their ability to participate fully and resulting in a plan that does not reflect their needs. The capacity of the planner and time provided to listen, engage and understand the person’s experience appears to be a key factor in determining the success of the planning process.

System issues

The introduction of the new IT platform (portal) by the NDIA in mid 2016 caused many problems for service providers operating in trial sites who were impacted by changed requirements, lack of communication, poor data migration and people and plans going ‘missing’. While many of the problems have gradually been resolved, eight months on there

are some matters still to be rectified, affecting our ability to claim payments for a number of the people we support. This would affect apparent plan utilisation rates.

Similarly, under in-kind arrangements for PIR participants transferring to the NDIS, service providers have been instructed by the Department of Health to no longer use the NDIS portal to log support provided and 'draw down' on in-kind funds. Instead separate records are kept and provided to the Department of Health via a monthly NDIS transition report. This could mean that support provided to previous PIR participants who have transitioned to the NDIS is not being captured and included in NDIA statistics, despite supports being provided in accordance with approved plans.

c) Why are more participants entering the Scheme from the trial sites than expected?

600,000 Australians are estimated to have a severe mental illness (DoHA 2013). The extent to which this impacts their day to day functioning and independence will vary from person to person, influenced by personal, historic, environmental and social factors – and ability to access services, including early intervention supports.

The 60,000 people identified by the Productivity Commission (and later updated by the NDIA to 64,000) as the number of people with psychosocial disability who would be Scheme participants was only ever an estimate. It is possible that more people in the 'severe mental illness' category will experience functional impacts that prevent them from participating fully in the community without assistance and support.

Providers in trial sites have been active in promoting the scheme in local communities and undoubtedly peer networks have been working to discuss the Scheme's operations and possibilities for support. As the Scheme becomes better known eligible people may be seeing it as a long-awaited opportunity to gain much needed supports.

It is therefore to be expected that people in trial sites are still hearing and learning about the Scheme and continuing to join it. This is likely to be an ongoing process.

d) What factors are contributing to increasing package costs? Why is there a mismatch between benchmark package costs and actual package costs?

The basis on which the NDIA has developed its benchmark package costs for people with psychosocial disability is not clear. It is not known what components have contributed to the benchmark packages, who was consulted in their development, nor what guidance is provided to NDIA planners in their application.

From our experience, the extent to which an individual with a mental health issue can function independently and participate in daily life is defined less by diagnosis and more by the presence of natural supports, positive relationships, meaningful activities and quality support services in the person's life, in combination with personal, historical and environmental factors. In this sense, the experience of each individual will vary considerably, as will the individual's own experience over the course of their lifetime. The individual variability in support requirements, given the complexity of psychosocial disability arising

from a mental health issue, may be a factor in actual package costs varying from benchmark costs. It is possible the benchmark costs have not factored in sufficient numbers or intensity of supports.

We believe that benchmark package costs would benefit from a transparent review, including input from people with lived experience resulting in psychosocial disability, and those with experience in providing community-based psychosocial support.

Another contributing factor may be a lack of knowledge and understanding on the part of NDIA planners in relation to mental health issues resulting in psychosocial disability and a need to be able to better identify reasonable and necessary support requirements. As already indicated, our experience is that the understanding of NDIA planners in this regard can be highly variable. Providing them with training and education on mental health issues may assist with driving the desired results.

2. Scheme boundaries

e) To what extent have the differences in eligibility criteria in the NDIS and what was proposed by the Productivity Commission affected participant numbers and/or costs in the NDIS?

It is likely that the inclusion of additional eligibility criteria – including substantially reduced functional capacity to undertake activities of learning and social interaction – will increase participant numbers. However, we would argue that the inclusion of these criteria is essential to enable a more holistic assessment of a person's functioning and its impact on daily life, in particular for those with psychosocial disability.

If the Scheme is about giving participants choice and control to lead an ordinary life, then it follows that an assessment of functional capacity to undertake learning and social interaction should be included. These are activities in which the majority of people routinely participate, and which are generally regarded as contributing to a meaningful life and sense of wellbeing.

For people with psychosocial disability, the provision of support to undertake learning or participate in social interaction can mean the difference between an isolated existence or a life with purpose, economic participation and increased independence.

On this basis, it could be argued that the eligibility criteria should be extended even further to include 'substantially reduced capacity to undertake employment'. This is another activity in which most of us of working age are engaged and which substantially increases economic participation, independence and sense of self-worth and purpose.

f) *Are there other aspects of the eligibility criteria of the NDIS that are affecting participation in the Scheme (to a greater or lesser extent than was expected)? If so, what changes could be made to improve eligibility criteria?*

We have suggested above that ‘reduced capacity to undertake employment’ should be included, on the basis that access to employment is, for most, a key part of living an ordinary life.

As already highlighted, our experience is that it is the inconsistent and imprecise application of the eligibility criteria in relation to people with psychosocial disability that is a major concern. We have suggested that NDIA staff need to enhance their knowledge and understanding of mental health issues that can result in psychosocial disability, and receive further guidance on applying the eligibility criteria accurately and consistently to this group.

A case in point is the concept of “permanency” as it applies to the eligibility criteria. Such a concept can be at odds with contemporary thinking and practice in relation to supporting people with lived experience of mental health issues, which is premised on taking a strengths-based, person-led approach focused on the individual’s unique recovery journey.

Further, Section 24(2) of the NDIS Act allows for the episodic nature of many mental health issues by recognising that while an acute illness may be episodic, impairments can be considered permanent.

NDIA staff need knowledge and skill to weigh up these factors in assessing eligibility. They need an understanding of mental health recovery and psychosocial disability. In addition, there is a need to be able to sensitively hold conversations that recognise the unique circumstances and strengths of each individual, at the same time that they adhere to processes that meet legislative and other requirements.

In the absence of this understanding we are seeing a reliance on reports from medical professionals, including confirmation of diagnoses, as key factors and the starting point in determining eligibility. This is a fundamental and inappropriate shift in the operation of the Scheme.

We would suggest that further training and guidance for NDIA staff needs to draw more on the wisdom and experience of people with lived experience of a mental health issue.

We note that people with a lived experience of a mental health issue that results in psychosocial disability can also be distrustful of, or find it difficult to navigate government bureaucracies and programs. Some may require time, additional support and/or the chance to hear first-hand from peers about their experience, before they are prepared to give something a go. In forums with the people we support, a common misconception that has prevented people from applying to access the Scheme, is that an NDIS package will impact on their ability to claim the Disability Support Pension. This may impact on participation rates.

For those who are isolated and/or not connected to existing services, they may not have had the opportunity to hear about the Scheme when it first commenced, and it has only been over time and with increased publicity or word of mouth that they have come to know about it.

g) To what extent is the speed of the NDIS rollout affecting eligibility assessment processes?

Undoubtedly, the speed of rollout, particularly in NSW, is affecting the thoroughness, consistency and quality of assessment and planning processes. We have heard of many instances of incorrect and/or inconsistent advice being provided by LACs and others in respect of eligibility for people with mental health issues who experience a psychosocial disability.

This ranges from 'mental health is the responsibility of the health system, not the NDIS' to 'you cannot access the NDIS until your condition is stabilised and treated by a medical professional'. Instances of certain diagnoses being ruled ineligible for some people (regardless of functional impact) but not for others have also been experienced.

It is not surprising that when there are targets to be met and delays – such as the NDIA portal malfunction - experienced, steps are taken to make up for lost time. However, when this is to the detriment of the very people the Scheme is designed to assist and results in fewer people than anticipated accessing the scheme (as has been the case for people with psychosocial disability during Quarter 1 of full rollout), corrective action is required.

The development of plans over the phone is also problematic and does not provide for a proper eligibility assessment, given the technological, psychological and physical challenges of the person in presenting their support needs adequately to a planner via this medium (see also 1(b) Utilisation rates for plans, above).

h) Is the current split between the services to be provided by the NDIS and those provided by mainstream services efficient and sufficiently clear? If not, how can arrangements be improved?

While the 'split' between services provided by mainstream services and the NDIS may, in theory, be clear and efficient (as set out in the bi-lateral agreements), in practice it can be a different story. Notwithstanding that people with disability have the same right of access to services as all Australians, their experience of accessing mainstream services – be it health, mental health, education and training, housing, employment, justice, transport or aged care - can be challenging.

Stigma, discrimination and/or lack of understanding can mean that people with a mental health issue can be wrongly judged by their diagnosis and seen as unreliable, dangerous, lacking in intellectual ability, or not suited to living in the community. Such attitudes can be prevalent among providers of mainstream services who may, consciously or unconsciously, not treat those with a psychosocial disability arising from a mental health issue fairly or equitably, relative to others.

For the split between mainstream services and the NDIS to operate effectively, mainstream services need to understand their responsibilities in respect of people with disabilities, they need skills and knowledge in order to fulfil these responsibilities, and they need sufficient resources and capacity. They also need an adequate understanding of, and linkages to, the NDIS.

i) Is there evidence of cost shifting, duplication of services or service gaps between the NDIS and mainstream services or scope creep in relation to services provided within the NDIS? If so how should these be resolved?

The ongoing under-funding of prevention and early intervention services, community based support and related services - such as affordable housing - for people with a mental health issue is well recognised and has been documented in various strategies and plans by Australian governments over many years. The advent of the NDIS does not resolve these problems nor absolve Governments from developing and leading strategies, in collaboration with other stakeholders, in order to remedy them. The majority of people who experience a mental health issue in the course of their lifetime will not qualify for the NDIS and will be reliant on other service systems to meet their support needs.

The concern is that the scale of the reform entailed by the NDIS will be seen by Governments as evidence that they have fulfilled their responsibilities to provide appropriate support to people with disabilities, and will mean that existing service gaps remain unaddressed.

Funding for the NDIS should not be at the cost of other essential government services for people with mental health issues more generally.

Failing to ensure that mainstream services, and, particularly specialist acute mental health services are adequately catering to the needs of people with a mental health issue will have the effect of exacerbating people's circumstances and conditions to the point where they may become eligible for the NDIS.

j) How will full rollout of the NDIS effect how mental health services are provided, both for those who qualify for support under the Scheme and for those who do not?

Mental health services are most effectively delivered through an integrated system of clinical care and psychosocial support in the community, which can be stepped up or down depending on the needs of the individual and delivered via collaborative arrangements between relevant mental health service providers, drawing on other supports and service systems as required.

Because the mainstream public mental health system tends to focus most predominantly on acute care needs, community based psychosocial support services play an important role in assisting people with mental health issues to transition from acute care to the community, participate in day to day life, and receive practical assistance to maintain their wellbeing and independence.

Under block grant funding arrangements, the ability of community managed organisations to respond to demand has always been restricted by available funds and some program requirements. The advent of the NDIS means more flexible funding to provide support to people with psychosocial disability, tailored to their individual needs.

However, there is a concern is that community based organisations may need to restrict the services they provide to concentrate on those that are more financially sustainable under the NDIS pricing regime. This could mean more organisations specialising in, say, Coordination of Supports or group programs, and fewer providing one-on-one support due to the level of the hourly rates of payment. The result of this would mean less choice for people with a psychosocial disability.

People not eligible for the NDIS are already experiencing uncertainty and confusion. Continuity of support arrangements are still not finalised, so it is unclear whether they will be able to continue to access the services they currently receive, post full Scheme rollout. The concern is that if people currently accessing support in the community have this support 'switched off' at a future point, their needs and circumstances could be exacerbated, pushing up demand for the NDIS.

We know that in some states a large number of mental health programs and services have been 'folded' into the NDIS. Given that the majority of people who will experience a mental health issue in their lifetime will not qualify for an NDIS package but may still require and benefit from psychosocial support, it is imperative that an effective, integrated mental health services system remains in-tact and sufficiently resourced to cater to need.

k) What, if anything, needs to be done to ensure the intersection between the NDIS and mental health services outside the Scheme remain effective?

To ensure an integrated system that takes a holistic approach and is responsive to the differing needs of people with mental health issues, it is important that the NDIS has strong links to and collaborates with other parts of the system. From our perspective, it would appear that the priority at the moment is the rollout of the Scheme, not smooth transition, collaboration or integration with other relevant service systems. This is problematic.

The transition of Partners in Recovery (PIR) participants to the NDIS has been slow moving and characterized by inconsistent decision-making and substantial changes to implementation as the transition rolls out. Many of the policy changes which have impacted PIR service delivery agencies appear to be caused by a lack of effective communication between the Department of Health (PIR funding body) and the National Disability Insurance Agency. Fundamental elements of the transition, such as access processes, reporting requirements, guidance materials and allocation of Coordination of Supports in plans are continually changing and still not finalised eight months after transition commenced. PIR Organisations are working effectively to progress the program transition in this space, but are fighting declining morale and ongoing uncertainty about key elements of our work.

While the NDIS is built on choice or control, the absence of alternative arrangements almost forces participants with psychosocial disability to apply for the NDIS or risk unavailability of

services. This is particularly true of the PHaMS program, where progressive cuts to funding levels have led to a significant reduction in services to existing participants. In this transition period, the withdrawal of services before new NDIS funded services arrive to take their place is creating significant service gaps.

For people who are not deemed eligible or choose not to test their eligibility, PIR services will continue to be provided until the proposed conclusion of the program on 30 June 2019. This presents greater certainty that PIR participants will receive necessary support for at least the next two and a half years. We have been advised that Continuity of Support arrangements for PIR participants and participants in other Commonwealth funded mental health programs will be advised in due course. Our understanding from the Hunter Trial site is that 80-90% of PIR participants are deemed eligible for the Scheme and will receive funded supports through the NDIS, but that the number of eligible Day to Day Living (D2DL) and Personal Helpers and Mentors (PHAMs) participants who are eligible for NDIS is significantly lower, meaning these Continuity of Support arrangements will be vital for a large number of people currently supported through Commonwealth mental health programs. Until these arrangements are advised there will be a significant degree of anxiety and uncertainty experienced by both people living with psychosocial disability and the sector which supports them.

On the ground, Local Area Coordinators (LACs) could play a significant role in fostering collaboration and integration. Indeed, our understanding is that the role LACs was originally intended to ensure that people not eligible for the NDIS could access mainstream services, that mainstream services were accessible and responsive, and that the links between the NDIS and other services were strong and effective.

As we understand it, LACs have instead been diverted into the individual planning function, so have not taken on this broader community development, organisational capacity building or systemic role.

If LACs were able to undertake their roles as originally intended, and if they were sufficiently knowledgeable and skilled in respect of psychosocial disability arising from a mental health issues and the mental health service system, they could potentially make a big impact in terms of ensuring an effective intersection between the NDIS and other mental health services outside the Scheme.

Failure to have such understanding can lead to an inappropriate overprovision or prescription of supports that can be, and are, otherwise provided through established services and models that build-in co-ordination of supports.

1) Is the range and type of services to be funded under the ILC program consistent with the goals of the program and the NDIS more generally? What, if anything, can be done to ensure the ILC and LAC initiatives remain useful and effective bridging tools between services for people with disability?

The goals of the ILC program are laudable and in keeping with the broader goals of the NDIS. Within this framework, the range and types of services to be funded appear logical. However, we are concerned that the ILC program will not deliver on its promise, and will not be an

effective bridging tool between services for people with disability, for the reasons set out below.

Currently, only \$132 million is allocated to ILC funding, with the lion's share of the original funding now paying for LACs who are undertaking the individual planning function. This means that only 0.6% of the total NDIS budget is available for achieving the ILC's important goals: that is, building the capacity of mainstream services to be inclusive of people with disability; and making sure that people with disability and their families have the skills, resources and confidence to participate in the community.

The recent 'national readiness' grants program, as part of the first round of ILC funding, allocated \$13 million for activities that 'increase mainstream services' knowledge and skills to meet the needs of people with disability' or that 'help community activities and programs understand the needs of people with disability and have the skills and knowledge they need to be more inclusive'.

Arguably, the level of funding - and its short-term nature - is not sufficient for grant recipients to effectively improve access to mainstream services or community activities, or build capacity. A case in point is the mental health system. Given that providing appropriate and timely clinical acute services to people with mental health issues should be its core business, it is questionable whether a one-off project, funded via a small grant, will be able to achieve the desired outcome for a joined-up system focusing on the clinical and non-clinical supports at a national level.

LACs are now consumed by their responsibilities for the individual planning process, and many appear to be struggling with the demands of this role. This role will need to continue for some time – arguably beyond the 'full rollout' date, in order to ensure that those who continue to enter the Scheme receive a plan that is appropriate to their needs. This means that the capacity of LACs to connect people who do not qualify for the Scheme to mainstream services – and to ensure that those services are accessible – will be limited.

It also remains to be seen whether it will be an effective model – for instance, will an LAC without a mental health background and employed by a community based service provider be able to affect the systemic change to the mainstream health/mental health systems to ensure that those not eligible for the NDIS receive the services and support they require?

3. Planning processes

m) Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved? How should the performance of planners be monitored and evaluated?

In general, people who participated in our focus groups reported feeling confusion and anxiety ahead of their planning meeting. They felt that there was a lack of communication and information regarding the process and they were unsure what questions would be asked and were worried that if they performed badly there would be negative consequences such

as losing their Disability Support Pension (DSP). Once at the planning meeting, where this was face-to-face, most people reported a positive experience.

However, increasingly we are finding that people are being contacted by the NDIA, or by an LAC, and that planning meetings are occurring over the phone. In our view, this is an inappropriate method for conducting such important meetings, particularly for people who live with a mental health issue. Many people will not answer calls when they do not recognise the number due to the anxiety they experience. For those that do answer the call, they are often taken by surprise by it and are not prepared, comfortable or confident. Coupled with the fact that they may not have a support person present, this can lead to an inaccurate representation of their support needs, and a subsequent inadequate plan.

During focus groups, there was an extremely negative view of phone interviews, with people advising that they found the experience overwhelming, leading to an inability to think 'on-the-spot'.

We would also argue that talking face-to-face to a person to ascertain their needs is more respectful and likely to enable an accurate assessment, reducing the need for follow-up meetings, review of decisions etc. While over the phone planning may seem like a cost-effective approach, in our experience this is a false economy as the results can be less than optimal – and does not support to goal of “greater choice and control”.

Monitoring of planners' performance needs to include feedback from the people who are the central focus of the planning process. The extent to which the person was provided with information about the process, was encouraged to ask questions and felt listened to, heard and respected should be key criteria. Participants in the planning process will need to be assured that their feedback can be provided anonymously, that it will not affect the outcome of their package, and that there will be no adverse consequences.

n) Do NDIA assessment tools meet the criteria of being valid, reliable, accurate and efficient? What are the likely challenges for monitoring and refining the assessment process and tools over time? What implications do these have for scheme costs?

The WHO-DAS 2.0 is the only NDIA recognised assessment tool that includes a measure of psychosocial functioning. It provides a summary measure of functioning and disability that is reliable and applicable across cultures, in adult populations. The 12-item version is user friendly and succinct, and can be administered by a lay interviewer, the person themselves or by a proxy, such as a family member or friend.

Focus groups undertaken by Flourish Australia with people we support indicated that they regarded the WHO-DAS 2.0 as easy to complete, non-intrusive and straightforward. However, how the WHO-DAS 2.0 assessment is undertaken and the extent to which the person administering the tool is engaged, supportive and understanding, are important factors.

We would also argue that, while it is a useful tool for identifying needs, matching support services and setting priorities and goals, it is only one input to this process. In our experience,

it is equally important to seek the views of the person and their family (and their service provider if appropriate) and to engage them in a conversation to properly understand impacts on daily life, their strengths and goals. This will be unique to each person and not something that can be determined solely by an assessment tool, no matter how valid, reliable or efficient.

NDIA staff involved with the WHO-DAS 2.0 need training not only in its administration to ensure consistency and accuracy, but also in how to establish rapport and an environment that is conducive to exploring a person's strengths and goals. In our view, this is the ongoing challenge, regardless of the assessment tool used.

o) Are the criteria for participant supports clear and effective? Is there sufficient guidance for assessors about how these criteria should be applied? Are there improvements that can be made, including where modifications to plans are required?

The criteria for supports are necessarily broad to cover the range of circumstances and support types to which they will apply but are very appropriate to the aims of the NDIS. However, their broad nature means that there is considerable room for interpretation in their application to individual participants.

For example, we would suggest that in the context of psychosocial disability, determining whether a support will assist the participant in achieving their stated goals and aspirations and represents good value for money, would require an understanding of mental health recovery and the role of psychosocial support in improving outcomes for people living with a mental health issue.

In the experience of Flourish Australia, there is considerable variation in how the criteria is applied in respect of psychosocial disability leading to plans that sometimes do not align with the individual's needs and/or which are lacking in some respect. This suggests that assessors require further guidance in how the criteria should apply. In particular, they require guidance and education to apply the criteria in respect of people with lived experience of a mental health issue.

This guidance and education would most appropriately come from people with lived experience of a mental health issue, in keeping with the NDIA's commitment to co-design.

p) To what extent does NDIA's budget based approach to planning create clear and effective criteria for determining participant supports?

The budget based approach appears to be a 'top down' response developed to manage cost pressures. This is at odds with the Scheme's intent to provide individually tailored supports to enable people with disability to exercise choice and control, achieve their goals and participate in the community.

Furthermore, the introduction of the 'My first plan' concept - which largely funds people's existing supports only - was 'sold' on the basis that this was to allow people with disability time to get used to the Scheme and to think about their goals in preparation for their Year 2

plan. The fact that it now appears to have been a measure to reduce rising costs suggests a lack of transparency on the part of the Agency.

The approach taken in aged care that allocates a holistic budget that can be used for a wide variety supports, without the category restrictions currently experienced in the Scheme, would be more consistent with true “choice and control” by the person.

4. Market readiness

q) What factors affect the supply and demand for disability care and support workers?

Increasing the disability workforce by 60-70,000 FTE by 2019/20 is a significant task, impacted by many variables. Chief among these is competition from the aged care and childcare sectors, also facing increasing demand and the need to grow their respective workforces.

There are challenges experienced in the imperfect markets currently in place for workforce across the country. Supply of adequate numbers of people with appropriate qualifications and experience in rural and remote locations continues to be challenging.

Employers are acutely aware of the changing expectations of employees. Younger people in particular no longer look for a job or career for life but might change careers a number of times throughout their lifetimes – and tend to move away from rural and remote settings. We are seeing a more mobile workforce, higher turnover and an increased desire for flexibility to accommodate study, family, travel or other interests. Workplace surveys consistently rate flexibility and positive work-life integration as the most important factors that people look for when seeking new employment opportunities.

Modern workplaces are also placing less emphasis on formal structures and more emphasis on what people do, the tools they need to help them, and how to make the workplace (whether ‘bricks and mortar’ or otherwise) an attractive and supportive environment.

There is a need to pursue innovative solutions to workforce demand and supply, drawing on the significant resource of people with disability.

Flourish Australia has had considerable success with its peer workforce strategy, under which we employ people with lived experience of a mental health issue who are able to draw purposefully on this in their support of others. There is evidence that peer support leads to significant reductions in hospital admissions/bed use, improved relationships with providers, higher levels of hopefulness for recovery and greater independence.

Not only does our peer workforce model mean good outcomes for the people we support, it also means good outcomes for our peer workers. We know that work is generally good for health and well-being, and that long-term work absence, work disability and unemployment have a negative impact on health and wellbeing (Australasian Faculty of Occupational and Environmental Medicine, 2011). Employing people with mental health issues can provide experienced and qualified staff, promote economic participation, and helps keep people well.

The current employment rate of people with disabilities in Australia is low against the OECD average. People with a disability in Australia are only half (50%) as likely to be employed as people without a disability. In comparison for the OECD, the relativity is 60% and for the top eight OECD countries, the relativity is closer to 70%. Australia has opportunity to improve.

The NDIS represents a landmark opportunity to grow the disability workforce to meet demand by increasing the number of people with disabilities who are employed.

For people with disability to make a real and substantial contribution to the employment demand arising from the NDIS, there will need to be strong Government, as a major employer in Australia, leadership and commitment to make it happen.

r) Are prices set by the NDIA at an efficient level? How ready is the disability sector for market prices?

Prices set by the NDIA are currently unrealistic. The NDIS funding model means that service providers are paid per unit of service provided, with the hourly rate purportedly calculated to include not only staff salary costs, but also the other relevant costs incurred in the provision of an hour of service (the on-costs). The box below sets out the challenges associated with this model at current pricing levels.

At Flourish Australia, the average hourly rate for a frontline mental health support worker is \$26.48. On top of this, on-costs of 15% need to be added to cover sick leave, Workers Compensation, Annual Leave, Long Service Leave etc.

Under the NDIS when a worker is sick or on leave their role needs to be back filled in order to fulfil Service Agreement obligations, ensure ongoing provision of service and generate income for the service provider. If all leave entitlements are taken, this has the effect of reducing a worker's availability to 44 weeks of the year, adding a further 18% to on-costs to cover back-fill arrangements.

This takes the average hourly rate, including these on-costs, to \$36.00. The NDIA's standard hourly price for one-on-one support is \$42.78.

This means that there is \$6.78 remaining to cover the time/costs incurred by a staff member in undertaking other key functions associated with providing high quality one-on-one support under the NDIS, for example:

- Supporting a person to understand and access the NDIS;
- Assisting the person to exercise choice and control and consider other service providers to meet their needs;
- Establishing their service agreement, explaining key policy matters (such as privacy and confidentiality) and orientating them to the service;
- Undertaking data entry and other administrative requirements;
- Liaising with family members, other service providers and health professionals; receiving supervision;
- Attending training, staff development and team meetings;
- Keeping up to date with policies, procedures and regulatory requirements;
- filing incident reports, etc.

The \$6.78 also has to contribute to the costs of equipment (such as a mobile phone or tablet), vehicle use, management oversight, a contribution to rent and whatever other overheads are incurred in the course of providing face-to-face service.

As the above highlights, it is simply not possible to cover costs under the existing pricing regime, even operating at the highest levels of efficiency.

Services for people with disabilities are essential services, as shown by the level of commitment and bi-partisan support for the NDIS. As such their provision should be driven by need and by 'consumers', not by the 'market' (particularly given the market is imperfect at present).

If pricing were to be set solely by the market, this would further open up the Scheme to for-profit providers who would, as the name implies, be there to make a profit. This could only be achieved by pushing the price up, or cutting costs and impacting on the quality of service.

While for-profit providers have already entered the market. Their NDIS 'product' is possibly serving as a loss leader with a view to attracting business and diverting it to other, more profitable products. Alternatively, it could be a means of building market share with a view to being well placed to dominate the market and set market prices, if and when price deregulation occurs. Either way, this is not in keeping with the intent of the Scheme which is about handing choice and control to people with disabilities.

We believe that prices should continue to be regulated, as happens for many essential services across different industries, but based on the real, efficient costs of providing quality services. In that regard, we reference the work of the Independent Hospital Pricing Authority in determining in efficient costs in that area (see: <https://www.ihpa.gov.au/>).

The pricing regime needs to recognise that a one size fits all approach is not appropriate. Providing support to someone with a psychosocial disability as a result of their mental health issue - to assist them to increase their independence and participation in the community - can be extremely complex and challenging work. It requires someone with expertise, experience, a commitment to recovery-focused practice. Our service model is premised on employing people with their own lived experience of a mental health issue (often in the role of a peer worker), as this facilitates empathy, understanding, hope and tangible proof that recovery is possible.

Under this model, the provision of support, supervision, training and development is vital to ensure that our staff maintain their own well-being and are able to draw appropriately on their own experience. We are working with people who in many instances have experienced significant trauma and who may have very complex needs. Attracting the right kind of staff with suitable experience and personal attributes is vital, as is being able to provide them with a safe work environment that nurtures and develops their skills. This is reflected in the costs of service delivery should be reflected in the rate of payment from the Scheme.

The current 'one size fits all' pricing regime does not recognise the different models of service delivery and practice frameworks, the different needs of Scheme participants, and the

importance of ensuring staff wellbeing. Along with the unrealistic unit prices set, it runs the risk of impacting significantly on service quality and tailored, individualised responses.

5. Governance and administration of the NDIS

A Scheme of such magnitude that has the ability to impact the lives of very vulnerable Australians and where the costs are shared across the community requires oversight, transparency and accountability in order to demonstrate effective stewardship of resources, value for money and results in the public interest.

We acknowledge the appointment of many new members of the NDIA board. We strongly support the ongoing roles of the Independent Advisory Council and the Joint Standing Committee on the NDIS. Both serve to increase independent input and oversight.

Additional mechanisms to enable input from people directly impacted by the Scheme so that they can contribute to co-design and system improvement are needed. The quarterly report to COAG would benefit from including participant views and stories to add a human dimension to what is otherwise a collection of important but impersonal statistics.

6. Paying for the NDIS

Bipartisan and ongoing commitment to the NDIS is required. Participants and their families need certainty that the Scheme is here to stay and will be able to fulfil its important objectives.

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