

Submission to the Productivity Commission's National Disability Insurance Scheme Costs Position Paper

National Mental Health Commission
July 2017

Introduction

The National Mental Health Commission (NMHC) welcomes the Productivity Commission's (PC) Position Paper on the National Disability Insurance Scheme (NDIS) Costs (the Position Paper). The NMHC believes that if the PC's proposed findings and recommendations are able to be acted on, there will be improvements for people with psychosocial disability – both those who access the scheme to receive NDIS packages and those who do not.

There are, however, several aspects of the Position Paper that the NMHC believes can be improved to increase the likelihood that the scheme will succeed in delivering the outcomes that governments and the wider community are seeking, while reducing the risks within the scheme. The following is a summary of the NMHC's views. Specific responses to relevant draft findings, recommendations are provided in **Attachment A**.

1. **Timeframe for implementation.** The NMHC agrees with the PC that the reduced timeframe for implementation has resulted in increased risks to the implementation of the NDIS, including risks to the welfare and outcomes of consumers, their families and their carers, and to the viability of some providers of important services. The NMHC notes that the PC does not explicitly recommend a revised timeframe for implementation. Rather, the PC recommends that the National Disability Insurance Agency (NDIA) strike a 'better balance' in its implementation of the scheme, but is unable to advise how this can be achieved. The inference seems to be that the PC believes the ambitious timetable for implementation should be amended. If that inference is correct, the NMHC suggests the PC makes a specific recommendation to that effect.

A better practice approach would be to first develop a detailed and systematic work plan that has a high probability of achieving the outcomes that governments and the community are seeking from the NDIS, and then to use that work plan timetable to adjust the implementation timeframe. It should also be used to inform funding decisions, including for the Information, Linkages and Capability building (ILC) element of the NDIS, Local Area Coordinators (LACs) and the NDIA's requirements. This work plan should include specific actions in relation to psychosocial disability, such as:

- finalisation of a functional assessment tool for psychosocial disability
- a psychosocial disability reference package
- disparities in outcomes for people with psychosocial disability compared to other types of disability
- the need for specific outcomes to be defined for psychosocial disability in the NDIS Outcomes Framework

- the need for specialist capabilities in psychosocial disability in various facets of the NDIS (e.g. assessors, planners, LACs, assertive outreach) (as per the PC's Draft Recommendation 4.2)
- processes to resolve outstanding issues with the interface with non-NDIS mental health and psychosocial disability services.

2. **People with psychosocial disability accessing the NDIS.** The NMHC notes the Position Paper states that to date around six per cent of scheme participants have a primary psychosocial disability, although acknowledges that this overall figure is affected by the differences in populations and timeframes for each of the trial sites, and the proportions in Barwon and Hunter are closer to the 14 per cent figure estimated in the PC's 2011 report. The NMHC is concerned that the NDIA's practices regarding access and eligibility processes (eg a high proportion of access and planning processes are now conducted by telephone) will exacerbate the trends identified by the evaluation of the NDIS trial, namely that people with psychosocial disability experience significantly worse outcomes from processes around access and eligibility processes, plan development and service delivery. The NDIA has taken a largely 'passive' approach to the access and eligibility process, with minimal outreach to engage 'hard to reach' potential clients – including those experiencing mental illness. This is likely to result in some individuals who are most in need not accessing the scheme. On the other hand, the NMHC is encouraged by NDIA data indicating that around 80 per cent of people applying for a package of supports to address a primary psychosocial disability are successful.

The NMHC believes there needs to be specific and transparent oversight of experiences and outcomes of people with psychosocial disability who access the scheme, as well as those who do not. Importantly, this function should sit independently of the NDIA, and draw on a range of sources including administrative data from the NDIS and other programs, as well as qualitative information (including information directly provided by participants and non-participants).

3. **'Psychosocial pathway'**. The NMHC agrees with the PC that a dedicated pathway for people seeking psychosocial disability supports warrants consideration (p. 144), even though the Draft Findings and Recommendations of the Position Paper are silent on the matter. The NMHC's main concern is that such an arrangement would need to be adequately resourced and managed, and subject to appropriate monitoring and reporting. There is a risk that governments agree to the PC's recommendation but decide to direct the NDIA to implement it within existing resources. Given many of the present difficulties seem to be due to reduced resourcing, this would be a negative outcome and probably worse than retaining the status quo. The NMHC therefore suggests the PC explicitly recommend that any such dedicated pathway be appropriately resourced, to recognise the additional costs associated with assisting people with mental illness to negotiate the process.
4. **Early intervention for psychosocial disability.** The NMHC believes there is a case to be put that the NDIS should include more options for people with psychosocial disability to take the early intervention pathway into the scheme. Psychosocial disability can be a highly dynamic condition and respond well to effective non-clinical interventions and support. This means that in the early stages of a mental illness or the (re)emergence of symptoms associated with a mental

illness and dealing with its effects on an individual's functioning and participation, effective support to deal with the effects on home life, work or study can result in a material and lasting improvement in the disabling effects of the condition and, sometimes, on the condition itself. In this way, early access to psychosocial supports can help to reduce demand for more intensive supports and reduce pressure on the NDIS overall. As a first step, the NHMC suggests an examination of the access requests to date to determine (a) how many people with psychosocial disability entered through the early intervention pathway and under what circumstances; (b) how many people were not granted access who might otherwise have benefited from an early intervention pathway; and (c) to what extent are early intervention supports accessible to people with psychosocial disability through the NDIS either through individual plans or other avenues such as ILC.

5. **People with psychosocial disability not accessing the NDIS.** A less visible cohort but arguably of more concern are the many people who have some level of psychosocial disability but who are not eligible for individualised funding under the NDIS, because their functional impairment is either not sufficiently severe or it is not deemed 'permanent or likely to be', or both. The size of this cohort could be as large as 190,000 people aged 0-64 years (according to estimates by the Department of Social Services (DSS) based on the National Mental Health Services Planning Framework (NMHSPF) and the DSS assumption that at full scheme the NDIS will support 64,000 people with a primary psychosocial disability and a further 30,000 or so with a secondary psychosocial disability). This is indicative of a long term and large gap between the level of need for psychosocial disability services and the supply of such services (noting the Department of Health has estimated that around 100,000 Australians access such services).
6. **Information, Linkages and Capacity building.** The NMHC supports the PC's draft recommendation 5.1, which calls for additional resourcing for the ILC over the transition period. However, it is not clear on what basis the PC has arrived at the draft recommendation figure. The NMHC notes that the PC's 2011 report (p. 788) estimated that capacity building would require \$200 million a year (in 2011 dollars), and that LACs funding would reach \$548 million a year, the Position Paper recommends only that the currently planned ILC funding at full scheme of \$131 million be brought forward to lift effort during the current transition phase. The NMHC believes there is a risk of major gaps being left by an under-resourced ILC, and suggests that the PC's final report should provide a rationale in light of these estimates in relation to what it considers would be adequate resourcing for the ILC, in the light of the 2011 report's estimates and the analysis that underpinned the original estimates.

There are also major concerns about the scope and function of the ILC as it is currently designed and deployed. If the ILC is to succeed in one of its key objectives – ie to reduce pressure on 'Tier 3' individually funded supports – it needs to have a much stronger role in funding services that provide outreach and engagement with people affected by disability (especially psychosocial disability), similar to services currently provided through the Commonwealth government's Partners in Recovery program.

7. **Capacity and capability of the mental health and community mental health system.** The NMHC welcomes the PC's findings and recommendation regarding the need to strengthen the performance and transparency of mainstream services, including mental health services,

through state and territory governments in particular taking action in this area. The NMHC believes, however, that more can and should be done in this area. Aside from greater transparency around estimates of need and administrative data on service delivery and outcomes (see item 13, below), there needs to be a nationally agreed and appropriately resourced analysis of the level and nature of need in the community and the capacity of service systems to meet that need.

8. **‘Reasonable and necessary’ supports.** The NMHC supports the PC’s proposed recommendation that ‘reasonable and necessary’ supports needs to be more explicitly defined, preferably including variations depending on the form and severity of disability involved. The NDIA still does not have a reference package defined for psychosocial supports (notwithstanding the Position Paper suggesting, at page 93, that all disability types have reference packages associated with them). This creates a high risk of variable package composition for similar cases across Australia.
9. **Psychosocial disability and ‘permanency’.** In discussing the NDIS eligibility requirement of ‘permanency’, the NMHC’s submission to the Issues Paper noted that ‘recovery is not inconsistent with the philosophical underpinnings of the NDIS’. However, and as highlighted by other submissions to the Issues Paper, the NMHC would like to reiterate that the permanency requirement *in practice* is leading to some anomalous outcomes for people with psychosocial disability.

The underlying tension between the recovery principle in mental health and the access requirement for the NDIS that the individual’s disability be ‘permanent or likely to be’ is a concern for many in the mental health sector. Some consumers are very reluctant to seek access to a scheme that would ‘label’ them as permanently incapacitated by their mental illness, preferring instead to focus on hope and optimism about their prospects and their capacity to cope with and adjust to their condition. There also appears to be a practical impact of this tension, with the NMHC aware of inconsistencies in the application of eligibility criteria and the planning process in relation to psychosocial disability, with different access and plan outcomes for people in broadly similar circumstances.

The NMHC acknowledges that the NDIS Rules on becoming a participant (rule 5.2) stipulate that episodic conditions (such as many mental illnesses) are not precluded from consideration for access to the scheme. However, the NMHC believes that variable outcomes in scheme access and supports indicate a general lack of understanding around psychosocial disability and that further clarification is required.

The NMHC suggests the PC give consideration to options that will help to provide a clearer basis for the interpretation and implementation of the original intention of the NDIS, support more effective and efficient targeting of the scheme towards the intended population, and help ‘normalise’ the place of psychosocial disability within the NDIS. Options for clarifying and providing greater guidance around psychosocial disability in the NDIS could include using a functional assessment tool specific to psychosocial disability and the finalisation of a psychosocial disability reference package. The PC could also consider recommending that the NDIA prioritise quality assurance processes towards people with psychosocial disability, given

the variations being observed in their rates of access, package details and broader outcomes and experiences with the scheme.

10. **Role of the National Disability Insurance Agency.** The NMHC acknowledges that the NDIA has been given an extremely difficult task. Implementing a reform of the scale and nature of the NDIS was always going to be challenging; implementing it with a curtailed timetable, reduced resourcing and under shared accountability arrangements where different governments have different expectations. For these reasons the NMHC supports the PC's Draft Findings and Recommendations regarding the role of the NDIA, especially the separation of the pricing function from the Agency. The NMHC also suggests the PC recommend that psychosocial disability supports be given specific consideration in any future pricing work.
11. **Housing and supported accommodation.** There is a dearth of detailed information on the numbers and circumstances of NDIS participants with psychosocial disability who are (a) experiencing housing difficulties and/or (b) have Shared Supported Accommodation (SSA) as part of their package. The lack of systematic information means that there is a high reliance on hearsay and anecdotal evidence. As the Position Paper shows (pp. 105-6), even calculating the cost of packages that include SSA is challenging. The NMHC therefore suggests that the PC include in its final report a recommendation that the NDIA provide more detailed information on the provision of SSA – including breakdown by disability type. State and territory governments should also be encouraged to publish information on the provision of supported accommodation services, including service gaps and the composition of the client cohort (eg whether they are NDIS clients or not).
12. **Systematic and individual advocacy.** The NMHC notes that there is no provision within the NDIS arrangements for funding to support systemic or individual advocacy. Consistent with the PC's 2011 recommendations, disability advocacy is instead funded through the National Disability Advocacy Program, administered by the Department of Social Services. The NMHC believes there are sound arguments for reconsidering this arrangement. The NDIS is a major part of the disability support system and there is a risk that consumers, their families and their carers are not accessing the advocacy support they need, either on an individual basis or systemically. The NMHC therefore suggests that the PC consider recommending that the NDIA have a dedicated funded program for advocacy.
13. **Data and analysis.** The data challenges in determining the prevalence, impact and treatment of mental health issues are compounded by the data challenges in the disability sector. This means that the data potential of the NDIS is very welcome, in providing valuable unit record level data for a cohort that can be statistically invisible. Similarly, there is valuable information available in the mental health sector, especially through the National Mental Health Services Planning Framework (NMHSPF). The NMHC therefore suggests that the PC recommend that the NDIA and the Department of Health (as the custodians of the NMHSPF) seek to make their respective datasets more publicly available for research and analysis, including potentially through dataset comparison. The NDIS data would be valuable in testing and verifying the service cost assumptions in the NMHSPF, while the demand-side analysis in the NMHSPF would provide considerable assistance to the NDIA in its service planning and actuarial analysis.

Relevant Draft Findings and Recommendations and Requests for Information: National Mental Health Commission Responses

DRAFT FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

Response: The NMHC agrees with this draft finding, and further suggests the PC make an explicit recommendation that the NDIA develop a detailed and systematic work plan against which the timeframe for implementation of the NDIS can be reviewed. This would provide clarity in relation to the PC's draft recommendation 9.5, which proposes that the NDIA "find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability."

DRAFT FINDING 2.4

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided.

However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.

Response: The NMHC agrees with this finding and further suggests that the PC also consider the extent to which arrangements for future monitoring, reporting and evaluation of the NDIS are in place to specifically consider progress in improving the outcomes for those participants who are most vulnerable, including those with psychosocial disability. The NMHC is unaware of plans for evaluation beyond the current evaluation of the NDIS trial phase.

INFORMATION REQUEST 4.1

Is the National Disability Insurance Scheme Act 2013 (Cwlth) sufficiently clear about how or whether the 'reasonable and necessary' criterion should be applied? Is there sufficient clarity around how the section 34(1) criteria relate to the consideration of what is reasonable and necessary?

Is better legislative direction about what is reasonable and necessary required? If so, what improvements should be made? What would be the implications of these changes for the financial sustainability of the scheme?

Response: The NMHC believes there could be greater clarity on this issue in the legislation. It is an especially challenging task to determine what are ‘reasonable and necessary’ supports for people with psychosocial disability, where the participant’s condition may not always manifest itself (episodic) and/or where the participant may not be able to articulate the full impact of their condition on their functioning and participation. The NMHC also suggests the PC consider a recommendation that the NDIA move as quickly as possible to finalising a reference package for psychosocial disability.

INFORMATION REQUEST 4.2

Should the National Disability Insurance Agency have the ability to delegate plan approval functions to Local Area Coordinators? What are the costs, benefits and risks of doing so? How can these be managed?

Response: This proposal would see LACs responsible for both plan design and approval. However, separation of these functions is good administrative practice, supporting quality and transparency and minimising inconsistencies between plans. Devolving plan approval to LACs would present risks of further inconsistency and inequity and diminished transparency and accountability around plans. This is a particular concern in relation to people with psychosocial disability, for whom there is already evidence about inconsistencies in access and eligibility processes, as well as for plan development. . It is not clear that any gains in terms of administrative costs would offset these risks. If the PC decides to recommend such a change, the NMHC suggests that a robust periodic auditing of participant plans also be recommended to ensure transparency and reduce the risk of excessive variability in plans for participants with similar circumstances (which the NHMC also recommends in relation to Draft Recommendation 4.2, below).

DRAFT RECOMMENDATION 4.1

The National Disability Insurance Agency should:

- implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review
- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants’ rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

Response: The NMHC broadly agrees with this recommendation, as it is very concerned at the lack of preparation and transparency around the planning process. The NMHC does not, however, support a review of phone planning protocols. Instead, the NMHC believes that for people with psychosocial disability phone planning should be minimised and only used under circumstances

where there is no better option available. People with mental health issues are at a high risk of not being able to effectively manage the access and planning process; phone planning exacerbates this risk.

DRAFT RECOMMENDATION 4.2

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

Response: The NMHC strongly agrees with this recommendation and suggests that it be augmented with a recommendation that the NDIA institute a periodic, transparent and independent auditing regime for planning decisions, to reduce the risk of undue variability across the system. Such an audit regime should be separately and adequately funded, with clear measures of success defined from the outset.

DRAFT FINDING 5.1

It is a false economy to have too few resources for Information Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

Response: The NMHC strongly agrees with this draft finding.

DRAFT RECOMMENDATION 5.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of \$131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach \$131 million should be made available from the National Disability Insurance Agency's program delivery budget.

The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of \$131 million per annum until results from this review are available.

Response: The NMHC notes that the PC's 2011 report proposed capacity building be funded at \$200 million per annum (in 2011 dollars) and that local area coordination be funded at \$548 million. The NMHC suggests it may be useful for the PC to specifically consider these estimates in its final report

of the current study and provide a rationale in light of these estimates in relation to what it considers would be adequate resourcing for the ILC.

DRAFT RECOMMENDATION 5.2

The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.

The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

Response: The NMHC strongly supports this recommendation and suggests the requirement for governments to report on continuity of support include timeframes over which that support is to be provided and transition arrangements beyond any finite timeframes (see comments on draft recommendation 5.3 below). The NMHC also suggests that the NDIA reporting on 'boundary issues' explicitly include the role of the ILC in facilitating effective interface arrangements between the NDIS and mainstream service systems, including community-based mental health and other support services frequently accessed by people with psychosocial disability. There also needs to be a focus on quantitative information about outcomes for people who seek but do not succeed in accessing the NDIS. Where possible, there should be improved levels of communication and consistency between information systems within the NDIS and those in mainstream service systems (eg unique record level data). As the body responsible for monitoring and reporting on national mental health and suicide prevention systems and outcomes, the NMHC would be pleased to work with the NDIA to explore opportunities for new approaches to information sharing and analysis across NDIS and other systems relevant to mental health and psychosocial disability.

DRAFT RECOMMENDATION 5.3

Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.

Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

Response: The NMHC strongly supports this recommendation. The NMHC’s proposal regarding communication and consistency between administrative systems under draft recommendation 5.2 above is also pertinent in this area. The NMHC suggests the PC further recommend that relevant COAG Councils and Committees provide regular (annual) detailed reports on the performance of relevant sectors in addressing the needs of people with disability, consistent with the National Disability Strategy and commitments in relation to the NDIS.

The NMHC believes there should be an explicit reference to the need for the relevant COAG Councils to make public relevant data and analysis. In the case of mental health, this would include more open access to the National Mental Health Services Planning Framework (NMHSPF). The NMHC suggests that the PC recommend more open access to models and estimates such as the NMHSPF, to facilitate better informed public consideration of populations of need and the adequacy and effectiveness of service systems. This is especially important in the context of the NDIS cost risks, as many mainstream mental health services and supports should (in principle at least) operate as early intervention to reduce the risk of individuals eventually ‘graduating’ to high cost systems aimed at the more severe end of the disability spectrum, most notably the NDIS.

The NMHC notes that in its 2011 report the PC recommended the NDIA establish memoranda of understanding with relevant service sectors to help govern the mainstream interface issues. The NMHC believes that there are strong grounds to require more explicit and sustained arrangements between the NDIA and Commonwealth, state and territory departments of health in their roles as system managers of Primary Health Networks and Local Hospital Networks (and equivalents).

DRAFT RECOMMENDATION 6.1

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA’s power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.

The body tasked with price regulation for scheme supports should:

- collect data on providers’ characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.

Response: The NMHC strongly supports this recommendation. There are concerns across the mental health sector around the pricing of NDIS supports and the current arrangements seem to put the NDIA in the position of both price regulator and purchaser of services. In relation to psychosocial supports, it may be appropriate to draw on the National Mental Health Services Planning Framework (NMHSPF) to help inform better understanding around the needs of people with psychosocial disability and service demands, estimate the cost of supply and analyse and benchmark provider costs and pricing (noting that the NMHSPF itself is an iterative model, requiring periodic updating as service models and cost structures change).

DRAFT FINDING 6.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.

Response: The NMHC strongly agrees with this draft finding. A further dimension of ‘thin markets’ is that those with ‘complex, specialised or high intensity needs, or challenging behaviours’ can often also be ‘hard to reach’, requiring active and persistent outreach and engagement arrangements. Such arrangements can be expensive and in the case of the NDIS they seem to have been largely dispensed with, due to cost constraints and a tendency to see the ‘choice and control’ model as implicitly placing the onus on the (sometimes highly compromised) individual to initiate and sustain engagement with the scheme and the NDIA. The NMHC therefore suggests that the draft finding be amended to reflect the ‘hard to reach’ cohort, and the risks created by the absence of effective outreach and engagement capability. The NMHC believes this is also consistent with the position outlined in the PC’s recent draft report on *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, which seeks to strike a balance between the provision of market-based human services where clients can and should exercise autonomy and choice, and giving assistance to those clients who may be less able to effectively exercise such choice.

INFORMATION REQUEST 6.1

In what circumstances are measures such as:

- *cross-government collaboration*
- *leveraging established community organisations*
- *using hub and spoke (scaffolding) models*
- *relying on other mainstream providers*

appropriate to meet the needs of participants in thin markets? What effects do each have on scheme costs and participant outcomes? Are there barriers to adopting these approaches?

Under what conditions should block-funding or direct commissioning of disability supports (including under 'provider of last resort' arrangements) occur in thin markets, and how should these conditions be measured?

Are there any other measures to address thin markets?

Response: The NMHC believes these and related measures (eg such as active outreach and engagement) are especially pertinent to the psychosocial disability cohort. Aside from adequacy and reliability of funding, a key barrier to these being implemented can be an underlying tension between the individualised market approach of the NDIS and the block grant funded community care approach that is a common characteristic of mainstream service systems. There can also be challenges around accountability, in that service providers and funders can be reluctant to either accept responsibility for clients who they see as 'belonging' in another service system or to give credit to allied service systems working with client groups that overlap with their own target cohort.

A key area of concern for psychosocial disability is that of group or community supports, where the benefits may be diffused across a client group and difficult to isolate (and fund) at the individual level (i.e. from individualised funding). People with some forms of mental health issues and associated disabilities can greatly benefit from social interactions with peers and the wider community, but categorising and pricing such activities at the individual level can be difficult. Other services such as assertive outreach are ill-suited for pricing and delivering through participant plans. It is therefore more appropriate that such services be block funded, and that their cohort of clients include (but not be limited to) NDIS clients. The NMHC suggests the PC consider the potential role of the ILC in addressing such areas in relation to thin markets.

The NMHC is aware that the Barkly trial site in the Northern Territory is the subject of specific work under the evaluation of the NDIS trial phase, but no information from the Barkly evaluation has been released as yet. The NMHCs suggests that the Barkly evaluation be considered in the context of considering thin markets and ways that they can be addressed, where those thin markets relate to remoteness and/or Indigenous populations.

INFORMATION REQUEST 6.2

What changes would be necessary to encourage a greater supply of disability supports over the transition period? Are there any approaches from other consumer-directed care sectors — such as aged care — that could be adopted to make supplying services more attractive?

Response:

In principle, the NMHC strongly supports choice and control for all service users, including people with mental illness, and notes that this can be achieved through a variety of ways, including the ability to make decisions about whether and which services to access, as well as the opportunity to make decisions about the way in which a person and a service interact. Enabling greater levels of independence, personal autonomy and choice and control for people with mental illness is an important tenet of recovery-oriented services. However, enabling choice is not always easy in practice, particularly where service users require additional support to make decisions or where there are features of the provider market that are not appropriate for supporting user choice.

The experience of the NDIS for participants, non-participants and service providers in psychosocial disability suggests that governments should exercise caution before introducing user-directed arrangements more broadly. Such reforms would be best considered only once there is clear evidence on what works and what doesn't for this cohort, including from the implementation of the NDIS. Consideration of further market-based reforms should first engage closely with users and providers of services, including in order to ascertain the appetite and capacity for further sectoral change.

The NMHC further suggests the PC consider the insights that can be shared between the current study into NDIS Costs and the PC's inquiry into *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*. For example, the PC's Draft Report finds that 'the characteristics of family and community services do not lend themselves to the introduction of greater user choice at this time', and that the focus should instead be on the commissioning process to improve the effectiveness of block-funded services. The NMHC believes the rationale for this finding and other analyses contained in that report could also be applied to other services for people with mental illness, including those being offered through the primary health system and the NDIS. The NMHC also believes the Human Services inquiry could also distil lessons from the roll-out of the NDIS, particularly around what is required to support choice and control for people with psychosocial disability and where block-funded arrangements may be warranted.

INFORMATION REQUEST 7.1

What is the best way for governments and the National Disability Insurance Agency to work together to develop a holistic workforce strategy to meet the workforce needs of the National Disability Insurance Scheme?

Response: The NMHC suggests that any workforce strategy or collaborative effort between the NDIA and governments should include an explicit goal of maximising the use of peer support workforces wherever possible. The mental health peer workforce is an increasingly important part of the solution for people with psychosocial disability, but it is often treated as an ‘afterthought’ in workforce planning and strategies.

DRAFT RECOMMENDATION 7.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

Response: The NMHC supports this draft recommendation and suggests that it include reporting on the number of applicants for access to the scheme who were not found eligible, and the reason. The NMHC believes that consideration could be given to commissioning the Australian Institute for Health and Welfare to undertake the collection and publication of the proposed workforce data. The ABS has stronger powers to require the provision of relevant data, but the AIHW is generally able to provide more detailed data access to users. The recommendation could therefore add the AIHW as an option for undertaking the collection and publication of the workforce data.

INFORMATION REQUEST 7.2

How has the introduction of the National Disability Insurance Scheme affected the supply and demand for respite services? Are there policy changes that should be made to allow for more effective provision of respite services, and how would these affect the net costs of the scheme and net costs to the community?

Response: Because the NDIS does not directly support carers, there is a dearth of detailed data on this issue. This means that it is difficult to determine the impact of the Commonwealth government’s decision to ‘roll in’ the Mental Health Respite: Carer Support program into the NDIS funding pool on respite services for carers of people with mental health issues. There is, however, considerable anecdotal evidence that some carers are adversely affected by this decision. As details of the new Integrated Plan for Carer Support Services are yet to be released and implemented, it is unclear to what extent it will connect with and address the needs of affected carers.

INFORMATION REQUEST 8.1

Is support coordination being appropriately targeted to meet the aims for which it was designed?

Response: Support coordination is an especially important function in relation to psychosocial disability, and there is anecdotal and evaluative evidence that some NDIS participants with psychosocial disability have experienced a diminution of support in this regard. The NMHC understands that support coordination services are not appearing or being priced in plans consistently or to the extent that might be reasonably expected. The NMHC believes there is a case for a psychosocial-specific support coordination in the NDIS, to address the specific and highly variable needs of this cohort. The NMHC suggests the PC consider mechanisms for reviewing and monitoring planning process in this regard, as well as the outstanding need to finalise a reference package specific to psychosocial disability.

INFORMATION REQUEST 8.2

Is there scope for Disability Support Organisations and private intermediaries to play a greater role in supporting participants? If so, how? How would their role compare to Local Area Coordinators and other support coordinators?

Are there any barriers to entry for intermediaries? Should intermediaries be able to provide supports when they also manage a participant's plan? Are there sufficient safeguards for the operation of intermediaries to protect participants?

Response: The NMHC does not have a strong view on this issue, other than to express caution regarding the vulnerabilities of people with psychosocial disability in being able to negotiate an already complex system without appropriate support. If a further layer of service provision is added, it would need to be carefully implemented with adequate safeguards so as to not create undue risks of confusion and/or exploitation for this cohort of participants.

DRAFT RECOMMENDATION 9.4

The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme's objectives.

The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).

The *Integrated NDIS Performance Reporting Framework* should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.

Response: The NMHC strongly supports this draft recommendation and suggests that the NDIA also be asked to publish the full Outcomes Framework it has developed to monitor participant outcomes. It should also be required to report regularly on unsuccessful applicants for access to the scheme, and the reasons for their not gaining access.

DRAFT RECOMMENDATION 9.5

In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

Response: The NMHC is concerned that this recommendation is not specific enough for it to be actionable by the NDIA. It is, as currently drafted, more a finding than a recommendation. As suggested in relation to Draft Finding 2.1, the NMHC suggests that the PC recommend that the NDIA undertake a detailed planning process for delivering the outputs and outcomes required of the NDIS and that the implementation timetable be adjusted accordingly, with the agreement of the COAG Disability Reform Council.

INFORMATION REQUEST 9.1

The Commission is seeking feedback on the most effective way to operationalise slowing down the rollout of the National Disability Insurance Scheme in the event it is required. Possible options include:

prioritising potential participants with more urgent and complex needs

delaying the transition in some areas

an across-the-board slowdown in the rate that participants are added to the scheme.

The Commission is also seeking feedback on the implications of slowing down the rollout.

Response: As noted in relation to Draft Finding 2.1 and Draft Recommendation 9.5, the NMHC believes the PC needs to explicitly recommend the preparation of a detailed plan of action to maximise the opportunities of the NDIS and a subsequent adjustment to the implementation timetable.

DRAFT FINDING 10.2

Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control.

The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.

Response: The NMHC agrees with this Draft Finding and suggests it be the subject of a specific recommendation by the PC. There is a risk that the current allocation of 100% of the risk of cost overruns to the Commonwealth creates an incentive for the Commonwealth to contain cost overruns at the risk of negative outcomes for participants and/or providers.

DRAFT RECOMMENDATION 10.3

In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.

Response: While the NMHC supports this recommendation in principle, it would counsel caution in applying too steep a phase out of in-kind funding arrangements, especially in areas where there are thin markets that risk creating a gap between block funding and individually funded arrangements.