

SUBMISSION

Anglicare Tasmania's Submission to the Productivity Commission's Study on the National Disability Insurance Scheme (NDIS) Costs

March 2017

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1. About Anglicare Tasmania's experience within the NDIS

Anglicare Tasmania's expertise in supporting people with disabilities

Anglicare Tasmania is the largest community service organisation in Tasmania with offices in Hobart, Glenorchy, Launceston, St Helens, Devonport, Burnie and Zeehan and a range of programs in rural areas.

Anglicare Tasmania's services include crisis services, accommodation support, mental health services, acquired injury, disability and aged care services, alcohol and other drug services and family support. In addition, Anglicare Tasmania's Social Action and Research Centre conducts research, policy and advocacy work with a focus on issues affecting Tasmanians on low incomes.

Anglicare Tasmania is committed to achieving social justice for all Tasmanians. It is our mission to speak out against poverty and injustice and offer decision-makers alternative solutions to help build a more just society. We provide opportunities for people in need to reach their full potential through our services, staff, research and advocacy.

Anglicare's work is guided by a set of values which includes these beliefs:

- that each person is valuable and deserves to be treated with respect and dignity;
- that each person has the capacity to make and to bear the responsibility for choices and decisions about their life;
- that support should be available to all who need it; and
- that every person can live life abundantly.

Anglicare Tasmania's Disability Services

Anglicare Tasmania's disability services provide support for people with developmental and acquired disability. Services are provided through three streams:

- **Community Support and Coordination** – predominantly for National Disability Insurance Scheme (NDIS) participants
- **Acquired Injury Support Services** – community and facility-based care, short and long term, including for claimants of the Motor Accidents Insurance Board

- **Residential Support Services** – shared accommodation for people with disabilities requiring supported accommodation, through the Shared Homes Program, respite and individual support packages (ISPs).

Between 1 January and 8 March 2017, Anglicare Tasmania provided services to approximately 232 clients, including approximately 87 NDIS participants.

Daily living and relationships are the most common service areas for Anglicare Tasmania's NDIS participants and for other Anglicare Tasmania disability clients. But a higher proportion of those NDIS supports are for relationships, compared to other disability service programs. (see Table 1).

This difference is possibly linked to the age cohorts accessing these different programs; NDIS in Tasmania is currently only available for Tasmanians under 26 (see table 3).

Table 1: Proportion of Anglicare Tasmania's disability services clients accessing service categories by program: NDIS, Disability Services and the Motor Accidents Insurance Board – 1 January to 8 March 2017

Anglicare Tasmania disability service categories	Proportion of Anglicare disability services clients accessing service categories by program		
	NDIS	ISP (Disability Services)	MAIB Attendant Care
Daily Living	54%	83%	67%
Relationships	34%	10%	23%
At Work	0%	0%	2%
Lifelong Learning	10%	2%	3%
Sleep Over	3%	5%	4%
Total	100%	100%	100%

Source: Anglicare Tasmania Disability Business Development Team (2017)

A significant proportion of Tasmania is classified as remote and the islands off Tasmania (Flinders and King Islands) are classified as very remote (AIHW 2004). Although NDIS participants are accessing relatively similar broad service categories across the state and across urban and regional areas (see Table 2a), the types of services they are accessing differ (Table 2b):

- Over three quarters of our community skill support is for our southern participants, as is nearly two thirds of our community access support and personal care.

- Three quarters of our mealtime support services and two thirds of our domestic care are for our northern participants.
- Half of our transport support is for our north west participants, who are predominantly in rural and remote locations.

Table 2: Proportion of Anglicare Tasmania disability services NDIS participants accessing service categories by Tasmanian region: Urban and Regional South, North, North West - 1 January to 8 March 2017

NDIS service categories	Proportion of Anglicare Tasmania disability services' NDIS participants accessing service categories by Tasmanian region					
	Urban Hobart	Urban Launceston	Urban North West	Regional South	Regional North	Regional North West
Daily Living	65%	69%	68%	68%	74%	66%
Relationships	23%	23%	30%	17%	26%	21%
At Work	3%	0%	0%	0%	0%	0%
Lifelong Learning	5%	3%	1%	9%	0%	4%
Sleep Over	4%	5%	0%	6%	0%	9%

Source: Anglicare Tasmania Disability Business Development Team (2017)

Table 2b: Proportion of Anglicare Tasmania disability services' NDIS participants accessing types of services by Tasmanian region: South, North, North West - 1 January to 8 March 2017

Anglicare Tasmania disability service categories	Proportion of Anglicare Tasmania disability services NDIS participants accessing service categories by Tasmanian region			
	South	North	North West	State wide
Community access	60%	35%	5%	100%
Community skill	77%	15%	8%	100%
Domestic (self-care)	31%	66%	3%	100%
Meals (self-care)	24%	76%	0%	100%
Personal care (self-care)	59%	33%	7%	100%
Transport	19%	30%	51%	100%

Source: Anglicare Tasmania Disability Business Development Team (2017)

Anglicare Tasmania's Mental Health Services

Anglicare Tasmania supports Tasmanians living with mental illness, their families, carers and communities. We offer NDIS services and a number of Commonwealth and State funded community services, as well as offering coordination roles across community and clinical supports, including:

- **NDIS** – both Coordinator of Supports and services line items
- **Support coordination** – Partnerships in Recovery
- **Services in the community** – Day 2 Day Living, Personal Helpers and Mentors Service, Recovery Program, Club Haven, Pathways, Reclaim your Life, Towards a Model of Supported Community Housing
- **Residential services** – Curraghmore residential and recovery support, Rocherlea Rehabilitation and Recovery Service
- **Early Support Services** – Mental Health First Aid and Youth Mental Health First Aid
- **Respite** – Our Time, Taz Kids and Champs Camps

Community Services Support Services assist over 1,000 clients state wide each month with psychosocial supports. In addition to this approximately 300 households are supported through Housing Connect to find and maintain accommodation and 500 clients per month are support through face-to-face and phone-based financial counselling support.

Additionally, 1,233 households are assisted monthly by Anglicare Tasmania staff within our Housing Connect partnership with other Tasmanian delivery partners, Centacare, Colony 47, Hobart City Mission and Salvation Army (Tasmania) to support and advise clients about:

- housing options
- applying for social housing
- private rental, including bond and rent arrears
- finding a bed for the night
- how to stay in their home
- seeking assistance following family violence.

Learning from Tasmania's experience

The NDIS policy framework and implementation systems are still developing. This is a crucial time to pause and consider how the scheme is being governed, resourced and implemented to avoid the impact of current problems multiplying as the scheme rolls out. With this in mind, Anglicare Tasmania welcomes the opportunity to provide the Productivity Commission with our experiences and views.

Due to Tasmania's involvement in the NDIS trial since July 2013 and the incremental way the roll out is occurring in this state, Anglicare Tasmania can offer some valuable insights into how the system is working so far for participants, their carers and families and for organisations working with them.

- Tasmania has been part of the NDIS trial, 'road testing' the system for young people. Since 1 July 2013, NDIS has been available for young people aged 15 to 24, with the addition of 12 to 14 year olds since 1 July 2016. We can provide particular insight into how young people, their carers and families and the services that support them are experiencing NDIS and other mental health and disability service responses in ways that enable, or inhibit, a contributing life.
- As a whole state trial area, Tasmania has had an initial insight into potential State Government mental health and disability funding and support responses for those both eligible and ineligible for NDIS support services.
- Unlike some other jurisdictions, Tasmania is in the fortunate position to be incrementally introducing NDIS by age cohort up to July 2019 (see Table 1). Tasmanian consumers, communities and service organisations have the opportunity to learn, reflect and adjust practice as we go.

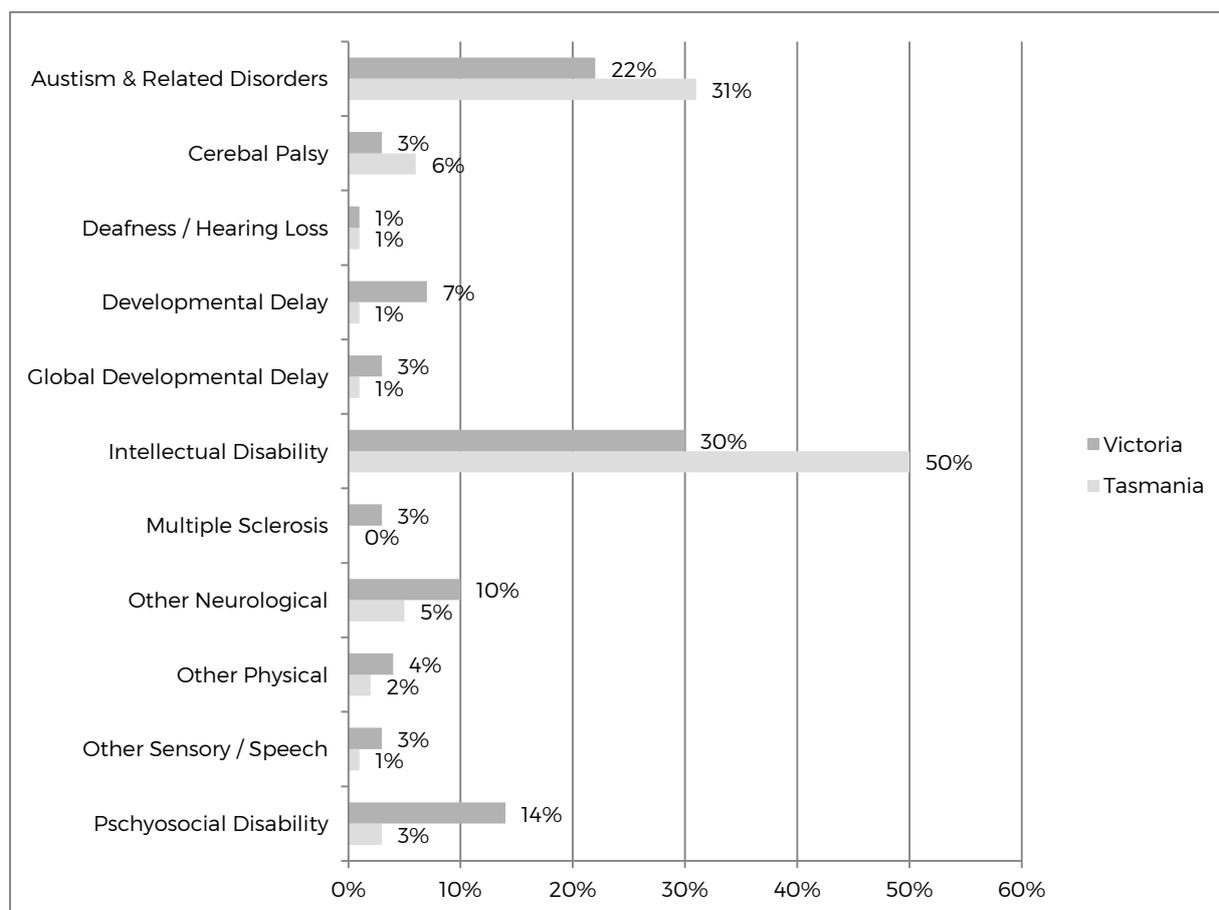
Table 3: Phased age-based roll out of NDIS funding in Tasmania and participant estimates

Introduction date	Tasmanian age cohort
1 July 2013	15 to 24 year olds
1 July 2016	12 to 14 years olds
1 January 2017	25 to 28 year olds
1 July 2017	4 to 11 year olds
1 January 2018	29 to 34 year olds
1 July 2018	3 year olds 35 to 49 year olds
1 January 2019	50 to 64 year olds

Due to the age specific roll out of NDIS here, we do not have an overall picture of the proportion of participants who will present with specific primary disabilities. However, we can provide insights into how the system is tracking and could be adapted to ensure younger participants are positively enabled to socially and economically participate within their communities.

Our younger Tasmanian participants so far have presented with a range of primary disabilities, particularly intellectual disability, autism and related disorders and 'other' neurological. Three per cent of participants having psychosocial disability as their primary diagnosis (see Fig 1).

Fig 1: NDIS Participants with and approved plan by primary disability: Tasmania and Victoria, 31 March 2016



Source: NDIA 2016a, p.15

Some systemic questions

In developing our submission, key overarching questions have emerged for us that we feel the Productivity Commission should consider in relation to the terms of reference.

These questions concern how we ensure all consumers living with disability have access to the types of supports they find useful to enhance their social and economic participation, who is responsible for ensuring this happens and how community and clinical services can be effectively and responsively resourced to deliver this by Commonwealth and State Governments.

These core policy design and resourcing issues colour our responses to the Productivity Commission's specific questions. Our overarching questions are:

- How can the recovery model of mental health services effectively shape NDIS planning and support?
- Is the NDIS engagement and planning system resourced adequately for this point in the roll out?

How can the recovery model of mental health services effectively shape NDIS planning and support?

We welcome NDIS's policy aim to work within the recovery model of mental health, as endorsed by the Australian Health Ministers' Advisory Council (AHMAC 2013a, b).

However, we are finding that the NDIS policy, assessment, planning, line items and pricing frameworks do not currently work for supporting a recovery model of mental health. On the contrary, the frameworks often work against this model, leading to many of the implementation issues we are flagging as needing attention in our submission.

There are a number of fundamental policy positions that could be considered in ensuring that people with severe and permanent psychosocial disabilities are better served by services under a recovery model. These options include:

- a) **investment in improvements to the existing NDIS** design and roll out that improve the outcomes for people with a psychosocial disability;
- b) **redesign of the NDIS** to address the specific needs of the people with a psychosocial disability within the recovery framework; or
- c) **the exclusion of people with a psychosocial disability from the NDIS** and the design of a system to support services that better aligns with the needs of people with a psychosocial disability.

Anglicare Tasmania is not recommending any one option in our submission. But our comments within this paper are mainly provided to inform a redesign of the NDIS system to address the specific needs of participants with a psychosocial disability within the recovery framework. For this to be an effective alternative to withdrawing people with psychosocial disability from NDIS, a number of structural changes to the current NDIS system would need to occur.

Is the NDIS engagement and planning system resourced adequately for this point in the roll out?

We support NDIA's endeavours to develop meaningful plans and set swift and responsive targets to review them.

A repeated question amongst our staff has been whether compromises are being made in how NDIS services are being implemented, due to NDIA being under-resourced for the current volume of business, or whether current implementation practices are part of the NDIS system design. This issue has had particular impacts on the adequacy of outreach and

engagement and the appropriateness and timeliness of the planning and review processes. These issues are also reflected in our comments throughout this submission.

2. Scheme costs

Cost drivers

Question block 1 (p.10)

i) Are there any cost drivers not identified above that should be considered in this study?

If so:

- how do they impact costs in the short and long term?

- how, and to what extent, can government influence them?

i.) Additional cost drivers: meeting relevant quality and service standards

Mental Health Standards

Operating *effectively* within the Mental Health Service Standards would be a significant additional cost driver for NDIS. It is an overarching, systemic and strategic driver for NDIS's approach and costs; it is not just a small tweak to how the scheme operates. Additionally, it is not something NDIA has control over in the long term. So NDIA will continually need to consider how such standards influence the NDIS model and costings.

Appropriate standards and pricing for mental health services

Anglicare Tasmania is finding that NDIS line item costings are not viable for sustaining the quality of services required within the National Mental Health Service Standards. We are losing about 50 per cent an hour on any given NDIS line item, or having to compromise on the service offer. For example, we may either have to offer a participant a less qualified worker, or halve the hours of service specified in their plan with a specialised worker. This is because current NDIS pricing is based on SCHADS 2, which is commonly used within the general disability sector, rather than SCHADS 4, which is more commonly offered for specialist mental health support workers. Longer term, this may lead to either a significant decline in the quality of mental health services, or market failure and severe consequences for community-based rehabilitation, as the Mental Health Council of Tasmania has flagged to the Joint Standing Committee recently (MHCOT 2017):

Members stressed that there is a high risk of seeing significant market failure across the sector. Community Mental Health Australia rightly points out that, "A range of highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation and their disappearance means that people will no longer have access to the services that help them to reduce the disabling impacts of their mental illness" (CMHA 2017). Consequently, the NDIS may potentially be faced with an exponentially growing level of disability while at the same time community-based rehabilitation services are experiencing loss of funding, loss of qualified mental health staff and the capacity to provide services commensurate with need. The potential loss of existing skilled and qualified staff and a de-skilling of the workforce mean that organisations are unable to offer services to people with NDIS Plans as well as those without

(MHCoT 2017).

Expanding the scope of supports (and therefore, the price)

There is a mismatch between the current scope of supports and the needs of participants in relation to clinical, as well as community, services.

Many NDIS line items are not specifically tailored to cater for enabling a contributing life. To build such a life, there is often a need for both clinical and community supports. For example, it is essential that NDIS participants have access to therapeutic conversations that assist people to overcome issues that are a barrier to participation resulting from mental illness. In contrast to existing mental health programs that provide facilitation or support, such as Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMS), such a combination of clinical and community support is not facilitated within the current scope of NDIS line items. Accessing occupational therapy for an autistic child may be a crucial part of building a contributing life; Cognitive Behavioural Therapy may support a young person to deal with anxiety related to interacting in an educational or social setting. Although such services may be therapeutic, as clinical services, it is unclear whether such services are permissible under the current NDIS framework.

If the mismatch between participants' needs and what the NDIS market offers is not addressed, there will be an oversupply of Support Workers offering lower level services (e.g. SCHADS 2 paid workers), when the needs will be for specialist Support Workers (i.e. SCHADS 4 paid workers) and Allied Health Professionals.

Quality Standards

There are potential cost impacts for service providers within the requirements for certification against the NDIS Quality and Safety Framework (NDIA 2017b). These are likely to be based on the organisation's size and scope of practice. Anglicare Tasmania estimates that, as a cost, this is likely to be between \$5K and \$15K per annum¹. Although there may be scope for mutual recognition across standards, these will be ongoing cost drivers for providers

Future estimates – some pressures emerging

Question block 2 (p.12)

ii.) Low utilisation rates:

- **Why are utilisation rates for plans so low?**
- **Are the supports not available for participants to purchase (or are there local or systemic gaps in markets)?**
- **Do participants not require all the support in their plans?**
- **Are they having difficulty implementing their plans?**
- **Are there other reasons for the low utilisation rates?**

iii) Why are more participants entering the scheme from the trial sites than expected?

iv) Why are lower than expected participants exiting the scheme?

v) What factors are contributing to increasing package costs?

vi) Why is there a mismatch between benchmark package costs and actual package costs?

ii.) Low utilisation rates

Why utilisation rates are low in Tasmania

In Anglicare Tasmania's experience, there may be a number of reasons for the underutilisation of plans in this state:

- **Initial plans covered long term goals:** During the trial period, participants had all of their current and future needs included in their NDIS plan. Some of the future needs

were not required during the first 12 months, so it's likely that some funding has not been fully utilised.

- **Putting the onus on the participant to connect their support:** Many participants require assistance to implement their plans. Initially, this was not readily forthcoming, hence some package funding was not utilised. However, all new participants have support coordination included in their plan, so should be guided to make the appropriate links to access services and supports and utilise the funding. But there may still be issues for participants with psychosocial disabilities, who may want and need a professional with whom they have developed a trusting relationship to connect to their support. If their preferred relationship is with an Allied Health Professional (who is not funded under NDIS), this may delay the process while they find an alternative Coordinator of Supports and then develops an effective working relationship. See *section xiii* for more detail on this.
- **Difficulty finding the right service providers:** The NDIA is reluctant to have participants engage with only one provider for all of their support, including Coordinator of Supports. However, it is our experience that a large number of participants want the same provider for all of their services, particularly those with mental ill health.
- **Funded support may not match participants' needs:** The automated planning process through the Local Area Coordinators (LACs) and reference packages is inserting inappropriate items in packages. If the right supports were funded at the right levels, plan utilisation would likely increase. A higher number of hours of support is generally funded for psychosocial participants. However, this is at an hourly rate which is too low to purchase allied health support. See *section i.* for more detail on this.
- **Packages are unable to respond to changing needs quick enough:** The review process can not respond to participants' changing needs efficiently, potentially affecting utilisation rates. See *section xiii.* for more detail on this.

Supports not available for participants to purchase (or local or systemic gaps in markets)

Supporting effective applications

Supporting both existing clients of other Commonwealth funded services to 'transition' to NDIS and community members who have not engaged previously with services to make a new application to NDIS are not funded activities within NDIS. Although the Information, Linkages and Capacity (ILC) Building Framework is looking to encourage more consumer engagement in applications, it does not look like it will offer support for individuals to get their diagnosis and submit NDIS applications.

Anglicare Tasmania supports our existing clients to obtain a diagnosis, if they do not have one already, and encourage them to make their NDIS applications. But this is an 'off the desk' activity which will not be sustainable as NDIS rolls out.

Support to access services for people with mental illness is a key part of current PIR activities. This service both helps to ensure that people are maximising their support entitlements and helps to address equity of access to services for all consumers, which might otherwise be out of kilter due to some people / families having more effective advocacy skills.

Given problems with the appropriateness of current NDIS planning processes (see *chapter 4*) and line items, it is our staff's experience that consumers with effective advocacy skills or families with such advocacy skills are likely to gain the most from their plans.

Not providing support for NDIS applicants is likely to exacerbate inequality of access to NDIS and is leading to participants presenting with vastly different levels of support.

People with Behaviours of Concern

If an NDIS participant with behaviours of concern has a positive support plan in place, they may attract high intensity support costs. But we remain concerned that current costings and line items do not adequately meet the needs of all such participants.

Anglicare Tasmania provided NDIA with research and recommendations related to NDIS costing to appropriately support people with behaviours of concern (Hinton 2014). Please see **appendix 1** for the full report.

We would like to refer the Commissioners to our full report on this matter (**see appendix 1**). In summary, the systemic market gap is being able to provide services for participants with behaviours of concern at the cost levels that are needed. The need for flexibility to respond to unanticipated and sudden changes in the level of support required and dealing with potentially volatile situations is not supported through NDIS at the moment.

The number of both management and support worker hours and the level of expertise needed to respond to changing needs in an appropriate and consistent manner is a specific type of service, which is not currently supported by NDIS costings. Due to needing to work across agencies to case manage complex needs, being able to respond quickly to changing needs and the intensity of working with challenging and changing behaviour, staff are unable to work as long as they might with other participants. This leads additional, uncosted costs to organisations including:

- **more intensive case management:** including more liaison with other providers and agencies (including Children's Services and / or Criminal Justice Services) to ensure that goals are aligned and services are working with each other to achieve these (see *section xi* for more on this), and more liaison with family members and carers. There is currently a lack of clarity in relation to the Coordinator of Supports role for people with complex needs. This results in additional hours of support provided, but not claimed.

- **increased staff support and training** to ensure those staff working with participants who have behaviours of concern are able to offer consistent, quality support, in the face of unpredictable and challenging behaviours. This is currently not included within NDIS costings.
- **a larger supply of staff** needed to work intensively with participants, but over shorter periods of time, which is particularly an issue in already challenged rural and remote areas (see section xxi.)

Specific services for those with behaviours of concern – flexible in nature and costed at appropriate levels – need to be incorporated into the NDIS market, if participants are not to be left behind. As our research outlines:

The market may...fail to guarantee services and/or a safety net for those with behaviours of concern while threatening the economic viability of provider organisations that are supporting large numbers. This could result in higher charges, poorer outcomes and a lower quality of life for those with behaviours of concern whilst eradicating their choice and control

(Hinton 2014, p.1).

Appropriate services for psychosocial disability

Given that the assessment and planning tools are not specifically designed to capture needs related to enabling people living with mental health conditions to access social and economic participation, many NDIS line items are not specifically tailored to cater for enabling a contributing life. To build such a life, there is often a need for both clinical and community supports. See section i.

Wrap around support

There is no option for wrap around support, which is preferable for mental health clients.

Individuals living with psychosocial disabilities often prefer to work with one worker or agency who can support all of their needs. Anglicare Tasmania's clients often have one worker, who support them to improve their mental health, find and maintain suitable housing and assist with overcoming the issues surrounding substance addiction. These different kinds of supports are not easily defined into blocks of time, but occur concurrently through the relationship between the Community Service Worker and their client.

Transport

Transport is a crucial facilitator of social and economic participation for people living with mental health conditions and an important cost for service providers reaching out in their

support work. Its importance is exacerbated within regional and rural areas, where travel to social activities, education, training and employment and clinical and community services may be longer and a significant cost (see *section xxi*).

Under current Commonwealth funded mental health programs, such as PIR, PhaMs and Day 2 Day Living (D2DL), transport costs for both service providers and for clients are funded as part of the grant. Within NDIS, it is a participant line item. There are a number of issues to address here.

Firstly, if transport funds within an Individual Support Plan (ISP) run out, this creates a potential barrier to participation in planned activities. Without a responsive review process, this is a challenge to resolve in a timely manner; a participant's options can be limited unless they fund the transport component themselves, often from their Disability Support Pension.

Anglicare Tasmania is also concerned about the uncertainty of continued taxi subsidies for Tasmanians with disabilities who receive funding through the NDIS. The State Government's temporary measure to subsidise fares until the end of June 2017 for this cohort if they exhaust their NDIS transport support funding is welcomed (Tasmanian Government 2016). But clarity is needed both on how the use of this subsidy will be reviewed and on timescales for deciding on the future of this subsidy. The imperative here is to ensure that Tasmanians receiving NDIS funding can continue to access public transport without cost barriers and on terms that do not disadvantage them in accessing services and supports. If NDIS transport support cannot cover full rate taxi fares to enable Tasmanians to achieve this, then continued subsidy will be a necessity to enable all Tasmanians with disabilities to sustain health and wellbeing, to have positive educational engagement and to consistently participate in social and economic life.

Additionally, transport costs for service providers are no longer funded, so participants living in regional and rural areas are likely to cost more to provide services for. This raises issues of equity and viability in pricing. (See *section xxi*. on rural and remote issues for more on this issue).

Specialist Disability Accommodation

Specialist Disability Accommodation (SDA) pricing covers additional cost for rent to owners when there is a vacancy. But the funding does not cover actual service provision costs. For example, if there are four people in a house and one leaves, the same staff ratio is required, but with three people funding the staff costs rather than four. Therefore there is a loss to the service provider. Currently the Tasmanian State Government's Department of Health and Human Services block funding covers this short fall, due to the house being funded rather than the individuals.

iii.) Why more participants than expected are entering the scheme

The additional participants that were identified in Tasmania were as a result of a miscount of students with disability in the school system. Numbers were only included from the Department of Education Specialist Disability Register (Department of Education 2013); they did not include all students who may be eligible for the NDIS.

Additionally, people who were previously managing with very little support are now entering the scheme due to publicity.

iv) Why fewer participants than expected are exiting the scheme

- **Tasmania's trial age cohorts:** Lower than expected exits in Tasmania may be related to the age cohorts that have moved into the NDIS. It was anticipated that children who received funding through the NDIS Education Childhood Early Intervention would need less support as result of the early intervention. This has not proven to be the case to date.
- **Concept of 'permanency':** The eligibility emphasis on permanency is leading to participation in the scheme being seen as a lifelong (see *section xiii.*)
- **Reviews are not conducted in a timely manner:** This is causing people to be less conservative about their support needs, as they won't be able to get additional support if needs change (see *section xiii.*).

v.) and vi.) Factors contributing to increasing package costs and mismatches between benchmark package costs and actual package costs.

During the trial periods, there has been a lower than expected proportion of low cost participants in Tasmania, compared to the national profile, and a higher than expected proportion of mid-range support packages (NDIA 2016a, p.13). Given that Tasmania is introducing the scheme in age cohorts, this may change over time.

It is our experience that package costs have decreased in Tasmania on average.

Anglicare Tasmania spends a significant amount of time speaking with people and their families/supports about the planning process and this time is unfunded.

In Anglicare Tasmania's experiences, some of the factors contributing to increased pack costs and leading to a mismatch between benchmark and actual costs are:

- **Unpredictable costs for complex needs:** Individuals with high and complex support needs have very high packages and it has not been possible to anticipate the true costs, as previously the State Government were the 'safety net' for this cohort.

- **Inappropriate planning:** Too many hours of support being funded for the wrong needs at the wrong rates.
- **Participants who are new to support:** There are groups with disabilities who were receiving little to no support prior to the scheme's implementation. '

Recommendations: scheme costs

Recommendation 1

Anglicare Tasmania encourages the Commission to consider an additional cost driver for NDIS – working effectively within relevant quality and service standards, such as the Mental Health Service Standards. Practically, that would involve the adoption of psychosocial service standards that reflect the National Mental Health Service Standards. Alternatively, people with psychosocial disabilities need to be excluded from NDIS and supported / funded through other, more appropriate mechanisms.

Recommendation 2

In order to work within the National Mental Health Service Standards and offer appropriate and responsive support for participants to lead a contributing life, NDIA need to create a psychosocial service and pricing system that better reflects the recovery concepts.

Practically, this may include:

- service line items specific to the needs of participants and service providers working within the recovery model of mental health services. These services should include any activities that may assist a participant to overcome challenges to social and economic participation, to ensure that support is coherent and comprehensive. These services need to include access to therapeutic clinical, as well as community, services such as Allied Health Professionals.
- enabling support to be matched to the needs of participants with mental ill health at appropriate price to ensure the sustainability of a quality mental health service..

Recommendation 3

Anglicare Tasmania supports the recommendations made to NDIA in our previous research around meeting the service needs for participants with behaviours of concern (Hinton 2014). In particular:

- NDIA needs to assess the full service needs and support costs and meet them through a higher intensity plus rate for such participants.

- Providers need to have access to a contingency fund which can be used to contain and address situations as they arise for people with behaviours of concern (see recommendation 20 on Provider of Last Resort)
- Federal or State Governments need to provide grants-based funding to enable providers to innovate and capacity build their approaches to effectively supporting participants with behaviours of concern.
- Care coordination for participants with behaviours of concern should be provided by the primary support provider.

Recommendation 4

Anglicare Tasmania encourages NDIA to review NDIS supports to more effectively meet participants' needs, including:

- Supporting participants to make applications for NDIS funds
- Supporting participants' full transport costs
- Simplifying the process to enable SDA providers to requote for participant accommodation support costs when a resident leaves, so there is no change to service for residents and to ensure service providers remain viable.

3. Scheme boundaries

Eligibility

Question block 3 (p.15)

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

viii.) 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 what was expected)? If so, what changes could be made to improve the eligibility criteria?

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

vii.) NDIS eligibility criteria and the Productivity Commission proposals

People living with mental illness commonly have a reduced capacity for social interaction; a response to this features heavily in plans.

viii.) Eligibility criteria affecting participation in the NDIS

Mental health has been retrospectively fitted into the NDIS scheme. As mental health is a specialist area of disability, it requires a specialist workforce from assessment through to service delivery and specifically designed information, guidance and operating frameworks. Such specialisations are yet to be embedded into NDIS (see section 1).

Eligibility and the planning and review processes are clear examples of where the existing system needs to be redesigned in order to be fit for purpose and may currently be inhibiting participation.

Unclear eligibility guidance

Mental health conditions are not as clear cut to diagnose as many physical disabilities. The lack of clarity in NDIA's guidance on what qualifies as a psychosocial disability for the purposes of NDIS is currently leading to inconsistent assessments. Anglicare Tasmania is

seeing participants with ostensibly very similar needs present with vastly different levels of ISPs.

There is a degree to which this is due to some consumers and their families having varied levels of self-advocacy skills (see *section xiii*). However, it is our staffs' experience that these discrepancies are mainly due to issues with the NDIS assessment tools not being sensitive enough to pick up psychosocial disability and consequent needs appropriately and LACs not having specialist knowledge in this area.

There is an urgent need to review current NDIA assessment and planning guidance to ensure it provides a clearer framework for LACs to make decisions around both NDIS psychosocial eligibility and support needs.

Permanency and the recovery model

One of the challenges for people accessing NDIS for psychosocial support is providing medical evidence that an impairment is likely to be permanent, as well as it having impacts on everyday life (NDIA 2015). This is particularly an issue for younger people, who our staff have now been working with for a significant period through the NDIS process. Professionals are reluctant to both diagnose and label symptoms as a specific illness and to confidently state that this is a permanent condition.

Additionally, many young people living with mental health conditions do not identify as or want to be seen as disabled; they are likely to be reluctant to buy into their condition being 'permanent', given the recovery model's emphasis on positive improvements. This is inhibiting access to NDIS support for many potential participants.

So not only is there likely to be a growing gap in comprehensively covering support services for those with diagnosed and undiagnosed mental health conditions as NDIS rolls out, but the reluctance for clinicians to label a disability as 'permanent' and 'persistent' is likely to exacerbate this gap. This leaves a significant number of vulnerable Tasmanians, often living with comorbid and complex support needs outside of NDIS support.

Other issues affecting participation

In our experience, some of the other issues with securing eligibility for NDIS amongst those living with mental health conditions are:

- Clients being transient, so not having secured a diagnosis to date.
- Clients having old diagnoses, so having challenges in obtaining the evidence to back this up.
- People living with mental health conditions may be slow to grasp the benefits of NDIS and reluctant to surrender their privacy.

- NDIS application and planning processes not creating space for trust and relationships to develop with planners (see chapter 4).

ix.) The speed of the NDIS rollout affecting eligibility assessment processes.

Within our trial area, as the roll out ramped up the speed of eligibility testing slowed significantly. It appears that compromises are being made in how NDIS services are implemented, due to NDIA being under-resourced for the current volume of business. This has had particular impacts on the adequacy of outreach and engagement and the appropriateness and timeliness of the planning and review processes (see *chapter 3 and section xiii.*).

There is a need to consider appropriate planning processes that allow time for LACs to build relationship with participants, understand their needs and assess eligibility thoroughly, and, in parallel, allows time for participants to both trust in the process and consider their plans. Under current resourcing levels, it may be a challenge for NDIA LACs to offer such a service.

With the significant demands in NDIA's planning and review services persisting and being likely to increase as more cohorts become eligible for NDIS funding, It must be ensured that NDIS participants can access support to identify their community support needs, plan their support, and choose and access appropriate services.

Question block 4 (p.15)

x.) What impact will the Education Childhood Early Intervention (ECEI) approach have on the number of children entering the scheme and the long-term costs of the NDIS?

x.) Impact of the Education Childhood Early Intervention

See sections ii to iv.

The intersection with mainstream services

Question block 5 (p.16)

**xi.) How has the interface between the NDIS and mainstream services been working?
Can the way the NDIS interacts with mainstream services be improved?**

xi.) Interface between NDIS and mainstream services

NDIS, Criminal Justice and Children's Services

There is an ongoing issue in relation to the roles and responsibilities between Mental Health and Disability Services, Children's Services and the Criminal Justice system. This is not a new issue, but is persisting in the transition from the grant funded system to the NDIS.

In our experience, it is challenging to get NDIS participants who have had regular interaction with the Criminal Justice system to be treated under the Mental Health Act rather than the Criminal Justice Act, particularly participants with complex diagnoses, such as Borderline Personality Disorders. This often leads to participants being stuck in a revolving door between the two systems, disrupting their trajectory towards recovery.

For example, NDIS does not provide funds to maintain a place within an accommodation service run by a disability provider for participants who are incarcerated and/or are given a custodial sentence. This disrupts exit strategies from the Criminal Justice system for such participants. Anglicare Tasmania has managed to negotiate locally with NDIA to pay the base rate for accommodation, a welcomed response. But this issue needs to be revisited in NDIS costs to ensure that NDIS provides a recovery framework for participants and the sector to work within.

NDIS and mental health services

Given that the boundary between clinical and non-clinical is not clear when it comes to therapeutic support for people with mental illness, the risk of NDIS scope creep is likely under the pressure to respond to the needs of people with mental illness. See *section i*.

Question block 6 (p.16)

xii.) How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?

xii.) How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?

What was the policy intention?

On 15 December 2015, the Commonwealth and Tasmanian Governments signed a bilateral agreement for the transition to and full roll out of NDIS (COAG 2015). The Council of Australian Governments' Disability Reform Council provides a forum for Commonwealth and State Governments to continue to discuss issues relating to reform in disability, including refining and further developing the NDIS. Paragraph 54 enables that, This Agreement may be amended at any time by agreement in writing by the Tasmanian Premier and the Commonwealth Minister for Social Services' (COAG 2015).

The Operational Plan Commitment between the Commonwealth and Tasmanian Governments specifies a number of commitments to find out the number of people ineligible for NDIS on the grounds of psychosocial disability and a commitment to continuity of support. But the commitment stops short of specifying who is responsible for leading these data gathering and funding initiatives. As such, we still do not understand the 'gap' that needs to be addressed in the mental health sector between those in and outside of NDIS.

It is worth noting that the bilateral agreement only commits to continuity of support for those clients who are with an existing mental health program **at the time that NDIS rolls out for their cohort**. It does not specifically mention those people living with complex, severe and/or persistent mental health conditions who are not engaged in support services at the time NDIS rolls out - i.e. potential consumers not engaged with any services and any future consumers.

Psychosocial support under the NDIS has been funded by transitioning funding from existing Commonwealth funded mental health programs (MHA 2017), such as:

- 100% of Personal Helpers and Mentors (PHaMs) funding
- 70% of Partners in Recovery (PIR) funding
- 50% of Day to Day Living (D2DL) funding and
- 35% of Mental Health Respite funding.

The assumption has been that NDIS will pick up support for those living with mental health conditions who previously received support under such programs, and the remaining funding would support those who are not eligible for NDIS. However, as the Mental Health Australia states, 'Emerging evidence reinforces concerns that... the NDIS could unintentionally result in a shortage of services for those people who will remain outside the NDIS' (MHA 2016, p. 11).

Impacts for consumers

In Tasmania, it has been agreed that the vast majority of Commonwealth and State Government community mental health funding is being cashed out to fund NDIS, but not all those Tasmanians living with mental health conditions are eligible for NDIS Individual Funding Packages. Many people with severe mental illness currently supported by Commonwealth and State Governments' community support programs, such as PIR, PHaMs, or D2DL are unlikely to be eligible for the NDIS because many people who need support to manage their mental illness are not experiencing a 'permanent' disability under the terms of the NDIS (Independent Advisory Committee for the National Disability Insurance Scheme 2014). Or they may not have a diagnosis, or clinicians are reluctant to diagnose their condition as 'permanent'. Yet their needs are often urgent and significant (see section viii.)

Table 4: Mental Illness Diagnosis Status - PIR Consortium Participants:

	PIR participant No by age cohort and Tasmanian region		Total PIR participant No	Total PIR participant %	PIR participant % with a likely diagnosis
	0 – 35 years	35 – 65 years			
Number of individuals with mental illness diagnosis considered to be ongoing	22 14 19	48 44 68	215	60	74
How many of remainder do you think would get a diagnosis?	5 5 1	13 9 9	42	12	15
Number of individuals remaining unlikely to have a mental illness diagnosis?	9 1 1	8 12 1	32	9	11
Number of individuals unable to say at this time	6 2 1	5 12 42	68	19	-
Total n	86	271	357		
Total %	24	76		100	100

Region: S, N, NW

Source: Partners in Recovery Consortium Tasmania 2017

We do not have data that tells us how many Tasmanians have severe and persistent mental illness and complex needs that means they may be included or excluded from funding under the NDIS model. Anglicare Tasmania estimates that around 72% of current PIR clients either have or would be likely to obtain a diagnosis that would qualify them for NDIS support on the grounds of psychosocial disability. That leaves 28% of those currently receiving support through PIR whose future support is unclear. Tasmania's PIR Consortium have estimated that 9% of their existing mental health clients would not qualify for NDIS and there were a further 19% of clients for whom partners were unsure (see Table 4).

The lack of clarity about the future support available for consumers living with mental health conditions who will not be eligible for NDIS is an unacceptable position for governments, for consumers and for service providers. It must be determined which systems, funded by whom, will be responsible for ensuring those Tasmanians with mental health conditions who are not eligible for NDIS packages receive the clinical and community support services they need.

It is urgent that the Commonwealth and State Governments work closely with the health and community sectors to get a firmer understanding of such data to enable strategic service planning and costing.

Support for carers

Nationally, at least half of current Mental Health Respite: Carer Support (MHR-CS) funding is being cashed out to provide NDIS funding (MHA 2017). Support for carers of NDIS eligible participants may be included within a participant's Individual Funding Package (IFP), if the participant chooses to include it. But it is not clear if there will be any way for such carers to access a support package directly. Nor is it clear what accessible support there will be for carers of consumers who are not eligible for NDIS funding, once current MHR-CS funding has been cashed out to fund NDIS. It must be determined which systems, funded by whom, will be responsible for carer policy and funding.

Impacts for service providers

Anglicare Tasmania provides services for 400 individuals through PIR, 200 through D2DL and reaches a further 400 people through family support within PHaMs. Funding under these programs is gradually being transferred into NDIS. For example, Anglicare Tasmania had a 16% decrease in PHaMs funding this year, as the cohort under 25 transferred to NDIS for psychosocial support. Additionally, State Government funded recovery and residential services are being cashed out, such as Anglicare Tasmania's Recovery programs and Curraghmore Residential and Recovery Support Service. To date, only a small proportion of

young people in the NDIS age cohort have been assessed as eligible for NDIS funding, leaving the remainder unable to access NDIS or Commonwealth funded support programs. Due to Anglicare Tasmania's integrated services model, we have maintained support for those ineligible for NDIS through drawing on other relevant programs that focus on comorbid issues, such as financial counselling, drug and alcohol services and housing. But this is not sustainable.

For those Tasmanians without a permanent diagnosis but who have comorbid and complex support needs directly and indirectly related to their mental health, withdrawing direct mental health support is likely to put more pressure on already stretched clinical and acute mental health support and intensive family support. This is a much more expensive and resource intense model of support for the State Government longer term. It is also a distinct move away from investing in preventative support highlighted in the State's mental health strategy, ReThink (DHHS 2015c).

On a workforce level, the insecurity of mental health funding means insecurity of employment for many specialist mental health workers. If they choose to leave their current positions, we risk losing important mental health expertise within the sector. This would be damaging for the quality and choice of mental health services within Tasmania. On an organisational level, we are also facing an uncertain future in terms of service planning and provision.

The services gap will reach a crisis point in July 2019 when existing funding for mental health programs outside of NDIS will finally be completely withdrawn. Ahead of this date, it is imperative for the State Governments to be talking with and agreeing with Commonwealth Government who will take responsibility for funding support for people with mental health conditions not eligible to receive NDIS funding in the short and longer terms. A longer term agreement may, of course, be guided by the Joint Standing Committee Inquiry into Mental Health within the NDIS (Parliament of Australia 2016) and the Productivity Commission's recommendations. But a shorter term agreement between State and Commonwealth Government is needed to bridge support over the coming financial years while the inquiries are conducted, reported upon and any recommendations considered and actioned. This would enable any State Government / partnered funding and resourcing to be allocated in a timely manner in forthcoming Commonwealth and State Budgets.

Given the current development of the Fifth National Mental Health Plan (DoH 2016b), the role of Primary Health Networks in providing support will also need consideration and clarity within any revised agreement.

Recommendations: scheme boundaries

Recommendation 5

Remove the notation of 'permanence' from NDIS eligibility criteria, or remove mental illness from the scheme.

Recommendation 6

Clarify guidance on what counts as a psychosocial disability and provide training on this issue for LACs.

Recommendation 7

NDIA need to review where NDIS coordination of supports sit within the responsibilities between Mental Health and Disability Services, Children's Services and the Criminal Justice system, to ensure the systems are working with, rather than against, each others' goals.

Recommendation 8

As a matter of urgency, Commonwealth and State Governments need to liaise to:

- how many people living with mental health conditions will not be eligible for support under NDIS – both those with severe and persistent conditions who currently receive mental health services under PIR, PHaMs and D2DL, and an estimate of future numbers
- what support will be available for consumers not eligible for support through and post-transition and fund that support
- what support will be directly available for carers for respite services.

Recommendation 9

As a point of urgency, NDIA, Commonwealth and State Governments need to keep consumers not eligible for NDIS engaged in leading a contributing life through committing to clear pathways of support.

4. Planning process

Question block 9 (p.18)

xiii.) Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved?

xiii.) Ensuring the planning process is valid, cost effective, reliable, clear and accessible.

The planning process is a key driver of the costs of the scheme and has questionable value. It is ineffective for all concerned at the moment.

Accessibility of the planning processes

Within Tasmania, NDIS planning is often conducted by Local Area Co-ordinators (LACs) who do not have specialist knowledge or understanding of disability or mental health issues. The planning is often conducted via a one-off phone discussion. Consequently this compressed planning process is often leading to inadequate plans and goals for participants, which then has a knock on effect on the relevance and types of support participants might access.

Transitioning to the NDIS can be a confusing and challenging process for many people. Currently there are no funded mechanisms beyond the NDIS website to support individuals to test their eligibility and prepare for planning meetings.

Due to the nature of their condition, participants with mental health conditions may find it difficult to articulate, or even disclose, to someone they have just met the full impact that their condition has on day to day life. Furthermore, asking participants to articulate the finer details of a plan that is intended to provide adequate support over 12 months is a daunting and anxiety-inducing task. In Anglicare Tasmania's current programs such as D2DL and PHaMs, development of a support plan is undertaken with an incremental planning process between participants and their matched worker which enables a trusting relationship to be developed and a greater understanding of the client's goals and support needs.

Anglicare Tasmania workers have attended a number of planning and LAC meetings with participants at their request, as many of our clients prefer the support of a worker they have a strong relationship with. Unfortunately, on multiple occasions Anglicare Tasmania has experienced both NDIA planners and LACs strongly resisting the presence of Support Workers, despite the wishes of the participant and their family. These situations have caused

distress to participants and do not show respect for the principles of choice and control the NDIA promotes.

Validity and reliability of the planning process

The lack of clarity in NDIA's guidelines on what qualifies as a psychosocial disability for the purposes of the NDIS is currently leading to inconsistent assessments. Anglicare Tasmania often works with participants with ostensibly very similar needs, but upon receiving their Individual Support Package, find that these individuals are offered vastly different levels of funding. In part this is due to some participants and their families having varied levels of self-advocacy skills, but these discrepancies can also be attributed to issues with the NDIS assessment tools.

Flexibility and responsiveness of the review process

We support NDIA's endeavours to develop meaningful plans and set swift and responsive targets to review them. But we have concerns about the current responsiveness of NDIA review periods.

NDIS participants who have been confirmed as having both a severe and permanent psychosocial disability need responsive support. Their symptoms may fluctuate and change rapidly and often, or may be episodic. This means that their support needs may change equally rapidly and often. To work within the recovery model, their package of support needs to be flexible enough to adapt with a participant's changing needs, as is possible within PHaMS and through PIR Support Facilitators.

We are finding that the rigidity of the NDIS planning and review process, as well as long delays in accessing reviews, do not allow for responsive plans and support to be put in place for participants. Although operational guidelines suggest NDIA has 14 days to decide to review a plan, Anglicare Tasmania have examples of cases where reviews have not been resolved for up to seven months. In all cases we have been involved with, timeframes have been very lengthy and involved a huge amount of follow up from families or workers.

We are finding that, when crises occur, participants and their families cannot get any additional support in an effective timeframe. This leaves them to deal with changing circumstances and crises largely alone, which can have catastrophic outcomes. Communication and clarity of process between key stakeholders is a significant issue here.

Given that mental illness may be episodic and support needs may change quickly, an agile review process is crucial to ensuring that participants have continuity of appropriate support.

Changing provider

Additionally, in some cases, when a support item is changed from one provider to another or a new service booking needs to be created, the service provider is not able to claim for the support delivered for two months. This is a significant period for a service provider to carry NDIA arrears. It may also impact on access to services for participants, as some service providers may not be able to carry this debt, or may be reluctant to take on an unfunded support role.

Question block 11 (p.20)

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

xv.) To what extent does the NDIA's budget-based approach to planning create clear and effective criteria for determining participant supports? To what extent does it lead to equitable outcomes for participants? What improvements could be made?

xvi.) What implications do the criteria and processes for determining supports have for the sustainability of scheme costs?

xvii.) Are the avenues for resolving disagreements about participant supports appropriate? How could they be improved?

xiv.) Criteria and guidance for participant supports

See comments in *section i*.

xv.) Equitable outcomes for participants

See comments in chapters 2 and 3 and sections xvii. and xxi.

Anglicare Tasmania would encourage NDIA to consider moving away from the current line item and category model to a banded one which maximises flexibility for participants.

Rather than clients needing to choose supports on a per unit/hour basis, in a banded support option, clients would be able to engage providers for a holistic package of support which works for them. For example they would be free to contract an agency or support worker to provide the wrap around support explained earlier in section ii, rather than

needing to choose individually billed items from restrictive categories with prescribed price points.

xvi.) Implications for the sustainability of scheme costs

The cost of providing support for participants with psychosocial needs is greatly increased through the NDIS in comparison to the current block funding model for programs such as D2DL, PHaMs and PIR. As an example, Anglicare Tasmania's total funding allocation in 2016-17 for the Day to Day Living (Pathways) program equates to approximately \$826 per client per year, with these clients receiving an average of 4.5 hours of individual and group-based psychosocial support per week. The NDIS plans Anglicare Tasmania is providing psychosocial support for are between \$10,000 to \$40,000 per participant for 12 months of support.

This creates a huge difference in ongoing costs for support between previous block funded and individually funded models. It also means that there is an inefficiency in how customers are supported. While NDIS plans do have the capacity to provide greater support to participants, we more often see packages that over-service and suffocate client needs. This is not consistent with the recovery model of supporting clients to learn self-management and resilience skills. It also means that there is a large amount of funding that is utilised for the sake of "not losing it when the plan is reviewed", rather than meeting the requirement for flexible in periods of greater need. More adequate and appropriate plans would also allow some of these over-servicing funds to be directed elsewhere (for example, consumers ineligible for NDIS).

Recommendations: planning process

Recommendation 10

NDIA is fully resourced during the roll out of NDIS to cope with the demands of conducting appropriate engagement, planning and reviews.

Recommendation 11

If mental health remains within the NDIS scheme, there needs to be:

- The creation of a specific psychosocial gateway service for people with a psychosocial disability that converts the concepts of permanent disability to a system that supports recovery. Practically, this may include NDIA Community Engagement staff and Local

Area Coordinators (LACs) who are specifically trained in understanding the needs of mental health consumers and appropriate service responses within the recovery model, to ensure engagement, planning and reviews are timely and relevant for participants.

- the creation of a psychosocial assessment, planning and review system *that embraces the concept of recovery for people with a psychosocial disability*. Namely:
 - an incremental planning process between participants and LACs that enables a trusting relationship to be developed
 - participants routinely having the options of face to face or phone interactions
 - specialist mental health trained LACs
 - specifically targeted line items that meet the needs of participants with psychosocial disabilities, including access to clinical therapeutic services, including Allied Health Professionals, costed at levels that are sustainable for providing a market in specialist mental health services
 - a more flexible review process that can respond to changes in participants' support needs in a more agile manner. (see recommendation 2).

Recommendation 12

The scheme could alternatively be modelled similarly to community aged care – eligibility determined, agreed funding packages provided based on pre-determined bands after which the participant or their nominee has full flexibility to purchase supports with that money.

5. Market readiness

Question block 12 (p.24)

xviii.) What factors affect the supply and demand for disability care and support workers, including allied health professionals? How do these factors vary by type of disability, jurisdiction, and occupation?

xix.) What are the advantages and disadvantages of making greater use of skilled migration to meet workforce targets? Are there particular roles where skilled migration would be more effective than others to meet such targets?

xvii.) Factors affecting the supply and demand for disability care and support workers.

Disability services

As NDIA acknowledge, the prevalence of part-time and casual workers within disability support is high (NDIA 2016a), due to fluctuations in market demand for disability services. This means that disability support workers often require more hours than are allocated by one organisation, leading to them working across a number of service providers. This is certainly the case in Tasmania.

Where the casualisation of the disability workforce leads to service availability issues, this presents a challenge to the sector to being market ready. NDIS participants may request specific workers and / or specific times for services and, as market-led service providers, we must be able to respond to these needs efficiently and effectively, or risk losing business.

Mental health

We have a number of risks to sustaining a quality mental health services workforce in Tasmania, as a result of NDIS' scope. This could impact on the long term supply of both community services workers and allied health professionals (see comments in *section i*). In summary:

- **Viability of offering specialist community mental health workers at SCADS 4:** Anglicare Tasmania is finding that NDIS line item costings are not viable for sustaining the quality of services required within the National Mental Health Service

Standards. Longer term, this may lead to either a significant decline in the quality of mental health services, or market failure and severe consequences for community-based rehabilitation.

- **Market for Allied Health Professionals:** As NDIS line items mostly do not cover and the rates do not meet appropriate levels for allied health professionals, the supply of AHPs in Tasmania, which is already a small market, could be affected longer term.

Will providers be ready?

Question block 13 (p.26)

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

xxi.) What is the capacity of providers to move to the full scheme? Does provider readiness and the quality of services vary across disabilities, jurisdictions, areas, participant age and types/range of supports?

xxii.) What are the best mechanisms for supplying thin markets, particularly rural/remote areas and scheme participants with costly, complex, specialised or high intensity needs?

xxiii.) How will the changed market design affect the degree of collaboration or co-operation between providers?

xviii.) Efficiency of prices set by the NDIA.

Anglicare Tasmania has raised concerns about the current pricing of line items in chapters 2 and 3.

The NDIA worked with NDS in 2015 to identify pricing issues and set a realistic and fair price; however the NDIA did not accept the price that was determined and subsequently did not endorse its implementation.

We fully support the Samaritans' paper (Baker Worthington Pty. Ltd. 2016) examining whether the NDIS cost methodology is reasonable (see Anglicare Australia 2017, appendix).

xix.) Capacity of providers to move to the full scheme.

The quality of service for people with mental illness is directly related to market rates for allied health professionals. The sector is ready for full roll out at market rates in order to maintain the appropriate levels of support. As highlighted in chapters 2 and 3:

- NDIS line item costings are not viable for sustaining a high quality mental health sector. Commonly, Anglicare Tasmania is losing about 50 per cent an hour on any given NDIS line item, or having to compromise on the service offer. For example, in some cases, Anglicare Tasmania can only offer a less qualified worker, or half the hours of service specified in their plan with a specialised worker.
- Current pricing is based on SCHADS 2, which is commonly used within the general disability sector, rather than SCHADS 4, which is more commonly offered for specialist mental health support workers. Longer term, this may lead to either a significant decline in the quality of mental health services, or market failure and severe consequences for community-based rehabilitation.

xx.) Supplying thin markets, particularly rural/ remote areas and scheme participants

Anglicare Tasmania welcomes NDIA's aspiration to support both service provision and innovation in thin markets and workforce supply, articulated through its recently released Rural and Remote Strategy (NDIA 2017). However, we are concerned that there is no direct funding attached to its implementation. As the NDIS rolls out and demand for services increases, supply of services and an appropriate workforce to rural and remote areas continues to be an issue in Tasmania.

Table 5: NDIA's estimates of the number of NDIS participants by year and region of service: Tasmania

Service region	30 June 2016	30 June 2017	30 June 2018	30 June 2019	Participants per 100km ²
Hobart	500	1,000	2,100	4,400	70
Launceston	100	300	700	1,300	90
North (excl. Launceston)	200	300	700	1,600	10
South (excl. Hobart)	100	100	300	800	<5
North West	200	500	1,100	2,500	10
Total	1,100	2,200	90	10,600	20

Source: NDIA 2016a, p.9

Tasmania has a relatively small population compared to other states and territories. A high proportion of Tasmania's population lives in rural / remote locations: approximately 38 per cent (around 190,000 people) live outside of the two 'urban' areas of Hobart and Launceston. (NDIA 2016a).

Tasmania also has a relatively low population density, compared to other states and territories (see table 5). As NDIA market analysis has flagged:

This impacts on the expected demand for NDIS supports, with regions outside of Hobart and Launceston having 10 or less participants per 100km2. In particular, the South (excl Hobart) is expected to have less than 5 participants per 100km2

(NDIA 2016a, p.9).

Table 6: Current and estimated demand in Tasmania - participants and costs

Service region	Participants				Cost (\$ millions)			
	Current	Full scheme	Growth #	Growth %	Current	Full scheme	Growth #	Growth %
Hobart	2,000	4,400	2,400	120%	100	200	100	100%
Launceston	700	1,300	600	86%	30	60	30	100%
North (excl. Launceston)	600	1,600	1,000	167%	30	70	40	133%
South (excl. Hobart)	200	800	600	300%	10	40	30	300%
North West	800	2,500	1,700	213%	50	110	60	120%
Total	4,300	10,600	6,300		220	480	260	

Source: NDIA 2016a, p.32

Given that Tasmanian markets are mainly regional and rural in their nature, we have all the usual challenges within service provision:

- limited service choice and availability
- the enhanced need for travel and transportation, exacerbated in Tasmania by poor public transport infrastructure
- difficulties with recruiting, training and retaining appropriate staff that meet the needs of clients locally.

It is anticipated that the Tasmanian regions which will require the largest growth in supply of services are those with the least dense populations (see Table 6) – i.e. the south (excl. Hobart) and the North West. So issues of thin markets are very important to how choice and control develops for Tasmania participants.

Workforce supply

The workforce providing disability supports in Tasmania is estimated to be approximately 1,750 to 2,150 full time equivalent (FTE) employees. To meet future demand, it is estimated that this workforce will need to grow by 82% by the end of 2018-19 (NDIA 2016a, p.33 & see Table 7). As NDIA has highlighted:

As the prevalence of part-time and casual workers in the disability support workforce is high, the actual number of additional workers required to meet increased demand will be greater than the required FTE increase in the workforce

(NDIA 2016a, p.33).

Table 7: NDIA's estimates of current and future workforce needs for the NDIS in Tasmania

Region	Current workforce	Estimated required workforce 2018-19
	FTE range	FTE range
Hobart	800-1,000	1,350-1,600
Launceston	250-300	400-500
North (excl. Launceston)	250-300	450-550
South (excl. Hobart)	50-100	250-300
North West	400-450	750-950
Total	1,750-2,150	3,200-3,900

Source: NDIA 2016a, p.24

As well as expanding service supply, it is also anticipated that the workforce needs to expand the most in the same areas of lowest density – the North West and the South (excl. Hobart) (see Table 7).

Some of the issues Anglicare Tasmania experiences in expanding our rural and remote workforce are:

- Recruitment and retention:** Due to the profile of many of our rural and remote communities, the pool of prospective workers can be limited by health and literacy levels. It can also be limited by poverty; the cost of travel to and from work can be substantial, given there is poor public transport infrastructure in Tasmania. If workers are servicing participants on the North West coast, for instance, Strahan to Smithton is over 250km. This impacts on staff's cost of travel and travel time, which has consequences for being able to provide services for participants at times they want them.

- **Securing availability:** Due to the small populations in many areas of Tasmania, there is competition for staff. And, due to the casual nature of the disability workforce, our staff often work for a number of service providers. This can lead to clashes in appointment scheduling, or staff simply not being available.
- **Finding staff participants want to work with:** As rural communities are often close knit, many people know each other. NDIS participants often request staff they do not know so that their privacy is maintained. This can cause challenges for supplying local staff for participants, leading to increased travel times for our staff in rural and remote areas, to ensure they are supporting clients outside of their own locale.

Such challenges need a strategic approach and resources behind it to tackle them. Anglicare Tasmania has developed a Rural and Remote Recruitment strategy. For example, our Human Resource staff and Managers are building up a presence within local communities to help actively recruit local people into our workforce and are also looking at partnering with other organisations to deliver services.

Supply of services to enable choice and control

The number of registered NDIS providers in Tasmania was 228 at the end of March 2016 (NDIA 2016a, p.35).

We are experiencing a number of pricing issues related to service provision within rural areas:

- **Travel costs:** In many of our regional and rural areas, such as the North West, our workers will often be providing support for one participant a day, or one participant every half day. As Anglicare Tasmania cannot bill a participant for travel costs incurred for staff from home to their first appointment and their return to home, Anglicare Tasmania either has to subsidise these expenses, or many of our casual staff have to pay for what can amount to substantial travel costs in order to support some of our rural participants. Although we can try to cluster appointments where possible, this somewhat works against the emphasis on participants' choice and control over when they receive services. It would likely also be of detriment to the first participant, who may end up with 40 minutes of service support rather than an hour.ⁱⁱ
- **Establishment fees:** Once a participant has an ISP, they need to liaise with service providers to establish how the supports will be delivered. The establishment fee is a set amount. Travel hours are not covered. In order to reach some of our rurally located participants, this can be a two hour trip each way for our staff. So currently, these are uncharged hours that have to be absorbed by Anglicare Tasmania.
- **High and complex needs:** The additional unclaimable costs created by supporting participants with high and complex needs are exacerbated in rural and remote areas, due to additional travel / hours (see earlier in this section). This, together with

the changing nature of participants' needs, inclines Anglicare Tasmania toward supporting a move to quotation as a method of handling complex cases.

Anglicare Tasmania notes that NDIA's Rural and Remote Strategy points to a number of options for developing thin markets, including:

- Working to understand local needs and challenges
- Developing a framework for Provider of Last Resort for remote areas in the event of provider failure / no provider being available (see *section xxvi.* for our comments on this)
- Supporting the implementation of the National Integrated Market, Sector and Workforce Strategy, ensuring NDIA has a range of levers to generate supply and recognising the need for service innovation (NDIA 2017, p.25).

These are welcomed initiatives; Anglicare Tasmania would hope they are also resourced. Amongst the options, Anglicare Tasmania encourages Commonwealth and State Governments to consider block funding as a method for supplying thin markets.

Innovation

Anglicare Tasmania welcomes the NDIA's push for innovation in service delivery and welcomes the intention to facilitate networks / communities of interest (NDIA 2017, p.32). However, given the tight margins of operation within NDIS, finding both the time and resources to do this and to prepare for market readiness is challenging. The current focus for operation is more on efficiencies than risk. In order to create space for innovation and development, capacity building funds continue to be needed for disability providers.

xxi.) Collaboration or co-operation between providers?

The move from being "friendly providers" to "competitors" is having a significant effect on services working collaboratively in ways that they may have done prior to the NDIS. Relationships are now often tense and fragmented, with providers reluctant to share information and resources. Given the need for partnerships and innovation, particularly to meet participants' needs in rural and remote areas, this is concerning.

Question block 14 (p.27)

xxiv.) How well-equipped are NDIS-eligible individuals (and their families and carers) to understand and interact with the scheme, negotiate plans, and find and negotiate supports with providers?

xxii.) Capacity of NDIS-eligible individuals (and their families and carers) to understand and interact with the scheme, negotiate plans, and find and negotiate supports with providers.

There has been a distinct lack of public information aimed at participants and families, so people remain unaware of what they need to do. The information provided about the scheme changes regularly and is confusing to participants.

They are ill-equipped to do all of the activity described. It is difficult for participants and their families to negotiate plans, as it is a case of not knowing what you don't know. They are not informed of the supports they may be eligible for and often have to push to be allowed to be supported through the transition and planning processes.

The NDIA have responded to this issue by assuring all participants that they can have funding for a coordinator of supports in their plan. However, generally, support coordination that is included in a plan is short term. This becomes a problem again when plans are due for review.

The scheme is not well designed for psychosocial support, as already articulated, and individuals entering into the scheme are often provided with a package which does not include funding appropriate for skilled psychosocial support. This causes further confusion.

A large number of clients with psychosocial disability do not identify with the disability label and therefore have strong negative emotions which need to be overcome before they are able to engage with the scheme (as described in section viii.). However, there is no funded support to achieve this.

At this stage, it is unclear whether ILC will address these issues adequately.

Recommendations: market readiness

Recommendation 13

NDIA could consider moving to market pricing now as a way to resolve the mismatch between the current price settings and market needs.

Recommendation 14

NDIA could consider quotation as a method to handle complex cases.

Recommendation 15

NDIA need to ensure there is funding to deliver its Rural and Remote Strategy, to ensure that local workforces and services meet the needs of NDIS participants.

Recommendation 16

Where markets are thin:

- allow the true cost of travel to be charged to participants for establishment and service fees, or provide service providers with travel funds
- Anglicare Tasmania encourages Commonwealth and State Governments to consider block funding as a method for supplying such markets, or ensuring there is a Provider of Last Resort (see recommendation 20)

Recommendation 17

In order to create space for innovation and development, including ensuring service providers are market ready, capacity building funds are needed for disability providers.

Recommendation 18

ILC needs to have a longer timeframe and be responsive to emerging needs that become apparent as NDIS rolls out. This should include funding gaps in support for consumers, carers and their families.

6. Governance and administration of the NDIS

Question block 15 (p.28)

xxiv.) Does the way that the NDIA measures its performance affect the delivery of the NDIS?

xxv.) Are there appropriate and effective mechanisms for dealing with disputes with the NDIA?

xxiii.) Measurement of NDIS performance

During the trial measure performance did seem to influence the delivery of the NDIS. However, with the transition to the full scheme the focus has been solely on getting the numbers through rather than quality.

Question block 17 (p.28)

xxvi.) Is there likely to be a need for a provider of last resort? If so, should it be the NDIA? How would this work?

xxiv.) Provider of last resort

Evidence has now shown that there absolutely is a need for a provider of last resort.

This is the role that Tasmania's State Government Department of Health and Human Services has previously held. The NDIA has handed responsibility for crisis management to the Coordinator of Supports, which has proven in several known situations to be ineffective, leaving the person either without support, inappropriately hospitalised, or incarcerated by the police.

The NDIA should not take on this role, as they are the funder, not the provider. However, they need to work with providers to develop this support, particularly for people with high and complex behavioural support needs.

Anglicare Tasmania currently provides an Intensive Support Service and would strongly support the provision of a provider of last resort model along the lines of what we currently offer and that which is provided in Queensland and Victoria, to include:

- Physical spaces across Tasmania that could accommodate no more than two participants at one time for up to six months
- The availability of a staff team at short notice
- A case management approach that works across agencies and services to offer wrap around support - managing behaviours of concern, addressing medical and clinical needs, community connections, a plan for monitoring and measuring outcomes and a transition plan back to the community and / or family, as appropriate
- Places for participants to exit to. This is the biggest challenge in Tasmania currently; for example, we have had clients waiting for four years to exit into an appropriate space.

Anglicare Tasmania is interested in developing such a service of this type in the future but lacks the infrastructure to do so at this point.

Recommendations: governance and administration

Recommendation 19

Disputes should be handled by a party independent of any service provider, including State Government.

Recommendation 20

NDIA needs to fund Providers of Last Resort within Tasmania. Funding should include:

- Short term accommodation across the state
- Crisis support teams to provide case management, wrap around clinical and community supports
- Places for participants to exit to.

7. Paying for the NDIS

Question block .18 (p.31)

xxvii.) *Does the current funding split between the Commonwealth and the States and Territories have implications for the scheme's sustainability? Does it affect the NDIA's capacity to deliver disability care to scheme participants at the lowest cost?*

xxviii.) *What proportion of a state or territory's contribution to the NDIS are in-kind services? Are there risks associated with in-kind service contributions?*

xxv.) Commonwealth / States and Territories funding

Support for all NDIS eligible participants with psychosocial disabilities

Anglicare Tasmania remains concerned that it is not clear who will be responsible for funding any additional NDIS participants over and above initial NDIA estimates (10,600 Tasmanians, NDIA 2016a).

xxvi.) Risks associated with in kind services

As we do not know the extent of consumer needs to be addressed at a state level by the Tasmanian Government within disability and mental health within and outside of NDIS, in-kind services are not an issue unless the amount allocated is not utilised.

Clarification is needed on what whether unspent in kind contributions from State Governments will be protected during the NDIS roll out period, to help Commonwealth and State Governments understand the full cash and resource implications for participants eligible for NDIS and consumers still requiring disability and mental health services outside of NDIS.

Recommendations: paying for the NDIS

Recommendation 21

As a matter of urgency, Commonwealth and State Governments need to clarify who is responsible for funding participants over and above initial NDIA estimates.

Recommendation 22

Clarification is needed on what whether unspent in kind contributions from State Governments will be protected during the NDIS toll out period, to help Commonwealth and State Governments understand the full cash and resource implications for participants eligible for NDIS and consumers still requiring disability and mental health services outside of NDIS.

Summary of recommendations

Scheme costs

Recommendation 1

Anglicare Tasmania encourages the Commission to consider an additional cost driver for NDIS – working effectively within relevant quality and service standards, such as the Mental Health Service Standards. Practically, that would involve the adoption of psychosocial service standards that reflect the National Mental Health Service Standards. Alternatively, people with psychosocial disabilities need to be excluded from NDIS and supported / funded through other, more appropriate mechanisms.

Recommendation 2

In order to work within the National Mental Health Service Standards and offer appropriate and responsive support for participants to lead a contributing life, NDIA need to create a psychosocial service and pricing system that better reflects the recovery concepts.

Practically, this may include:

- service line items specific to the needs of participants and service providers working within the recovery model of mental health services. These services should include any activities that may assist a participant to overcome challenges to social and economic participation, to ensure that support is coherent and comprehensive. These services need to include access to therapeutic clinical, as well as community, services such as Allied Health Professionals.
- enabling support to be matched to the needs of participants with mental ill health at appropriate price to ensure the sustainability of a quality mental health service..

Recommendation 3

Anglicare Tasmania supports the recommendations made to NDIA in our previous research around meeting the service needs for participants with behaviours of concern (Hinton 2014).

In particular:

- NDIA needs to assess the full service needs and support costs and meet them through a higher intensity plus rate for such participants.
- Providers need to have access to a contingency fund which can be used to contain and address situations as they arise for people with behaviours of concern (see recommendation 20 on Provider of Last Resort)

- Federal or State Governments need to provide grants-based funding to enable providers to innovate and capacity build their approaches to effectively supporting participants with behaviours of concern.
- Care coordination for participants with behaviours of concern should be provided by the primary support provider.

Recommendation 4

Anglicare Tasmania encourages NDIA to review NDIS supports to more effectively meet participants' needs, including:

- Supporting participants to make applications for NDIS funds
- Supporting participants' full transport costs
- Simplifying the process to enable SDA providers to requote for participant accommodation support costs when a resident leaves, so there is no change to service for residents and to ensure service providers remain viable.

Scheme boundaries

Recommendation 5

Remove the notation of 'permanence' from NDIS eligibility criteria, or remove mental illness from the scheme.

Recommendation 6

Clarify guidance on what counts as a psychosocial disability and provide training on this issue for LACs.

Recommendation 7

NDIA need to review where NDIS coordination of supports sit within the responsibilities between Mental Health and Disability Services, Children's Services and the Criminal Justice system, to ensure the systems are working with, rather than against, each others' goals.

Recommendation 8

As a matter of urgency, Commonwealth and State Governments need to liaise to:

- how many people living with mental health conditions will not be eligible for support under NDIS – both those with severe and persistent conditions who currently receive mental health services under PIR, PHaMs and D2DL, and an estimate of future numbers
- what support will be available for consumers not eligible for support through and post-transition and fund that support
- what support will be directly available for carers for respite services.

Recommendation 9

As a point of urgency, NDIA, Commonwealth and State Governments need to keep consumers not eligible for NDIS engaged in leading a contributing life through committing to clear pathways of support.

Planning process

Recommendation 10

NDIA is fully resourced during the roll out of NDIS to cope with the demands of conducting appropriate engagement, planning and reviews.

Recommendation 11

If mental health remains within the NDIS scheme, there needs to be:

- The creation of a specific psychosocial gateway service for people with a psychosocial disability that converts the concepts of permanent disability to a system that supports recovery. Practically, this may include NDIA Community Engagement staff and Local Area Coordinators (LACs) who are specifically trained in understanding the needs of mental health consumers and appropriate service responses within the recovery model, to ensure engagement, planning and reviews are timely and relevant for participants.
- the creation of a psychosocial assessment, planning and review system *that embraces the concept of recovery for people with a psychosocial disability*. Namely:
 - an incremental planning process between participants and LACs that enables a trusting relationship to be developed
 - participants routinely having the options of face to face or phone interactions
 - specialist mental health trained LACs
 - specifically targeted line items that meet the needs of participants with psychosocial disabilities, including access to clinical therapeutic services, including Allied Health Professionals, costed at levels that are sustainable for providing a market in specialist mental health services
 - a more flexible review process that can respond to changes in participants' support needs in a more agile manner. (see recommendation 2).

Recommendation 12

The scheme could alternatively be modelled similarly to community aged care – eligibility determined, agreed funding packages provided based on pre-determined bands after which the participant or their nominee has full flexibility to purchase supports with that money.

Market readiness

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Appendix 1: Hinton, T 2014, *Uncounted costs – choice and control for people with behaviours of concern*

ⁱ Please note that the figures provided are estimates based on current certification costs and will rely on the final version of the standards. The framework identifies that, for large providers, requirements will be on higher risk supports - quality assurance certification focused on compliance with practice standards and management of risks, including governance and internal quality systems. Requirements will be tailored to the scope of supports offered. The lower rate we have provided will depend on our current relationship with ACIS and whether the NDIS standards map well to them and provide us with an opportunity to transition and extend our current certification. Depending on MAIB requirements this may not be an option. The upper amount will be likely if we need to seek complete certification across the organisation.

ⁱⁱ If support is less than four hours, the first hour of support includes an allowance of 20 minutes for travel, with only 40 minutes of service delivery.