

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

Introduction

CMHA would like to thank the Productivity Commission (the Commission) for the opportunity to make a submission to the National Disability Insurance Scheme (NDIS) Costs Issues Paper.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital to ensure that the recovery focus of community managed mental health services — which has come to inform the overall approach that is taken to addressing mental illness — is not lost. We also do not want to create a situation where some people receive a high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not.

CMHA's submission to the Issues Paper will address the majority of the questions posed by the Commission.

Background information

CMHA would like to make some comments in relation to the background information provided in the issues paper, which is relevant to the overall discussion and examination of costs. This primarily relates to the way the NDIS is being implemented, in that the intent of the scheme is not bearing out in the actual implementation.

An issue which CMHA raised in the submission to the Joint Standing Committee on the NDIS inquiry into mental health was that the scheme is not consistent in how it is being implemented¹. The 'What is this study about' section notes that the NDIS distinguishes itself from previous approaches in a number of ways including that it is a national scheme. The announcement that Western Australia (WA) would be implementing its own state-based system has immediately created a situation where there will not be a

¹ Joint Standing Committee on the NDIS – The provisions of services under the NDIS for people with psychosocial disabilities related to a mental health condition, Community Mental Health Australia Submission, 2017, http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Submissions

nationally consistent scheme and further anecdotal information from states and territories indicate differences in implementation based on expertise in state and territory or regional areas.

The background information notes that the 2011 Commission inquiry into the state of disability care and support services recommended that a new national scheme would deliver benefits such as improved wellbeing; better options for employment, independent living and community participation; and efficiency gains and savings in disability and other support systems. At the time the community managed mental health sector supported these identified benefits and consequently supports the NDIS. However, a key issue is in the actual implementation of the scheme where the focus is becoming about signing people up within a defined timeframe rather than the quality of support that is being provided to people.

The issues paper notes that this is a new approach to disability care and support and CMHA acknowledges that when a new approach such as this is introduced there will be problems and issues to address. The issues paper states that 'A market-based approach aims to create incentives that better provide participants with quantity, quality and variety of services they desire in an efficient way'. A key issue with the implementation that CMHA would ask the Commission to consider in their analysis, and which is showing in the implementation of the NDIS particularly for people living with a mental illness, is that we are not dealing with 'widgets' but people and pure market-based mechanisms will not be easily transferable to a scheme dealing with complex cases.

People in the community sector are very aware of financial sustainability being a significant issue in any service system and it is an issue they have to deal with every day. Therefore, the need for the NDIS to be financially sustainable is also recognised. However, the aim of the NDIS is to deliver a better system of care than people living with a mental illness have received before and that they don't have reduced care. If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost. This is the concern that CMHA has and believes that the Commission in assessing whether or not the NDIS is financially sustainable must investigate how the scheme is being implemented and how this is being managed.

Issues Paper Questions

Scheme Costs

Cost drivers - Any cost drivers not identified that should be considered in the study

A significant area where CMHA believes there must be a focus for the Commission in terms of cost drivers is on how the NDIS is being implemented, in particular the structure and administration of the National Disability Insurance Agency (NDIA) and the overall structure and administration of the NDIS through the Federal Government. This would most likely come under the cost driver of 'Delivery' as identified by the Commission, however there is currently in the Commission's Issues Paper and the implementation processes, an emphasis on providers – including providers and consequently consumers taking on the largest amount of risk. It needs to be recognised that the way governments and agencies implement the NDIS are also going to have a significant impact on the costs of the NDIS.

In terms of both the short and long-term impacts on cost, creating administrative processes that drive up the costs of delivering the NDIS add considerably to the costs of the NDIS. Government has a significant influence on this, particularly in terms of how the governing legislation for the NDIS is implemented, monitored and evaluated.

The use or interpretation of the NDIS Act 2013 by the NDIA appears to be an area requiring examination. The December 2015 independent review of the NDIS legislation by Ernst and Young² stated as a key finding that while, at the time, the legislative framework was broadly enabling government to progress the NDIS Act, an important caveat was that the NDIS was at an early stage and evolving. That as the scheme moved into more locations and took on more people, a key recommendation was the government should conduct another review in 2 to 3 years to ensure the legislation was 'fit for purpose' for full scheme.

Issues are occurring with requests for plan amendments triggering reviews of full plan, which are done centrally rather than regionally. Clients are generally not permitted to see a plan before it is finalised, which anecdotally providers state is hindering clients understanding of their plan. The NDIA are stating verbally in meetings that the planning process is adhering to legislation. CMHA contends that a review of the legislation is required as its interpretation is leading to implementation problems and escalating administrative costs with the scheme.

Recommendation: The NDIS Act must be reviewed now that the legislation is actually at implementation, as recommended by Ernst and Young's 2015 review of the NDIS legislation.

The current experience and pressures emerging – Low rates for utilisation of plans; more participants entering than expected; benchmark package costs and actual package costs.

Regarding utilisation rates for packages, there must be accurate information and data on why this is occurring. In terms of mental health, anecdotally the view is this is due to three key factors:

- The knowledge and experience of assessors and planners to develop packages for people living with a mental illness.
- The unavailability of services in particular areas/regions.
- The often episodic nature of mental illness which can make package use uneven.

The feedback from the sector has been that plan implementation has been difficult due to many people not understanding what are the types of services they can purchase and what is then in their final package. A central part of this occurring is the understanding of the planners as to what services are available. This does not mean these services won't be available, however, the community-managed sector needs to be supported to enable them to evolve and maintain services, and the planners need to be well linked into and aware of what supports that are currently available. This is particularly important in remote areas, including in Aboriginal and Torres Strait Islander communities, where services are often provided by a regional council.

² Ernst and Young, Independent review of the NDIS Act, December 2015, https://www.dss.gov.au/sites/default/files/documents/04_2016/independent_review_of_the_ndis_act.pdf

If a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended in the future, thereby reducing administrative burden on the NDIA and building confidence in the process for the consumer.

In terms of the numbers of participants entering the NDIS in trials sites, whether this is more or less than expected feedback suggests this may be due to inconsistency in implementation of processes such as planning and assessment occurring in different regions and states and territories. It would be vital for the NDIA and Government to assess and manage data to examine if this is the case, as that type of analysis will be vital to ensure that lessons learnt from the trial sites are actually acted on.

The situation in the ACT must be noted and considered whereby the 'estimate' for the number of participants was reached and a disagreement ensued between the Federal Government and the ACT Government about who was responsible for funding people entering the NDIS over this estimate. This fact that the numbers are a 'best estimate' and, particularly in the area of mental health, there will be people who aren't currently engaged in the service system or where new diagnoses will occur that will impact on numbers. Again we are dealing with people and the complexities of this will not fit easily into a market based scheme.

A central issue for mental health being a part of the NDIS has been mental health not fitting into the pricing structures of the NDIS, therefore a mismatch between benchmark costs and actual costs of packages for people living with a mental illness in a disability structured market will be an issue. There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, with a seeming misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports. Therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. This is particularly difficult in remote communities including Aboriginal mental health workers.

Currently the NDIS sets the basic rate for support work at \$43.58 per hour. Rob Woolley, General Manager of Just Better Care was quoted in an ABC article as describing this as "a bargain basement rate for what is expected to be a platinum quality service."³ The discrepancy in NDIS rates and what organisations have previously been paying support workers and other staff, puts significant pressure on organisations and places at risk the required number of workers available to provide services at NDIS rates and the Government's commitment that nobody would be worse off on the NDIS.

Community-managed mental health organisations within the community-managed mental health sector prioritise community-based rehabilitation to support individuals to recover, and through this the sector has developed a workforce that is appropriately qualified and skilled to deliver these services and a culture that reflects the appropriate standards. In Victoria for example, 90 per cent of the community mental health sector holds a diploma or higher qualification.

³ Norman Hermant, 'We have grave concerns': There could be trouble ahead for the NDIS if the ACT's problems go national, Updated 6 Jan 2017 <http://www.abc.net.au/news/2017-01-03/ndis-there-could-be-trouble-ahead-after-problems-in-act/8157662>

However, the hourly rates included in the NDIS pricing structure demonstrate a lack of acknowledgement and understanding about the level of skills and expertise that are required to provide disability support to individuals with serious mental illness.

It is widely accepted that people with high and complex needs cost more to support, and that this requires that higher complexity be factored into the NDIA price guide. A recent article in the ACTCOSS publication “NDIS transition – Where have we landed?” of their journal *Update*, notes that “A one size fits all approach is at odds with the other pricing structures in the NDIS.”⁴ This article also makes the point that a requirement for support staff on weekends and public holidays will result in additional costs. While the NDIS recognises complexity of support and differentiation in cost of service provision due to penalty rates in some of its pricing, it only provides a “maximum payment for short term accommodation in a centre or group residence set at a single rate per person per 24-hour period. This is an inclusive, all expenses price for a 24-hour period with no additional loading permitted. While this amount may be adequate for a range of lower needs participants, it is often not sufficient for those requiring higher support or levels of supervision to stay safe, particularly during higher wage periods.”⁵

The implications of the current pricing for community-managed mental health services are potentially:

- The exclusion of participants with higher needs that require higher levels of staff support from these services, and the withdrawal of service providers.
- The loss of existing skilled and qualified staff and a de-skilling of the workforce. In time providers may well opt to hire the lower-skilled staff they can afford to be able to offer NDIS services. This will impact on recovery-focused psychosocial rehabilitation supports which will develop into generalist disability supports.
- Service providers may choose to only provide low-priced supports if the NDIS participant also purchases higher-priced supports from them, effectively aiming to some degree offset losses on support with profits on another. This limits choice and control and undermines the objectives of the NDIS.

Scheme Boundaries

The extent that the speed of the NDIS rollout is affecting eligibility assessment processes

The main driver for the rollout of the scheme being the number of people that are signed up within a given timeframe is a significant issue which has flow-on effects to other areas of the NDIS. Currently the main indicator of success for the scheme, including consumer satisfaction, is the number of people who receive plans. This shows nothing about the numbers of people asking for a review, the quality of the plans or any measure of actual consumer satisfaction with their plan. Carers and their involvement or experiences are currently not a consideration for the NDIS.

⁴ Marymead, The Disability Trust, Hartley Lifecare, Duo, and Carers ACT, Challenges of converting the NDIS category of ‘short term accommodation’ to meet need, ACTCOSS Update Journal, Issue 77, Spring 2016, p. 11, <https://actcoss.org.au/publications/quarterly-journal-update/update-issue-77-spring-2016-ndis-transition-where-have-we>

⁵ Ibid.

A drive to increase efficiency or more precisely the numbers in the NDIS, such as the move to telephone interviews, may reduce initial costs but then lead to an increase in the number of people asking for reviews or appeals which actually then increases administrative costs.

CMHA is concerned that the NDIA is moving away from face-to-face assessment and planning for people applying for the NDIS. This will have a significant impact on all people applying for the NDIS, but particularly people with any form of mental illness or cognitive impairment or disability, as it creates significant difficulties for communicating or assessing their level of need. Further for mental health, which is typically episodic, having non-face-to-face assessment and planning creates difficulties in adequately assessing need and the person's circumstances. This will also discriminate against and effect people with English as a second or third language.

Some service providers have reported that conducting engagement and planning via the telephone limits the assessor's ability to get a true understanding of an individual and their situation, particularly given a large proportion of communication is non-verbal.

Non-verbal communication is an essential part of building rapport with people with a psychosocial disability. This is especially true for people who experience symptoms such as depressive thoughts or paranoia. While using technology plays an important role in increasing access to services, a move away from face-to-face consultations will also mean a lack of rapport and an increase in the number of people who will disengage from services.

As noted earlier the use or interpretation of the NDIS Act 2013 by the NDIA appears to be an area requiring examination, as it is impacting on the assessment and planning process. A review of the legislation is required as its interpretation is leading to implementation problems and escalating administrative costs with the scheme.

Recommendation: There must be indicators that sit along-side the indicator of the number of people receiving plans such as the number of reviews and appeals requested, and consumer satisfaction with and an understanding of plans received.

Intersection with mainstream services:

- *Clarity regarding split between mainstream and NDIS provided services.*
- *Costing shifting, duplication of services or service gaps.*
- *The interface between mainstream and NDIS services.*
- *Mental health services for those who are eligible and those who are not, and ensuring the intersection between the NDIS and mental health services outside the scheme remains effective.*

The interface between the NDIS and mainstream services and the gaps that will be created for mental health in the transition to the NDIS are some of the most significant and concerning issues for the community-managed mental health sector.

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 these services that help them to reduce the disabling impacts of their mental illness. This has

consequent issues in relation to the NDIS such as the potential for a growing level of disability over time of people entering the scheme, as well as the appropriateness of the pricing structure and its relationship to qualified mental health staffing being able to provide effective rehabilitation services, and therefore the level of funding provided to mental health NDIS packages.

It is vital to ensure that mental health services are funded accurately through an appropriate mechanism. If this does not occur, it may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.

A central issue with the NDIS is the differences that are occurring between states and territories and the scheme being one of national consistency. There is a general guarantee in the bilateral agreements between the Federal Government and the states and territories for continuity of support to people who are transitioning from existing services to the NDIS. However, this guarantee is being impacted at different levels with states and territories, and federally funded programs transitioning to the NDIS. Some states are ceasing to fund some state-based and funded psychosocial services or services that assist people with psychosocial disability. This situation is also partly due to the timing of transitioning occurring at different stages and therefore people's access to the NDIS.

CMHA has significant concerns with the gap in service provision that will be created with the transferring of funds for federally funded mental health programs from the Department of Health (DoH) and Department of Social Services (DSS) for Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PhaMs) to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS.

Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health stated in Budgets Estimates on 1 March for the Health Portfolio on questioning about who was responsible for the group of people currently receiving Health Department funding who won't be eligible for the NDIS that 'We have responsibility for two programs and will continue to have responsibility for those right up until the end of June 2019. Over that time the clients in those programs will transition across (to the NDIS)'. Mr Cormack also stated that the policy responsibility for people who will not be eligible for the NDIS is not with Health but DSS.⁶ There is currently a situation where no Federal Government department is taking 'policy' responsibility for people who currently receive Federal Government funded services but who will not transition with this funding to the NDIS, and there is a distinct lack of urgency from the Federal Government on this matter.

Central to the importance of the programs – in particular PIR and D2DL – is that they adopted a recovery focus within a health and social response. Given the Department of Health have policy responsibility for the development of the Fifth National Mental Health Plan; mental health funding transferring to the Primary Health Networks (PHNs); and will have funding responsibility for PIR and D2DL until mid-2019, they must continue to have responsibility for people they have been funding who will not be eligible for the NDIS. States and territories must continue to fund mental health psychosocial services in their

⁶ Commonwealth of Australia, Proof Committee Hansard, Senate – Community Affairs Legislation Committee. Estimates Wednesday 1 March 2017, Canberra.

http://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/clacctte/estimates/add1617/index

jurisdictions, however the Federal Government must provide leadership on community based psychosocial services that are about coordinating a range of services.

CMHA contends that the Federal Government must continue to fund a flexible, low barrier to entry service (as per PIR, D2DL and PHaMs) that sits outside of the NDIS for people who need ongoing community and coordination support. Consideration needs to be given to how people living with a mental health condition who need to have collaborative and coordinated care continue to receive this care within a health framework, and to develop mechanisms to fund this. It may not be appropriate for such a service to sit within the NDIS, as people who need this type of coordinated care may not engage with the NDIS, if they believe they are or are found to be ineligible, and require a different type of service to what is the focus of the NDIS.

CMHA has proposed a project in the 2017-18 Federal Pre-Budget Submission⁷ to develop options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access Federally funded programs, ensuring that their rehabilitation and support needs are met whether eligible or not. These options should be developed in partnership with and therefore supported by the community managed mental health sector, providers, consumers and carers. They will provide the Government with a clear set of options that are suitable, and provide direction on how services could be funded.

There has been no sector-wide evaluation of the estimated number of people with psychosocial disability currently in federally funded programs who won't be eligible for the NDIS. Anecdotal NDIS eligibility estimates in states and territories for people already in federally funded programs is generally between 20-40%. There is a general lack of access to data outside of and/or across state and Commonwealth government departments to help manage change occurring through NDIS implementation and other mental health sector reforms being implemented through the PHNs.

NSW has noted that some organisations delivering these federally funded programs have audited their client caseload and report that only 30% may access NDIS. While the Hunter NDIS trial site experience demonstrates that this seems to be growing with time, experience and a growing understanding of the evidence required to support access. In the ACT, where NDIS roll-out for mental health is the most progressed, it is expected that there will be approximately 63 people who are currently in PIR alone who won't have an NDIS package by the time the service is scheduled to close on 30 June 2017. In Victoria, it is estimated that as many as 10,000 Victorians living with serious mental illness will be ineligible for the NDIS and are at risk of not receiving appropriate psychosocial rehabilitation services⁸.

Recommendation: The Department of Health must continue to fund a low barrier to entry, flexible program for people living with a mental illness who will not be eligible for the NDIS.

⁷ Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, <http://www.treasury.gov.au/~media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20PreBudget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx>

⁸ Based on modelling undertaken for the State Government PDRSS (Psychiatric Disability Rehabilitation Support Services) reforms: Deloitte Access Economics – PDRSS Demand Modelling Report, Oct 2013.

Information, Linkages and Capacity (ILC) building framework

Given the limited amount of funding available under the Information, Linkages and Capacity (ILC) building framework, and the fact that there is no quarantining for psychosocial disability and/or mental health, access to this funding will be highly competitive. Overall, ILC doesn't have the capacity to provide for the scope of what existing services deliver, and respond to the needs of people who won't be eligible for the NDIS.

It is likely that large organisations providing services to people with mental health conditions are considering tendering through building upon and/or establishing an evidence base for programs that they already run. The 'ineligible activity' guidance in the Program Guidelines for 'peak body activities, such as policy advice, advocacy or operational costs' requires clarification, as it is unclear if peak bodies, including but not limited to consumer and/or carer organisations, are able to apply.

In Victoria, throughout the trial process and now, even during implementation of the NDIS throughout the state, the premise of the ILC is not being achieved. For example, Local Area Coordination (LAC) is funded under the ILC framework to connect people who are outside of the NDIS to informal supports, whilst also providing assistance with the planning process for those that are eligible. However, currently the efforts of the LAC's in Victoria are focused almost entirely on moving in scope and new participants into the scheme to meet targets, creating a gap in meeting the needs of those ineligible for the NDIS.

The situation for understanding where mental health prevention, promotion and early intervention practice sits in an NDIS environment with parallel mental health sector reforms through PHNs is particularly complicated. The NDIS 'Applied Principles' state that rehabilitation is a health/mental health mainstream responsibility, however, psychosocial services and supports that build individual and/or community mental health and prevent psychosocial disability arising are known evidence based practice.⁹

As CMHA has stated in other parts of this submission, it is vital that states and territories continue to provide a well-funded state or territory based mental health system for people with psychosocial disability regardless of the other reforms occurring.

Planning Process

The planning process – valid, cost effective, reliable, clear and accessible; and performance of planners being monitored and evaluated.

CMHA is in full agreement with the point made by the Commission in the Issues Paper that 'Robust planning processes and assessment tools, and sufficiently skilled and impartial planners, are therefore important for the ongoing financial sustainability of the scheme'. CMHA believes this is a central issue and relates to the points made earlier in this submission that assessor and planners understanding of mental illness is impacting on the quality of assessments and plans and the consequent understanding

⁹ MIND and the University of Melbourne (2016). *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery*,

https://www.mindaustralia.org.au/assets/docs/research/Mind_report_early_intervention_NDIS_condensed.pdf

consumers have of their plans. This then impacts on the way the plans are implemented and where reviews and appeals occur.

A significant issue, particularly for people living with a mental illness, is having plans completed over the telephone and draft plans not being viewed before they are finalised. These issues have been addressed earlier in the submission.

Providers have suggested that having pre-planning assistance for consumers and allowing consumers to view their plan before it is finalised would be steps to address some of the problems occurring. The pre-planning phase is viewed as vital, and it is important that people receive information to help in the pre-planning phase, as many people are going to planning sessions unprepared and individuals don't always know what they can ask for or how to articulate their disability. The required information would include:

- What documentation is needed to support the assessment process?
- Guidance on how people can be thinking about goals and how their needs may change in future.
- Guidance on the types of services that are available.
- What services do they currently receive as compared to what is actually available?

The NDIA must play a role in ensuring such information is provided, but currently this is not occurring.

In Victoria, for example, PHaMs programs in Barwon were provided with extended state funding to assist those consumers to transition into the NDIS. Many consumers credited their PHaMs worker with getting them into the NDIS, saying that without their worker organising the paperwork and giving them a stronger voice during the planning stage, they doubt they could have secured eligibility or a funding package on their own.

The following quote from a provider in the NT exemplifies the issues occurring with the planning process:

The main issue affecting the majority of our clients is their failure to participate fully in discussions regarding transition to the NDIS as many struggle to fully understand the scheme. It is challenging to communicate all the aspects of the NDIS and build the understanding of clients regarding the assessment process, how they will access services and how they may be affected if deemed ineligible. To overcome these issues there is continuous engagement with the client with the support of their family members, however this can be a long and resource intensive process. Another issue is that our clients are very transient and some, despite all efforts, cannot be contacted.

A further issue raised has been planners being adequately experienced in mental distress. In order to be effective, planners need to have an understanding of psychosocial disability and mental illness, and the impact these have on the entire planning process and future needs of the consumers/ participants. This includes adopting a recovery framework to developing a plan and assessing people's needs. A provider of an Aboriginal and Torres Strait Islander service in the NT has also made the point that many of their clients have elements of post-traumatic stress disorder (PTSD) due to intergenerational trauma,

therefore an understanding of not just mental health but culturally relevant factors such as background needs be a significant consideration. This also applies to people from CALD backgrounds.

A service provider in Victoria has stated that:

Many people with long-term psychosocial disability have become so institutionalised by the mental health system (even if they have never been in a psychiatric institution) that they are not familiar with exercising choice, and have difficulty conceptualising what is possible. Unless planners are skilled and experienced in working with people with psychosocial disability it will be difficult for them to understand this and to adapt their processes accordingly. As above, socially isolated consumers are likely to be highly anxious about meeting with planners and may have difficulty conceptualising the planner as being a person who is 'on their side' – they are far more used to dealing with agencies and officials who want to narrow their options rather than expand them.

As raised earlier, the plan review function is an important part of the overall planning process and must be sustainable now and into the future. Requests for amendments to plans triggering reviews which are done nationally and clients not being allowed to view plans before they are finalised, is creating inflexible processes and escalating administrative costs of the scheme.

There needs to be an adaptive and flexible approach to the planning process, providing consumers with the opportunity to review plans prior to them being finalised by the NDIA. There are incidents where people don't know what they are going to get until the plan is submitted – and there is currently no opportunity to take time to consider the plan before it is finalised. Then, if it turns out that the plan is not working for them they need to go through a lengthy appeal process.

For example, a service provider in Victoria reported that, "20-30% of plans needed to be reviewed as supports outlined in the plans were inadequate. There are delays of up to 4 months in getting a plan reviewed by the NDIA."

Plan errors and inconsistencies not only create confusion and frustration for consumers, their families and carers, they also place a heavy administrative burden on community mental health organisations and the NDIA.

Regarding indicators for the performance of planners, as noted earlier there must be indicators that sit along-side the indicator of the number of people receiving plans such as the number of reviews and appeals requested, and consumer satisfaction with and understanding of plans received.

Recommendation: The planning process must be conducted by people with experience in and an understanding of mental health and culturally relevant factors; consumers must be able to view and understand a plan before it is finalised; and assessment and planning for people living with a mental illness or people who do not have English as a first or second language must be conducted face-to-face and not over the telephone, unless it is determined this is appropriate.

Assessment tools – meeting the criteria of valid, reliable, accurate and efficient, and monitoring this over time

An issue that has been raised by providers is that there should be a functional assessment tool for people living with a mental illness seeking NDIS eligibility. Diagnosis for mental illness will not in many instances provide an understanding of a person’s functional capability and in situations where assessors and planners do not have specific mental health and cultural awareness training, this lack of understanding will have an impact.

CMHA understands that the NDIA is examining the potential use of a mental health functional assessment tool and would urge this work to be completed as a matter of importance. While CMHA is pleased that the NDIA is undertaking this work, the concern is that this work was not undertaken prior to implementation and the potential impact this is having on people’s eligibility and the level of support they receive through the NDIS.

The challenges in monitoring and refining the assessment process and tools over time will, as per the overall assessment of the NDIS, having indicators that provide only an indication of numbers of plans as opposed to the quality and satisfaction of the plans.

Market Readiness

The community managed mental health workforce

As addressed earlier in ‘Scheme Costs’, a central issue is mental health not fitting into the pricing structures of the NDIS. There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, the skills and knowledge required are different with the NDIS pricing structure able to fund disability support, and therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. The issues raised in the ‘Scheme Costs’ section are relevant in terms of the community-managed mental health sector not only being prepared, but supported to make the transition.

The withdrawal of block-funding entirely is also a concern. In the *Power to Persuade* blog Simon Viereck, Executive Officer, Mental Health Community Coalition ACT is quoted as stating this will “result in little capacity in community-managed organisations to support people with psychosocial disability to engage with and access the NDIS. This puts the responsibility back on the NDIA and Local Area Coordinators to take up this engagement work. It is unclear what this means for the many people with psychosocial disability who are expected to access the NDIS, but are not yet engaged.”¹⁰

Simon Viereck also makes the point that the NDIS 'market' is not a market. He notes that within the scheme, prices are fixed, supports are strictly defined, administrative burdens have increased, and there is a significant information gap. His description of the ‘market’ is as a one-sided affair. That is: “To the extent it is a market, this is reflected in service closures, workers leaving, business mergers, and less choice and control. Unless service providers are given the freedom to decide which services they want to offer, to price those services, and to test whether they can sell their product in the market at the

¹⁰ Transition to change: Lessons from the act NDIS trial, Power to Persuade Blog, July 13, 2016, <http://www.powertopersuade.org.au/blog/transition-to-change-reflections-on-the-act-ndis-trial/12/7/2016>

price they ask, the NDIS won't produce efficient market-based outcomes and won't work for provider organisations".¹¹

The Mental Health Council of Tasmania (MHCT) identified that a member organisation was struggling to remain viable within the fee rates of the NDIS:

The fee rates determined by the NDIS to be paid for PHaMs services by NDIS participants are insufficient to cover delivery costs, especially for consumers who need mentoring, coordinating and family support services as opposed to more intensive services. Funding is often sufficient only to cover staff salaries at a comparatively junior level (CSW 3 and below). This makes it difficult for the sector to retain staff with degree qualifications who are required to effectively deliver programs for consumers with complex needs. The amounts set out in the NDIS Price Guide are not enough to fund complex case coordination or skilled staff particularly once expenses such as developing individual case plans and group programs, travelling time, making and following up referrals and so on have been removed.

The MHCT have also identified the following concerns of members:

- That with the potential loss of 30% of their client base their viability may be compromised. For service providers who are juggling clients with packages and clients without packages there is also a moral and financial dilemma. To survive, providers need to take the NDIS clients attached to higher value packages but this means that other individuals are at risk of delayed or no access to supports.
- With regards to pricing, line item costings aren't viable for the mental health sector. Current pricing is based on the general disability sector at SCHADS level 2 which is effectively the lowest common denominator. One Tasmanian service provider is experiencing a loss of about 50% an hour on any given line item. To be viable, service providers feel that it will create a market where clients are 'cherry picked' based on higher priced line items. A new pricing catalogue is needed, based on the service costs as related to providing psychosocial rather than just disability supports.

An issue that has been raised by all state and territories is a high risk of seeing significant market failure across the sector. 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 means that that organisations are unable to offer services to people with NDIS Plans as well as those without.

CMHA's Federal Pre-Budget Submission 2017-18¹² outlined the need to develop a National Mental Health Workforce Strategy and conduct regional Communities of Practice to support NDIS transition. A key piece of work that is required is an examination of the overall workforce in mental health to ensure

¹¹ Ibid.

¹² Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, <http://www.treasury.gov.au/~media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20PreBudget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx>

there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms.

The lack of a comprehensive national mental health workforce strategy has been a significant policy gap. The workforce strategies that have been developed have not addressed the community managed psychosocial rehabilitation sector and has meant that reforms which have a significant impact have no guiding policy.

Support for carers

CMHA contends that support for carers should be separate to the NDIS, in that carers should not have their access to services, such as respite, tied to the assessment of the person they care for. This is problematic in general, but particularly in mental health where a person may be unwell and not recognise the need for a carer or recognise that they have a carer. This was also a recommendation of the NMHC report.

It goes to the issue, which CMHA has made in a number of submissions, that mental health cannot be simply made to fit a system, which is focused on disability support when psychosocial rehabilitation is a very different concept. A failure to recognise the complexities and issues particular to mental health may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.

The Commission's Issues paper lists as one of the workforce challenges that reducing the burden on informal carers will affect the need for formal carers. The ideal that the load of informal carers caring for someone living with a mental illness will be reduced by the NDIS is somewhat of a false ideal. The reality of mental health carers is that they are typically – without the NDIS or not – going to be the first person that is called on by the person they care for. The supports for consumers are being provided in a different way or via a different mechanism, but that informal network of supports that a consumer needs and often relies on will continue to be a factor.

Recommendation: Support for carers of people living with a mental illness should be separate to the NDIS.

Provider and participant readiness

Issues regarding the impact on the community managed mental health workforce are raised in the above section '*The community-managed mental health workforce*' and concerns issues such as the pricing structure not providing the flexibility for providers to support highly complex clients and where needs are episodic. Anecdotal feedback from the states and territories has been that a competitive environment is having an impact on provider's willingness to collaborate and share best-practice mechanisms of transitioning to the NDIS.

CMHA's Federal Pre-Budget Submission 2017-18¹³ outlined the need to conduct regional Communities of Practice to support NDIS transition. Through the experiences from the implementation of mental health within the NDIS in trial sites, it has become evident that support is required for transition, in

¹³ Ibid

particular the community managed mental health sector, to be ready and able to maintain services and support people within the NDIS.

Communities of Practice are an effective and efficient mechanism to assist organisations to transition to the NDIS, and to utilise and act on lessons learned. As states and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements, regionally based approaches to identify innovations, in addition to national and state and territory approaches, are needed.

Further with regards to the removal of block funding, Sebastian Rosenberg, Brain & Mind Research Institute, University of Sydney, refers to the increasing rarity of longer term contracts or block funding arrangements between governments and non-government service providers as resulting in making “planning and workforce development in the community mental health sector impossible.”¹⁴

Mission Australia have also referred to the implications of losing block funding:

“The ramp-down of block funding from DSS for PHaMs is based on the assumption that an increasing proportion of PHaMs consumers will be fee-paying through the NDIS, which will ensure their viability. However, we are becoming increasingly concerned that the number of PHaMs consumers (either current or new) who will become fee-paying NDIS consumers of PHaMs has been overestimated, although this varies widely by region. For example, in Tasmania, DSS figures show that 57 per cent of all PHaMs consumers are not transitioning to NDIS, and our own service experience suggests even less comprehensive transition with only 10 out of 150 PHaMs consumers in our Tasmanian sites having been assessed as eligible for an IFP. In one of our NSW PHaMs sites, however, approximately 90 per cent of clients have been assessed as eligible, although more recently applications have been knocked back at higher rates. Nonetheless, given the regional variation and the very low rates of successful applications in some areas, like Mental Health Australia we remain concerned about the proportion of community mental health consumers transitioning into the NDIS, including PHaMs and PIR participants.”¹⁵

Governance and administration of the NDIS

Existing administrative and governance arrangements and the NDIA measuring performance

The governance and administration of the NDIS is a significant issue and will be central to the success and sustainability of the NDIS. CMHA has raised these issues throughout this submission and reiterates the need for a review of the NDIS Act to assess the impact it may be having on the implementation and administration of the NDIS.

¹⁴ Sebastian Rosenberg, Challenges and opportunities for community mental health in Australia, newparadigm, Summer 2017, p. 12, http://www.vicserv.org.au/images/PDF/newparadigm_/2017newparadigmSummer.pdf

¹⁵ Mission Australia (2017) *Submission to the Joint Standing Committee on the NDIS: The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, pp. 8-9, file:///C:/Users/policy.MHCT/Downloads/submission-to-the-joint-standing-committee-on-the-ndis%20(1).pdf

There must be indicators that sit along-side the indicator of the number of people receiving plans such as the number of reviews and appeals requested, and consumer satisfaction with and understanding of plans received.

CMHA recently supported a call by the disability sector to include genuine engagement with consumers in their governance structures and that people with a disability are a central part of the overall decision-making structures, including representation on the NDIS Board.

CMHA's Federal Pre-Budget Submission 2017-18¹⁶ called for the development of quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact, with the skills and knowledge required different to the NDIS pricing structure able to fund disability support. The NDIS funds disability services not psychosocial rehabilitation services.

The Federal Government recently announced the Quality and Safeguard Framework for the NDIS. In order to maintain and support the community mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that quality assurance processes specifically for psychosocial services are developed. This work can be accommodated within the existing work being undertaken by the Government to develop the Framework.

Recommendation: Quality assurance processes specifically tailored for psychosocial support services must be developed as a part of the NDIS Quality and Safeguarding Framework.

Paying for the NDIS

Commonwealth and state and territory funding; risk sharing; and paying for the NDIS

As noted earlier CMHA has raised concerns about cost shifting occurring between the state and territory and federal governments. This includes the withdrawal of funding for state and territory funded mental health programs under the guise of this gap being addressed by the NDIS; inconsistency with state and territory governments not confirming future state and territory funding when they are or will be at full NDIS implementation; and the situation which occurred in the ACT with the 'estimate' for NDIS clients being reached but neither the ACT or Federal Government taking responsibility for the required funding shortfall.

The lack of transparency in the bilateral agreements which provide no information on funding contributions or commitments by governments to both the NDIS or state and territory mental health programs and services. Having a stated guarantee of 'continuity of service' provides only assurances in word but not in actuality.

¹⁶ Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, <http://www.treasury.gov.au/~media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20PreBudget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx>

CMHA made a submission to the Senate Community Affairs Legislation Committee Inquiry on the NDIS Savings Fund Special Account Bill 2016 where CMHA recognised the Government's need to provide a sustainable and established source of funding for the NDIS, but would not want to see this done on the basis of incomplete financial and other data, which for mental health may not be known for a number of years. CMHA's submission to the Bill related to issues around having sound information on which to base the establishment of ongoing funding for mental health in the NDIS into the future.¹⁷

CMHA supports the submission by the Australian Council of Social Service (ACOSS) to the inquiry on the NDIS Savings Fund Special Account Bill 2016 which refers to other areas of essential human services not being targeted to fund another area of human services such as the NDIS.¹⁸

Conclusion

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. However, it is vital to ensure that the recovery focus of community managed mental health services remains, and that people living with a mental health condition have their psychosocial needs met regardless of whether they are eligible for the NDIS or not. The NDIS is predicated on having a well-funded mental health system outside of the scheme, and governments at all levels = federal, state and territory - have joint responsibility to ensure this occurs.

CMHA makes the following recommendations in relation to the questions posed in the Issues Paper:

- The NDIS Act must be reviewed now that the legislation is actually at implementation, as recommended by Ernst and Young's 2015 review of the NDIS legislation.
- There must be indicators that sit along-side the indicator of the number of people receiving plans, such as the number of reviews and appeals requested and consumer satisfaction with and an understanding of plans received.
- The Department of Health must continue to fund a low barrier to entry, flexible program for people living with a mental illness who will not be eligible for the NDIS.
- The planning process must be conducted by people with experience in and an understanding of mental health and culturally relevant factors; consumers must be able to view and understand a plan before it is finalised; and assessment and planning for people living with a mental illness or people who do not have English as a first or second language must be conducted face-to-face and not over the telephone, unless it is determined this is appropriate.
- Support for carers of people living with a mental illness should be separate to the NDIS.
- Quality assurance processes specifically tailored for psychosocial support services must be developed as a part of the NDIS Quality and Safeguarding Framework.

¹⁷ Community Mental Health Australia submission to the Senate Community Affairs Legislation Committee Inquiry on the National Disability Insurance Scheme Savings Fund Special Account Bill 2016.

¹⁸ Australian Council of Social Service, Re Inquiry into the National Disability Insurance Scheme Savings Fund Special Account Bill 2016, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/NDISSavingsFund/Submissions