



ACT Legislative Assembly inquiry into the implementation, performance and governance of the National Disability Insurance Scheme

MHCC ACT Submission

29 March 2018



mental health
community coalition ACT

Peak Body in the ACT for the Community Mental Health Sector

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About MHCC ACT

The Mental Health Community Coalition of the ACT (MHCC ACT), established in 2004 as a peak agency, provides vital advocacy, representational and capacity building roles for the community-managed mental health sector in the ACT. This sector covers the range of non-government organisations that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness.

The MHCC ACT vision is to be the voice for quality mental health services shaped by lived experience. Our purpose is to foster the capacity of ACT community managed mental health services to support people to live a meaningful and dignified life.

Our strategic goals are:

- To support providers deliver quality, sustainable, recovery-oriented services
- To represent our members and provide advice that is valued and respected
- To showcase the role of community managed services in supporting peoples' recovery
- To ensure MHCC ACT is well governed, ethical and has good employment practices.

Introduction and recommendations

MHCC ACT welcomes the opportunity to provide a submission to this inquiry by the ACT Legislative Assembly into the implementation, performance and governance of the National Disability Insurance Scheme in the ACT.

The introduction of the NDIS is a massive change to the way disability support services are negotiated, structured and purchased in Australia. The intent to give participants more control and choice in their lives is absolutely correct. The promise to leave no one worse off should be upheld. The objectives of the scheme outlined in the *NDIS Act*¹, are worth reiterating:

- supporting the independence and social and economic participation of people with disability
- providing reasonable and necessary supports, including early intervention supports, for participants
- enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports
- facilitating the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability and
- promoting the provision of high quality and innovative supports to people with disability.

As with many major policy reforms, however, the NDIS has had aspects that have worked well and those which have not. The intent of this submission is to present a realistic picture of the ACT experience of the introduction of the scheme from the MHCC ACT perspective as the peak body for community managed mental health service providers.

While the NDIS has been life changing for individuals where it works well, unfortunately even though we are nearly five years down the track, there are still many issues with the way the NDIS is working in practice which are a cause for great concern – particularly when it comes to PSD. Importantly, most of these issues are not new: stakeholders from a wide range of

¹https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/DisabilityInsuranceScheme

perspectives have been trying to have these things heard, understood and addressed right from before the scheme was implemented.

Very recently, there are signs that change might be afoot. However, it is slow, incremental and it will take time for the impact to be felt. Stakeholders are experiencing an NDIA which is a little more open to two-way meaningful dialogue. Unfortunately though, there is still a lack of a true partnership approach; and a general ‘we know best’ attitude coming from the NDIA.

As more time passes without fundamental and effective change – at least as it applies to PSD services – it is hard not to conclude that the NDIS will continue to erode many aspects of the ACT mental health support sector that, while imperfect, was better able to cater to the range of recovery and other support needs of people with mental illness and PSD prior to the NDIS. In the ACT at least, the NDIS is expressing itself more like an attendant care system rather than a wraparound holistic rehabilitation service. This is particularly devastating in the ACT which was widely acknowledged as being one of the better jurisdictions to live in if you were in need of mental health services.

Despite the considerable challenges caused by the NDIS, MHCC ACT continues to work with determination to try and ensure that the NDIS leads to the positive changes for people with psychosocial disability as envisioned. We also keep working to ensure that all people in need of support for mental illness have access to effective services regardless of whether they have an NDIS package.

Setting the scene for this submission

As the peak body for community managed mental health services in the ACT, MHCC ACT’s submission focusses entirely on psycho-social disability services and the NDIS, and the implications from this for mental health services more broadly². Due to our role as a peak body we are made aware more often of the difficulties and issues with systems, rather than the positives and successes. Having said that, there is nothing to suggest that the issues raised in this submission are overstated or not a cause for real concern and a decisive response.

² While we recognise there is a certain commonality of experiences with other areas of disability, there are also some very specific challenges fitting psychosocial disability into the NDIS model.

This submission draws on the experiences of MHCC ACT as it has worked to support the transition to the NDIS in the ACT. Importantly this includes the specific experiences of member organisations, many of which have supplied MHCC ACT with case studies. Seven member organisations also completed a targeted questionnaire designed to elicit information for this inquiry³. The responses to this survey are summarised at [Attachment 1](#)

MHCC ACT also works with consumers and carers impacted by the NDIS. A core value of the organisation is to value and be informed by the lived experience of those experiencing mental ill health as we strive to improve things at a systemic level. We also work closely with the ACT Mental Health Consumer Network and the Carers ACT Mental Health Programs. The experience of consumers and carers with the NDIS are mostly consistent with those of service providers.

At the beginning of 2017 the Commonwealth government announced a number of inquiries into the NDIS. MHCC ACT made submissions to these. Although a year has passed, most of the issues MHCC ACT and other organisations noted in various submissions to the Commonwealth Government, remain to varying degrees. For this reason, the Executive Summaries of each of these submissions has been attached ([Attachment 2](#)) to this submission for the information of the Committee (full submissions are available on our website or by contacting the office). We also attach for your information two letters MHCC ACT wrote to ACT Ministers ([Attachments 3 and 4](#)):

- raising concerns about the NDIS Plan review process and its outcomes (2017), and
- expressing serious concerns about the NDIS and people with psychosocial disability (2016)

MHCC ACT also refers the Committee to the various submissions made by [Community Mental Health Australia \(CMHA\)](#), 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

³ Seven respondents, though for about half the survey only 3 answered questions. However, these answers are very much in keeping with those expressed in other reporting on the NDIS.

organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

<http://cmha.org.au/publications/#Submissions>

In particular we draw the Committee’s attention to the “*Mind the Gap*” (2018) report, compiled by the University of Sydney and CMHA. This report highlights both problems with the current state of the NDIS for people with psychosocial disability as well as solutions proposed to address them. It is consistent with MHCC ACT stakeholders’ experience in the ACT:

“While the NDIS is an exciting reform for people with disability, its current structure does not fit easily with the lived experience of people with psychosocial disability ... What this report shows is that people with psychosocial disability have significant problems accessing and being accepted into the scheme, and that plans are not meeting their needs. ... What is significantly worrying is that at full roll out the scheme is only designed to meet the needs of 64,000 people with severe mental illness, yet existing services are being closed and funding moved into the NDIS. This means that many people are going to miss out on the services they need.”

Report author Associate Professor Jennifer Smith-Merry from the Faculty of Health Sciences at the University of Sydney, 2018⁴.

The Vice-President of CMHA, Kerry Hawkins, went on to say:

“The report reinforces the gaps the sector has been identifying including that people with psychosocial disability are not engaging, not applying or withdrawing from applying, that the criteria are creating barriers, and support to access the NDIS is lacking.”

Finally, MHCC ACT is close to launching a [report into the ACT experience of the introduction of the NDIS](#). This document sets out to ‘tell the story’ of the impact of the introduction of the NDIS in the ACT. It synthesises the voice of consumers, carers and service providers in

⁴ <http://cmha.org.au/wp-content/uploads/2018/01/FINAL-NDIS-Mind-the-gap-report-media-release.pdf>

expressing their combined experiences of the NDIS during the trial period and the first year of full rollout of the Scheme in the Australian Capital Territory (ACT).⁵

MHCC ACT would be happy to provide a copy of this report to the Committee if requested.

MHCC ACT is also very happy to provide further evidence to this inquiry.

Recommendations

Where it is working well, the NDIS is changing people's lives for the better. But the magnitude of issues around the NDIS is too big. It is in many cases degrading people's quality of life now. It is threatening the viability of reputable service providers. In many cases stakeholders are reporting that they feel worse off now than before the NDIS.

RECOMMENDATION 1: The ACT renew efforts at the Commonwealth level to expedite changes needed to make the NDIS a scheme which can deliver on its objectives. Countless studies have shown that the investment incurred will produce benefits to every Australian.

RECOMMENDATION 2: Work with the Commonwealth and the NDIA to ensure that all work undertaken by service providers in relation to the NDIS is properly funded – especially when they are working to ensure their clients receive quality NDIS services; they meet NDIS compliance requirements; they meet NDIA administrative requirements; and they can maintain quality NDIS workforces.

The NDIS was not intended to replace the health system. People with mental illness and PSD need both. Increasingly the NDIS is becoming the mental health system in the ACT – except that it leaves people out. At the moment there is a growing void in services for people with mental illness and PSD who do not have NDIS packages. This needs to be rectified urgently.

RECOMMENDATION 3: In partnership with service providers, consumers and carers, the ACT government invest in ensuring that there is a mental holistic mental health support system in the ACT so that people who need services get the right service at the right time in the right place.

⁵ Information was gathered in a number of different ways for this report, including a specific interview process to gather experiences of service providers, consumers and carers.

To date (beginning 2018), there has been no clear articulation by any Government Department or the National Disability Insurance Agency (NDIA) about what continuity of support actually looks like in practice, or what the provider of last resort would look like and who the provider/s would be.

RECOMMENDATION 4: With reference to the CMHA position paper on Continuity of Care⁶, work closely with Commonwealth counterparts to define and implement systems to ensure that no one misses out on the support needed for their mental health.

There will always be areas of overlap and soft boundaries between health, disability and social services. With the introduction of the NDIS, and definition of some mental illness as PSD, the confusion and blurring has become an impediment to person centred services. There have been cases where people have ended up very sick in hospital due to such fundamental misunderstandings or unable to get issues resolved due to 'buck passing'.

RECOMMENDATION 5: Work within government and between governments, using a person-centred approach, to clarify where responsibilities lie and educate all stakeholders around this.

It is widely reported that the advent of the NDIS has enormously increased organisations' administration and compliance costs, and that this is mostly unfunded.

RECOMMENDATION 6: Work collaboratively with the Commonwealth and the NDIA to deepen understanding of what is gained and what is lost by high administration and compliance requirements.

RECOMMENDATION 7: Work collaboratively with the Commonwealth and the NDIA to streamline processes to reduce the amount of administration required for the functioning of the NDIS. Work with government counterparts to better understand what is driving such a dramatic change; what is the cost-benefit

⁶ <http://cmha.org.au/publications/#policy-documents>

analysis (ie. could the time and money be better spent on direct service delivery and client interaction); and ways that the burden might be lessened.

RECOMMENDATION 8: Work collaboratively with the Commonwealth and the NDIA to better understand compliance requirements. Where possible the NDIA should make greater reliance on existing systems rather than introduce new ones over the top.

MHCC ACT is aware of widespread dissatisfaction with many of the repercussions from the introduction of the NDIS. Yet it is difficult to gather the evidence in a compelling and rigorous way to probe deeper and understand just what is happening. Such an understanding is necessary in terms of both making the case for and designing the sort of programs that ensure we have an effective mental health system and NDIS in the ACT.

RECOMMENDATION 9: An independent survey be commissioned of mental health system and NDIS stakeholders in the ACT to learn more about consumers, carers and service providers experiences. Design of this survey should be informed by the various stakeholders including providers, carers and consumers.

Many reputable ACT service providers with a demonstrated track record for quality service delivery are experiencing financial distress. The majority of this is attributed to the introduction of the NDIS, the folding of existing program funding into the NDIS, and the end of bloc funding. This is leading many to consider the viability of remaining as an NDIS provider but at the same time they are motivated to try and make their service work within the NDIS framework in the interest of their client base.

RECOMMENDATION 10: The ACT government, working with the Commonwealth, NDIA, and sector stakeholders, undertake work to properly understand what is driving such financial stress – where the cost pressures are, what is driving them, and what is needed to prevent them.

RECOMMENDATION 11: The ACT Government understand what is needed to prevent NDIS related market failure causing service providers to withdraw from the NDIS or fall over altogether in the ACT. Then working in partnership with the sector, implement appropriate measures to reduce the risk of such a thing

happening, and thereby ensuring all people with mental illness and PSD in the ACT can access effective, holistic services when they need them.

Body of this submission

It is not an understatement to state that the advent of the NDIS in the ACT has put the sector and the people it provides services to, under enormous strain. Much has been lost along the way to now. Some people's lives have changed for the better, but many others appear to have been left in a worse position. Many service providers are struggling to remain viable. Many people without an NDIS package have very limited choice and availability of appropriate services to support them.

The scheduled transition of population groups from former support services to the NDIS has finished in the ACT; though of course people meeting access requirements will continue to enter the scheme over time. For community managed mental health service providers in the ACT, however, many would still regard themselves in a process of adjustment and transition to the NDIS. Although the intensity of change experienced during the trial phase has passed, organisations are still adjusting and developing their business models and service offerings in response to the changes brought about by the introduction of the NDIS – particularly financial, administrative and workforce pressures.

Perverse incentives created

The design and implementation choices made around the scheme have led to many instances of market failure. In particular, the decision by the Commonwealth to implement the scheme from the top tier of the pyramid before the other two base layers were solid has created a perverse incentive for people to try and obtain an individual package. In the ACT this was exacerbated by:

- the requirement by the ACT government that all people in existing ACT government funded programs deemed in scope for the NDIS test their eligibility for an individual NDIS package; and to retest this if they were at first found ineligible
- funding for existing programs considered in-scope for the NDIS was withdrawn at the point that someone was found eligible which often left a significant gap between that point and the point from which they received and were able to activate a plan
- no certainty around funding services for people not found eligible – widespread view that in fact there is now no mainstream services funding entity
- widely held view that the ILC funding is not significant enough to make much impact
- ILC funding structured as individual grants rather solid baseline support services for the majority of people with mental illness

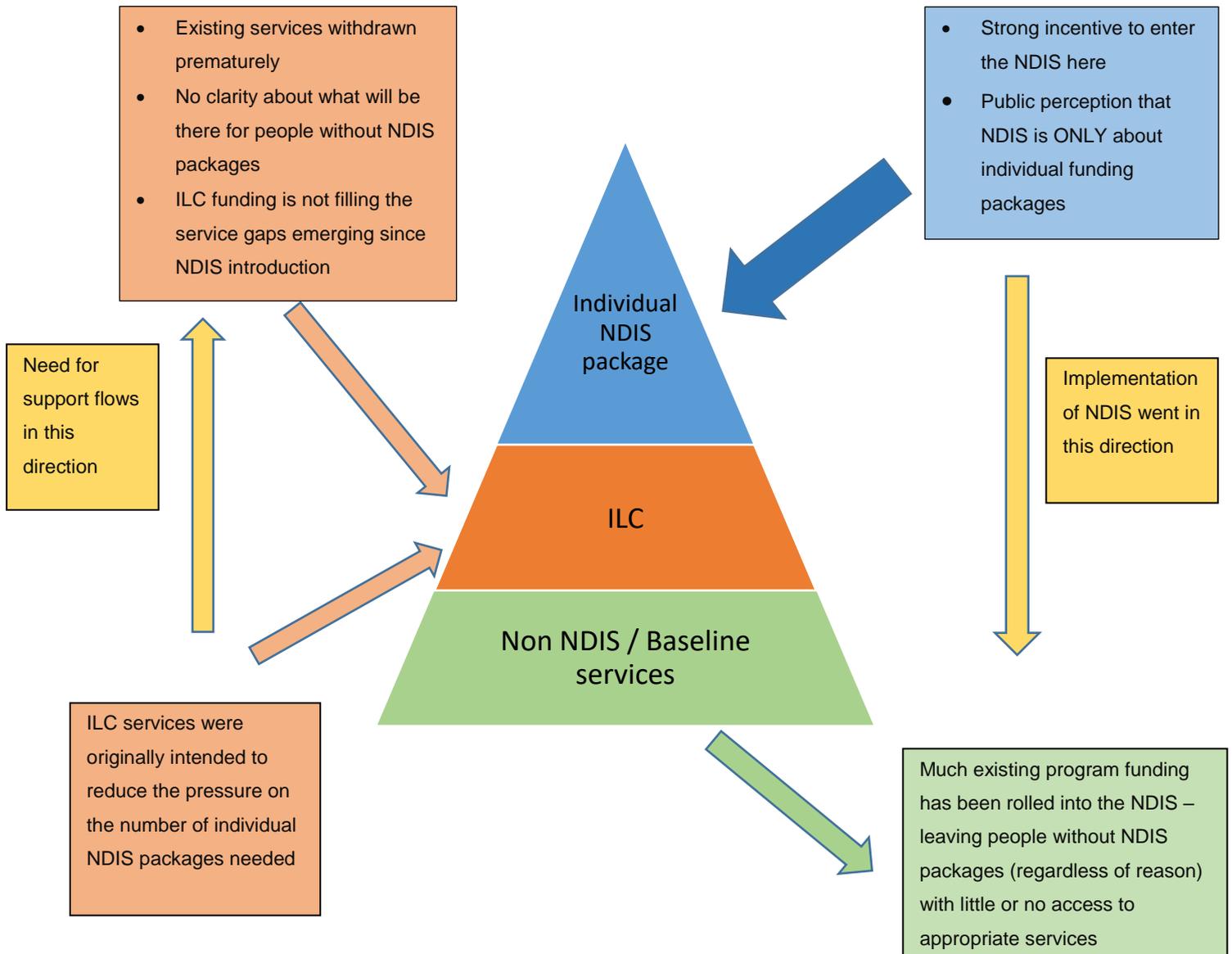


Diagram 1. The NDIS pyramid: budgetary pressures at IFP level constraining investment in baseline services.

Perception of inadequate funding for and uncertainty around base level services has created rational decision to apply for individual funding packages

Diagram 1. illustrates the pressure on the NDIS for increasing numbers of individual funding packages. MHCC ACT is aware of instances whereby the only reason a person applied for an NDIS package is to ensure continuity of base services, the funding for which was moved into the NDIS. One recent example was of a person needing cleaning services to maintain a tenancy. Given the costs of interacting with the NDIS – time and administration especially – this does not seem like an efficient way to obtain the services needed. On the other hand, if this person suddenly became relatively unwell, having an NDIS package might facilitate access to additional services which might otherwise not be available any more.

Another area where distortions are being created is in the area of the NDIS pricing framework. This was covered in the MHCC ACT submission to the Productivity Commission in 2017. The Executive summary of this is at [Attachment 2](#); and the full submission is on the MHCC ACT website⁷. Essentially the issue here is that the pricing framework has translated into an increased casualisation of the workforce, and a downward pressure on wages. This can only lead to an erosion in service quality over the longer period. The recommendations in the final Productivity Commission report, if implemented would improve things to some extent. It is well documented that an investment in the mental health and wellbeing in the Australian population leads to positive returns.

In the ACT collaboration between the ACT Government and community managed mental health providers had led to an average Cert IV level qualification prior to the advent of the NDIS. Even at this level, average wages would not typically be considered high. Many organisations can now only afford to employ people at a Cert II equivalent level. For PSD this means workers are often not appropriately qualified or skilled – at least in comparison to what was considered appropriate before the NDIS.

Looking at ways of upskilling or incentivising the workforce are important. But if this is not matched by commensurate wages and salaries it is likely that the sector will simply experience the costs associated with a high rate of job churn. If this was to eventuate, it is hard to see that this could do anything other than place downward pressure on service offerings and quality.

Service providers strained

Most organisations know that change is challenging, and that mistakes will be made along the way. The difference with the introduction of the NDIS is that the scope and pace of change, coupled with an inappropriate funding model and service scoping framework for PSD, information gaps, and a distinct lack of a partnership approach from the NDIA and, to a lesser extent, the local ACT government, pushed many organisations to limits not previously experienced. This was definitely the case in the ACT during the NDIS trial phase, and the first year of full rollout.

These types of concerns are well summarised in the MHCC ACT Submission to the Joint Standing Committee Inquiry into the NDIS early in 2017. Unfortunately, the government response to that report does not offer much hope for a significant improvement in the situation for NDIS participants with PSD.

The following quotes from the MHCC ACT survey for this submission express the pressures and changes well:

“It has created much more complexity and uncertainty in delivering services for us as an organisation, making it very difficult to plan a business model that we can work towards

⁷ <https://mhccact.org.au/our-work/submissions/>

achieving. The administrative burden is enormous and almost impossible to sustain. We have had to close our doors to people requesting services for shorter periods of time and needing flexibility. The constant changing goal posts of rules by the NDIA causes confusion and mistakes that then take many unfunded hours to rectify. We have lost experienced recovery workers who are no longer catered for in an NDIS model. This is a huge loss for our participants and for us as an organisation. We have had to employ staff on lower wages and with differing conditions to those in block funded programs. Thousands of unfunded hours to sort administrative discrepancies and fight unreasonable planning and review decisions.”

very difficult to make the program sustainable due to having to employ staff at a lower level, the ever changing price code, [that] we are still supporting participants are not eligible, ... the length of time it takes for applications to be processed and who is there available to assist participants to apply for NDIS. [It] is a loss to our organisation to continually help people to apply.

There has certainly been change - paradigm, cultural, HR practices, risk management etc. Constantly, reassessing the position of the organisation. Administrator processes and requirements have increased by 400% - including finance, management and other hidden processes by staff as we monitor the work flows. Robust providing quality services is not a word I would use. I would say flexible and able to change as the environment changes

Purely from a business point of view, financial sustainability is very difficult to establish with the funding body of NDIS, however without services such as the one we provide, participants with a psychosocial disability would go completely unheard and unrecognised

Yes - the flexibility has gone. This includes the organisation being able to provide services with another staff member as the consumer is now creating dependency on one person instead of a team. Also not being able to flex funding to meet the individual needs between a bucket of block funding to individual packages that run out

The attitude of the NDIS is still they are the expert and the community sector does not know [anything].

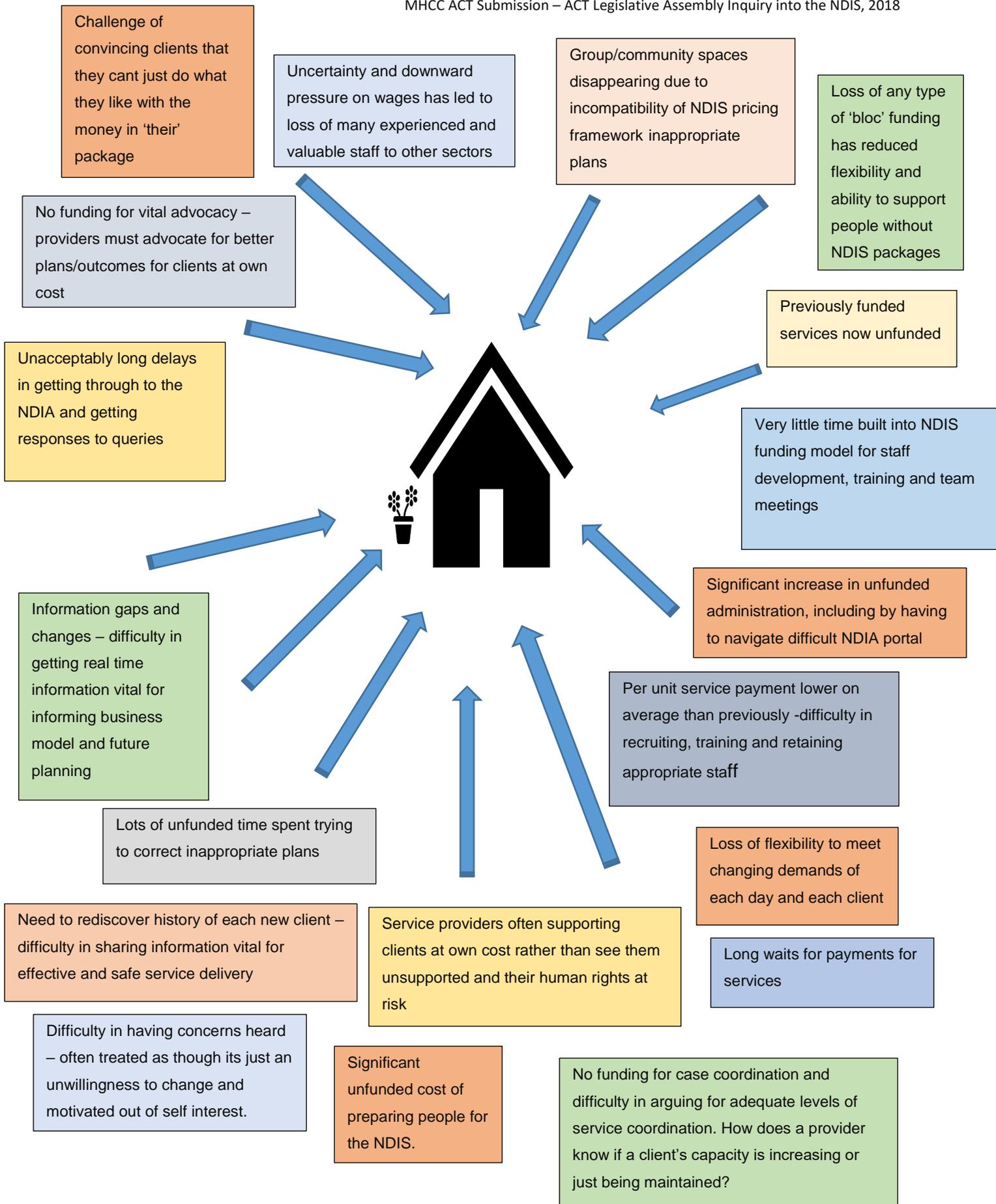
The business assumptions under the NDIS are not based on real businesses within a quality framework.

MHCC ACT is aware of at least one organisation that has withdrawn registration from the NDIS. We also know that many organisations have questioned the viability of providing services for people with PSD within the NDIS framework into the medium term future. Our members are carrying higher debt levels; but true to their values are supporting clients at their own cost rather than leave them with nothing.

This situation is not sustainable, particularly given people with mental illness and PSD are some of the most vulnerable people in our society.

For too long now, when issues are raised about the NDIS framework, the Act is used by Government and the NDIA as the reason it just has to be that way. This has stymied a solutions focus and partnership approach to some really important issues threatening the viability of services and the support available to people in need. When organisations do find ways to deliver quality recovery oriented services to NDIS participants, they often have to be careful how they present these solutions in fear of the response that might come from the NDIA. As stated by one organisation in the MHCC ACT survey:

The NDIS framework makes it difficult to deliver recovery services but we have forged a model that can work. It requires combining service delivery with support coordination (with two clearly different teams) but important communication between the teams to be able to support the participant with recovery activities. We have seen some fantastic results using this model but are acutely aware that it is not the preferred model of the NDIA.



ACT Specificities

In many of the MHCC ACT Submissions we have stated that the ACT is akin to the ‘canary in the coalmine’ – we serve as a litmus test for other whole-of-jurisdiction implementation of the NDIS as we are the first to be in this position.

The ACT is relatively small, affluent and well educated. It has pockets of disadvantage, often hidden. The ACT had a relatively high standard of mental health services before the NDIS. The concern is that if the NDIS can cause the sort of unintended negative impacts in this situation then it is likely to be magnified in other larger more disparate jurisdictions, and particularly in regional and remote areas.

Having said that, the situation in the ACT has definitely been made worse by being a test site. It is widely acknowledged that this scheme is being built as it goes. Many have likened it to a plane being built while it flies – that obviously poses the danger of a crash.

One of the strengths in the ACT is access to government. This made it possible for productive collaboration between the ACT Government and MHCC ACT and its members. In many instances we were also able to involve the local NDIA office staff. Although coming from different perspectives, it has been commented on that these activities helped in information sharing and clarifying understanding around various issues.

The ACT Government NDIS Taskforce was useful in supporting the transition. However, in the view of MHCC ACT and many of its stakeholders, the Taskforce was wound up prematurely. As noted at the beginning of this submission, the transition in terms of organisations’ business models and the fact that the NDIS is still being built, means there is ongoing need for support through the transition. In this regard, MHCC ACT is pleased that the ACT Office for Disability is now specifically active in this space.

The respondents to the MHCC ACT survey for this submission showed that they do not feel well supported by the both levels of government or the NDIA against a number of criteria.

There has been little apparent attention given to the implications of the ACT being the place of service delivery of many NSW residents. Also, the wider implications of the NDIS do not seem to be well understood or taken into account by non-NDIS areas of the ACT government and their activities, including inside the Department of Health.

There is a lack of detailed ACT wide data on the mental health system in the ACT that would have made some of the decision making around sector support and development during this period less difficult and more impactful.

Attachments

Survey response

Seven MHCC ACT member organisations completed a survey designed specifically to gather data for this Inquiry.⁸

Q1-4. looked at the characteristics of the respondent organisations:

- Majority have been delivering services in the ACT since before the NDIS was introduced. Only one organisation is more recent.
- Four of the seven respondents deliver services only in the ACT
- Funding models varied, but a strong reliance on some form of government funding
- All of them deliver mental health support services and the majority also deliver PSD services

Q5. Asked about the specific services provided by organisations:

- 5 x Daily living
- 4 x Support Coordination
- 3 x Suicide prevention/postvention
- 3 x Accommodation
- 2 x PIR
- 2 x PHAMS
- 1 x Housing Support
- 1 x Addiction
- 1 x Physical health
- 1 x SUSD
- 1 x Outreach

Q6-7 asked about an organisations' client base

- All but one deliver services to people without NDIS packages
- Most deliver services to self-managed NDIS participants

⁸ Survey graphics indicate an eighth respondent – this was from another peak body which had no intention of filling out the survey

Q8-11 not included here

Q11-12. NDIS registration

Most organisations that responded are NDIS registered.

Views were divided (50/50) as to whether becoming a registered NDIS provider had produced good outcomes or not. However, the comments provided are telling:

“It has created much more complexity and uncertainty in delivering services for us as an organisation, making it very difficult to plan a business model that we can work towards achieving. The administrative burden is enormous and almost impossible to sustain. We have had to close our doors to people requesting services for shorter periods of time and needing flexibility. The constant changing goal posts of rules by the NDIA causes confusion and mistakes that then take many unfunded hours to rectify. We have lost experienced recovery workers who are no longer catered for in an NDIS model. This is a huge loss for our participants and for us as an organisation. We have had to employ staff on lower wages and with differing conditions to those in block funded programs. Thousands of unfunded hours to sort administrative discrepancies and fight unreasonable planning and review decisions.”

“Difficult to answer due to going from block funding to NDIS where we still are supporting participants who are not eligible for NDIS.”

“The attitude of the NDIS is still they are the expert and the community sector does not know [anything]. The participants - difficult to transition in; ... a proportion of the participants, have never had to make [such decisions] before ... and now they do not know how to ask for a service, they just demand”

Q13-14. Business viability under the NDIS

Of the five organisations which answered this question, four answered that they were not viable purely based on revenue generated from NDIS service delivery.

They commented as follows:

“very difficult to make the program sustainable due to having to employ staff at a lower level, the ever changing price code, [that] we are still supporting participants are not eligible, ... the length of time it takes for applications to be processed and who is there available to assist participants to apply for NDIS. [It] is a loss to our organisation to continually help people to apply.”

“This has been a real struggle and we are not winning!”

“Some are and some are not. Access, and Group psychosocial services are not viable”

When asked to comment about the need to cross subsidise from other parts of their organisation in order to support the provision of NDIS services, one organisation thought it was viable to continue cross subsidising from other programs in support of NDIS services, and two organisations considered it ethical to do so.

The following comments were made:

“It takes away from other services as well that are also being continually squeezed. We are currently having to restructure and cost cut as a result which is affecting the whole organisation.”

“The business assumptions under the NDIS are not based on real businesses within a quality framework.”

Q15. Unfunded NDIS costs

Survey participants were asked to list up to five unfunded costs under the NDIS, in priority order. Answers showed that costs associated with all aspects of NDIS related administration as well as advocacy (in the broadest sense) on behalf of clients were the most common and burdensome unfunded costs.

Following are the costs as recorded by respondents:

1. Administration; rectifying planning decisions in plan reviews; supporting people transitioning into the NDIS
2. Travel costs are not viable; sorting our billing anomalies and mistakes; supporting people through plan reviews
3. Team meetings and supervision; advocating for individuals (even though we are not meant to); financial plan management need to automatically have a budget identified for follow up on services
4. Set up costs; bringing in new systems to manage the NDIS – eg. IT; no funding support for individuals during times of change – eg. moving house, finding a home, etc.
5. support through application process; providing unfunded services to individuals while plans are waiting to be sorted – not always billable; dealing with participant expectations when they want services not provided by NDIS

Q16-17 Most and least adequately funded NDIS services

Respondents were asked what were the most adequately funded NDIS services. Again they were given the option to list up to five in priority order. Interestingly only two services were noted here, and were listed as first in priority order. Noone listed any other services for priority options 2-5. The two services were:

1. Supported independent living; and more recently respite services.

One organisation went as far as saying:

“None are adequately funded. Difference between the amount per hour and the amount in a plan. SC is regularly being cut to inadequate amounts. Core supports often have reasonable budgets but it is difficult to make a viable service offering.”

Following from this, respondents were asked to list the least adequately funded or not funded at all. The responses were:

1. Support coordination; access services
2. Support work for community access; outreach services
3. Transport; support coordination is the right \$/hour but there is not enough hours in the package
4. Psychology
5. Group activities

Q18. NDIS and the recovery framework

A lot of work has been done to position the mental health sector in a recovery framework. It is often stated that the NDIS is incompatible to working within a recovery framework. Respondents were asked to comment - positive and/or negative - on how the NDIS has impacted their ability to deliver recovery oriented services to NDIS participants (max 5; in priority order).

First priority

NDIS only provides for linear recovery; thus when a participant needs further support ... during a psychosocial dip, he or she does not have the funding for increased support during this time.

The NDIS framework makes it difficult to deliver recovery services but we have forged a model that can work. It requires combining service delivery with support coordination (with two clearly different teams) but important communication between the teams to be able to support the participant with recovery activities. We have seen some fantastic results using this model but are acutely aware that it is not the preferred model of the NDIA.

Focus is still on dysfunctional framework for funding

Second

NDIS Goals help to align person centred plans and support.

The participants have to go over their dysfunctionality every time the plan is reviewed

Third

NDIS often reduces funding after a year which puts a heavy amount of pressure on psychosocial participants to quickly reach all their goals.

Participants - now demand services, not ask

Fourth

NDIS causes a divide between those who are eligible and receive support, and those that do not. The participants who are not eligible but require support do not reach their goals as a result.

Expectation from NDIS that the participants will need decreased services in a one year period instead of seeing the journey.

Fifth

NDIS is supposedly person centred, but [it is] not strengths based

Q19. Organisation robustness

Respondents were asked to comment on whether they considered their organisation as more robust and able to operate efficiently in a market environment, while delivering quality services, as a result of the changes made since the introduction of the NDIS. Only three organisations responded to this question but their answers indicate that organisations are not as robust as they otherwise might be:

Yes; being a large organisation we have been able to carry costs throughout the transition. In addition, the organisation has a main focus in the area of mental health.

No

There has certainly been change - paradigm, cultural, HR practices, risk management etc. Constantly, reassessing the position of the organisation. Administrator processes and requirements have increased by 400% - including finance, management and other hidden processes by staff as we monitor the work flows. Robust providing quality services is not a word I would use. I would say flexible and able to change as the environment changes

Q20. Has there been any consideration given to de-registering from the NDIS?

Only three organisations answered this question and they all replied that they had. It is evident from the tone of the answers that the welfare of their client base is what is keeping these organisations engaged with the NDIS. When asked to comment, this is what they replied:

Purely from a business point of view, financial sustainability is very difficult to establish with the funding body of NDIS, however without services such as the one we provide, participants with a psychosocial disability would go completely unheard and unrecognised.

We would not do this lightly but unless we can turn our financial situation around we will be considering pulling out of the NDIS.

We are monitoring this position

Q21-22. Change in organisation capacity brought about by the NDIS – clients with NDIS packages

The three respondents to this question noted that they have less organisational flexibility to respond to clients differing needs – particularly those with the most complex needs, those who do not have an NDIS package and those in a period of greater need due to the episodic nature of mental illness.

Yes. We currently provide support to those that are not eligible for the NDIS or are going through what is known, by NDIS, as 'situational mental health' and our capacity to support these people as the organisation would like is limited.

It is a different service offering from what we had with PHaMs, PIR and HASI/HARI. Many client needs are met with the NDIS packages, but the higher level recovery work that we did is less obvious and flexible.

Yes - the flexibility has gone. This includes the organisation being able to provide services with another staff member as the consumer is now creating dependency on one person instead of a team. Also not being able to flex funding to meet the individual needs between a bucket of block funding to individual packages that run out

Two out of three organisations felt they were able to access services that clients need. It was noted however, that what clients 'want' is not always so easy to manage – especially when things are outside of the scope of the NDIS.

Psychology services are often noted as difficult to access with very few registered under the NDIS. On the positive side, one organisation noted that service offerings have generally improved over the past six months.

Psychology is extremely difficult to access, with the exception that a participant is plan-managed and introduces a plan management service. The amount of psychologists registered for the NDIS are very few and far between

Not always ... But service offerings have improved over the last 6 months.

The word 'want' does not always fit into the Recovery Framework - some requests are outside the scope of the NDIS boundaries. There is a gap then or the service is the public system which still has access blocks.

Q23. Change in organisation capacity brought about by the NDIS – clients without NDIS packages

Three out of the four respondents did not feel confident that they could access adequate services for clients without NDIS packages – either within their organisation or from another provider. Given the majority of people in need of support for their mental health will not be eligible for NDIS packages this is an area for particular concern. In the longer term too this might lead to more people becoming unwell enough that they will be eligible for an NDIS package.

There is no current funding body for participants who are ineligible for the NDIS or have mental health issues or a diagnosis that is not considered permanent or lifelong; this is a large percentage of those with mental health issues.

There are almost no options for those without packages for longer term support other than the the 3 months offered by TRec or Way Back.

The service framework and the boundaries of the NDIS still don't match.

Q24-26. Governance and management of the NDIS

With a focus mainly on the past 12 months we asked respondents to rate the performance of the NDIA, the ACT Government and the Commonwealth Government against 9-10 criteria. Overall, respondents were not very happy with the role any of these entities have played in terms of the governance and management of the NDIS

With respect to the NDIA, the three respondents judged the performance to be generally poor. 'Real time updates of changes to aspects of the NDIS' was the only criteria rated 'reasonable' by two respondents. All other criteria listed were rated by at least two of the respondents as poor.

The turn around time for any review is way too extensive, ... it is not followed up for 6-8 months on average

This is an area that is improving but has a long way to go. [The NDIS] need to trust their partners

With respect to the ACT Government, they were rated 'reasonable' against more of the criteria than the NDIS – with all three respondents rating 'general communication with clients' as reasonable. However, they were rated poor by all respondents for change management, realistic expectations about the transition and understanding the impact of the change on PSD and MH services.

For many things related to the viability of organizations the ACT Government has been missing in action!

The ACT services, acute and primary, are behind the community sector in relation to shifting paradigms. But they are moving. Still wanting what was provided by the ACT govt through the community sector. There is some denial at the ground level - education and exposure to the sector environment may help. This is a part of the transition.

With respect to the commonwealth government, they were rated as poor for most criteria by two out of the three respondents. All respondents viewed the Commonwealth as poor when it came to realistic expectations about the transition process. Specific comments:

Especially in relation to the future of PIR

They asked if a PHaMs service can be built into the NDIS world - the answer is no!

Q27. Clarity of roles between different levels of government

The three respondents consider there is a lack of clarity and some duplication of roles. However, their views are further clarified by the comments each made:

No duplication however lack of clarity.

Both are MIA!

The issue is that the NDIS is evolving and the boundaries are still being developed. So all parties are confused. Although the NDIS will state what they will not do. Duplication is occurring and private companies are trying to milk the system during its early stages

Q28-29 Where to go when need help

All three respondents commented that their first point of call when they need to address an issue either with an individual client or a more systemic nature, their first point of call would be the NDIA (as opposed to ACT or Commonwealth governments, or 'other')

Q30-33 Workforce structure

The three respondents have workforces pertaining to MH and PSD services ranging from 13 to 31. When this is translated into full-time equivalents, the numbers drop, indicating the high rate of part-time and casual employment.

The three respondents to the question about the change to staffing profiles since the introduction of the NDIS indicated a higher level of casualisation of their workforces:

Significantly. Staff members were transitioned to casual and pay levels were decreased.

Yes

Yes - increased casualisation and time framed contracts.

Q35-36. How the workforce has changed

Two organisations felt that the staffing profile had ‘about the same’ capacity to deliver quality recovery oriented services now as compared to before the NDIS, while one felt that they had less capacity in this regard.

We have amazing staff doing recovery work but we have lost some of the higher level more nuanced recovery experience

There are more administrative components to their job now than before

There were three responses to a question about the nature of the changes to the workforce. They were asked to answer ‘much less’, ‘about the same’ or ‘much more’ against a number of criteria. The key results are:

- All reported ‘much less’ supervision/management of individual staff, and training and development
- ‘Much less’ was reported for team/staff meetings by two of the three
- ‘Much more’ was reported by two of the organisations for continuous quality improvement, innovation and commitment to corporate values in daily work.
- ‘About the same’ was reported by two organisations for induction processes and staff retention

Further clarity was given to this question by the comments made:

With the introduction of NDIS and all the requirements, staff induction and training is required to be more intensive however funding does not exist to provide it.

It is very hard to answer this question as the nature of the work and the workforce is different!

The values of the organisation have been scrutinized within the NDIS service delivery model. There has been a turnover of staff due to the change in work practices required, more than the values. Staff are getting their peers to replace themselves as they move to other areas of professional development. Continuous improvement - if not done we would not be here. Supervision - has been made more efficient but less time. The issue is that the industrial law and what the participants want, don't always meet.

Q37. No comments provided on the Human Services Registrar.

Q38. Working with the local LAC – Feros Care

There is general dissatisfaction expressed in the sector with the choice of LAC for the ACT and its introduction. The following three responses are in keeping with this sentiment:

Local area coordinators do not understand psychosocial or provide any coordination for those with a psychosocial disability. They are often unable to make contact with the psychosocial participants we support, therefore we are required to provide the same if not more support than before, when support coordination was adequate.

The introduction of LAC's into the ACT was woeful - no warning for participants and service providers about what this would mean and the impacts it would have on our services and business models. LACs has very little PSD experience. Automatic transfer of plans to the LAC was difficult for all involved and often not even communicated leaving us in the dark.

Yes - they are still defensive. But learning the environment. They are not accredited against the MH Standards 2010.

Q39. Early childhood intervention – no comments made

Q40. Unique factors in the ACT

Two comments were provided in response to the question about unique factors in the ACT affecting the rollout of the NDIS:

Being a trail site with whole of population roll out has been difficult and not given the territory a chance to think what they would do in hindsight.

Yes - ACT is the whole in the doughnut with regional NSW surrounding the ACT. NSW provides funding for services in the ACT, participants are mobile and the ACT hasn't openly recognised this to its workforce. The ACT is small compared to other states and territories but it is well educated - with a hidden group [of disadvantage]

ENDS

- Attachment 2:** Document named *NDIS-Exec Summaries-may17*
- Attachment 3:** Document named *Plan review concerns-letter-3Aug17*
- Attachment 4:** Document named *Letter-Final-FINAL-NDIS-Ministers-serious-concerns-27June16*

NDIS – Summary of key issues

25 May 2017

Background

The following is the collection of Executive Summaries from the submissions made by MHCC ACT to the various Commonwealth government inquiries into the NDIS in the first months of 2017.

Executive Summaries

1. Joint Standing Committee on the NDIS

Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

27 Feb 2017

The National Disability Insurance Scheme (NDIS) is a worthy initiative and one with the potential to improve the lives of thousands of people living with disability, their families and carers. As such, it has the potential to contribute significantly to future economic growth and the wellbeing of all Australians.

MHCC ACT and its members and stakeholders remain committed to working towards the success of the scheme.

However, the NDIS is not, and cannot be, a replacement for the mental health system and both disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness.

‘Watch out - the baby is disappearing with the bath water!’

‘Look look – what wonderful new clothes the Emperor is wearing!’



Where the NDIS is working well it is changing the lives of participants. Concerningly, however, there are many areas where the NDIS is not working well. Even those people who ultimately experience positive life change as a result of the NDIS, often have encountered significant issues and barriers before reaching this point. People are disengaging as a result of the extent and ongoing nature of these difficulties. Services are being withdrawn. Highly skilled workers are leaving for more job security and better pay.

People are being left worse off as a result of the introduction of the NDIS; a two-tier system of service access and quality is starting to emerge; downward pressure is being placed on service and workforce quality; inconsistencies in the value and types of supports offered abound; the ground is constantly moving beneath the feet of service providers; and in many fundamental ways the NDIS does not easily accommodate psycho-social disability (PSD).

The NDIS is becoming overly bureaucratic and lacking in transparency. Risk is being unreasonably shifted onto service providers. There are no apparent systems in place to measure outcomes (as opposed to outputs). Communication with stakeholders is woefully inadequate.

The NDIS is desperately in need of a partnership approach whereby the expertise of Consumers, Carers and Providers is sought out and valued.

The issues raised in this submission need to be addressed if the NDIS is to deliver on its stated goals and in the process leave no one worse off. Psychosocial rehabilitation and recovery must be part of the NDIS.

MHCC ACT strongly endorses the Submissions made by its State and Territory counterparts, and our peak body, Community Mental Health Australia. We also endorse the submission of Mental Health Australia.

In support of our submission we have **attached** the following documents

- Letter to then Minister for Health, The Hon Sussan Ley, MP et al from Simon Viereck, EO, MHCC ACT dated 27 June 2016



- Response to this letter from Anne Skordis, GM, Scheme Transition Division, NDIS, dated 17 August 2016
- Presentation made by Leith Felton-Taylor, Manager, Policy and Sector Development, MHCC ACT to ACTCOSS Forum ‘Lost in Transition’, 26 February 2016

Following are the key recommendations from the Mental Health Community Coalition on behalf of its membership and stakeholders:

- Adopt a partnership approach in the further development and implementation of the NDIS from this day forward; recognising and valuing the significant experience and expertise of Carers, Consumers and Providers, and the contribution they are willing and able to make.
- Ensure service gaps are filled and no one is left worse off as a result of the NDIS
- Address market failures that threaten to undermine the ability of the NDIS to facilitate the provision of quality sustainable services.
- Significantly broaden the scope and increase the capacity of the ILC/second tier of the NDIS to be an effective baseline of support for people with disability, thereby reducing demand for Individual Funding Packages (IFPs)
- Introduce changes to the NDIS to make it a better fit for people with PSD; consider adopting multiple pathways through the scheme to cater for the differences in types of disability and an effective way to allow for crises situations. Ensure psychosocial rehabilitation and recovery can be supported in IFPs.
- Improve consistency of plans for people with similar support needs; consider establishment of disability specialist planning teams, as successfully trialed in the ACT to achieve this.
- Avoid the development of a two-tiered system. Simplify requirements and processes; especially when it comes to provider registration processes; plan amendments should be enabled without impact on the rest of the plan; plan reviews should involve real evaluation; and restrictions around how funding can be used.
- Increase transparency generally across the scheme.
- Introduce an effective communications strategy including an email alert system for important messages.



- Stop the rush – slow down and do it properly. An effective transition will lead to a stronger NDIS and more of the benefits that the Productivity Commission first identified as potentially flowing from such a scheme.

ENDS



2. Productivity Commission Report into NDIS Costs

24 March 2017

MHCC ACT appreciates opportunity to respond to the Productivity Commission discussion paper on NDIS Costs.

As the peak body for community managed mental health service providers in the ACT, this submission will focus entirely on to PSD. While we recognise there is a certain commonality of experiences with other areas of disability, there are also some very specific challenges fitting PSD into the NDIS model. Our submission is also shaped from the perspective of being the only whole of jurisdiction NDIS trial site.

The experience in the ACT is too easily dismissed due to the small size of the jurisdiction, the fact that it is essentially one city, and that its population is relatively well educated and affluent. These same characteristics of the ACT would suggest that implementing the NDIS in the ACT should be easier than in most other parts of Australia. If NDIS implementation is proving problematic in the ACT – too often leaving people worse off, opening up service gaps, proven services disappearing – then it might serve as a warning to the rest of Australia where the challenges of implementation will be greater.

Is the ACT the ‘canary in the NDIS coalmine’ for the rest of Australia?

MHCC ACT views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. It offers flow on benefits that will affect all Australians. But we must take care to ensure that we get it right. This requires time, investment, flexibility and persistence.

The NDIS is working well for some people, of course. But even these people have often had to overcome challenges to achieve this outcome.

However, in many ways the NDIS is not working well yet. While the rhetoric around the NDIS framework is about markets, it doesn’t take long to realise that it is not actually a market. It is a government managed and controlled system with great ambition, with fixed prices, information gaps, inexplicable outcomes and overly burdensome administrative practices.

MHCC ACT sees the key issues as:



- Inadequate understanding of the complexities and specificities of PSD as compared to general disability, throughout the scheme and its governance and management structures.
- Refusal to take a partnership approach with the sector, and in doing so benefit from the breadth and depth of expertise of providers, carers and consumers.
- A pricing framework that is pushing towards commodification of services – an outcome not in the best interest of participants or achieving NDIS objectives.
- A pricing framework which is putting downward pressure on workforce quality, and organisations' capacity to attract, retain, train and develop a workforce that can deliver safe quality outcomes.
- A pace of implementation that is too fast for effective change management and is leading to the disappearance and shortage of services.
- Lack of integration with, and spill over effects onto, mainstream services. This is resulting in service gaps and disruption for people not eligible for NDIS IFPs.
- Loss of some highly effective programs such as D2DL, PHaMS, PIR. This is contributing to service gaps and also creating problems for continuity of care and helping to support people's systems to not regress.
- Significant unfunded cost and risk shifting to service providers in particular, but also to consumers and carers.
- Targets that mean that focus is on getting people into the system quickly rather than overall outcomes from doing so.
- Carers have not been at all well supported, undermining one of the pillars of the scheme

A series of recommendations have been made throughout this submission as to how to these address issues might be addressed.

Our overall recommendation however, is to view the NDIS as a long-term investment in Australia's future. Well-funded and structured it will deliver benefits to every Australian,



especially those with disability. Dividends will flow although they may take a while to become evident.

On the other hand, if done badly it will incur significant human and economic costs. The state of market disruption already caused by the NDIS would also mean that fixing a failed system would be incredibly expensive to tax payers.

MHCC ACT also support the responses to this process from our peak body, Community Mental Health Australia. We also support submissions from our ACT member organisations.

MHCC ACT also refers the Productivity Commission to the submission we made to the Joint Standing Committee for the NDIS inquiry into provision of services for people with PSD under the NDIS.

We are very willing to contribute more to this process if asked.

ENDS



3. 2017 NDIS Price Controls Review

MHCC ACT response to the NDIA Discussion Paper

28 April 2017

MHCC ACT values the opportunity to provide a response to the NDIA discussion paper on '2017 Price Controls Review'.

Our response is written entirely from the perspective of the provision of services that support people with mental illness and psychosocial disability (PSD). It is informed by a direct survey of our stakeholders in which we asked the questions posed in the NDIA paper. It is also informed by the experience gained in the ACT as the only whole of jurisdiction NDIS Trial site, and the information we have consolidated in responding to the other reviews of the workings of the NDIS currently underway. As such, we also direct you to the publicly available submissions MHCC ACT made to the:

- Joint Standing Committee on the NDIS Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition (27 February 2017)
- Productivity Commission report into NDIS Costs (24 March 2017)
- Senate Standing Committees on Community Affairs Inquiry into the Delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities (28 April 2017)
- Australian National Audit Office Audit into Decision-making controls for sustainability — National Disability Insurance Scheme access (forthcoming)

For the NDIA to open up discussion around the assumptions underlying the way prices are set and to raise the possibility that prices need to rise, fills our stakeholders with hope. Concerns about the artificially low levels of prices available under the NDIS have been raised from before the trial began in the ACT. It has been exceedingly difficult to achieve any understanding of the validity of these concerns.

The community-managed sector has managed to operate with minimal funding for decades. It is known for its relatively low wages and limited career structures. Indeed, one of its



biggest difficulties has been in attracting and retaining well-qualified and experienced staff. The Fair Work Commission Equal Remuneration Order (2012) illustrates that this is not a fantasy. Yet the introduction of the NDIS is effectively putting downward pressure on wages once again, through setting very low prices that translate into generally lower wages and an increasingly casualised workforce across the sector.

Our key recommendations arising from the NDIA discussion paper are as follows:

- Redesign the price review process - a three week turnaround is not an adequate amount of time to provide meaningful input into such an important process
- Strongly promote the price review process – a media release, headlines in the NDIS e-newsletter and highlighted on the front of the website as a minimum
- Urgently review and revise the modelling underlying the NDIS pricing of supports for people with PSD. Recognise that for support to be effective the model needs to be informed by expertise and understanding of:
 - the specificities and complexity of supporting people with PSD
 - the episodic nature of PSD
 - the importance of both individual and group based supports
 - the need for a relatively stable, well qualified and experienced workforce
 - the particular risk management strategies that are important for effective PSD supports
 - the significant cost shifting to the community sector resulting from the NDIS – for example, the increased administrative burden (particularly when the NDIA itself is not functioning efficiently or effectively yet)
 - the cost of compliance with the broader legal framework governing organisations operating in this sector.



- The NDIS does not replace the health system – a whole of government approach is required to ensure that all people with mental illness and PSD can access a full range of effective services, regardless of whether they are a NDIS participant or not.

If the NDIS continues without these sorts of changes, indications from the experience in the ACT at least, are that the scheme will not deliver on its objectives. If the NDIS is allowed to fail to deliver effective support to people with PSD it is likely to impose a much bigger human and economic cost to Australia than would be the case if the scheme were adequately structured and funded in the first place..

The experience in the ACT is too often easily dismissed due to the small size of the jurisdiction, the fact that it is essentially one city, and that its population is relatively well educated and affluent. These same characteristics of the ACT would suggest that implementing the NDIS in the ACT should be easier than in most other parts of Australia. If NDIS implementation is proving problematic in the ACT – too often leaving people worse off, opening up service gaps, proven services disappearing – then it might serve as a warning to the rest of Australia where the challenges of implementation will be greater.

In the ACT we are seeing a reduction in quality services and an increase in sector fragmentation and competition following the introduction of the NDIS. There is no longer a sense of supporting the community as a whole but rather (and reasonably so) organisational survival.

Downward pressure on prices, and subsequently wages, drives outcomes that are not in the best interests of service users. It can only lead to:

- The commodification of services, and corresponding lowering of quality
- Ethical decisions to withdraw services rather than provide them at low quality
- Less qualified and experienced workforce unable to deliver the full range of recovery oriented services required to support people with PSD to stay in their communities
 - especially those people with the most complex needs
- Higher demand on tertiary more expensive health services, especially hospitals.



- Over time, a sector that is not robust, diverse and innovative – leaving consumers and carers with little choice and control over their lives.

There has been a distinct lack of a partnership approach in building the NDIS pricing framework, and other related areas of the NDIS. If consumers, carers and providers had been recognised from the start as holding years of valuable expertise, experience and knowledge around the provision of these services, many costly mistakes could well have been avoided. Instead, this group has largely been viewed with suspicion, as being driven by narrow self-interest. As a result an ‘us and them’ attitude has prevailed.

What has been created by the way the NDIS has been implemented is not an efficient market place. Prices are fixed (artificially low), services are defined by a third party, access is managed, change is managed, and the scheme is being driven almost wholly by entry number targets. The way these variables interact is producing many detrimental market distortions.

ENDS



4. Senate Standing Committees on Community Affairs Inquiry

Delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities

28 April 2017

Recommendation: A whole of government approach be taken to ensure that group based services and community spaces continue to be funded and available for people with psychosocial disability. More specifically:

- That state and territory governments continue to fund a suite of psychosocial rehabilitation and recovery services for people living with a mental illness.
- Ensure the ongoing viability of community spaces catering for people with PSD.
- That the Commonwealth Government fund, through a suitable mechanism, a flexible, low-barrier-to-entry services – similar to Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PHaMs) – outside of the NDIS for people who need ongoing community and coordination support.
- That the Commonwealth Government enact a mechanism to provide continuity of supports for people with mental illness and PSD who are ineligible for the NDIS.

MHCC ACT appreciates the opportunity to respond to the Senate Standing Committees on Community Affairs Inquiry on the delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities. As the peak body for community managed mental health service providers in the ACT, this submission will focus entirely on psychosocial disability (PSD) and the effect that the NDIS is having on community and social participation of people with PSD. Our submission is also shaped from the perspective of being the only whole of jurisdiction NDIS trial site.

MHCC ACT views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. It offers flow on benefits that will affect all Australians. But we must take care to ensure that we get it right. This requires time, investment, flexibility and persistence. MHCC ACT and its members and stakeholders remain committed to working towards the success of the scheme. However, the NDIS should not be taken as the only means to fund the services that people need to participate in economic, cultural, social, civil and political life.



However the unintended flow on affects from the NDIS is resulting in loss of group based and drop in style social participation services and community spaces in which to deliver these services. This has a real impact on the lives of people with PSD and their carers and is undermining the stated outcomes of the National Disability Strategy of ensuring people with disability are able to participate in economic, cultural, social, civil and political life. MHCC ACT sees the key issues as:

- Inadequate understanding of the complexities and specificities of PSD as compared to general disability.
- Loss of some highly effective programs such as like Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PHaMs) This is contributing to service gaps and also creating problems for continuity of care and helping to support people's systems to not regress.
- A pace of implementation for the NDIS that is too fast for effective change management and is leading to the disappearance and shortage of services.
- Refusal to take a partnership approach with the sector, and in doing so benefit from the breadth and depth of expertise of providers, carers and consumers.

A whole of government approach needs to be taken to ensure that people with PSD have the continuity of support they need for their health and wellbeing; to cater for the episodic nature of PSD; and to be integrated with society in which they live.

ENDS



5. Australian National Audit Office Performance Audit

Decision-making controls for sustainability - NDIS access

5 May 2017

MHCC ACT values the opportunity to contribute to this Australian National Audit Office (ANAO) performance audit process.

The National Disability Insurance Scheme (NDIS) is a worthy initiative and one with the potential to improve the lives of thousands of people living with disability, their families and carers. As such, it has the potential to contribute significantly to future economic growth and the wellbeing of all Australians. As MHCC ACT is the peak body for community managed mental health services in the ACT, this submission focussed entirely on the NDIS as it pertains to psychosocial disability (PSD)

MHCC ACT and its members and stakeholders remain committed to the success of the scheme. Where the NDIS is working well it is changing the lives of participants for the better. Even those people who ultimately experience positive life change from participation in the NDIS, have often overcome significant hurdles before reaching this point.

MHCC ACT on behalf of its members and stakeholders therefore makes the following high-level recommendations:

- The NDIS is managed as a long-term investment in Australia's future. Well-funded and structured it will deliver benefits to every Australian, especially those with disability. Dividends will flow although they may take a while to become evident.
- The NDIS needs to be driven by effective quality outcomes rather than artificial scheme participation rates.
- An urgent review be undertaken of NDIS mechanisms with the intent of improving transparency and producing consistent quality outcomes
- Systems need to be transparent and user friendly, especially the user portal and the NDIA website



- Change needs to be managed such that adequate notice is given; written advice is available well before the change; and that such communication is effectively disseminated
- The NDIS framework be made compatible with the existing legal and industrial relations environment governing this sector in Australia
- The higher relative cost and complexities of supporting people with PSD needs to be understood and catered for
- NDIA staff have adequate disability specific skills and qualification to produce Individual Funding Plans (IFPs) that lead to results consistent with the NDIS objectives.
- A partnership approach be developed by the NDIS to make use of the valuable expertise available in the participant and provider communities
- Recognise that for NDIS objectives to be met and the scheme sustainable, IFPs must effectively support participants and a strong robust and innovative services sector needs to be available for participants to choose from.
- The NDIS is not, and cannot be, a replacement for the mental health system. Disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness.

Perhaps what is confronting about the NDIS is that for the first time Australians are starting to understand the extent of disability in our communities and the true cost of adequately supporting people with disability to live a normal life. This is particularly the case for PSD – which has for too long been hidden away and not funded in any way commensurate to its share of the burden of disease in the community.

The human and economic cost of properly supporting disability do not disappear if any part of the system, including the NDIS, is allowed to fail or deviate from its objectives. Instead the costs get transferred to other areas, becoming much bigger in the process: people die, have a high churn rate through the more costly hospital and other tertiary mental health systems,



and unpaid carers cannot participate in the workforce and become unwell themselves. The NDIS is an investment in a better and more cost effective way of supporting disability and keeping people out of hospital. It will take time before the benefits flow, especially in a more systemic way. We should not let short termism undermine this potential.

The National Mental Health Commission demonstrated very clearly the costs associated with mental illness and the benefits of getting our approach right, for all Australians, in its 1 December 2014 report, “Contributing lives, thriving communities – Review of Mental Health programmes and services”.

The NDIS remains complex and challenging to navigate; and like many new schemes, it abounds with problem areas:

- Many participants are not experiencing increased choice and control over their lives and IFPs are not necessarily supporting their mental health and wellbeing adequately.
- Carers are commonly having to devote more time to administration – to the extent even of having to resign from paid workforce – while at the same time losing the little bit of respite and other supports they once received under block funding
- Service providers are struggling to remain viable under a scheme where they are expected to offer the same scope and quality of services, but with less funding.

The insight MHCC ACT has gained working directly with community-managed providers of support to people with PSD under the NDIS shows that in too many cases, decisions and processes around access and eligibility are not well informed, and are not producing optimal results. The problems experienced in the ACT are now being magnified as the scheme rolls out nationally.

MHCC ACT strongly endorse the submission made by its peak organisation, Community Mental Health Australia (CMHA), to this process. It also refers the ANAO to the submissions that MHCC ACT and CMHA have made to other similar processes currently underway:

- Joint Standing Committee on the NDIS Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition (27 February 2017)



- Productivity Commission inquiry into NDIS Costs (24 March 2017)
- Senate Standing Committees on Community Affairs Inquiry – Delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities.

MHCC ACT is happy to assist this process in any way, including by providing more information or clarity on any issues raised.

ENDS





Shane Rattenbury
Minister for Mental Health

Rachel Stephen-Smith
Minister for Disability, Children and Youth

Dear Ministers

National Disability Insurance Scheme (NDIS) – annual reviews of NDIS funding packages leaving participants in a dangerous situation in Canberra

I am writing to raise our serious concerns about the outcomes for NDIS participants with psychosocial disability (PSD) from the NDIS plan review process. These people are some of the most vulnerable in our society yet there appears to be a strong trend to dramatically reduce the scope and value of their NDIS supports at annual plan review. This potentially places people's lives at risk. There are also important implications for government if unusually high numbers of people suddenly need more intensive, higher cost tertiary health services.

We value our working relationship with the ACT Government and its Directorates, and particularly our ability to raise the serious concerns we have in regard to people receiving support packages for PSD from the NDIS. We are particularly pleased to see the strengthening of the Office for Disability in the Community Services Directorate to facilitate more transition work on the NDIS in the ACT.

In regard to our concerns around the NDIS plan review outcomes in the ACT, our specific recommendations to you are as follows:

- 1. We recommend that the ACT Government demand a cessation to the dramatic cuts being experienced by NDIS participants with PSD at the time of annual review of their IFPs, and crucially that Support Coordination (SC) is maintained at an appropriate level.**
- 2. We also recommend that the ACT Government require that NDIA Planners be adequately qualified (training and experience) to understand the specificities of the disability they are assessing, particularly in regard to PSD.**
 - This is in keeping with the Draft Recommendation 4.2 of the Productivity Commissions' NDIS Costs position paper, July 2017: *'..... For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.'*
 - It is also in keeping with the lessons learnt during the ACT NDIS trial period
- 3. We urge the ACT government obtain detailed answers from the National Disability Agency (NDIA) and relevant Federal government agencies to the following questions:**
 - What is the explanation for the trend to substantially lower the value of IFPs in the ACT at annual review?



- What proportion of IFPs for people with a primary disability of PSD in the ACT have been reduced at review?
- By what amount and percentage have IFPs been reduced – in total and average per person?
- On what grounds is ‘Coordination of Supports’ (paid at \$94.06/hr) being reduced so dramatically for participants with PSD in the ACT?
 - Is Feros Care taking over ‘Coordination of Supports’ (rather than just support connection)? If yes, then
 - on what basis and what proportion of ACT plans with PSD as the primary disability?
 - why has it not been clearly communicated?
 - what is the evidence that Feros Care is capable now to take this role?
- What proportion of plan reviews are undertaken by phone? What evidence was used to support phone based interviews as an effective method of engagement, in particular with regard to participants with PSD
- What is the evidence that the people undertaking plan reviews with participants with PSD are appropriately qualified to do so and have an adequate understanding of PSD?
- When internal review is required of a plan for a participant with PSD, what is the evidence that justifies a two-three month turnaround period when a case is considered urgent; and up to six months when not marked urgent?
- Why are service providers not able to claim for the time and resources needed to complete the NDIA internal review process to advocate on behalf of the participants?

While there are success stories, there are also far too many stories of people being left worse off by the NDIS. As the peak body for community managed mental health services, MHCC ACT has made submissions (available on our website at <https://mhccact.org.au/submissions/>) to the current national reviews into the NDIS. We raised concerns in these submissions about the process behind NDIS plans and plan reviews – particularly the annual review. We are hopeful that the outcomes will address many of the issues hampering the effective delivery of the NDIS.

However, these processes will take some time to complete and implement, while the need in the ACT is immediate. Action needs to be taken now.

Indeed, on page 30 of the Productivity Commissions’ NDIS Costs position paper, July 2017, they recommend that neither the federal government or state and territory governments should be removing any funding until there is a clear picture both about what is still being provided and what ‘continuity of support’ actually means:

The interface between supports for people with disability will take time to determine at the coalface, but until those interfaces and the associated boundaries are settled, it is important that governments do not withdraw from services too quickly, as any gaps that emerge will place added burdens on people with disability and their families.

For some time we have been hearing of NDIS participants having their packages significantly cut at the annual review process – in the media, from service providers and individuals. It is our belief, that we are approaching a critical junction in this regard in the ACT. Such reports are increasing in frequency, and a large number of participants with PSD are due for annual plan review in the next few months.

Reports from the major community managed mental health service providers in the ACT show a systemic issue of dramatic reductions in NDIS funding packages after annual review – organisations such as Woden Community Service, Mental Health Foundation, Catholic Care, St Vincent de Paul and Richmond Fellowship. St Vincent de Paul reports that out of seven reviews completed in the last two months, five participants have had their packages reduced by \$128,000 in total. Some participants they were seeing daily, now only receive minimal support. Typical of the sort of stories MHCC ACT are hearing, is this one from St Vincent de Paul:

The participant's original package was \$37,000; but after annual review the package was reduced to just \$2,500. All of his external supports have dropped out completely and he is back where he was before NDIS – if not worse. All his cleaning supports, his laundry and social supports have dropped out completely. An internal review was completed and sent to NDIS two months ago with an urgent status. We check it weekly for progress. To date there has been no progress with this review. The client, who has a psychosocial diagnosis, is now isolated within his home.

Through our involvement in our national peak, Community Mental Health Australia (CMHA), we are hearing from other States and Territories, similar stories and concerns.

For service providers to be able to supply quality, recovery oriented, supports to NDIS participants they need the structure and the budget of plans to be consistent and adequate. Typically, this means relatively large amounts of:

- 'Category 9' supports, and
- 'Coordination of supports' paid at the higher \$94.06/hr level. This allows the level of coordination required when client's needs are complex, as they often are with PSD. This higher rate allows for essentials such as responding to and resolving points of crises; case coordination and relationship building; co-designing capacity building activities.

However, it is in these same areas that providers and participants are reporting the largest cuts in plans after annual review.

Such outcomes of so many annual plan reviews being reported to MHCC ACT indicate a specific NDIA directive or policy to substantially cut the size of IFPs – even though this is denied by the NDIA. There is no other way to explain the cuts we are seeing, especially in the area of Category 9 supports and support coordination. It is not consistent with the intent or the letter of the NDIS to be making decisions that effectively put people's lives at risk and undermine their basic human rights.

It is difficult not to conclude that part of this is also driven by an ongoing lack of understanding and acceptance of the specificities of PSD, made worse by the often invisible nature of this condition. It is

easier to recognise disability when a person is lacking a limb; more challenging when they look 'normal'.

It is critical that planners understand that an improvement in a participant's wellbeing is not in itself a justification for a radical cut in their NDIS funded supports – an analogy is that a wheelchair is not assumed to be no longer essential just because a physically disabled person is able to move around more freely. As stated in the case study at Attachment 2:

“... the NDIA has very little understanding of psychosocial disability and the damage that they can do to people with psychosocial disability by giving them funding, hope and a better quality of life one year and then taking it away the next year. This reinforces what has continually happened to them in the past. Having said that, it is happening right across the disability sector.”

We have **attached** several case studies to illustrate our view that it is now critical to put something in place to ensure that NDIS participants are able to access the support they need. Service providers in the ACT should not be asked to do this for free, or out of a sense of duty. The more expensive clinical and emergency services are already at capacity in the ACT. Many NDIS participants do not have Carers with the advocacy skills demonstrated in the attached case study to improve a very poor outcome.

In view of this situation, MHCC ACT, in our capacity as peak body, are considering lodging an FOI request to the NDIA to discover the change in value and composition of IFPs where PSD is a listed disability. It is in the public interest to know the facts:

- Are NDIS participants being effectively resourced?
- What is the evidence driving NDIS planning outcomes?
- Are tax payers funds being used effectively in the short and longer term?

In closing, we thank you for your consideration of this letter and look forward to your response to our recommendations. We strongly encourage you to give the issues raised in this letter a high priority given the implications for the wellbeing of people with mental illness and their carers; the ongoing viability of quality mental health services in the ACT; and the implications for ACT government tertiary level mental health and emergency services.

Yours faithfully



Simon Viereck
Executive Officer
Mental Health Community Coalition ACT

3 August 2017

**Community managed mental health service provider very concerned for its clients
Woden Community Service, ACT**

Woden Community Service (WCS) are poised to have the results of a large cohort of reviews in the next month or so and many are pending, having had their reviews. Many of those came into WCS from HASI/HARI funding last year. There are about 28 of these out of over 60 coordinated participants.

What WCS have experienced recently doesn't fill us with confidence.

This is what WCS are expecting with the rest of the impending plan reviews. The WCS team have been hearing that Feros is saying, "the NDIS will no longer provide Support Coordination - and we will be doing all the coordination now". One of the WCS participants from the HASI/HARI cohort went to her review meeting with her WCS Coordinator and was greeted by the Feros planner who said, "hello, I'm your new coordinator". This was before the Feros employee knew anything of her background and level of need.

Other plans that have been reviewed have had coordination reduced significantly or cut completely. In some cases WCS have taken the plans to the first internal NDIS review. Small amounts of coordination have been clawed back in some cases – but certainly no more than an hour a week; we will just have to relinquish others.

We are finding that there is no longer support for capacity building for mentoring, peer support and skill development - the only place in the NDIS price guide that mentions this is the Category 9 items. WCS have tried to argue the importance of these supports but to no avail.

With all the plans up for review over the next month we are very concerned that plans will be reduced to a level where they are ineffective.

**My child's funding package dramatically slashed after review (de-identified for privacy)
Woden Community Service, ACT**

Summary: Participant plan reduced by 80% after review despite request for existing supports to continue and additional supports be added.. Participant had been a 'success story', and the carer a vocal advocate for the benefits of the NDIS. The funding reduction caused serious concern for the participant's wellbeing, and major anxiety for the carer. Advocacy from carer in particular, but also the provider, resulted in a review. Plan was improved but still not what was requested. Outcome due largely to advocacy skills of the carer – many participants with PSD do not have access to such effective advocacy.

The story – in the words of the carer (edited)

Part 1: result of annual plan review

My child's plan after annual review by the NDIA is terrible - it is 23.5% of the original plan, and will not cover the support currently received. Our story was a success story in that we were getting more support than we had ever had before - now we will not even get enough to cover the current supports that are making such a difference in our child's life.

I have done presentations, a webinar, teleconferences, and filming promoting the NDIS and telling our good news story of the support and services we were able to get. The plan review outcome has now made this a very cruel ironic joke.

We are very very worried what impact this is going to have on our child's mental and physical health, which is already deteriorating. We are very distressed and I had an anxiety attack on receipt of the plan. We believe that this new plan is potentially life threatening for our child. We are devastated and believe this is a human rights issue.

Apparently, people in Canberra are getting their NDIS packages slashed and it is causing a great deal of distress and anxiety for everyone involved: consumers, carers and service providers.

This highlights that the NDIA has very little understanding of psychosocial disability and the damage that they can do to people with psychosocial disability by giving them funding, hope and a better quality of life one year and then taking it away the next year. This reinforces what has continually happened to them in the past. Having said that, it is happening right across the disability sector.

The NDIA have now become just another government department whose focus is in cutting costs and making life hard for vulnerable people with disabilities.

Part 2: NDIA response

The NDIA are now working on a better plan in consultation with another more experienced planner and our support coordinator. It took longer than advised, and while we clawed back funding to be able to continue current support with a plan manager to enable us to employ outside of NDIA registered, it was not completely satisfactory.

There was a mistake made with some assessment input (not clear on this). But the main issue is the planner was obviously not trained properly, not a mental health planner, didn't read the records, didn't review the last plan to see what had worked, revisit goals, etc etc. The planner didn't pick up that we wanted to continue with current support, plus some more.

NDIA also appear to be using a different assessment tool from when we did the original plan. I am not clear on this but it may be computer generated – this is just from what I have heard from others in the disability area. Apparently they are quite secretive about what assessment tools they use.

I think the main problem is that planners are not trained properly and people are not getting planners that have a background in the disability they have – in our case mental health – and do not go through the process correctly to make sure that all needs are being met in their plan.

There is also a problem with the processes, and possibly computer-generated assessments. The "reasonable and necessary" component does not allow for people to be more innovative in finding solutions - i.e. services and supports that are outside of what is set out as being "reasonable and necessary".

Another major issue that will have adverse implications into the future for consumers, carers, service providers and qualified staff is that NDIA will not pay the higher rate of pay for qualified, skilled and experienced staff – see below Part.3, asking NDIA to clarify their reasoning for not doing this. NDIA has not responded to this email as yet and previously ignored an email from the Manager at WCS explaining that his support staff were specially qualified to provide support to those with a psychosocial disability.

Part 3: Seeking clarity from the NDIA

Would you be able to clarify why NDIA do not to pay for the higher quality, Peer Support/Recovery focused service, at the appropriate level i.e. "life transition planning, mentoring, peer support and individual skill development" (support item ref 09_006_0106_6_3 in the price guide)?

- It is the only place in the price guide that mentions mentoring and peer support.
- This type of support is provided by appropriately qualified, skilled support workers. It is essential capacity building support for people with psychosocial disability to improve their quality of life and to help them lead a more independent life into the future.

We find it very strange that the line item the NDIA are referring to as "Capacity Building" which is developing individual skills and providing training (15_037_0117_1_3) is paid at less than Core supports

- How are we going to find the necessary qualified people by paying them at a lower rate?

This is very worrying. It is hard for us to understand why the NDIA do not consider that the Peer Support/Recovery focused service at the appropriate level, ie. "life transition planning, mentoring, peer support and individual skill development", as "reasonable and necessary" .

This is a bit like the old proverb: "*give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.*" In other words, this is short sighted and will not achieve the outcomes we need.

This is not what we expected when consumers and carers fought so hard to have psychosocial disability included in the NDIS, and fought so hard for NDIA to understand the complexities and needs of someone with a psychosocial disability. It undermines the whole concept of NDIS.

No response received from NDIA to date.

Service provider supporting client with no funding, due to plan review outcome Woden Community Service, ACT

Debbie (de-identified for privacy) spent 18 months homeless and has severe and persistent mental illness (schizophrenia) and complex needs. Debbie had trouble getting a service to help implement her plan due to the complexity of her needs. She certainly suits a recovery focused NDIS provider but her new plan jeopardises any chance for recovery and a decent quality of life. It's a tragedy and a travesty what happened to Debbie as a result of her plan review. It has absolutely no relation to the first plan and the NDIA appear entirely uninterested in the evidence provided.

Debbie has said that she needs to get out to feel better, but it is difficult for her to go out by herself. She also needs more "Improved Daily Living" (psychologist) and "Increased Social and Community Participation" (mentoring) to help her overcome claustrophobia and anxiety.

Debbie's new plan started on 1 May, but we did not get the plan until 2 June. Debbie's services were reduced from five 2-hour support worker shifts per week, to one 2-hour shift per week. But we continued providing services five days per week while we were waiting for the new plan.

After ten weeks of significantly reduced services under the new plan, Debbie's support worker contacted the coordinator and said that she had noticed that Debbie was speaking quite aggressively and when going to the bathroom she was talking to herself. The support worker also said that Debbie's house was quite untidy and that this is the worst state the support worker had ever seen Debbie in, and was questioning if there was a change in her medications.

We have now run out of funding for a support worker, but we have to continue, otherwise Debbie would be totally isolated.

Comparison of original plan, and subsequent plan after review

- First NDIS plan Goal: To continue increasing my community access.
- Second NDIS plan Goal: To maintain my health and wellbeing.

Support Area	First plan	Second plan	Notes
Improved Life Choices (financial management)	0	1369.12	Plan management is only useful if the entire package budget warrants it. But there is nothing in this plan to warrant its use due to low value of improved daily living, core supports and increased social and community participation.
Improved Daily Living	3,443.00	630.88	Equivalent to less than 4 sessions of psychology – entirely inadequate.
Support Coordination	7,599.00	566.10	10 hrs of support connection per year. This is an unacceptable



			reduction and in no way can meet Debbie's complex needs
Transport	1,575.00	1606.00	Did not receive the transport allowance for last plan. NDIA was called and emailed - was told in an email she did not have it. I emailed NDIA back and said that she does have it (with plan attached), but have not heard back.
Core Supports	16,737.00	3108.00	71 hrs per year, already used in the first 6 weeks. There was a delay in receiving Debbie's plan because NDIA had an incorrect address. I had to pick the plan up from NDIA.
Increased social and community participation	5,615.00	0	99 hrs per year or about 2 hrs per week in the old plan. Did not start using her plan until later, because of changes in agencies and the complexity of the case.



To:

Minister for Health
The Hon Sussan Ley MP

Minister for Social Services
Hon Christian Porter MP

Assistant Minister for Disability Services
The Hon Jane Prentice MP

ACT Minister for Disability
Chris Bourke MLA

ACT Minister for Health
Simon Corbell MLA

Cc:

Senator for ACT
Senator Zed Seselja
Liberal Party of Australia

Senator for the ACT
Shadow Minister for Mental Health
Senator Katy Gallagher
Australian Labor Party

Member for Fraser, ACT
Hon Dr Andrew Leigh MP

Member for Canberra, ACT
Ms Gai Brodtmann MP

Candidate for Fenner, ACT
Mr Robert Gunning
Liberal Party of Australia

Candidate for Senator for ACT
Dr Christina Hobbs
The Greens

Dear Minister

SUBJECT: Urgent action required - NDIS and people with psychosocial disability

We are writing in our capacity as the peak body for community managed mental health service providers in the ACT, and therefore on their behalf. We are in constant contact with our 49 members, the majority of whom are not-for-profit (NFP) mental health service providers.

The National Disability Insurance Scheme (NDIS) has the potential to improve the lives of people with disability; as such Australia is a leader in its commitment to properly fund the support needs of people with disability. It is without question that our members, and by extension consumers and carers, want the NDIS to succeed.

However, our members are also telling us that despite their best endeavours, they are deeply concerned about their ability to offer sustainable, safe, quality support services to people with mental illness and psychosocial disability (PSD) within the NDIS framework.

They report to us that aspects of the framework – particularly the financial aspects – do not adequately support people with PSD, and that although full scheme rollout is imminent,



there remains a lack of clarity in many areas that directly impact on community mental health services. In short, the NDIS framework reflects a lack of understanding around the particular requirements of effective support for people with PSD.

We are recommending urgent action in six key areas of concern, specifically in relation to how the NDIS applies to PSD:

- 1. The NDIS should be underpinned by a funding and pricing model that recognises and supports provision of reasonable and necessary support services to eligible people, including services tailored to the specific needs of people with PSD at all levels of complexity**
- 2. Identify and address barriers to access and appropriate support specific to PSD**
- 3. The implementation processes for the NDIS are creating impediments to efficiency and service delivery**
- 4. Investment and certainty in programs for people not eligible for NDIS Individual Funding Packages (IFPs) but still requiring support services**
- 5. Ensuring carers of people with PSD are no worse off**
- 6. Safety and risk management policies need to be implemented**

The important reasons for these concerns are explained in more detail in **Attachment 1** to this letter. In writing this letter we also recognise that some of the concerns raised are shared by members of the general disability community.

As a whole of jurisdiction trial site, the ACT has early experience of the impacts of the NDIS framework on PSD services. Through our involvement with Community Mental Health Australia – the alliance of State and Territory community mental health peak bodies – we know that our concerns are shared more broadly across Australia. The report from the Barwon trial site in Victoria (*Learn and Build in Barwon*, June 2015, Psychiatric Disability Services of Victoria) raises issues that are typically being experienced by other trial sites.

Ramifications from these issues are starting to be reported in the media. Most recently, there was extensive coverage of the imminent closure of 'Pathways', a respected service provider in Geelong. This service supports 366 people with mental illness and employs 144 staff. See, for example, *Federal Election 2016: suicide warning over late NDIS 'bungling'*, (The Australian, May 17 2016.)

Our members have experienced many examples of the changes taking place in service provision that reduce confidence that the NDIS will deliver effectively for people with PSD. One ACT organisation has had to completely restructure to remain viable under the NDIS. In doing so, they stopped offering a respected and effective independent living program in favour of a supported residential program. Participants displaced as a result of this

restructure have been transitioned to other organisations' services, but this has left receiving organisations without capacity to meet growing demand. In turn, the receiving organisations are now left with the uncertainty of whether it remains viable for them to deliver these services in the medium to longer term. We are also getting reports of a lack of NDIS registered psychologists in the ACT.

Organisations tell us that staff roles have been restructured to lower Award classifications because this is required to ensure an organisation can cover all employer obligations within the NDIS financial framework. However, they are unable to attract suitable applicants at these lower rates of pay. Experienced, qualified and dedicated staff are leaving for other job offers in light of lower pay, poor career progression prospects and job insecurity.

Even as we finalise this letter more significant changes have been announced without adequate lead time, training or detailed information – the introduction of “My First Plan”, a new provider portal and user registration process, new service booking processes, and the closure of the existing participant and provider portals.

Our members (and other organisations) are consistently telling us that organisational sustainability under the NDIS is only possible if an organisation has the ability to cross subsidise from other activities or funding. It is not reasonable or sustainable that the NDIS financial framework place organisations in this position.

The issues we raise cross both Commonwealth and State/Territory government jurisdictions, making it imperative for all levels of government to communicate effectively and work cooperatively to ensure the viability of the scheme. As a peak body we have been raising these and other concerns with the National Disability Insurance Agency (NDIA) and ACT Government on behalf of our members since the beginning of the trial in the ACT. While all parties have been collaborating and working hard to implement the NDIS, the concerns highlighted in this letter remain unresolved despite best efforts.

When it was introduced, the Government promised that ‘no one will be worse off’ under the NDIS. It also stated that the NDIS would facilitate a better life for people with disability, and give them more choice and control in the services they receive and the way they live. In our experience, the NDIS works well for only some of the people who are eligible, and there is a risk that many others will ‘fall through the gaps’.

The majority of the issues highlighted in this letter emanate from shortcomings in the NDIS financial model and support catalogue, which in turn reflects the general lack of understanding of PSD and how to provide reasonable and necessary support for people with PSD.

Without adequate support, people with PSD become unwell and the cost to society is much greater in terms of withdrawal from economic activity; increased demand on informal supports, including family members ceasing work to take on caring roles; and increased demand for the more costly parts of the health system (including forensic mental health).

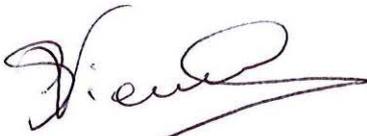
This letter is not motivated by a reluctance to change, improve or by the possibility of for-profit service providers entering the sector. Rather it is driven by concern about the needs of people with PSD and what we see as poorly managed risks to their recovery, wellbeing and social and economic inclusion.

The misalignment of NDIS prices with the actual costs of quality community managed mental health services is substantial, and places people with mental illness and PSD at risk. While we agree that there is always room for improvement, ‘community managed services provide

a critical gateway for people affected by mental illness to live valued lives in the community'. Further, '... [there is] also a strong and growing evidence base [in support of this] in addition to people's lived experience of recovery' (*Taking our place – Community Mental Health in Australia* pp.12-14, 2012).

Unless action is taken to resolve the concerns outlined above, what our members and other jurisdictions are experiencing leaves us very concerned that the NDIS will fail to deliver on its economic and social objectives. Without redress, the NDIS will not be able to facilitate longer term savings resulting from people with mental illness and PSD being socially and economically engaged, being supported to manage their episodic increase and decrease in needs, and being kept out of hospital.

Yours faithfully,



Simon Viereck
Executive Officer
Mental Health Community Coalition ACT (MHCC ACT)

27 June 2016

This letter is endorsed by the following organisations:

ACT Council of Social Services	Northside Community Service
ACT Mental Health Consumer Network	Richmond Fellowship
Belconnen Community Services	Schizophrenia Fellowship of NSW Inc (ACT)
Carers ACT	St Vincent de Paul Society - Canberra/Goulburn
Mental Health Australia (MHA)	Woden Community Service
Mental Health Foundation ACT	Women's Centre for Health Matters
MI Fellowship	Youth Coalition of the ACT

Attachment 1

We are recommending urgent changes to the NDIS in order to safeguard the lives of people living with mental illness and PSD – some of Australia’s most vulnerable people.

Change needs to be enacted in the following six key areas as a priority:

1. The NDIS should be underpinned by a funding and pricing model that recognises and supports provision of reasonable and necessary support services to eligible people, including services tailored to the specific needs of people with PSD at all levels of complexity
 - a. The NDIS model effectively halves the hourly rate paid for a range of typical PSD supports as compared to the previous system, and is leading to PSD services being withdrawn or closed and a downgrading of workforce quality.
 - b. Only those people with severe and enduring mental illness who have the most complex needs - approximately 10-12% - are estimated to be eligible for IFPs. The 2011 Productivity Commission's Disability Care and Support report that helped cement the introduction of the NDIS, references existing and significant workforce shortages in community mental health. It notes the more specialist and highly qualified nature of this workforce compared to the disability workforce, and that this workforce is misunderstood and undervalued.
 - c. Our members have worked hard over decades to increase provision and quality of evidence-based recovery-focussed community based support following the deinstitutionalising in the 1980s and 1990s. It would be wrong if the NDIS took service provision and workforce quality backwards.
 - d. For organisations to offer a wide variety of quality sustainable services they need to be able to maintain back office functions; train, develop and supervise staff; develop innovative and specialist services; and be flexible enough to respond quickly to unpredictable deterioration in mental health status that leads to escalation of needs and crises.
 - e. A financial model with correlation between prices paid and actual costs of service delivery, will ensure a full range of services by reducing the incentive for organisations to 'cherry pick' only the better funded supports.

2. Identify and address barriers to access and appropriate support specific to PSD
 - a. The barrier imposed by the deficits-based language and entry requirements of the NDIS is real to many people and cannot be overstated. After years of focus on hope, recovery and a person's strengths, it is not simply a case of 'getting used to' the language.
 - b. The nature of mental illness in itself can be a barrier to entry and appropriate support – PSD is often an episodic 'invisible' disability that means needs are not evident to others, and people often lack the motivation and cognitive ability to access and generally engage with the scheme. The recent announcement of the My First Plan process is illustrative of this: many people with PSD do not have access to, cannot use, or refuse to use, a computer – even more so if the use or website is obviously connected with government.
 - c. Some people do not recognise they need support or that support is available to them. This has implications for themselves and the people who offer informal support (families, friends, carers).
 - d. Due to the episodic nature of PSD, people's decision making ability can vary. The implications from this in terms of initial engagement, planning, plan implementation

- and management, review, assessing progress and long term engagement are complex, and risk mitigation around all these needs to be tailored to PSD.
- e. People with PSD and complex needs require sophisticated psychosocial interventions as part of their daily supports. As noted above the NDIS pricing framework doesn't support a workforce with the capability to deliver such interventions.
 - f. Self-managed Individual Funding Packages (IFPs) are particularly challenging - both for the risk that a person may have capacity whilst making the plan and then become unwell and unable to manage the plan as well as was originally expected; and/or in that impaired capacity at the time of planning results in their right to choice and control being curtailed for the duration of the plan. This poses risks both to them and their carers.
3. The implementation processes for the NDIS are creating impediments to efficiency and service delivery
- a. Planning and funding is needed from governments for a transition period that will take several years. The NDIS is a radical change in the provision and purchasing of services, requiring enormous amounts of (largely unfunded) work both to engage and prepare people with PSD, and to implement restructured business models.
 - b. NDIS implementation is taking place in the midst of other significant mental health and wider health sector funding and service delivery reforms – thereby creating layers of uncertainty and change that need to be managed despite the lack of clarity and alignment in timeframes.
 - c. Backlogs in NDIA processes and systems are already leading to cases where State/Territory funding is cut to an organisation before NDIS funding is available. As a result some organisations are carrying tens of thousands of dollars of liabilities for support provided, which are not always fully refunded.
 - d. Organisations are being told to reorient everything they do to a market mindset, yet the administration of the scheme does not facilitate an effective market: prices are fixed, supports are strictly defined, administrative burdens are being increased, information gaps abound, changes are constantly being made, and communication around all the above is often not available in a uniform or timely manner.
 - e. A good example of the previous point is the recent announcement to the sector that not only are the NDIS Portals being closed for the last two weeks of June, but the new portals being opened from 1 July will require organisations and participants to undertake a new registration process and training in the new system.
 - f. Full Scheme implementation needs to be based on an evaluation of the experiences in trial sites, with the scheme adjusted accordingly. Publication of evaluation results and learnings would provide a useful resource for all involved.
 - g. Consultation timeframes on aspects of the scheme development are often inadequate for deep engagement; and subsequent decisions reflect little change in response to input. There are many examples of this, but the processes around the Information, Linkages and Capacity Building (ILC) framework and the recent pricing review stand out. In the case of the new "My First Plan" process we are not aware of any consultation.
 - h. Uncertainty remains around funding, capacity and other operational matters more broadly. Indeed, the Community Council for Australia (CCA) recently wrote to political candidates across the country asking eight questions on how they plan to support the Not for Profit sector, two of which are to do with ending funding uncertainty.

4. **Investment and certainty in programs for people not eligible for NDIS IFPs but still requiring support services**
 - a. There is an urgent need for clarity for the approximately 90 per cent of people with severe and enduring mental illness who will not be eligible for IFPs. Full Scheme implementation starts on 1 July 2016 which means that cessation of NDIS 'in-scope' program funding is imminent, but not everyone currently supported through these programs is being found eligible for IFPs – continuity of support arrangements for these participants remains unclear, at least in part.
 - b. Scores of people in the ACT require PSD support services on a non-permanent basis each year. There is no clarity about how this support will be provided in the future.
 - c. Investment in the Information, Linkages and Capacity Building (ILC) component of the NDIS needs to go well beyond the meagre amount allocated nationally if it is to fulfil its stated aim of providing baseline support infrastructure that keeps to a minimum the number of people needing IFPs.
 - d. We still don't actually know what supports the ILC will deliver for people with PSD. In the ACT the only mental health service identified as an ILC service is the Volunteering ACT *Connections Volunteers* 'buddy' program.
 - e. Without clarity and certainty over funding it is difficult for organisations to provide services and increases the risk of people 'falling through the gaps'.

5. **Ensuring carers of people with PSD are no worse off**
 - Carers are directly impacted by whether the person they care for will be eligible for the NDIS and/or choose to engage with the Scheme.
 - The needs of carers, including young carers, and how they will be impacted by the NDIS rollout have not been adequately examined. Carer needs have to be better addressed in NDIS plans to ensure that carers are able to keep caring for their loved ones and be socially and economically engaged in the community.
 - Planners must examine the consumers' needs in relation to what is being defunded from carer support services but consumers are inadvertently not planning for – e.g. domestic assistance and support workers who can step in when carers are unwell, working etc.
 - Funding for respite and some carer support services are considered in-scope for NDIS, yet access to respite and carer focussed supports is seriously curtailed in NDIS plans.

6. **Safety and risk management policies need to be implemented**
 - a. Quality and safeguards standards need to be clarified and implemented – indeed these should have been in place when trials began.
 - b. The lack of a quality and safeguards framework poses serious risks to participants as well as to workers who are entering participants' homes with very limited information about them or any risk factors.
 - c. The recent changes to the NDIS Portal for consumers is a case in point. Many people with psychosocial disability will need support to engage with MyPortal. There is no funding or capacity for community service providers to help them with this. If somehow support coordinators are to help people with accessing MyPortal, they may be asking participants for their MyGov login details in direct contravention of the MyGov Terms of Use (see Version 2016/3.1 – section 2.1). This is obviously an unacceptable position and level of risk to impose on service providers.
 - d. The NDIS financial framework makes meeting existing standards and industrial relations requirements very difficult to impossible.