Submission to the Joint Standing Committee on the National Disability Insurance Scheme

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

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Preface

The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of the community managed mental health sector in Tasmania, providing a public voice for people affected by mental illness and the organisations in the community sector that work with them. MHCT advocates for effective public policy on mental health for the benefit of the Tasmanian community as a whole and has a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania.

MHCT welcomes the opportunity to respond to the Joint Standing Committee on the National Disability Insurance Scheme on the provision of services under the Scheme for people with psychosocial disabilities related to a mental health condition. We acknowledge the efforts of the National Disability Insurance Agency (NDIA) to continue to improve and refine the roll-out of National Disability Insurance Scheme (NDIS) packages for people with psychosocial disability. We recognise the benefits that the NDIS has the potential to bring to the lives of people living with psychosocial disability. However, it is vital that the recovery focus of community managed mental health services – providers of psychosocial supports - is not diluted or lost in this new system. MHCT is also concerned that the lack of information and clear communication about gaps and how they will be addressed could create a situation where some people receive a high level of support and others may receive very little support at all. The psychosocial needs of people living with a mental illness, regardless of whether they are eligible for an NDIS package or not, must be provided for. Another area of concern is the uncertainty of ongoing support for carers and families and lack of a clear future direction for carer services.

MHCT would like to acknowledge the analysis undertaken by our national body, Community Mental Health Australia (CMHA) and also the work of Mental Health Australia (MHA) in this area. In the interests of 'not reinventing the wheel', we have referred within this submission to the work done by both organisations in the areas of policy and governance.

Our response is based on consultation with MHCT members who are service providers delivering Commonwealth funded mental health programs which are transitioning to the NDIS. The feedback we received from these organisations provides a clear picture of the operational implications of the transition to the NDIS for the Tasmanian community managed mental health sector which has been providing evidence based psychosocial supports to mental health consumers and carer supports over many years. We have also spoken to our Consumer and Carer peak bodies to ensure that their perspectives are reflected in this submission.

One area of urgent concern to our members is that many organisations have lost funding through the transition phase, which has a variable impact on the services and the supports they can offer. These particular member organisations have stressed that, transition arrangements in terms of how to meet gaps and ensure no disadvantage have not been clearly articulated and that the decrease in funding is already having a detrimental effect. For example, we have heard of services that cannot continue to provide supports for a number of their clients and have had to exit them or try to find programs for them which are not necessarily mental health specific. Staffing levels for some services have been reduced, resulting in concerns about their future viability. Service providers are unsure of what the immediate and long term impact the NDIS transition will have on their services and, therefore, are unable to give their clients, carers and families the reassurance

and confidence that their support needs will be met. This does little to provide consumers the assurance that they deserve and need.

Section One

a) The eligibility criteria for the NDIS for people with a psychosocial disability.

MHCT members and providers of community managed psychosocial supports have observed that, from the outset, there has been no articulation of the difference of eligibility for Commonwealth funded programs and NDIS packages (IFP). At this stage, clear benchmarks have not been established for NDIS eligibility of people with psychosocial disability. These could provide a clear understanding of the difference and provide more psychosocial-specific guidance to assessors.

Lack of clear benchmarks could impact on eligibility rates. The Independent Advisory Council (IAC) of the NDIA has noted that, "Ineligibility rates for applicants with a mental illness are significantly higher than those resulting from applications from people with physical, intellectual and sensory disabilities. The reasons for this are unclear and need further investigation."[1] We believe that the lack of knowledge and understanding of psychosocial disability, enshrined in clear benchmarks, must be a contributing factor to this discrepancy.

Our recent discussions with Tasmanian providers of Commonwealth funded programs has resulted in general agreement that around 30% of all Commonwealth program participants will be ineligible for the NDIS. In the case of eligibility of Personal Helpers and Mentors services (PHaMs) clients, our members tell us that government has levelled the criticism that PHaMs was always meant for the same cohort as the NDIS but providers have allowed the "worried well" to access it. However, a comparison of the eligibility criteria shows that the PHaMs cohort could never transition wholesale into the NDIS. The Government's guarantee around continuity of support for non-eligible clients is evidence that they knew this. Some program providers have already narrowed their intake criteria to reflect NDIS eligibility criteria, in anticipation of the transition to NDIS, e.g. PHaMs providers asking for a diagnosis as part of their program intake.

Eligibility and planning processes

There is clearly an issue with differences in access eligibility across the country in the area of psychosocial disability. Members of MHCT have described to us the lack of a standardised approach and the inconsistency in the eligibility and planning processes. The tool used for assessment is not geared for psychosocial disability and the planning tool does not include line items specific to psychosocial supports.

Because of this lack of a standard approach, catering specifically for psychosocial disability, the planning process seems to be conducted on a case by case basis. This has led to some less than optimal outcomes, for example we have heard anecdotally that those people who can better put their case are often receiving large packages even where they do not need such a high level of support, while others, who clearly need more

[1] Independent Advisory Council (IAC) (2015), IAC advice on implementing the NDIS for people with mental health issue, https://www.ndis.gov.au/about-us/governance/IAC/iac-advice-mental-health

support, are receiving minimal packages because they cannot articulate their needs or provide a convincing argument.

In general, this speaks to the need for the development and adoption of criteria to make the NDIS process to determine eligibility more appropriate to mental health clients. This should include specific assessors who are skilled and knowledgeable about mental health and the particular issues and needs of people with mental illness. Knowledge and understanding of the role of carers and families is also critical for this cohort. There is significant evidence demonstrating that "family - and other interpersonal relationships help to shape a person's identity and have a significant impact on a consumer's mental health and wellbeing, as well as on outcome and recovery,"[2] and it is important that the NDIS acknowledges and is inclusive of these relationships.

It has been stated by many in the sector, and MHCT would like to again emphasise, that the underlying issue for people with mental illness is that the original design of the NDIS did not include psychosocial disability and that its inclusion has been a process of trying to retrofit it into the existing model. This has arisen out of a failure to understand and recognise the very different concept of psychosocial rehabilitation and the complexities and issues particular to mental health.

Recommendations:
Investigate and adopt a consistent and standardised approach in the eligibility and planning processes including ensuring that the tool used for assessment is specifically geared for psychosocial disability.

Section Two:

b) The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular;

c) Whether these services will continue to be provided for people deemed ineligible for the NDIS.

d) The transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;

e) Whether these services will continue to be provided for people deemed ineligible for the NDIS.

MHCT has heard from members of their concern that the re-direction of existing mental health funding into the NDIS will possibly negatively affect services supporting consumers and families and carers of a person living with a mental health issue in Tasmania. This relates in particular to the number of Commonwealth funded mental health programs which will be progressively rolled over into the NDIS. These programs include Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMS), and the Day-to-Day Living Program (D2DL). It has been assumed that most people currently participating in these programs will transition to the NDIS, especially PIR and D2DL clients who are assumed to have high levels of psychosocial disability and complex needs.

[2] MHPOD, Working with families to aid recovery, http://www.mhpod.gov.au/assets/sample_topics/combined/Social_relationshipsworking_with_families/objective1/overview.html

Gaps

Our members inform us that gaps in service provision are starting to emerge and they predict that a significant group of people currently accessing these programs are at risk of losing support altogether. Already, in the early stages indications from the trial sites showed with regards to PIR clients transitioning to NDIS that only 50 of their 229 trial site clients received NDIS Tier 3.[3] Based on current estimates, many of the people receiving assistance from the funding will be ineligible for the NDIS and will not be able to access the same quality and level of support through the PHNs which thus far have been directed by the Federal Government not to commission psychosocial services.

At this stage, there is no publically available data regarding outcomes of the 'phasing in' to the NDIS of people receiving PHaMS, D2DL or other Commonwealth mental health program services. Providers of PHaMS services in the Hunter trial site reported that in their experience only 20 to 30% of existing clients may be eligible for Tier 3 NDIA funded services and supports. In Tasmania community managed providers of these programs have estimated that:

- PIR: 30% of current participants in the program will not be eligible for NDIS individual support packages.
- D2DL: 30% of existing clients will not be eligible for a Tier 3 NDIA funded services and supports.
- PHaMS: 30% - 70% of current participants in the program will not be eligible for NDIS individual support packages. This variance is explained by the low thresholds for people accessing the program and the resulting mix from mild to moderate to severe participants.

The following table captures the key eligibility criteria across the Commonwealth funded mental health programs in scope for the NDIS, demonstrating where they align with the NDIS and where there is clear divergence. It is evident from this snapshot, that these program participants were never going to transition wholesale into the NDIS.

[3] Mental Health Coordinating Council (2015), Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis, Sydney, MHCC, p. 38. http://www.mhcc.org.au/media/67408/mhcc-hunter-trial-site-2yr-report-aug2015.pdf

Commonwealth funded mental health programs transitioning to the NDIS

PROGRAM SCOPE/ ELIGIBILITY	SEVERITY OF CONDITION	DIAGNOSIS REQUIRED	PERMANENCE REQUIRED	RECOVERY APPROACH	ENGAGES HOMELESS/ TRANSIENT	AGE COHORT
Personal Helpers and Mentors (PHaMs), DSS	Severe	×	×	✓	✓	16+
Mental Health Respite: Carer Support (MHR:CS), DSS	Unspecified, however carer must have "poor physical or mental health"	×	×	✓	×	Unspecified
Partners in Recovery (PIR), DOH	Severe and persistent	×	×	✓	✓	Unspecified
Day to Day Living (D2DL), DOH	Severe and persistent	×	×	✓	✓	16+
National Disability Insurance Scheme (NDIS), NDIA	Considers functional impairment not severity	✓	✓	"Recovery for people with psychosocial disability is consistent with the principles of the NDIS"	×	Currently: 12-28 At full scheme: 0-65

In their submission Community Mental Health Australia (CMHA) has made the argument that the participants in these programs have been supported by Federal funding for over a decade and once that funding ceases there will be, based on all projections, many people currently participating who will be found ineligible for Individual NDIS packages and therefore without services at all. CMHA notes, "If this gap isn't addressed, the impact will be felt by state and territory mental health systems, and potentially the welfare system. This obviously creates significant gaps, which states, territories and the federal government must take responsibility for and work together in genuine collaboration to ensure these people continue to receive services."[4] This does not take into account those people who in the future will not be eligible for NDIS but will still need a higher level of mental health support than will be provided through the primary health networks.

The NDIA's IAC has reinforced this concern, reporting that, "there is a concern that state and territory commitment of ongoing funding for people with episodic mental health issues will not be adequate.

[4] CMHA (2017), Submission to the Joint Standing Committee on the National Disability Insurance Scheme on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

Compounding this, the loss of the PHaMs, D2DL and PIR programs will exacerbate this funding create gaps and lead to service shortfall."[5]

For carers and families supporting people with mental health issues, the gaps created by ineligibility for NDIS packages will result in a greater onus on informal supports, without the benefit of the respite services for which they were eligible before the funding for the Mental Health Respite: Carer Support programs rolls over into the NDIS. Furthermore, although it may be assumed that those carers whose loved ones receive NDIS packages will be relieved of much of their caring onus, this elides the reality that very few packages will provide 24/7 care and carers will continue to cover the shortfall in services and provide the emotional care that their loved ones require.

The concerns about future service shortfalls are very real. With regard to PHaMs and Mental Health Carers Respite (MHC/Respite) – funded by the Department of Social Services, although these were designed for people needing support on their short to medium term journey to greater independence, there are consumers and carers in these programs who will need the longer term and more intensive supports offered by a package in the NDIS.

Mental Health Australia has made the strong point that, "with the huge unmet need for these programs, demonstrated by nation-wide waiting lists and low but steadily increasing referral rates from primary health and clinical services, they should be retained at least at the current level of access. Current funding for these programs is in the order of $200 million, which should continue, to ensure no loss of access. The source of these funds should be from outside the NDIS, to ensure adequate resources are available within the NDIS for people who need the more intensive, ongoing supports offered by an IFP."[6] The PHaMS programs is one that can assist people with mental health problems in maintaining their mental health at a level where they would not need to transition to NDIS supports. For this reason, it is a significant contributor to early intervention and prevention and should remain available outside of the NDIS.

Our colleagues at CMHA have referred to the September 2016 Intermediate Report of the Evaluation of the NDIS by the National Institute of Labour Studies, Flinders University which concluded that an unintended consequence of NDIS funding for individualised support services and not group-based services was a negative impact on social participation.[7] CMHA believes, and MHCT concurs, that "this is an issue which must be taken into consideration for people with a psychosocial disability where social participation and engagement can be an important part of a person's rehabilitation and recovery."[8]

[5] Independent Advisory Council (IAC) (2015), op.cit.
[6] Mental Health Australia, Key actions to ensure continued access to community support for people affected by severe mental illness during NDIS transition and beyond, https://mhaustralia.org/sites/default/files/docs/draft_position_paper_on_community_support_during_ndis_transition_and_beyond.pdf
[7] Mavromaras, K., Moskos, M. and Mahuteau, S. (2016) Evaluation of the NDIS, Intermediate Report, September 2016. Adelaide: National Institute of Labour Studies, Flinders University.
[8] CMHA (2017), op. cit.

Continuity of service and 'no disadvantage'

Both levels of government have made a commitment to the 'principle of no disadvantage' through the bilateral agreement between the Commonwealth and Tasmanian Governments. This commitment is to make sure that 'no one will be worse off' under the scheme. As outlined by the NDIA, where NDIS does not fund a support previously received by a participant, or if a prospective participant is not eligible for the NDIS, the Agency will identify alternative supports or refer the participant to other systems to ensure each person will achieve the 'same outcomes as a participant under the NDIS'.

However, our members inform us that people are already falling through the cracks as exiting services transition to the NDIS. Many services at both federal and state levels are being restricted to existing clients and closing down in stages during the transitioning period. Funding is decreasing annually until the full roll-out of the NDIS in 2019 even though demand is still high with many people ineligible for NDIS packages. Government guidelines direct services to concentrate their efforts on transitioning clients which further restricts the diminishing resources needed to provide services. Because in many cases the NDIS is now the only place to go for support, our members tell us that they put an enormous amount of effort into helping their clients access NDIS Individual Funding Plans (IFP). A consistent theme is that for those found ineligible for the NDIS, a loss of support programs will mean that their illness will worsen with time.

All indications are that existing community mental health services will need to continue for people who will be ineligible for an IFP. This was also recognised by the Productivity Commission which noted that the NDIS "will always be just one part of a broader suite of services that are potentially relevant to people with a disability.[9]" It is unclear, however, how jurisdictions will interpret their "no disadvantage" commitment and what mental health and specialist disability services they will continue to provide.

Recommendations:

- All governments should reiterate their commitment to maintaining or increasing levels of service for both current and future consumers of mental health services, and provide transparency to service providers and consumers on how this will work.
- Align funding to the continuing transition process for D2DL and PHaMS programs with individual funding transition arrangements developed that ensure program funding can be accessed right up to full scheme.
- Continued support must be guaranteed for the cohort currently accessing the PIR, D2DLand PHaMS programs who are deemed ineligible for NDIS.
- The Carers Respite (MHC/Respite) funded by the Department of Social Services should be retained at least at the current level of access and ongoing supports for carers need to be investigated and put in place.

[9] Productivity Commission (2011), Inquiry Report: Disability Care and Support, Volume 1, p. 163, http://www.pc.gov.au/inquiries/completed/disability-support/report/disability-support-volume1.pdf

Section Three:

f) The scope and level of funding for mental health services under the Information, Linkages and Capacity building framework.

It was assumed by our sector that the Information, Linkages and Capacity (ILC) tier of supports would pick up the ineligible cohort but this hasn't been borne out in ILC design. At this stage, $132m has been allocated to the ILC with the greater part (over $550 million) of the original ILC funding allocated to Local Area Coordinators (LAC). The ILC budget is now to be split between the recently announced Jurisdictional and National Readiness grants programs. Basically, this means organisations will be able to apply for non-recurrent, non-core, non-advocacy funding to develop projects that fit within the ILC scope. Organisations will need to demonstrate that they do not replicate LAC work; that their work is scalable and able to quickly achieve community development outcomes with short term funding.

At this stage, however, organisations remain confused about how the ILC program will operate. The adequacy of funding, and the scope of services spelt out in the ILC Framework is entirely dependent on what community mental health services each jurisdiction will continue to provide, which services are rolled into Tier 3, and the number of people with a psychosocial disability who will receive an IFP in Tier 3. These issues are still very unclear and the community managed mental health sector is keenly awaiting clarification.

Mental Health Australia has referred to the difficulty of assessing whether the ILC system or the Framework will be adequate to meet population needs, "in the absence of additional information about future funding levels, likely participant numbers for ILC and which existing community mental health programs will continue outside the NDIS."[10]

Section Four:

g) The planning process for people with a psychosocial disability, and the role of primary health networks in that process.

MHCT members have informed us of the need for more flexibility around the planning process and telephone interviews. There is also abundant evidence that thus far the assessment and planning processes for people with mental illness needs more work. Issues members raised with us include:

- Plans are restricted by lack of mental health specific line items. Line items for psychosocial supports do not currently exist.
- There is no standard level of support in the planning process due to lack of specific psychosocial knowledge, understanding and supports so that each applicant must argue their case which can lead to unfair and inequitable outcomes.
- Assessors and planners are not matched to clients, instead clients are required to fit into a disability framework and often diagnosis is used as a proxy for entitlement.

[10] MHA (2015), op.cit, p. 7.

- The planning stage does not take into account the complexity of each applicant and service providers cannot deduce from the completed forms what the level of complexity may be.
- Planning that leads to a true understanding of need requires time, but the NDIS focuses on providing needs for day to day living at a basic level. Thus far multiple plan revisions have been required "as participants did not appreciate the need to include all existing supports or because planners with inadequate understanding of mental health prepared inadequate plans."[11]
- Plans do not adequately address rehabilitation and recovery needs. CMHA has noted that "a 2015 report by VICSERV on the NDIS Barwon trial concluded that the NDIS wasn't effectively delivering rehabilitation focused services, and the federal and the state/territory governments should provide funding for these and disability support services."[12]
- Many people with psychosocial disability have found the NDIS planning process highly stressful, especially those without a support person to be with them during the planning process. The telephone interview mode is particularly difficult for people with psychosocial disability who, on the whole, do better at face to face meetings.
- A completed plan can lead to disappointment when there are items included which cannot be implemented for a number of reasons, for example, services are not available in the region the participant lives in; what appear to be generous funding allocations translate into limited support hours or providers are unable to provide supports in a particular way.
- Providers are not funded by the NDIS to engage clients in conversation about the Scheme and preparation for a planning conversation with NDIS. It may be assumed by government that this is the work of the LACs, but in fact, many service providers are doing much of this work which is not being acknowledged or compensated. This kind of preliminary planning can take several sessions and will not generally be possible once the gradual withdrawal of existing funding is completed. The need for this support to assist a person to apply for the NDIS has emerged because of the lengthy bureaucratic process, invasive questioning, no support for the crucial annual planning meeting phase and clients' cynicism about the likelihood of a positive outcome (which makes many people reluctant to apply and many will simply refuse to do so). This is especially the case for those who experience paranoia, feel strongly excluded from society, have a trauma background or are from marginalised groups. These factors are likely to apply to many people who have a psychosocial disability severe enough to be eligible for the NDIS. Adequate resourcing and compensation would also recognise the existing trust based relationships between clients and workers which holds great value for people transitioning to NDIS packages.
- A further failure of the transition process is that the NDIS entry and planning processes take months. Assuming eligibility, this means a gap of three months or more without support for participants who have been exited from other programs.
- In terms of the role of PHNs there is of course the need for standardised approach by GPs and psychologists in their assessment of patients to support applications for NDIS packages. There is also a

[11] Simon Viereck, (2016), Transition to change: Lessons from the act NDIS trial, Power to Persuade website, http://www.powertopersuade.org.au/blog/transition-to-change-reflections-on-the-act-ndis-trial/12/7/2016
[12] CMHA (2017), op. cit

referral and awareness raising role to help patients understand about the NDIS and whether they should apply. However, there continues to be a problem in terms of support for those who are ineligible and still require psychosocial supports. PHNs have been directed not to commission programs which deliver these supports, even while it is clear that a significant gap will exist.

Recommendations:

- Review line items to encompass psychosocial supports into the line items list.
- Ensure that assessors and planners have sufficient mental health knowledge to provide best outcomes for people with psychosocial disability.
- Funding is made available for existing trusted supports (if available) to assist people in the NDIS planning process, and investigation made into how a tailored psychosocial assessment process could build in flexibility to allow for reducing barriers as identified.
- Acknowledge and support, through adequate resourcing, the work undertaken by community managed mental health service providers to prepare clients for transition, assessment and an approved package.

Section Five:

h) Whether spending on services for people with a psychosocial disability is in line with projections

It has been estimated that when fully implemented about 57,000 Australians with psychosocial disability will be eligible for the scheme and individually funded packages (13% of the total 430,000 NDIS population). According to our members, the NDIA used significantly outdated data (2007 ABS figures) to estimate the number of psychosocial disability packages required, meaning there was never going to be an adequate number of places.

Mental Health Australia has estimated that, in any 12-month period, approximately 170,000 people will need individual support services from outside the clinical system for a severe mental illness and/or associated psychosocial disability. "These services could come from an Individually Funded Package (IFP), ILC, or other Commonwealth, state or territory mental health and community mental health systems. The number of people who may need some sort of community mental health service who do not have an IFP is likely to be higher than those who do receive an IFP – particularly because of the high turnover in service access among the population of people with mental illness compared with physical disabilities."[13]

This highlights:

- The inadequacy of funding projections for the total number of people who will need psychosocial supports in the community whether eligible or ineligible for NDIS packages.
- The importance of ILC-funded services in the service offering for people with psychosocial disability and mental illness and the need for continued community based psychosocial support programs to be funded outside of the NDIS.

[13] MHA (2015), op.cit, p. 6.

Section Six:

i) Any related matter.

Regionality

- Consistent with other jurisdictions, the challenges of providing support to participants who reside outside of major Tasmanian population centres was highlighted by MHCT members.
- Providers delivering programs regionally named a variety of factors that must be considered including recruiting and retaining a skilled workforce, transport and travel, and the importance of partnerships and collaborations.

Issues related to the ongoing viability of the community managed mental health sector

- Our members are concerned that with the potential loss of 30% of their client base their viability may be compromised. For service providers who are juggling clients with packages and clients without packages there is also a moral and financial dilemma. To survive, providers need to take the NDIS clients attached to higher value packages but this means that other individuals are at risk of delayed or no access to supports.
- With regards to pricing – line item costings aren't viable for the mental health sector. Current pricing is based on the general disability sector at SCHADS level 2 which is effectively the lowest common denominator. One Tasmanian service provider has informed us that it is experiencing a loss of about 50% an hour on any given line item. In order to be viable, service providers feel that it will create a market where clients are 'cherry picked' based on higher priced line items. A new pricing catalogue is needed, based on the service costs as related to providing psychosocial rather than just disability supports.
- Members stressed that there is a high risk of seeing significant market failure across the sector. CMHA rightly points out that, "A range of highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation and their disappearance means that people will no longer have access to the services that help them to reduce the disabling impacts of their mental illness."[14] Consequently, the NDIS may potentially be faced with an exponentially growing level of disability while at the same time community-based rehabilitation services are experiencing loss of funding, loss of qualified mental health staff and the capacity to provide services commensurate with need. The potential loss of existing skilled and qualified staff and a de-skilling of the workforce means that that organisations are unable to offer services to people with NDIS Plans as well as those without.
- MHCT has heard concerns about the reliance of the NDIS market model and the ILC Commissioning Framework on competition and how this will impact smaller service providers. The sector has suggested that critical to the success of the NDIS is the availability and viability of a range of services and the success of the ILC system will depend on ILC-funded services, combined with services funded through other

[14] CMHA (2017), op. cit

systems, working together in facilitating an adequate provision of services for people who do not receive an IFP.

Recommendations:

- A new pricing catalogue is needed, based on the service costs as related to providing psychosocial rather than disability supports.
- Put in place benchmarks and industry regulations to sanction a uniform level of support worker qualification, thereby ensuring that supports are being provided by adequately trained and qualified staff.

This is not a recovery model

- Mental health sector advocates have long been concerned about the concept of 'severe and recurring' (which replaced 'permanent disability' but is only marginally better). This has presented a barrier for individuals seeking access to the Scheme and for workers supporting them. Many potential NDIS participants are objecting to the idea of signing up to having 'severe and recurring' disability.
- Young people in particular desire to build for themselves a contributing, satisfying life in spite of their diagnosis and the mental health sector has done all it can to encourage optimism and resilience. There is emerging evidence that young people do not wish to be part of a scheme that does not fit their notion of a recovery journey.
- Members have described to us how NDIS plans can undermine all the work done to help clients on their recovery journey. For example, one participant who was working with a community managed service provider to become independent enough to catch public transport to enable her to get to a TAFE class by bus. This person was given a package that included being driven to TAFE, thereby undermining the recovery focus of her previous supports. Another example is of a person taken to a supermarket for a weekly shop but not assisted in how to complete this task alone. These kinds of supports demonstrate complete misunderstanding of recovery although the NDIA does claim a recovery focus.

Carer supports

- There remains a lack of detail on how the NDIS will support the wellbeing of carers and sustain their valuable caring role, making it difficult to project the extent carers and families will rely on services that fall beyond the scope of the NDIS.
- Many of the persons cared for by mental health carers will be ineligible for the NDIS, and will continue to rely on supports outside the scope of the NDIS, supports and services under the health and mental health system, or non-government organisations that receive State and Commonwealth funding.
- Under initial NDIS bilateral arrangements, funding for the respite support for young carers and the Mental Health Respite: Carer Support programs (Department of Social Services programs) will also transition into the NDIS. As far as ILC goes, there is no indication of how respite services will be encompassed within that

program since they are not mentioned under the list of examples of individual capacity building services identified under Stream 4.

- With no clear understanding of how the NDIS roll-out will affect consumers and carers, especially in the transition phase of the Commonwealth funded programs (PIR, PHaMS, D2DL) there is a risk of increasing the financial and emotional burden on families and carers to the detriment of sustaining the caring role, and therefore, the wellbeing of the person they care for.

Recommendations:

- Supports for the families and carers of a person living with a mental health issue, both within and beyond the scope of the NDIS, must be adequately and appropriately funded, recognising the unique value of carers and families supporting people living with a psychosocial disability.
- Build the capacity of carers, through training and skills development, to continue to provide informal support, especially in regional areas.

Summary of Recommendations

- Investigate and adopt a consistent and standardised approach in the eligibility and planning processes including ensuring that the tool used for assessment is specifically geared for psychosocial disability.
- All governments should reiterate their commitment to maintaining or increasing levels of service for both current and future consumers of mental health services, and provide transparency to service providers and consumers on how this will work.
- Align funding to the continuing transition process for D2DL and PHaMS programs with individual funding transition arrangements developed that ensure program funding can be accessed right up to full scheme.
- Continued support must be guaranteed for the cohort currently accessing the Partners in Recovery and PHaMS programs who are deemed ineligible for NDIS.
- The Carers Respite (MHC/Respite) funded by the Department of Social Services should be retained at least at the current level of access and ongoing supports for carers need to investigated and put in place.
- Review line items to encompass psychosocial supports into the line items list.
- Ensure that assessors and planners have sufficient mental health knowledge to provide best outcomes for people with psychosocial disability.
- Funding is made available for existing trusted supports (if available) to assist people in the NDIS planning process, and investigation made into how a tailored psychosocial assessment process could build in flexibility to allow for reducing barriers as identified.
- Acknowledge and support, through adequate resourcing, the work undertaken by community managed mental health service providers to prepare clients for transition, assessment and an approved package.
- A new pricing catalogue is needed, based on the service costs as related to providing psychosocial rather than disability supports.
- Put in place benchmarks and industry regulations to sanction a uniform level of support worker qualification, thereby ensuring that supports are being provided by adequately trained and qualified staff.
- Supports for the families and carers of a person living with a mental health issue, both within and beyond the scope of the NDIS, must be adequately and appropriately funded, recognising the unique value of carers and families supporting people living with a psychosocial disability.
- Build the capacity of carers, through training and skills development, to continue to provide informal support, especially in regional areas.