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

Market Readiness for the National Disability Insurance Scheme

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Preface

The Mental Health Council of Tasmania (MHCT) is a member based peak body. We represent and promote the interests of community managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian.

MHCT welcomes the opportunity to respond to the Joint Standing Committee on the National Disability Insurance Scheme on the topic of Market Readiness for the National Disability Insurance Scheme. We note that our responses are informed by direct consultation with our members and relate specifically to Tasmania's community mental health sector rather than the state's disability sector generally.

We wish to emphasise that whilst our submission is based upon targeted member discussion with direct reference to the market readiness of the Scheme, many of the concerns and recommendations raised have been previously articulated through earlier inquiries and consultation mechanisms. The recommendations made by the Joint Standing Committee in their inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition remain vital and pressingly urgent[1]. Similarly, a number of the chief concerns articulated within this submission would be substantially mitigated if government decision-makers were to endorse and adopt the recommendations of the Productivity Commission in their 2017 review of NDIS costs[2].

Our overarching recommendation, therefore, is that previously identified solutions to improve the experience of NDIS participants with a mental health condition and to sustain the mental health service system as a whole, be supported and implemented without further delay.

Finally, we note that the submission is structured to reflect the terms of reference of this inquiry, but that given the impossibility of separating out certain themes and issues as they pertain to psychosocial disability, we have grouped some terms of reference together.

a. The transition to a market based system for service providers

The pressures of NDIS transition on mental health service providers are well documented, most recently by the joint University of Sydney and Community Mental Health Australia (CMHA) project, *Mind the Gap: The National Disability Insurance Scheme and psychosocial disability*[3].

Amongst discussion of issues generally, the *Mind the Gap* report articulates a range of nationally relevant provider concerns associated with the shift to a market based system, including: the unfunded overhead costs of transition; the discrepancy between NDIS pricing and the Award rate of pay for qualified mental health workers; high staff turnover as a result of an increasingly casualised and unstable workforce; the perceived cultural clash between person-centred care and a business model of service delivery; and inconsistent, unsatisfactory interfaces and channels of communication with the National Disability Insurance Agency (NDIA).

MHCT members have reinforced the critical nature of these issues in the Tasmanian context, with an overwhelming emphasis on the whole-of-organisation consequences of shifting from government block funding to unit based, fee-for-service funding. What this means for organisations that wish to become registered NDIS providers is a fundamental remodelling of their financial systems including payroll, together

[1] *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.* Joint Standing Committee on the National Disability Insurance Scheme, 2017, p. xiii-xvi.
[2] *National Disability Insurance Scheme (NDIS) Costs: Productivity Commission Study Report*. Australian Government Productivity Commission, 2017, p. 51-67.
[3] *Mind the Gap: The National Disability Insurance Scheme and psychosocial disability – Final Report: Stakeholder identified gaps and solutions*. The University of Sydney and Community Mental Health Australia, 2018.

with a new approach to the pricing and marketing of services, often accompanied by a wholesale reconfiguring of organisational structures and staffing.

Our members emphasise that such changes mean a colossal cultural shift for organisations in addition to a comprehensive financial restructure, and that the scale of this transformation is not only a major hurdle for some but also a complete barrier for others. While the service provision landscape in Tasmania features organisations of all sizes we have an appreciably high number of small and micro providers, reflecting the state's characteristically regional, highly dispersed population. For these smaller providers particularly, finding the human and financial resources to comprehensively transform a business can be an impossible task.

We are beginning to see the impact of this on the future of Tasmania's already limited market, with some specialist mental health service providers reporting that they have elected not to offer NDIS services, others indicating they will reduce the number or type of services they offer, and still others considering merging with generalist disability providers. This leaves a question mark hanging over the survival and viability of many individual service providers but also over the market as a whole, as a reduction in individual organisational service capability inevitably means a reduction in overall sector capacity.

Our members also suggest that Tasmanian service providers generally are underprepared for full Scheme rollout, due to the age based, staggered introduction of the NDIS into the state and the resulting high volume of participants yet to transition to the Scheme. Currently the NDIS is available to eligible Tasmanians aged 4-34 years, with the 0-3 and 35-49 age cohorts due to transition from 1 July 2018 and the 50-64 age cohort joining the Scheme from 1 January 2019. In relation to the onset and diagnosis of severe and persistent mental health conditions, providers point out that the 35-49 age cohort is statistically significant and that for many organisations this group makes up a large portion of their clientele.

In terms of market readiness, what this means is that specialist mental health providers have had relatively few participants able to test their eligibility and join the Scheme, and as a result many report having only partially adapted their systems to NDIS processes. Such organisations remain in limbo between old systems and structures and new market imperatives, unsure quite if and how they will continue to operate when the flood gates open in July of this year.

b. Participant readiness to navigate new markets

The uneasy relationship between a consumer group versed in mental health recovery and a deficit-based insurance scheme built on the language of disability has been well established and doesn't need to be restated. In the context of this inquiry, however, it is worth noting that even the requirements of the NDIS access process undermine key aspects of recovery, and that as a result mental health consumers continue to report serious doubts about the ability of the NDIS to support their wellbeing, despite the passionate encouragement of service providers who are well aware there may be no support alternatives for those who do not transition to the Scheme as anticipated.

MHCT members note that a mistrust of systems and of medical professionals is a common feature of many mental health conditions, and that the NDIS requires participants to navigate both these things in order to access the Scheme. As a consequence of their illness and the way it impacts everyday relationships and functionality, mental health consumers often have a history of disengaging from therapeutic supports and programs, which is why some of the most effective psychosocial support programs of recent years have been built on the principle of 'low barrier to entry'[4].

[4] *Position Statement: National Disability Insurance Scheme and Psychosocial Disability*. Community Mental Health Australia, 2017, p. 6.

In addition to requiring a degree of trusting engagement with the medical system in order to secure a current clinical diagnosis – a process which may itself be traumatising – our members note that the range of documentation needed to complete a persuasive NDIS access request can be costly to the point of being prohibitive for mental health consumers, many of whom have low incomes.

This is well illustrated by an example provided to us by a member organisation recently. They describe supporting a young man with persistent mental health problems and a diagnosis of schizophrenia to test his eligibility for the NDIS. One of the key requirements was a letter from the consumer's treating psychiatrist to support his eligibility. However, the psychiatry practice in question advised the young man it would not be possible for his psychiatrist to write a letter as this was a time-consuming process for which the psychiatrist would not be paid. Staff with the service provider organisation attempted to explore an alternative avenue with the client, suggesting he see another psychiatrist to secure the supporting letter. However, the young man was reluctant do so as his psychiatry practice had advised him he would be unable to see his current psychiatrist again if he saw another clinician. The outcome for the young man in question is that he no longer wishes to test his eligibility for the NDIS as he has become fearful of forced change and losing what little psychosocial support he currently receives. As a humanitarian entrant to Australia this has only exacerbated past trauma experiences.

In addition to illustrating some of the specific NDIS access challenges for individuals with a mental health condition, the above example shows how particularly difficult access can be for certain population groups. It is not easy to neatly demonstrate or articulate the impacts of trauma even when it pervades and impairs every aspect of daily life and clinicians in Australia are often hesitant to provide permanent diagnoses. This is perhaps one reason why the original estimate for the percentage of NDIS participants who would come from a CALD background was 21.9% when, in practice, the percentage of CALD participants with an approved plan is only 4%[5].

Without wishing to labour points that have been made repeatedly in previous inquiry processes, our members note that other factors influencing participants' readiness to navigate new markets include: fear of losing access to current supports that are sustaining them, particularly when continuity of support arrangements are yet to be clarified by either the Commonwealth Government or the Tasmanian Government; inconsistency of NDIS access decisions and of planning processes, with some participants securing large individual packages and others with similar experiences and clinical histories deemed ineligible or securing small packages only; confusion about how and whether to involve carers and family members in the access and planning processes; social and geographical isolation, meaning participants are unable or unwilling to complete the process of testing their eligibility or to utilise a plan once approved; the experience of other participants with a mental illness whose plans have been slashed on review, reinforcing the perception that the episodic nature of many mental health conditions means participants will lose their funding if it isn't utilised.

[5] *The NDIS and Culturally and Linguistically Diverse Communities: Aiming high for equitable access in Queensland*. AMPARO Advocacy Inc., 2016, p. 4.

c. The development of the disability workforce to support the emerging market

d. The impact of pricing on the development of the market

MHCT members are deeply concerned about the impact of NDIS rollout on the Tasmanian mental health workforce. So far they have not observed a workforce that is adapting, diversifying and growing to meet a hungry market energised by client choice and control – in fact, quite the opposite.

Virtually all members who discussed this topic with us indicated that as the funding for current community-delivered psychosocial support programs dries up – namely, Partners in Recovery (PIR), Personal Helpers and Mentors Scheme (PHaMS), Day to Day Living (D2DL) and Mental Health Respite: Carer Support (MHR:CS) – there is an equivalent and increasing loss of staff. In fact, a number of our members say they expect most program staff to turn over completely and that they will require an entirely new workforce to come on board in order to deliver supports under the NDIS.

There are a number of reasons for this. The majority of Tasmanian mental health service providers employ staff with specialist mental health qualifications who are paid at SCHADS Award Level 4 or higher. NDIS supports are mostly priced for delivery by generalist disability support workers at a SCHADS Level 2. If an organisation intends to provide mental health supports under the NDIS, it must either find the additional funds to continue paying specialist staff at a higher rate than it is compensated for, or it must replace its existing workforce with less qualified support workers. This dilemma is why some of Tasmania's larger community service providers who have multiple service streams with which to buffer themselves, continue to provide mental health services despite making a 50% loss per episode of care. Understandably, these providers say this is not sustainable long term and they are considering their future in mental health service delivery as a result.

Other workforce impacts include the shift to casualisation, reflecting the fact that organisations can only afford to pay staff per unit of care that they deliver, and the loss of professional development opportunities, supervision, and career pathways within the sector. These are significant structural and cultural shifts for individual workers and organisations to grapple with, but they also present very real challenges for the mental health sector as whole. Without the introduction of targeted strategies to retain staff and sustain organisations through this period of transformative change, we risk losing much of the acquired skill and expertise within Tasmania's community mental health workforce.

To date, any pricing fixes made in an attempt to ameliorate workforce and market concerns have been insufficient, and MHCT joins the broader mental health and disability sectors across the country in calling for the NDIA to relinquish its control over NDIS price-setting in favour of independent price monitoring and regulation.

e. The role of the NDIA as a market steward

f. Market intervention options to address thin markets, including in remote Indigenous communities

Given the very real risk that the state's specialist mental health workforce will shrink rather than grow through NDIS transition, it seems clear that that the NDIA needs to do more to bolster and stimulate the market. Tasmanian communities are not remote in the way that many Northern Territory or Western Australian communities are, however the state as a whole is often designated 'regional' as a result of our low population

density and the fact that, of all the states and territories, Tasmania has the highest proportion of its population living outside a capital city (57% at June 2015)[6].

Our members point out that when Tasmanian services delivering mental health supports are operating at a loss, there is little incentive for providers to expand into new geographical regions of the state. The consequence of this, unfortunately, is that some individuals who have gained access to the NDIS on the basis of psychosocial disability have found that they are unable to utilise their funds because there are simply no suitable services in their local area, and neither they nor providers are funded to travel. It is not so much a question of exercising choice and control as a question of accessing any supports at all.

Other consequences of thin markets include the tendency for generalist disability providers to pick up mental health clients, despite having no specialist training or knowledge. Our members were at pains to emphasise the quality and safety risk that this presents, both to the participant and the worker. An example given was a disability worker employed to assist a client with a diagnosis of schizophrenia with showering, shopping and meal preparation, despite having no prior experience of psychosis or its preliminary signs.

MHCT believes a range of interventions are urgently required to counter the market's clear lack of confidence and failure to grow. Potential solutions include the development of a long-term mental health workforce strategy that includes mental health peer workers; the addition of appropriately-priced specialist mental health supports in the NDIS price guide; funding to allow organisations to offer professional development to staff outside of NDIS service delivery; and funding to assist clients to travel to services or services to reach clients in isolated areas.

g. The provision of housing options for people with disability, with particular reference to the impact of SDA supports on the disability housing market

i. Provider of last resort arrangements, including for crisis accommodation

Based on the stated imperative within Tasmania's Bilateral Agreement that 'continuity of support' arrangements be put in place, we know it was understood from the outset that a percentage of Tasmanians currently receiving disability supports would not be eligible for the NDIS, instead requiring alternative pathways to access ongoing necessary services[7].

Likewise, the NDIA and states and territories individually have foreshadowed the need for a 'provider of last resort' arrangement, to ensure participants can access supports in thin markets or in the case of market failure. Alarmingly, halfway through NDIS rollout in Tasmania, the state remains without a clear framework for the provision of either continuity of support or a provider of last resort. MHCT members report devastating instances of consumers falling through the gap as a result.

As an example, we have a PHaMS provider in Tasmania who in late 2016 exited over 90 clients from the program due to reduced program funding, with only a small percentage of these individuals finding alternative community-based supports despite the dedicated efforts of PHaMs staff to relocate them within other services.

In relation to safety nets and service boundaries, we hear consistently from members that housing and accommodation is another area of complexity for the mental health cohort. As we know, Specialist Disability Accommodation (SDA) is reserved for those with the highest support needs and, based on Productivity

[6] *Regional Population Growth Australia, 2014-2015 – Tasmania: State Summary*. Australian Bureau of Statistics [abs.gov.au], accessed 17/02/18.

[7] *Bilateral Agreement between the Commonwealth and Tasmania for the transition to an NDIS: Schedule D – Continuity of Support Arrangements in Tasmania*. Commonwealth of Australia, 2015.

Commission modelling, will be included in the NDIS plans of approximately 6% of participants[8]. Tasmania generally is enduring a crisis of low housing stock and there is already a well-documented lack of residential housing options for people with severe and complex mental illness.

A member organisation who provides homelessness supports to men describes the anguished cycle in which individuals find themselves when they do not have access to adequate psychosocial supports or stable accommodation, often self-medicating with drugs or alcohol and enduring repeat crisis presentations to hospital emergency departments.

Members say that when there are insufficient referral pathways available for acutely unwell individuals upon hospital discharge – and this includes the average three month wait between an NDIS access request being submitted and notification of an access decision – the inevitable alternative is heavy drug prescribing. With so much progress in the development of recovery-orientated mental health practices it is tragic to think that some individuals may languish under sedation because they cannot access appropriate therapeutic interventions and wholistic support to rebuild their lives.

h. The impact of the Quality and Safeguarding Framework on the development of the market

MHCT members made no particular comment on the above, beyond suggesting that in recognition of the many and varied administrative and financial burdens of NDIS transition on providers, the NDIA consider financially mitigating or incentivising costs associated with compliance to any new quality and safeguarding requirements.

j. Any other related matters

In conclusion, MHCT wishes to acknowledge the NDIA's commitment to improve and refine NDIS outcomes for individuals with a mental health condition. We trust that the current project of developing a dedicated psychosocial pathway will significantly ease Scheme access experiences for this cohort, and we urge the Agency and other government stakeholders to take further tangible action to support consumers, service providers and the broader mental health sector through NDIS transition.

In relation to market readiness, we make the below recommendations on behalf of our members.

Recommendations

1) **The Joint Standing Committee's recommendations in relation to the provision of services under the NDIS for people with psychosocial disabilities should be adopted as a matter of urgency, including and especially the recommendation that continuity of support arrangements be clarified for all individuals currently receiving mental health supports who are not eligible for the NDIS.**
2) **The NDIA should be relieved of its role as NDIS price regulator. Instead, this function should be delivered by an entity that is independent, transparent and able to respond promptly and flexibly to market conditions.**
3) **The NDIS pricing structure should be adjusted to address the well documented disconnect between unit prices and the Award rate of pay for qualified mental health workers. The inclusion of specific psychosocial line items is a potential solution.**
4) **The NDIA should publicly clarify provider of last resort arrangements in each state and territory.**

[8] *NDIS Specialist Disability Accommodation*. National Disability Services, 2017, p. 2.

5) **The NDIA should work with state and territory governments to assess the impact of NDIS transition on local workforces and to develop long-term workforce strategies for each jurisdiction. Strategies should include detail about specialist workforces, including mental health peer workers, and articulate career pathways within NDIS service delivery.**

6) **The NDIA should introduce a range of market interventions to ensure the sustainability of specialist disability sectors through transition, including financially mitigating the ever increasing administrative and compliance burden on providers.**

7) **Additional resources should be made available to organisations supporting hard to engage cohorts through NDIS pre-planning and transition, including individuals from a CALD background and those who are homeless. This may include funding for advocates and translators skilled in psychosocial disability.**

We would welcome the opportunity to provide further information on any aspect of this submission at the Committee's request.