Submission on NDIS Planning and Supported Independent Living

Thank you for the opportunity to make this submission. Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations. Through them CMHA has a direct link and provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation.

The organisations represented through CMHA are:

1. Mental Health Coalition of South Australia
2. Mental Health Community Coalition of the ACT
3. Mental Health Coordinating Council NSW
4. Mental Health Council of Tasmania
5. Northern Territory Mental Health Coalition
6. Mental Health Victoria
7. Queensland Alliance for Mental Health
8. Western Australian Association for Mental Health

Our submission consists of three parts:

A. Some General Introductory Comments about NDIS Planning
B. The combined response from two Community Managed Organisations (CMOs) that both are mental health service providers situated in the Northern Territory
C. An extract on from CMHA's draft report (soon to be released[1]) on the transition of people living with psychosocial disabilities to the NDIS from three previously funded Commonwealth Programs

A. <u>Some General Introductory Comments about NDIS Planning</u>

Developing high quality NDIS Plans is a challenging task. There are at least 3 major domains of consideration that require high level of skill to appreciate, master and reconcile.

- Firstly, there are the needs, expectations and understanding of the participants and their carers
- Secondly there are the requirements and practical constraints of the NDIS itself
- Thirdly there is the deep understanding and skill required to design "<u>a good plan</u>"

While much can and should be said about the first two considerations, in this introductory comment we briefly focus on this third consideration which we propose is **the one which most underappreciated**.

By way of analogy, in the world of building and construction the need for having a qualified architect that have had several years of training to develop their skills is understood and appreciated. An NDIS plan can have, and usually does have, a major impact upon a person's life (and often also that of their carers). For many people this is the major plan in their life and indeed for them functions as their Life Plan. **This is no small responsibility.**

[1] [1] It is expected that this Report will be released by the end of September

For in an NDIS plan incorporates (implicit or explicit) assumptions about what a person's future potential could be. The combinations and core supports and capacity building components chosen are shaped by what could be. **This is not a routine administrative activity.**

A good architect must have both a deep understanding of their customers' needs and dreams (if they have them). A good architect must also often imagine an exciting vision, and where a customer's hopes and expectations are low, "sell" that vision to their customer and get their buy-in.

It may be a challenge to achieve, but NDIS planners need to be Life Architects sensitive to their customers dreams and/or where necessary help create a dream and then with considerable skill, set out the components and sequence for the management of project of assisting a person to construct a fulfilled life of realised potential. Else is a building more important than a person.

The depth of this skillset and personal qualities needed to do this well is not well appreciated, nor thus resourced. **The process of NDIS planning will continue to be unsatisfactory until it is.**

B. Responses from Two NT Mental Health CMOs.

Supported Independent Living

CMO 1: "In Alice Springs there is no community housing, residential rehab or specialist mental health housing. There is an 8 year wait for public housing (and 5 years for people with high priority). There is no interest in SDA due to issues of scale; and the private rental completely unaffordable. SIL is the only way to house people but leads to a more institutionalised approach. SIL is provided here by agencies who are used to working with people with a life-long disability rather than encompassing a recovery approach with adults who with the right support have the potential for significant future independence."

"We need more diversified models suited to people with a psychosocial disability; congregate settings are often not the right model; people are being placed into settings where a casualised workforce that has high turnover and is inadequately trained and is unable to implement recovery focused approaches so people are becoming more institutionalised (e.g. staff packing a person's lunch rather than helping them to make their own lunch)." Many of these clients, who we knew well from the previously defunded programs, don't necessarily need 24 hours staffing, but a level of more concentrated and highly skilled support tailored to their needs and focused on developing their independence."

CMO 2: "In regard to Supported Independent Living in regional and rural NT we have an extremely "thin market" and there are many liabilities that are borne by providers that are not recognised or remunerated such as: providers make a loss if the SIL premises is not fully occupied by SIL participants; providers are liable for any damages to house asset / property which is not recoverable from SIL participants or their plan (e.g. the participant bond is not sufficient to cover damages); there is a mismatch in the timing of a start-up costs for SIL Housing for SIL NDIS payments; there is a significant unfunded administration burden if a participant changes housing; finding SIL Houses in the private rentals is very challenging as often neighbours object to the local councils because of anticipated disturbance; insurance costs become high if claims are made as premiums then increase; we are aware of instances where there is poor configuration of SIL premises (e.g. no separate facilities for participants bathroom, no office space, or escape routes); also there needs to be better compatibility assessments to ensure that participants will get along; in summary SIL costs can be often greater than SIL in participants packages so it is no wonder that few organisations wish to do it."

"What is needed is better understanding and estimating of the irregular support needs (1:1) of participant in the plan; adequate funding to induct and train a skilled workforce available to support participants under SIL and to undertake complex activities like resolving disputes between residents ; better rostering of staff to support individual requirements; adequate resources such as vehicles; improvements are needed in the planning process and in the timing of payments."

Planning

CMO 1: "There is no face to face training in the NT available to show staff how to support someone to complete an application. The only training is interstate and we cannot afford this given the turnover we experience. There are online resources however these do not always suit our people."

"Access to the NDIS and language the NDIA use is not conducive with the recovery model as it mandates that we demonstrate the person is permanently disabled with no likelihood of recovering (lifelong illness = insurance). This is often the exact opposite of what we have been trying to convince people for years that they are not permanently damaged and can get a life".

"Assessment and planning is not culturally appropriate with NO resources for ATSI other than 'simple English' which is still quite challenging."

"When access is not met, we very rarely receive the letter stating which clause in the act effected the decision that was made. Indeed, we are often the main contact for the client and we still do not receive this letter and often have to chase it up."

"While we are trying to assist clients to make their application to the NDIS, helping clients complete their applications for the NDIS uses up all the PHN funded support time that the participants would usually have (e.g. we might usually provide 4 hours psychosocial support per week face to face, but now can only do 2 hours because the staff member spends the other 2 hours helping completing administrative burden of chasing up NDIS, gathering support letters, etc..".

CMO 2: "Local planners have limited understanding of psychosocial disability and don't know how to structure a plan that meets the needs of the group, or sometimes how to interact effectively with the client to draw out meaningful and relevant goals."

"Plans are often inadequate and the protracted time it takes for review and leaves the client and the provider in limbo. When we get plans for the first time and draw the attention of NDIS to the flaws, they suggest we go to review which can take in the region of 6 months."

"Providers don't know whether to continue delivering services that may end up not being funded properly in the new plan – for example the protracted time it takes for review means that funded supports have all been used and so we don't know whether to suspend services or not."

"A broader concern is that with the loss of PIR we no longer have capacity for care coordination in the service system for people with complex needs, the crisis capacity within NDIS can't be activated quickly enough and there is no longer a clear sense of where the duty of care to a client sits. We can see that this is already impacting in our service system – there was strong reliance of on the PiR to activate the system in the past – and now it isn't anyone's job. Defunding PiR and PHaMs right when it was needed has set mental health services back 5 to 10 years. Sitting alongside this is a huge amount of confusion about the health interface and no leadership on this from NT Department of Health."

C. Extract from draft CMHA Report Commonwealth Mental Health Programs Transitions to NDIS

Community Mental Health Australia (CMHA) and the University of Sydney over an 11-month period have collected, analysed and reported[2] on data regarding the transition to the NDIS of clients from three Commonwealth funded programs for people living with serious mental illness. These three programs were the Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs) and Support for Day to Day Living (D2DL) in the Community and have now been discontinued as transition to the NDIS takes place[3].

Data were collected and reported in three iterative phases. In total 138 datasets were provided by 84 PIR, PHaMs or D2DL programs from 41 community-based mental health focused organisations spanning all states and territories. Data were captured for 3,138 individuals living with mental illness in phase one, 8,162 in phase two, and 6,005 in phase three. Only data from currently active clients were provided.

In summary, for people reported on who were still in transition and/or had submitted NDIS applications:

- In phases 1 and 2 a relatively consistent proportion of all active clients had submitted an application – around 50%. This dropped to 44% in Phase 3 (at 30 June 2019).
- The proportion of all active clients who applied for the NDIS and were assessed as eligible has reduced from around 30% in Phase 1 to under 15% in the Phase 3.
- Clients who had applied and were assessed as ineligible for the NDIS was relatively consistent across each phase, ranging from around 14% in phases 1 and 2 to 11.6% in Phase 3.
- There is an increasing proportion of people awaiting outcomes for applications submitted (17.7% of all active clients who had applied for the NDIS in Phase 3).
- At 30 June 2019, 22% of all Phase 3 active clients had not commenced OR did not intend to submit an application, while 26.7% were preparing to apply for a first or second time.

In relation to NDIS Plans, it is important to acknowledge the good work that the NDIA is doing to address many of the issues raised in this and previous reports. To quote one PiR provider.

> *"An enormous amount of work has been done in the NDIS space to increase the access of people with a psychosocial disability and we have appreciated these endeavours. We are also heartened that measures have been put in place to ensure that nobody loses out on support in our area with NPS extension and COS funding coming through. We have already noticed the huge difference an NDIS package can make in the life of a person with mental health struggles and this has made transition incredibly rewarding work for our staff"*

Despite these efforts the qualitative data is dominated by widespread concerns, such as inconsistent approaches to NDIA assessment and appeals, inconsistent NDIA staff understanding of psychosocial disability with no improvement in the proportion of plans perceived as inappropriate.

There is an important limitation to this data – that it is based upon the opinion of mental health staff rather than clients themselves. However, in the absence of data collected on client perspectives and the absence of government provided data on the proportions of people who have submitted requests for review of their plans, these findings provide valuable insights.

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[2] Phase 1and Phase 2 Reports: https://cmha.org.au/publications/

[3] Note: Two new Commonwealth programs intended to address the needs of people who are not eligible for the NDIS and who may 'fall through the gaps', the National Psychosocial Support (NPS) Measure and Continuity of Support (CoS) have commenced. This project is tracking the successful and unsuccessful NDIS transitions of previous program participants with a psychosocial disability. In addition, funding was provided late in the transition process to PHNs to support those clients who were previously in the Commonwealth Programs who are yet to test their eligibility.

In Phases 2 and 3 of the data collection for this report, programs provided data regarding their assessment of the appropriateness or otherwise of NDIS plans. In Phase 2 this provider assessment was given for 959 eligible people – (50% of the potential data set). In Phase 3 this assessment was provided for 256 eligible people (67% of the potential data set). The findings suggest that over time, rather than seeing an improvement in the proportion of appropriate plans, providers are reporting a greater proportion of plans they believed were inappropriate. Across both phases, around one third of plans were deemed inappropriate.

The proportion of plans deemed appropriate ranged dramatically across individual programs/services irrespective of program type (PIR, PHAMS or D2DL) with some deeming all plans to be inappropriate and others deeming all to be appropriate. This inconsistency of 'satisfaction' between programs is consistent across both phases.

Equally disparate was the proportion of people from services who were submitting requests for plan **reviews**. No requests for plan reviews were submitted by unsatisfied clients of some services, and all unsatisfied clients in other services had submitted a request for a plan review.

Table 11. Assessment of Perceived Appropriateness of plans – Comparison across Phases

	PHASE 1	**PHASE 2**	**PHASE 3**
Data available for each phase	Data not sought in this phase	42 programs/959 people	32 programs/256 people
Deemed Appropriate		695 (72.5%)	166 (64.8%)
Deemed Inappropriate		264 (27.5%)	90 (35.2%)

Figure 10. Assessment of Appropriateness of plans and review requests lodged

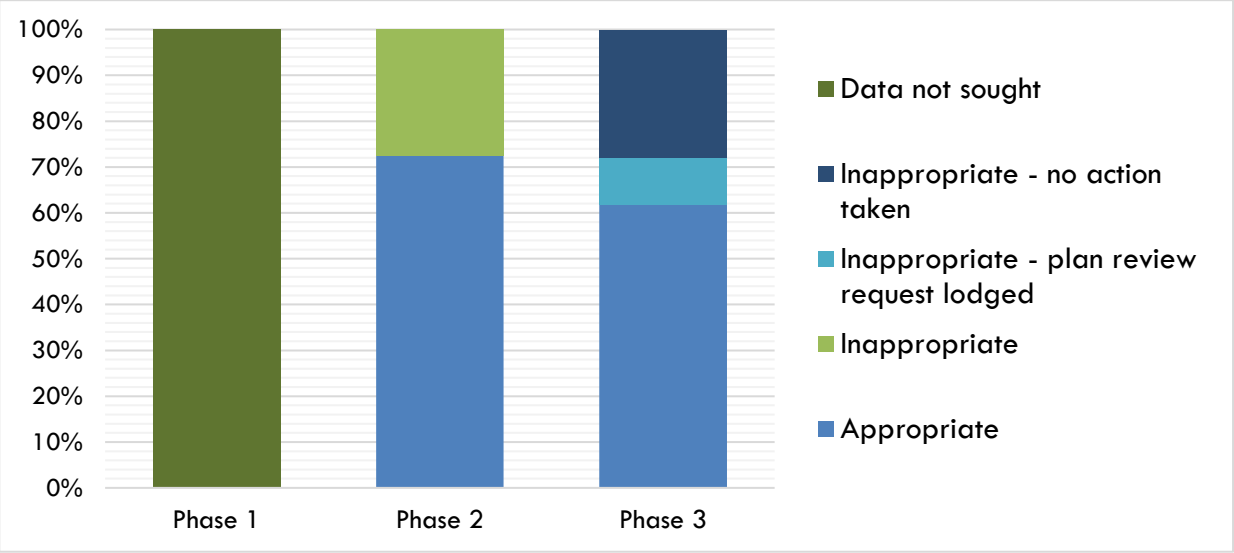

Table 13. Why plans were considered inappropriate (themes) – data from Phase 2

Themes	**Number ***	**Percentage**
Plan does not align with psychosocial support needs	24	96
Number of hours in the plan is inadequate	22	88
Lack of needed Support Coordination in the plan	7	28
Funding amount in the plan is inadequate	4	16
Persons support needs and goals have changed in interim	4	16
Admin errors - service booking to wrong org etc	3	12
Important supports omitted in the second plan	3	12
Support coordination was not outlined as in-kind	3	12
The ultimate plan does not align with planning meeting decisions	2	8
Transport related – limited or not appropriate type	2	8
Inappropriate process - phone call out of blue	1	4

Note. * A total of 25 programs responded to this question

Several Providers described issues with a lack of service providers needed to action people's NDIS plans. This lack of available providers to action plans has been referred to as 'thin' markets. While thin markets were highlighted as a particular issue within rural and remote regions and communities, providers in major cities also described the lack of services available to action people's NDIS plans.

Several providers also expressed concerns about seeing reductions in people's plans at review. They reported that these reductions were because of an assumed lack of need based upon under-utilisation in the previous year. They believed that this demonstrated a lack of understanding of psychosocial disability. Reasons for under-utilisation included periods of hospitalisation, periods of acute illness as well as inability to find/access services to action plans.

Thank you for the opportunity to make this submission.

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