Mental Health
Australia

mhaustralia.org

The implementation and operation of the psychiatric disability elements of the National Disability Insurance Scheme: A recommended set of approaches

TECHNICAL PAPER PREPARED BY DAVID MCGRATH CONSULTING ON BEHALF OF MENTAL HEALTH AUSTRALIA

Caveat

This paper draws on both public and unpublished data to support its assumptions. Of particular importance, it draws on the modelling work undertaken in the development of the National Mental Health Service Planning Framework (NMHSPF), a piece of work undertaken by the NSW and Queensland Governments on behalf of Health Ministers, and as yet unendorsed for distribution. The modelling work has been provided to Mental Health Australia as part of its involvement in the modelling group, and in recognition of their contribution to the work.

This paper has been prepared as a technical paper for use by Mental Health Australia and by government planners and has not been drafted for the purposes of public release. Policy options and recommendations put forward are not necessarily endorsed by Mental Health Australia.

Contents

---

1. Foreword by Mental Health Australia

The National Disability Insurance Scheme (NDIS) presents an historic opportunity for people with psychosocial disability to receive the support they need to live contributing lives – support that is sorely lacking at present.

While the promise of the NDIS is great, Mental Health Australia remains concerned about how it will apply in practice for people with mental illness. Certain aspects of Scheme design – as set out in legislation and in intergovernmental agreements – do not yet seem consistent with contemporary recovery-focussed practice or with the need to expand support services for people with severe mental illness.

With some important design principles still to be confirmed, it is unclear how the Scheme will complement and interact with service systems outside the NDIS, both in the immediate future and as the Scheme matures. Similarly, we not yet understand in sufficient detail where the 'border' between the NDIS and other systems will be drawn, or how systems on either side of that border will relate to each other.

It would disappointing if the early implementation of this major reform unintentionally resulted in reduced service access for some groups – a risk that appears to be very real in the trial sites today. The difficulties that the National Disability Insurance Agency (NDIA) has experienced transitioning mental health programs into the Scheme highlight the inconsistencies between the policy architecture currently in place and the realities of delivering the right support to this population group.

Mental Health Australia commissioned this paper because of the growing risk that these challenges will not be resolved before July 2016, when the transition to national rollout will commence. A key consideration is the contribution that the Information, Linkages and Capacity Building initiative will make in supplementing services purchased through Individually Funded Packages (IFP). At the time of writing, the nature and the scale of that contribution is not known to non-government stakeholders.

Resolving these issues will require an overarching vision of the whole suite of services and supports for mental health consumers and carers. For that vision to emerge, we need new governance arrangements that extend across boundaries between the NDIS and other systems, and across levels of government. The task will involve input not only from the NDIA but also from state, territory and Commonwealth governments.

With just a year to go until transition, we still do not know which system (or systems), funded by which level of government (or both), will have responsibility for particular mental health services provided in the community. Some answers may emerge through intergovernmental negotiations in the second half of 2015, yet there is no formal mechanism for the non-government sector to inform these negotiations. This is despite the critical role that community mental health and other non-government providers must play in the future Scheme.

While still a work in progress, the National Mental Health Service Planning Framework (NMHSPF) is the best available source of information we have on the diverse needs of the broader population of people with mental illness, including but not limited to those who will eventually be NDIS participants. The NMHSPF was developed with input from a diverse array of experts across the sector; its development and application were key ambitions of the Fourth National Mental Health Plan. Before key decisions about Scheme design are made, the knowledge underpinning the NMHSPF must inform deliberations regarding the interaction between the NDIS and other systems.

The analysis presented in this paper indicates that, if these complex questions of policy and funding are not resolved quickly, service access may be reduced for at least 100,000 people (and possibly many more) with severe mental illness. These people have fallen through the gaps for too long; it is now time for government to confirm how it will turn the promise of the NDIS into improved and well-integrated arrangements to help them lead contributing lives.

Reflecting the highly uncertain policy situation, this paper answers some questions but raises many others. We hope that it provides an overview of the whole system that can help governments deliver on their existing obligations (under agreements establishing the NDIS) to guarantee continuity of service. As always, Mental Health Australia stands ready to assist as governments consider these complex and critical questions.

Disclaimer: The policy options and recommendations in this paper are drawn from David McGrath Consulting's analysis. While these are well worth further consideration, the recommendations do not necessarily represent Mental Health Australia's position.

2. Executive Summary

The NDIS is a new entrant on the service delivery landscape for individuals with significant mental illnesses and has the potential to greatly increase access to community supports for this population.

This paper seeks to identify and quantify the risks associated with the current NDIS policy framework (acknowledging that some elements are still under development), and makes suggestions on how to progress appropriate risk mitigation.

The population that is in scope for the psychosocial disability elements of the NDIS is people with a severe mental illness and a significant functional impairment that is likely to be permanent. It is estimated that the population of Australians with severe mental illness in Australia is 502,000 adults and a further 123,000 persons aged under 18, based on population modelling from a number of sources. The subset of those with significant permanent functional impairments is less clear.

The NMHSPF, progressed on behalf of all Health Ministers by New South Wales and Queensland, utilised academic literature and expert opinion to assign those with a severe mental illness into groups on the basis of similar care needs, called *care packages*. The types of community supports[1] in these packages have substantial equivalence with the supports offered in the NDIS to date. The NMHSPF is therefore highly relevant to the task of identifying the needs of the broader population of people living with severe mental illness.

Using the NMHSPF, we can estimate that each year approximately 290,000 persons with a severe mental illness require some form of community support (individual support, group support or non-acute residential) including 180,000 adults who require individual community support. In addition there are 153,600 mental health consumers whose *carers* require some form of support.

This paper raises the following issues:

- Given the NDIS is modelling, and therefore presumably budgeting, for only 57,000 individuals with a psychiatric disability to participate in the scheme, which system(s), funded by which level(s) of government, is/are responsible for the remaining 229,000 with a severe mental illness who need community support?
- Since carer funding is being cashed out, but carers are not in scope for their own NDIS Individual Funding Packages, which system(s), funded by which level(s) of government, is/are responsible for carer policy and funding?

---

[1] Community supports include non-clinical community based services designed to assist those with a mental illness to participate in their communities and to have meaningful and contributing lives.

- How are the differences between psychosocial disability and other forms of disability accommodated by the NDIS Rules, Operational Guidelines and other NDIA protocols?
- How are consumers and carers meant to navigate the system interfaces created by the NDIS?
- Where does policy and planning for mental health community support take place and who makes the policy decisions?

These issues will require changes to Ministerial oversight and governance, operational procedures, scheme design and government policy commitments. This paper outlines a range of options, but makes no firm recommendations about which particular path is most desirable. The intention is to link the facts about the population in need with possible solutions, to inform governments as they consider how to respond.

The NDIS provides a significant opportunity to increase supports and improve outcomes for some mental health consumers and carers. However the policy risks associated with the momentum and scale of, and the impact on, systems that interface with the NDIS must be better understood if they are to be properly mitigated.

3. Introduction

The purpose of this paper is to consider the existing policy framework underpinning the NDIS, as it applies to psychosocial disability, and to recommend policy shifts and operational changes. This analysis is informed by data from the NMHSPF regarding the needs of the population in question.

The original conception of the NDIS by the Productivity Commission (PC) reflected an intention to ensure the needs of the severely disabled were catered for over the duration of their lifespans. The PC report makes clear that the intent of the NDIS is not for "the scheme to address the care and support needs of all individuals, but rather should focus on those where such needs are greatest".

The PC foresaw three tiers of support, ranging from early, population based, interventions, through linkages to care pathways through the Information, Linkages and Capacity Building Framework (ILC), previously known as tier 2, and finally intensive Individually Funded Packages (IFPs), previously known as tier 3.

In the area of psychosocial disability there are already a range of services being provided in the community by the Commonwealth government and individual state and territory governments that cut across each of the three tiers of support.

Funding of the NDIS has involved bi-lateral agreements between individual state and territory governments and the Commonwealth Government. The inclusion of existing mental health program funding in those financing arrangements has not been uniform: in some states existing mental health funding has been added to a state's contribution to the NDIS; in others it has not. In some cases state-funded, IFP-targeted programs have been transferred but programs targeted at tier 1 and ILC populations have been retained by the states. In some cases programs that traverse all three tiers have be transferred in their entirety.

Policy accountability for the implementation of the NDIS sits with the Disability Reform Council under the Council of Australian Governments (COAG) framework. This body is made up of Ministers from the Commonwealth, states and territories with responsibility for disability services, but does not include Ministers with responsibility for health or mental health.

There are a number of unanswered questions which arise from these funding and policy arrangements. For example, **what is the NDIS responsible for in a policy and operational sense? Is the Disability Reform Council only setting policy parameters for supports for those with an IFP? If so, how are they being synthesised with the policy parameters for those who don't meet the IFP criteria?**

There is a risk that the NDIS will set up a funding and policy framework for IFP only, and other governments will have to work reactively around that in determining responses to other types of presentations. This creates a significant risk that policy will be driven by cost shifting, rather than by a focus on improving outcomes.

A related concern is about what happens to the services transferred into the NDIS, which currently provide services for clients out of scope for an IFP. **How will the continuity of service guarantee in the Intergovernmental Agreement (IGA) be monitored, and which jurisdiction is responsible for rectifying poor outcomes? Who is responsible for ensuring that a community support system exists for those who do not qualify for an IFP? How are those who would have received support in the future, if current arrangements had continued, meant to navigate this system?**

Annexure E of the IGA for the NDIS provides for continuity of support for existing recipients of community support who do not meet NDIS access criteria. However, it only applies to those already receiving a service when the launch sites were established. It does not apply to the cohort of individuals with the same presenting circumstances who were not in a program at the time, or whose need for support at that level manifests in the future. As such there is a future cohort of people who under current policy arrangements are considered to require support, who under the NDIS implementation will no longer be able to receive it, unless some alternative non-NDIS arrangements are provided. In the psychosocial disability space this population is substantial, as this paper will make clear.

ILC supports may address these questions, but that appears doubtful if current policy thinking is any guide.

Annexure E of the IGA does not specify the precise funding or policy commitments that governments are making to ensure continuity of support. Clause 14 states ‘each government will be responsible for determining how it wishes to provide continuity of support’. This lack of detail could lead to significant confusion for referring services and public sector agencies and incompatibility across systems. This may mean, for example, that consumers receive conflicting advice from their clinical service providers on the ground.

The underlying message of the continuity of support commitment as articulated in Annexure E appears to be that **support arrangements are a matter for the national framework only if someone is accepted into the NDIS**. This does not allow for the creation of a seamless, well-understood system, where perverse incentives and the risk of gaming or cost-shifting are minimised. **The narrow focus on those already receiving support could be interpreted by those charged with implementing policy that any support systems outside the NDIS are only legacy systems which will decay as current participants transition into the NDIS.** There is a clear need to review the existing continuity of support commitments prior to transition to full scheme.

The NDIS offers considerable opportunities for those with a mental illness to achieve the supports they need to live in the community, and to do so within a predictable, organised system driven by their own goals and perspectives on service offerings. To prevent unintended consequences in the reform process, it is important that the NDIS builds on the strengths of the existing system wherever possible, and utilises expert judgements about the impairment thresholds necessary for different kinds of support.

This paper will address the concerns of the mental health sector about the impact of the NDIS on the existing mental health support system. Some of these impacts will be a highly desirable, while others will be significantly problematic. The paper:

- Quantifies the number of people requiring community support for a mental health condition.

- Compares the proposed NDIS arrangements with existing modelling of community support types and levels of service.
- Analyses and estimates the total need for community support within the cohort with a severe mental illness.
- Reviews the current resourcing for community support by jurisdictions.
- Analyses a range of policy and operational risks
- Presents options to improve system design and recommendations for action.

4. Population needing care and support

The NDIS will provide only one component of the necessary supports that the total cohort of those with a mental illness need. As such services provided through the NDIS cannot be identified in isolation from other services. As a first step, it is necessary to identify the total population in need of care and the nature of that care.

Modelling work undertaken by NSW Health, Queensland Health and through the NMHSPF process has identified very similar prevalence rates of mental illness for the purpose of population planning. Table 1 indicates the prevalence of mental illness by level of severity and the associated number of people across the Australian population requiring support. Table 2 presents prevalence numbers and rates broken down by age group.

Table 1: Population Prevalence of Mental Illness using 2015 Australian population[2]

SEVERITY OF ILLNESS	POPULATION PREVALENCE	TOTAL POPULATION
Mild mental illness	8.8%	2,085,829
Moderate mental illness	4.5%	1,052,968
Severe mental illness	2.9%	685,719
TOTAL	**16.2%**	**3,839,907**

Table 2: Age distribution of Mental Illness using 2015 Australian population[3]

AGE IN YEARS	MILD ILLNESS		MODERATE ILLNESS		SEVERE ILLNESS	
	Prevalence	Population	Prevalence	Population	Prevalence	Population
0-4	8.8%	136,634	4.4%	68,316	2.2%	34,159
5-11	8.9%	182,654	4.4%	91,426	2.2%	45,867
12-17	8.5%	155,640	4.4%	79,458	2.3%	42,758
18-64	9.4%	1,420,567	4.8%	718,592	3.3%	502,169
65+	5.8%	190,336	2.9%	95,176	1.8%	60,766
TOTAL	**8.8%**	**2,085,831**	**4.5%**	**1,052,968**	**2.9%**	**685,719**

---

[2] Australian Burden of Disease Study

[3] NMHSPF adjusted for 2015 Australian population.

The NDIS is targeted at those with severe and persistent illnesses that cause a permanent disability or limitation in function. As such it is not the entire “severe illness” cohort are in scope for the NDIS. However, those group out of scope for the NDIS will still need community supports, and in fact many who will likely not meet the access criteria are already receiving such supports.

NDIS modelling for psychosocial disabilities has been based on adults aged 18-64, thus we will use the subset of 502,169 people with a severe mental illness.[4] The next task is to identify the subset of people who need NDIS-type supports, and then to identify what supports are provided to those who have a severe illness but who will not meet the access criteria for an IFP.

This will allow us to estimate the burden on the NDIS with regard to individual funding packages for the psychosocial disability component, and to identify the numbers of people requiring supports who will not have access to IFPs. This out-of-scope population can then be separated into the population currently receiving support who may have that support threatened by contributions to the Scheme, and those who currently have no access to support but nonetheless may require it in the future.

In addition to this analysis, it is important to identify the types of supports that are foreseen across all these groups.

Key Facts

- There are approximately 502,000 adults with a severe mental illness in Australia based on the Australian census population adjusted to 2015.
- There are a further 123,000 people aged under 18 with a severe mental illness in Australia based on the same population.

---

[4] Note: this number has been adjusted for population growth since 2011. With estimated growth in the Australian population since 2011 of 6.4% as of 1 March 2015, the figures in the NMHSPF were adjusted upwards by 6.4%.

5. Estimates of need for care and support

5.1 National Mental Health Service Planning Framework Service Elements

The numbers presented below are drawn from the NMHSPF, and represent the size of the population with severe mental illness that is likely to need community support analogous to that which would be provided through IFPs. This information is needed before we can identify the various programs that can meet that need, any gap, and an appropriate set of policy responses both within and outside the NDIS.

A detailed description of the NMHSPF, and how these figures have been determined is at Appendix A.

The most appropriate start point is to identify the total number of people with a need for community support. The NMHSPF allows calculation, based on the academic literature and expert opinion, of the total number of potential participants of support programs through aggregation of those who would receive a community support component in a NMHSPF care package.

The NMHSPF used a methodology of categorising client groups into mild, moderate or severe illnesses. It then groups them within these categories on the basis of the likely mix of care they would need. It was done this way, rather than by diagnostic category, as diagnostic category in mental health is a poor predictor of resource inputs, accounting for only about 23% of the variance in costs.[5] These care groupings are known as care packages, and could include any of the service elements in any of the streams in the taxonomy described in Appendix A.

Table 3 lists care packages for those individuals aged 18-64 categorised with a severe illness. The population rate expected to access those packages and the total participants in each package are based on the national population in the 2011 Australian census.

---

[5] IHPA, Mental Health cost modeling work. See www.ihpa.gov.au

Table 3: Severe illness care packages for those aged 18-64 and cohort sizes.

SEVERE CARE PACKAGES 18-64 YEARS	NATIONAL POPULATION	POP RATE (%)
Severe Ambulatory Low Intensity Care	232,300	1.64
Severe Ambulatory Functionally Impaired	58,075	0.41
Severe Ambulatory Clozapine	14,851	0.11
Severe Ambulatory Complex	46,089	0.33
Severe Ambulatory Eating Disorders	11,654	0.08
Severe Same Day ECT General Medical	6,280	0.044
Severe Cons Liaison to Gen Med beds primary MH diagnosis	14,834	0.105
Severe Cons Liaison Mother Baby obstetric stay	1,931	0.014
Severe Mother Baby Inpatient	594	0.004
Mother with child specialist inpatient	446	0.003
Severe Ambulatory and Bed, Early Psychosis Year 1	4,544	0.032
Severe Ambulatory and Bed, Early Psychosis Year 2	3,636	0.026
Severe Eating Disorders With Hospital Stay	2,387	0.017
Severe with inpatient stay but low community support	31,916	0.225
Severe Same Day ECT Specialist Psych Facility	6,280	0.044
Severe Sub acute Step Up Unit	3,738	0.026
Severe including acute inpatient unit stay	21,805	0.154
Severe specialist MH unit with step down	5,607	0.04
Severe Rehab, Sub acute residential	1,003	0.007
Severe Sub Acute Intensive	191	0.001
Severe Long Stay Non acute residential 24hr/day staff	2,085	0.015
Severe Very Long Stay Non acute intensive	521	0.004
Total	**470,767**[6]	

Table 3 apportions all those with a severe illness into a particular care package for any 12-month period. Each person identified within the national population is a unique individual for that 12-month period. Thus if someone who is nominally assigned a "Severe ambulatory complex" care package they would not appear in any other care package.

These figures reflect the care needed in any given 12-month period. This allows aggregation for the purposes of estimating annual activity targets and annual budgets. Numbers would normally grow over time, consistent with population growth, unless there is substantial improvement or decline in the effectiveness of population level interventions.

---

[6] The difference between this figure and the figure for the severe adult population in table 2 is due to the 6.4% population growth since 2011 and the rounding of fractional figures across multiple packages.

5.2 Individual Support

The next step is to identify the proportion in each care package who are expected to need individual community support and rehabilitation. From this, it is possible to identify the cohort for IFP services under the NDIS; the remainder will need support provided by other service systems. The NMHSPF provides detailed breakdowns of the percentage of each care package cohort that will need each activity type over a 12-month period. This allows for a robust estimation of the percentage of each cohort that will require community supports in a given year. This does not automatically equate with the numbers that will need support over a lifetime, as discussed below.

Table 4: Adult population with mental illness requiring individual support by care package

SEVERE CARE PACKAGES 18-64 YEARS	NATIONAL POPULATION	INDIVIDUAL SUPPORT RATE	IND SUPPORT POPULATION
Severe Ambulatory Low	232,300	10%	23,230
Severe Ambulatory Functionally impaired	58,075	75%	43,556
Severe Ambulatory Clozapine	14,851	100%	14,851
Severe Ambulatory Complex	46,089	100%	46,089
Severe Ambulatory Eating Disorders	11,654	0%	0
Severe Same Day ECT Gen Med	6,280	0%	0
Severe Consult Liaison to Gen med beds primary MH diag	14,834	10%	1,483
Severe CL Mother Baby obstetric stay	1,931	0%	0
Severe Mother Baby inpatient	594	0%	0
Mother with child specialist inpatient	446	0%	0
Severe Ambulatory and Bed, Early Psychosis Yr 1	4,544	83%	3,771
Severe Ambulatory and Bed, Early Psychosis Yr 2	3,636	73%	2,654
Severe Eating Disorders With Hospital Stay	2,387	0%	0
Severe with inpatient stay but low comm support	31,916	3%	957
Severe Same Day ECT Specialist Psych Facility	6,280	0%	0
Severe Sub acute Step Up Unit	3,738	100%	3,738
Severe including acute inpatient unit stay	21,805	100%	21,805
Severe specialist MH unit with step down	5,607	100%	5,607
Severe Rehab, Sub acute residential	1,003	100%	1,003
Severe Sub Acute Intensive	191	100%	191
Severe Long Stay Non acute residential 24hr/day staff	2,085	0%	0
Severe Very Long Stay Non acute intensive	521	0%	0
Total	**470,767**		**168,937**[7]

---

[7] Individual cells have been rounded and thus the total may contain rounding errors.

Applying the expected care rates related to individual community support gives an estimate of the upper bound of likely NDIS participants with IFPs of 168937 in a given 12 month period. This figure needs carefully interpretation:

- It includes modelled care provided both by peers and non-peers. This is not necessarily material, given the anticipated type of support is the same. It is unclear if the NDIS has a view that peer provided supports are excluded from IFP service provision, in which case the above figure would reduced.
- It excludes extremely complex long stay patients in 365 day care in a given year. This is consistent with the intent of the NDIS not to replace existing mainstream services, however this cohort of approximately 2600 would likely be 100% in scope for IFPs if they were discharged and as such are a “latent” NDIS IFP cohort in a given 12 month period.

It does not include those aged under 18, in order to be comparable to the NDIA modelling of 57,000. However, the NDIA operational guidelines do not specify any requirements that the participant be over 18. This is an anomaly that requires clarification. Table 5 indicates the population with severe illness under 18 and their expected individual community support rates, showing there is a further 32,173 possible participants in the 0-17 age group requiring individual support.

Table 5: Those with a severe mental illness aged 0-17 and community support rates.

SEVERE CARE PACKAGES 18-64 YEARS	NATIONAL POPULATION	INDIVIDUAL SUPPORT RATE	IND SUPPORT POPULATION
Ambulatory only 0-4 years	32,149	0%	0
Ambulatory 5-11 Years	41,815	0%	0
Ambulatory Complex 5-11 Years	1,293	0%	0
Ambulatory 12-17 Years	28,498	100%	28,498
Ambulatory Complex 12-17 Years	5,343	25%	1,335
Ambulatory Outreach 12-17 Years	1,781	0%	0
Ambulatory Eating Disorders 12-17	2,859	35%	1,000
Early Psychosis Year 1	947	83%	786
Early Psychosis Year 2	758	73%	553
Total			**32,173**

Adjusting the above three cohorts for population growth of 6.4% since the NMHSPF data was produced means that individual supports will be needed for 179,816 adults, 2766 ‘latent’ participants, and 34,232 individuals under 18 on the basis of the 2015 population.

These figures are relevant to determining the population with a severe mental illness that need individual community support, whether through the NDIS or otherwise. The final figure for NDIS IFP participation is dependent upon the assessment processes and tools and their capacity to differentiate meaningfully between individuals within the care package populations above.

The NMHSPF also models three other service elements: group support and rehabilitation, residential crisis and respite services, and family and carer support. These have overlapping but not identical populations to those modelled above. In some cases the modelling makes clear the degree of overlap and in others it will require estimation.

5.3 Group Support

The NMHSPF also identifies the quantum of populations in care packages who require support and rehabilitation that can be provided in a group setting rather than as individual one on one support. It is unclear if the NDIS modelling for IFPs has included consumers who are deemed to need group support only. A determination that group support is appropriate can be made on a range of factors including clinical benefits of reducing social isolation, need for additional oversight or even just on consumer preference. It does not necessarily imply a higher level of overall capacity or an absence of significant impairment.

By necessity estimates of those who are not captured in the individual support cohort above requires some degree of estimation based on the NMHSPF modelling. Conservative estimates are contained in Table 6 below.

It can be seen from the table below estimations that show that there is approximately 68,000[8] individuals across the country with a severe mental illness who require support and rehabilitation that can, or ought, to be provided in a group setting, who are not modelled as requiring individual support as well. Adjusting the NMHSPF outputs for population growth to 2015 (6.4%) increases this cohort to 72,435. This is in addition to the 'individual support' cohort identified above.

Table 6: Care packages and group support only rates

SEVERE CARE PACKAGES 18-64 YEARS	UNIQUE PARTICIPANT GROUP SUPPORT RATE[9]	GROUP SUPPORT POP
Severe Ambulatory Low	20%	46,460
Severe Ambulatory Functionally impaired	20%	11,615
Severe Ambulatory Clozapine	0%	0
Severe Ambulatory Complex	0%	0
Severe Ambulatory Eating Disorders	30%	3,496
Severe Same Day ECT Gen Med	0%	0
Severe Consult Liaison to Gen med beds primary MH diag	20%	2,967
Severe CL Mother Baby obstetric stay	0%	0
Severe Mother Baby inpatient	0%	0
Mother with child specialist inpatient	0%	0
Severe Ambulatory and Bed, Early Psychosis Yr 1	0%	0
Severe Ambulatory and Bed, Early Psychosis Yr 2	25%	909
Severe Eating Disorders With Hospital Stay	30%	716
Severe with inpatient stay but low comm support	6%	1,915

---

[8] In 2011 population terms.

[9] This is an estimate of the proportion of the care package cohort who need group support who are considered **not** to also need individual support.

SEVERE CARE PACKAGES 18-64 YEARS	UNIQUE PARTICIPANT GROUP SUPPORT RATE[9]	GROUP SUPPORT POP
Severe Same Day ECT Specialist Psych Facility	0%	0
Severe Sub acute Step Up Unit	0%	0
Severe including acute inpatient unit stay	0%	0
Severe specialist MH unit with step down	0%	0
Severe Rehab, Sub acute residential	0%	0
Severe Sub Acute Intensive	0%	0
Severe Long Stay Non acute residential 24hr/day staff	0%	0
Severe Very Long Stay Non acute intensive	0%	0
Total		68,078

This population may not all be in scope for NDIS IFPs; potentially none of them may be considered in scope. However they all have a severe mental illness and require support from some service system, and it is crucial that the arrival of the NDIS does not obscure this fact.

Table 7 below therefore identifies the total Australian population with a mental illness, based on the Australian population at the 2011 census, who require community support from the Australian mental health service system in all its constituent parts. The estimate derived from NMHSPF modelling is approximately 275,000 persons requiring community support; when adjusted for population growth of 6.4% since 2011 the number is approximately 290,000.

Table 7: Total estimated population[10] of those with a severe mental illness requiring some support

COHORT	INDIVIDUALS REQUIRING SUPPORT
Severe Mental illness aged 18-64 Individual Support	179,816
Severe Mental illness aged 18-64 "Latent" Participants	2,766
Severe Mental Illness aged 12-17 Individual Support	34,232
Severe Mental Illness aged 18-64 Group Support Only	72,435
TOTAL	289,249

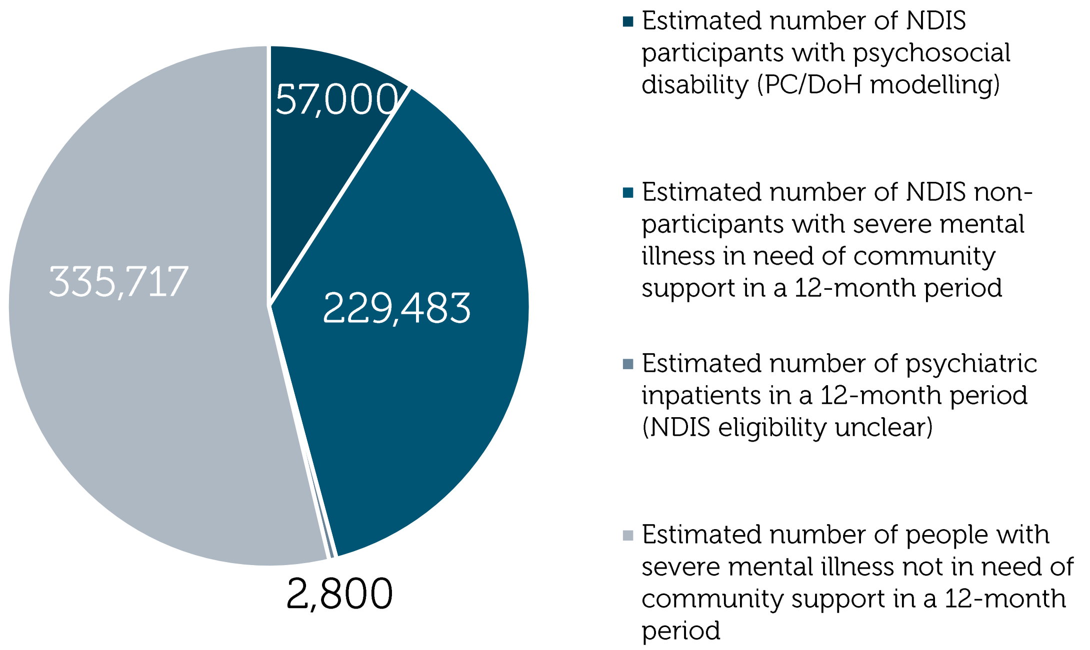
These numbers lead to a glaring policy question: when compared with modelling estimating that IFP participants with psychiatric disability will number only 57,000, which government, and which government portfolios, are responsible for the policy debate, operational arrangements and funding for the remaining 229,000?[11]

---

[10] Based on the NMHSPF data adjusted for population growth at the time of estimation. Population growth on March 1st 2015 was 6.4%.

[11] This figure excludes the 2,766 extremely complex long stay patients, who need 365 day residential care in a given year.

Figure 1: Total population with severe mental illness nationally, including estimated NDIS participants and non-participants.



5.4 Residential Crisis and Respite Support

For the purposes of completeness there are two other service elements of the NMHSPF community support taxonomy that should be referenced. The first of these is the residential crisis and respite support services.

The NMHSPF taxonomy describes residential crisis and respite services as 'staffed home-like facilities in the community, providing short-term accommodation where people in crisis can go to stabilise their illness. Options can include crisis residential services where stays are limited to up to 48 hours through to planned respite of up to 14 days.'

These are non-clinical services, provided in community settings. Services on hospital campuses would not be in scope for this service element as they would fall under admitted care. They generally provide skills development programs that may include education about mental illness and recovery, advice on managing household tasks, vocational advice or a focus on personal wellbeing and relaxation techniques. These services are generally consistent with the intent of services to be available under the NDIS.

The NMHSPF modelling for these services did not seek to provide a unique cohort through care packages modelling; instead it identified how many people would need respite in addition to their care package. The NMHSPF describes this as a 'sprinkle' across the care packages. This makes it difficult to assess if there are any unique participants receiving this service element only, without additional group or individual support.

However, clinical logic would suggest that those whose symptoms and circumstances required respite would likely be in a care package where some individual or group support was already modelled. As such, it would be reasonable to preclude any material effect on the estimate of the overall unique cohort needing servicing. As such the estimate below indicating residential crisis and respite should not be considered as an additional population to that calculated above. It is included here for the purposes of allowing any necessary resource modelling for these service types to occur at a later date.

The NMHSPF concluded that there was a population of approximately 15372 people who needed residential crisis and respite support in addition to their care package, including a small subset of approximately 100 who needed intensive long stay arrangements. Adjusting this to 2015 population size leads to 16,356 people needing these services.

5.5 Family and Carer Support

The final NMHSPF service element that needs to be addressed is family and carer support. Supports for families and carers within an IFP are available if negotiated between participant and the NDIA. This could create tension requiring a policy response, given a lot of current carer funding is accessed directly by carers through service providers. Further, if IFPs have a designated funding limit, it is conceivable that carer support may be traded off against individual supports.

Carer support is explicitly referenced as an ILC-type support, and given the intention of the Commonwealth to commit funds from its Mental Health Respite: Carer Support Program, it is likely to be a significant component of ILC funding. The NMHSPF modelled the expected needs for family and carer supports and these are presented in Table 8. Note the numbers are the numbers of consumers whose carers will require family and carer support, not the number of individual carers.

Table 8: Family and Carer Support Modelling for Consumers aged 18-64 years

SEVERE CARE PACKAGES 18-64 YEARS	NATIONAL POPULATION	FAMILY AND CARER SUPPORT RATE	FAMILY AND CARER POPULATION
Severe Ambulatory Low	232,300	0%	0
Severe Ambulatory Functionally impaired	58,075	50%	29,038
Severe Ambulatory Clozapine	14,851	50%	7,426
Severe Ambulatory Complex	46,089	20%	9,218
Severe Ambulatory Eating Disorders	11,654	60%	6,992
Severe Same Day ECT Gen Med	6,280	0%	0
Severe Consult Liaison to Gen med beds primary MH diag	14,834	0%	0
Severe CL Mother Baby obstetric stay	1,931	0%	0
Severe Mother Baby inpatient	594	0%	0
Mother with child specialist inpatient	446	0%	0
Severe Ambulatory and Bed, Early Psychosis Yr 1	4,544	33%	1,500
Severe Ambulatory and Bed, Early Psychosis Yr 2	3,636	33%	1,200
Severe Eating Disorders With Hospital Stay	2,387	60%	1,432
Severe with inpatient stay but low comm support	31,916		0
Severe Same Day ECT Specialist Psych Facility	6,280	0%	0

SEVERE CARE PACKAGES 18-64 YEARS	NATIONAL POPULATION	FAMILY AND CARER SUPPORT RATE	FAMILY AND CARER POPULATION
Severe Sub acute Step Up Unit	3,738	20%	747
Severe including acute inpatient unit stay	21,805	20%	4,361
Severe specialist MH unit with step down	5,607	20%	1,121
Severe Rehab, Sub acute residential	1,003	20%	200
Severe Sub Acute Intensive	191	20%	38
Severe Long Stay Non acute residential 24hr/day staff	2,085	0%	0
Severe Very Long Stay Non acute intensive	521	0%	0
Total	**470,767**		**63,274**

Table 8 indicates that for adults aged 18-64, there will be 63,274[12] consumers whose families and carers will require one of the service types that are part of the family and carer support service element. It is unclear how the NDIS will provide family and carer support, and how families and carers can ensure that appropriate support through an IFP or otherwise. Currently, carer program funds are directed toward carers, with access determined between carer and service provider. In IFPs, carers can be provided supports if the participant agrees, but this is determined as part of the planning process with the participant.

In addition to the population in Table 8, there are an estimated 81,000[13] carers for people under 18 years with a severe mental illness who will require support. It is not evident that these people have been modelled at all by the NDIS.

Table 9: Total Potential Families and Carers Requiring Support

COHORTS	TOTAL POPULATION
Families and Carers of Consumers Aged 18-64	63,274
Families and Carers of Consumers Aged 0-17	81,136
Total	**144,410**
Adjusting for Population Growth of 6.4% since 2011 census.	**153,652**

Key Points

- There are 289,000 persons (including 180,000 adults) in Australia with a severe mental illness requiring some form of community support. The NDIA is only modelling support for 57,000 of them.
- There are 153,600 consumers with a severe mental illness who have carers who require community support.

---

[12] The NMHSPF used the 2011 Australian census population.

[13] The NMHSPF used the 2011 Australian census population.

5.6 Contributing Program Type Supports

There are a number of mental health programs that are intended to be rolled into the NDIS either in kind or cashed out. As noted earlier there are two key questions regarding the transition of these programs into the NDIS:

First, will those who are currently receiving support from these programs continue to do so, irrespective of whether they meet the IFP threshold? It would clearly be a negative outcome if the implementation of the NDIS removed support from someone who was gaining benefits from it on the basis of a new assessment process and criteria.

Second, will the cohort who would have benefited from these programs in the future – on the basis of its current entry standards – retain access to some form of support in the future? This could be through entry to the IFP component of the NDIS, through the ILC component of the NDIS, or through the provision of alternative programs by Commonwealth, State and Territory governments.

Clearly the nature and scale of current supports offered by these contributing programs are relevant to the determination of the need being met by the NDIS. Various programs currently funded by the Commonwealth are described below. Further information is required in order to identify the program-specific contributions of each state and territory to the NDIS. Jurisdictions are currently mapping their programs to the ILC Framework; it is unclear how much this exercise will resolve information gaps regarding state/territory funded programs and services.

Personal Helpers and Mentors (PHaMs)

PHaMs provides practical assistance and intensive one on one support to develop better relationships with family and friends and to manage everyday tasks. The activities that are incorporated into the PHaMs program funding arrangements include forming links and relationships with other local services and stakeholders, supporting return to employment and study, and supporting performance of domestic tasks. The Commonwealth government has indicated that PHaMs is 100% in scope for the NDIS. It is assumed that this means that its activities are 100% consistent with NDIS-funded activity, and that its access criteria will be 100% compatible with that of the NDIS.

The access criteria for PHaMs do not specify an older age limit. Data for 2013-14 indicates 1311 participants were 60 years or over. It is conceivable that a number of existing PHaMs participants will be excluded from the NDIS on the basis of age. These people will need to be supported by the appropriate aged care system and/or any community mental health programs which remain following NDIS transition.

The modelling undertaken by the NDIA only includes people aged 18-64, whereas PHaMs caters for people as young as 16. This appears to be an oversight in their modelling, given there does not appear to be any basis for excluding people under the age of 18 from the NDIS.

Of particular interest is that one third of participants (5,998) exited the PHaMs program during 2013-14. This would seem to be incongruous with the concept of a permanent disability requiring lifetime support, which is central to the NDIS IFP arrangements. Further explanation is required to understand how PHaMs funding will be distributed across NDIS funding categories.

Partners in Recovery (PIR)

The Partners in Recovery program is a Commonwealth program that has been determined as 70% in scope for the NDIS. Its role in trial sites has been described as 'Assistance in coordinating or managing life stages, transitions and supports' (Coordination of Supports) which may include assisting the consumer with budgeting, parenting training, developing capacity and resilience in the participant's network, coordinating complex supports, life planning and resolving crisis situations.'[14] PIR is aimed at people with severe mental illness and as such is anticipated to have a high overlap with the NDIS. In the Hunter trial approximately 65% of PIR participants have been accepted into the NDIS. However the sample size is low, and we cannot yet be confident that this will reflect the number of PIR participants who would ultimately be NDIS participants in the future in other locations.

There is currently no published official Commonwealth performance data on the PIR program and its participants, which makes it difficult to assess the accuracy of the overlap with the intended NDIS cohort.

Mental Health Respite: Carer Support (MHR-CS)

The Mental Health Respite for Carers program has been assessed as being 50% in scope for the NDIS.

Support provide through this program includes:

- Relief from the caring role either through short-term respite or through social and recreational activities.
- Provision of carer support through counselling, practical assistance, advocacy services and peer support and mentoring.
- Supports through education, information and access to services to assist in obtaining referrals, improving knowledge about mental illness and improving carer wellbeing.

These activities are all targeted at carers, rather than consumers. Given that carers do not have any automatic entitlements to support through an IFP, there is a risk of an effective transfer of funds from carers to consumers, creating additional unmet need for carer support.

In 2013-14 this program assisted 40,467 carers. If the MHR-CS program is considered 50% in scope for NDIS then approximately 20,000 carers will need to be supported in order to maintain the current level of support.

The performance data currently collected and reported by the Commonwealth government for this program does not break down the support activities provided under this program. If some MHR-CS type supports are excluded from NDIS support provision this will reduce the overall level of support provided to future participants.

Support for Day to Day Living in the Community (D2D)

The Commonwealth has indicated that the Support for Day to Day Living program is 35% in scope for the NDIS. This program is focussed on those with a severe and persistent mental illness who experience social isolation, although a formal diagnosis is not required. The program aims to increase the ability of entrants to participate in social and recreational activities and to increase their overall level of independence. Examples of funded activities

---

[14] Hunter PIR and the NDIS, Building a Stronger Partnership, February 2015.

include cooking classes, bushwalking, gym and swimming classes, arts classes and social outings.

Given the severe and persistent diagnostic access criteria and the program's objective of increasing independence and social isolation, It is unclear on what basis the Commonwealth has attributed this program as being only 35% in scope for the NDIS, since many of the activities look to be completely aligned with NDIS support intentions.

While the Commonwealth has undertaken an evaluation of the Day to Day Living program, it focuses on 'a narrative outline of consumer achievement' and admitted that 'there is no mechanism for providing a more quantitative assessment across the measure.' This again makes it difficult to assess the validity of Commonwealth assumptions associated with this program.

State and Territory Run Programs

There is not an extensive amount of information regarding the state and territory programs to be incorporated into the NDIS upon full transition. However, there is information on programs from launch sites that could provide some insight into the impact of the full scheme.

As noted earlier, some jurisdictions have decided to roll all of their community mental health support programs into the NDIS while others are continuing to fund their mental health community support programs in parallel. This makes it difficult to assess the overlap between program characteristics and target populations. Some of this information may come to light following the mapping of state/territory programs against the ILC Framework. In the meantime, the absence of a nationally consistent approach to the transition of state/territory programs and the apparent incentive for cost-shifting as intergovernmental negotiations take place reinforce the policy disconnect contributing to the uncertainty about the future of mental health programs in the NDIS.

6. Current resourcing care and support nationally by jurisdiction

The modelling in this paper suggests that current funded supports for people with mental illness, across service systems and jurisdictions, are not meeting community need. The scale of unmet need at present would make it difficult to apportion apportioning policy and funding responsibility for community care and support to a particular jurisdictional level or service system. Each system and government sets its own policy framework and access criteria; there is no attempt to match patient cohorts across these frameworks and criteria. In such circumstances, it is difficult to hold anyone accountable for those not receiving support to which they might otherwise be entitled.

To effectively address any unmet need, an attempt must be made to quantify in some detail the funds currently being provided to, and the activities carried out through, the community support system in mental health. This will in turn help to identify logical system interfaces for managing the multiple populations requiring support, whether through the NDIS or through other systems.

6.1 Expenditure on Community Support

Obtaining accurate figures for national expenditure on mental health at a level of detail to allow effective service splits is difficult. A regular time series exists under the National Mental Health Report series prepared by the Commonwealth Department of Health, however its most recent publication in this series was 2013, covering the 2010-11 period. This is the most up-to-date and accurate data on overall spend on mental health by category.

The 2013 Mental Health Report indicates that nationally $6.9 billion was spent on mental health in the reporting year (2010-11). A number of categories of spending are identified; those most relevant to community support being State and Territory NGO spending (3.4% of overall spend), Australian Government NGO support programs (2.2%) and state/territory residential (staffed) programs (3.5%). The total dollar figure associated with these categories are therefore $235 million on state territory NGO's, $152 million on Commonwealth NGO's and $241.5 million on state and territory residential staffed services.

The 2014 Mental Health Services in Australia (MHSiA) report indicates that the overall spend had grown to $7.2 billion by 2012-13; however, the MHSiA report does not split by category in the same way as the National Mental Health Report. Applying the same splits in spending categories as indicated in the 2013 Mental Health Report to the MHSiA total budget then we can estimate a total spend in 2012-13 of $245 million for State and Territory NGO spending, $158 million for Commonwealth NGO spending and $252 million for residential services. This makes a total of $655 million in 2012-13.

The draft eligibility paper for the psychiatric disability component of the NDIS indicates an estimate of $1.8 billion per annum in funding to psychosocial disability support at full scheme rollout. This is a substantial increase on estimates of mental health specific funded community support levels in 2012-13.

A report by Medibank and the Nous Group on direct funding to mental health estimated that the total spend to those with a mental illness via both mental health portfolio and disability portfolio community support programs is approximately $1.8 billion. Nous drew some of its figures from the 2012 Report on Government Services. This is a remarkably similar figure to the estimated budget for NDIS packages in draft eligibility documentation.

Key Points

- Medibank Private and the Nous Group estimate that $1.8 billion was spent in 2011/12 on community support to those with psychiatric disability, which incorporates both disability portfolio and mental health portfolio supports.
- The NDIA have indicated that approximately $1.8 billion in funding for psychosocial disability is likely to be provided.
- Given the current level of unmet need in the community and the policy intent behind the NDIS, it would be surprising if full NDIS implementation did not coincide with an overall increase in funding for mental health support services delivered in the community.

6.2 Service Utilisation

The MHSiA report[15] provides data on a range of characteristics associated with mental health programs nationally. The most recent data available is for 2011-12.[16]

Data from the most recent MHSiA report on psychiatric disability support services use indicates that 87,600 people across Australia accessed such services, including both residential and non-residential services. The types of services included in the data set include accommodation support, employment services, services focussed on improving social independence, group homes and hostels.

Individuals did not have to have a primary psychiatric disability in order to access these services; those with a secondary diagnosis were also eligible. Interestingly the figure for those with a primary psychiatric disability accessing services in that year was 56,733 - a figure strikingly similar to numbers of people with psychosocial disability estimated to access an NDIS IFP.

If the modelling mechanism behind the original estimate of 57,000 was indeed drawn from the data behind the MHSiA report, this would be extremely problematic. MHSiA data reflects

---

[15] Prepared by the Australian Institute for Health and Welfare
[16] Published in 2014.

only services accessed, not services needed. Given demand far exceeds supply in mental health care services, the number of services accessed is a proxy for services funded rather than community need. It is reasonable to assume that this number would fluctuate substantially depending on the level of funding available.

To illustrate the point, the proportion of those people with a psychotic illness who received community support through NGOs increased from 18.9% to 26.5% between 1997-98 and 2010, while funding to NGO's increased by a comparable level over the same period. Figures on current levels of service utilisation are useful, but they cannot be interpreted as an indicator of need.

Key Points

- 56,733 people with a primary psychiatric disability accessed psychiatric disability services in 2011-12, according to the Mental Health Services in Australia report. This figure indicates the number of people using these services, but does not necessarily reflect the level of community need, which is likely to be much higher.
- The NDIA is modelling for 57,000 people with psychosocial disabilities to be eligible for an IFP.
- As an entitlement-driven scheme, the NDIS should lead to an increase in the provision of services to people with psychosocial disabilities to match the level of community need.

7. Policy options

7.1 Defining the Problem

The data outlined above suggest a set of interrelated problems requiring resolution.

Problem 1: Who is responsible for the residual needs of the population that does not receive an NDIS IFP?

- The NDIS IFP population of 57,000 is only approximately one fifth of the total population (290,000 in 2015 Australian population terms) requiring community support.
- This requires a policy and funding response for the remaining 229,000 people with severe mental illness requiring community support.
- Funding arrangements and jurisdictional responsibility for the remaining 229,000 appear to be split across future NDIS ILC supports, existing Commonwealth programs across Health and DSS, and existing state/territory programs.
- No one framework ensures policy accountability for this residual group. There is no policy entity to target advocacy to or to be held accountable to the community.

Problem 2: Where do services for carers fit into national service arrangements?

- The total number of mental health consumers who have carers with support needs nationally is approximately 153,600.
- Half of the funds from Commonwealth programs for carers, supporting 40,000 carers annually, are marked for inclusion into the NDIS. These will be attributed to IFP client packages only.
- Carers services are not clearly identified in the overall NDIS policy framework in quantum, type or scale. They are referenced as an IFP-type support at the discretion of the consumer participant, but are also referenced in the ILC Framework.
- Are funds therefore being transferred from carer support to consumer packages? Who is accountable to the community for this from a policy perspective?

Problem 3: Neither the NDIS policy framework nor NDIA operational protocols properly address differences in principles between concepts relevant for 'mainstream' disability services and mental health services.

- The legislation for the NDIS does not differentiate between disability types when it describes the fundamental objects and principles that underlie the scheme.
- These principles include concepts related to permanency of disability and commitments to lifetime support.
- This will involve a shift in orientation for those participating in the existing program structure who will in future be part of the NDIS, and will leave a policy and operational disconnect with the residual parts of the service system managed through existing policy frameworks.
- How will the issue of interfaces be managed by the operational protocols for the NDIA?

Problem 4: How are consumers and carers meant to navigate the various system interfaces?

- The numerical analysis above highlights the risk that the NDIS will exacerbate the existing supply and demand gap in the provision of mental health community supports by removing alternative funded programs from the overall national system of services for mental health consumers and carers. To avoid this, the NDIS must be part of a multi system, multi-interface, national mental health community support infrastructure.
- The ILC Framework makes reference to co-ordination and assistance with referral between service providers, who may be funded via different policy systems. It is not clear whether this is a brokerage arrangement where ILC support providers take responsibility for ensuring that appropriate support arrangements are met, or simply provision of a phone number and pamphlet before being metaphorically 'shown the door' – or something between either extreme. The specifics of the co-ordination arrangements will be material, given the likelihood that multiple service systems will have offerings for mental health consumers and carers. How will governments collectively ensure that consumers and carers can readily navigate and access the system?
- How will governments collectively prevent service rationing or cost-shifting by cross-referral to agencies funded through competing policy arrangements?

Problem 5: Where does overall planning for mental health community support arrangements happen and who makes the decisions?

- NDIS policy leadership is provided by the Disability Reform Council. This group is made up of Ministers in each jurisdiction with responsibility for Disability service provision.
- Individual jurisdictions set policy for community supports within their jurisdiction, separate from the NDIS.

- National policies and plans that are mental health specific are developed and overseen by the COAG Health Council. Membership is usually health ministers from each jurisdiction.
- Therefore there are three systems of policy setting pertinent to mental health community support, which on current evidence, are making plans and decisions within their own remits, likely 'with reference' to plans in the 'other' systems.
- This is inherently inefficient and is likely to lead to adverse outcomes. What thinking has been done to recognise this and overcome it through proactive joint planning arrangements?

7.2 Potential Policy Responses

There are a range of potential levers and mechanisms that could be put in place to create incentives and monitoring structures for change. Options are outlined below.

Policy Governance, Oversight & Risk Management Structures

Mental health is a multi-portfolio, cross jurisdictional issue and would benefit greatly from such ministerial oversight, in the way that National Drug Strategy action has over the past thirty years. The Ministerial Council on Drug Strategy, which included both health and law enforcement ministers, was highly successful in reducing harm associated with illicit drugs and building co-operation between health and law enforcement agencies. The same co-operation between health and disability could be generated by a similar Mental Health arrangement. In the absence of agreement to such an arrangement, regular joint meetings of the Disability Reform Council and Health Council could provide an alternative approach.

This structure would involve:

- A joint planning framework for mental health community support with accompanying allocation of service delivery and client cohort accountabilities
- Policy advice mechanisms
- A monitoring and review framework consistent with the targets and indicators proposed to COAG.

The agreement to such a joint sitting provides a clear location of authority in a federated system for examining and resolving interface issues between systems.

Given the major changes to the mental health system associated with the NDIS, significant new investment, and a clear desire by all stakeholders to improve outcomes, governments should commit to improved data collection, collation and public reporting, consistent with the targets and indicators already proposed to COAG. Such data could include, for example:

- Presentations for community support (referred and non-referred)
- Outcomes of assessments as to severity of illness and functional impairment, linked to eligibility for the NDIS and other programs or services
- Alternative pathways and services accessed where these are outside the NDIS
- Other indicators relevant to mental health, including indicators generated outside jurisdictional data collection mechanisms where this would assist policy deliberations and improve accountability to the public.

Legislative Change within current NDIS scheme scope

It is impossible to review the arrangements for psychosocial disability within the NDIS without giving consideration to the option of legislative change. This should not however be pursued lightly, as it will be a lengthy process and subject to political pressures associated with such changes. There needs to be a compelling case therefore to justify the legislative change.

The *National Disability Insurance Scheme Act 2013* ('the Act') specifies that the impairments associated with an individual's disability 'are, or are likely to be, permanent'. The issues associated with this provision have been well documented previously, and are a key source of discussion and debate within and between the NDIA and the mental health sector.

Legislative change to amend the language associated with s24 is one possibility that could be considered. It is possible that an additional element could be added to s24 (1) (b) that states 'unless the impairment relates to psychiatric disability', which may create an exclusion to the permanency provision for psychiatric disability. However, it would be reasonable if amending the permanency provision to also remove the presumption of lifetime support, as the two are clearly logically interrelated. This would require amendment to section 29 to identify the conditions for cessation of participation on the basis of symptom and functional improvement and the nature of the review process involved. This may impose an additional administrative burden on the NDIA however, as additional reviews would likely follow such a change.

An alternative way to approach the problem is in the interpretation of 'or are likely to be' as dealt with in the NDIS Rules and Operational Guidelines. This phrase effectively reduces the decision to a balance of probabilities consideration, that is, a 51% likelihood of lasting impairment. Assessment would be based in part on diagnosis, degree of disability and functional impairment. Communicating decisions to applicants should also clearly state that decisions are based on actuarial criteria rather than a judgement about an individual's unique circumstances or their prospect for recover.

With these and other issues relating to the Act, there is substantial scope for the NDIA to use its discretion in interpreting certain key provisions to assist in the task of implementation. To date it is unclear whether the legislative changes outlined above could be avoided through judicious application of this discretion on issues affecting the psychosocial disability component if the NDIS. In any case, there is a clear need to reduce or avoid intrusive and unhelpful conversations about 'permanence' with consumers and carers, and simultaneously abrogate the need for lengthy debate on legislative change.

Expand the scope of the NDIS

Given the concerns about policy, planning, service access and consumer navigation associated with the current multi-system approach, more interventionist solutions to the problems identified could be considered.

If a single community support service system is desired as an alternative to the approach currently proposed, then one of the methods to achieve this could to expand the scope of the NDIA's activities beyond that contained in the Act and have it administer all funds associated with mental health community support options. This would mean one central planning agency could construct its tiers of service offering with reference to each other. This would in turn reduce the risks of service gaps, and if any were identified they could be resolved within a single policy structure. It would also allow for a single set of contract management arrangements, pricing models and performance structures to be developed for service provider benefit, thus potentially reducing administrative complexity.

In order to achieve this, states and territories would need to provide their existing funding for these service types. There may also need to be a referral of powers from the states dependent upon the long term constitutional interpretation of the Williams (No 2). The amount of funding provided by states and territories is captured via the Mental Health Report (see above), so the quantum of funding transfer would be identifiable.

However, any expansion of the NDIS or NDIA would require fundamental reconsideration of funding arrangements, given that the Commonwealth is currently underwriting 100 per cent of the funding risk for unmet need. This is unlikely to be acceptable for the Commonwealth if the scope of the NDIS is expanded. Similarly, the timing of the implementation process would also warrant reconsideration, given the additional complexity of the NDIA's task and its difficulties to date in clarifying an approach to psychosocial disability that the non-government mental health sector can understand and endorse.

Withdraw psychiatric disability support funding from the NDIS

An alternative approach that may achieve the same overall policy object is to remove the budgeted amount for psychiatric disability services under the NDIS and disburse these funds to the states and territories to develop unified policy systems in each local jurisdiction.

This would in theory lead allow for policy and planning synthesis within each jurisdiction. Identifying the exact quantum of funds may not be a simple matter, however, as Commonwealth funds 'intended' for psychosocial disability are not available publicly. Further, the Commonwealth's commitment to accept 100% funding risk for unmet need from the scheme would be foregone.

This scenario could allow the Commonwealth to step completely out of funding for mental health community supports, as its involvement in this space has only been recent and aligned with COAG interests over the last decade. It would be a significant loss to have the Commonwealth abandon key policy objectives around mental health community support. In particular, the agreed national goal to assist community-based mental health services to grow, in order to ease the pressure on the acute mental health system, would be subject to each jurisdiction's commitment in practice through adequate resourcing.

A cross-jurisdictional service guarantee

If it is accepted that the current multi-jurisdictional, multi-portfolio, multi-agency approach is to continue then additional architecture should be built into the system to assist in managing negative consumer experiences with poorly integrated policy and service responses to need.

Governments could enter into a community support "access guarantee" to those individuals who have a severe mental illness who present to the NDIA or other relevant service providers. The National Mental Health Policy has for some time had a policy of "no wrong door" for those seeking assistance, however this has to date rarely manifested in a concrete mechanism for achieving such an outcome.

A nationally consistent, evidence-based screening process may be required to determine whether someone has a severe mental illness and/or psychosocial disability, prior to making any determinations about other service access criteria. Anyone who presents to the NDIA and meets the relevant criteria for access to the broader mental health "system", but does not meet the access criteria for the NDIS, would have their details provided to a nominated officer in their resident jurisdiction. An example may be the secretary of the Department of Health, who could, of course, delegate the function.

The nominated officer would then have accountability for brokering referral arrangements with other service providers and for initiating contact with that service provider. In this way governments could ensure that individuals with a mental illness are matched to a necessary support place and not just "bounced" out of the NDIS.

This arrangement should lead to the development of a screening tool, used across jurisdictional planning and cohort allocations, and a clear service map relating funded service providers to target groups.

Tracking arrangements would also be needed to meet the continuity of support requirements in Annexure E of the IGA establishing the NDIS. Similar procedures already exist in other areas of government, such as under the National Partnership Agreement (NPA) on Training Places for Single and Teenage Parents. That NPA provided for similar tracking of individuals, in order to ensure that the guarantee of a training place was met.

Data on individuals who are referred by the NDIA should be aggregated and publically reported, with information regarding entry into community support also reported. This would ensure there is accountability for governments, and would demonstrate that the NDIS has not inadvertently widened service gaps. It would also provide more reliable estimates for future planning.

Operational Guidelines changes

The NDIA uses Operational Guidelines, based on the NDIS Rules, to inform its implementation of the scheme and its day-to-day contacts with potential participants. As with the Act (discussed above), the Operational Guidelines can be useful tools for influencing how the NDIS is applied in individual circumstances, and if worded and applied carefully can resolve many potential problems regarding Scheme design.

Nevertheless, some of the most significant problems associated with the psychosocial disability component of the NDIS do not in fact relate to the Scheme's operation or to implementation. Rather, these problems relate more fundamentally to how the scheme fits into the remainder of the mental health service system, and how planning and policy can be undertaken in a co-ordinated fashion to maximise the chances of good consumer and carer outcomes. If these issues can be resolved collectively by governments, then the gains from adjustment to Operational Guidelines, which are largely at the NDIA's discretion, will be relatively minor by comparison.

That said, there are some areas where the Operational Guidelines could be improved to assist with implementing the NDIS for people with psychosocial disability. For example, a standalone set of Operational Guidelines and assessment protocols could be developed for psychosocial disability. These should reflect the principles of recovery and map to the service support frameworks familiar to the mental health sector. It is essential that staff conducting the assessments and eligibility criteria have the right experience and qualifications to apply the tools to the circumstances of individual participants.

Alternatively, the Operational Guidelines could be revised to provide direction on different approaches appropriate for different types of disabilities. Currently, the Operational Guidelines on planning and assessment and review of support plans do not make any reference to differentiation in approach to an individual with a mental illness. This is of particular concern in relation to the appointment of nominees, as no reference is made to potential sensitivities in the relationship between a consumers and his or her carer(s).

Another useful approach might be to develop client navigation tools that clearly articulate the relationship between the NDIS and other available supports, and indicate where the central contact points, or information guides are, to navigate the system. These materials may already exist (e.g. within the NDIS participant portal) but no evidence could be found confirming this. Such a tool would indicate the level of assistance from designated individuals (e.g. an NDIA official, a provider, a state-funded health service, etc) that someone should expect in order to navigate the system. If governments collectively have determined to run a multifaceted community support system, then responsibility for navigating that system lies with governments and not with consumers and carers themselves.

The mental health "system" has long been identified as being unnecessarily complex and further consideration of how to mitigate any additional complexity resulting from implementation of the NDIS will improve outcomes for consumers, carers, service providers and governments.

8. Recommended actions

The table below summarises the options for policy action in the preceding section, along with some considerations that can assist in determining immediate responses to the concerns outlined in this paper.

POLICY OPTION	IMPLEMENTABLE WITHOUT SIGNIFICANT SYSTEM RESISITANCE	LIKELY TO BE EFFECTIVE IN SOLVING CURRENT NDIS TRANSITION PROBLEMS	LIKELY TO IMPROVE OUTCOMES FOR CONSUMERS IN THE LONG TERM	RECOMMENDED AS A POLICY RESPONSE
Annual or semi-annual Joint Sitting of Disability Reform Council and Health Council	✓	✓	✓	✓
Establishment of Ministerial Council on Mental Health Reform	✗	✓	✓	✓
Mental Health Community Support NDIS Risk Management Report	✗	✓	✓	✓
Legislative change to s24 and s29 of the National Disability Insurance Scheme Act	✗	✗	✓	✗
Develop a suite of operational tools to improve operational application of the element ‘or likely to be’ in s24 (1) (b) of the NDIS Act.	✓	✗	✓	✓
Expand the scope and responsibilities of the NDIA	✗	✗	?	✗
Withdraw psychiatric disability from the NDIS and let states run community support programs and policy	✗	✗	✗	✗

Governments Commit to a cross jurisdictional service guarantee, potentially through the scheduled revision to Annex E of the intergovernmental agreement, regarding continuity of support.	✗	✓	✓	✓
Commitment by governments to report publically on outcomes for those with a severe mental illness not accepted into the NDIS.	✓	✓	✓	✓
Development of psychiatric disability specific set of operational guidelines	✓	✓	✓	✓
Development of mental health specific overall system navigation tools	✓	✓	✓	✓

Appendix A – NMHSPF Background

Definition of the population size requiring support is the first step in identifying the amount of support that needs to be available in the system. The next step is to split the population into 'like' groupings and make an epidemiological linkage between these groupings and the service activity they require. This amalgam of service activity is called the service package.

The 'package' identifies the amount of each anticipated service element needed for the relevant populations as determined by expert opinion and the academic literature. This is a description of the NMHSPF process.

This is an evidence-based method for determining the overall population need for support and allows aggregation of service activity by service element. In order to make this a meaningful exercise however, the number of service elements needs to be limited to those that are genuinely differentiable and not those that just have different terminology but similar service offerings. That is, a national taxonomy of service elements is required.

The defined service elements in the taxonomy developed by the NMHSPF was determined by academic and clinical consensus with reference to the available literature. The taxonomy breaks up the services offered to individuals with mental illnesses into five service streams, these being:

- Primary and Specialised Clinical Ambulatory Mental Health care services
- Specialised Mental Health Community Support Services
- Specialised Bed Based Mental Health Care Services
- Medications
- Non Mental Health Care Services

This group of five streams encompasses all activity that is relevant to the care of someone with a mental illness. Of course, the NDIS does not purport to intrude on much of this space. The NDIS service offerings, including the services identified for in-kind support from participating jurisdictions, are only relevant to one of these streams; Specialised Mental Health Community Support Services. As such, further description will only focus on this stream.

Within the Specialised Mental Health Community Support Services stream there are four service categories that make up the totality of community support services that are modelled by the NMHSPF. These services categories are:

- Individual Support and Rehabilitation Services
- Group Support and Rehabilitation Services

- Other Residential Services
- Family and Carer Support

Each of the service elements that appear in the care packages fit into one of the four categories above. The table below demonstrates how the elements fit in.

Table 1: Service elements within each category of the Specialised Mental Health Community Support services stream.

SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES STREAM	
SERVICE CATEGORIES	**SERVICE ELEMENTS**
Individual Support and Rehabilitation Services	• Individual Support and Rehabilitation • Individual Peer work
Group Support and Rehabilitation Services	• Group Support and Rehabilitation • Group based Peer work
Other Residential Services	• Residential Crisis and Respite Services
Family and Carer Support	• Flexible respite • Day respite • Family Support Services • Group Carer Support Services • Individual Carer Support Services

It is at the service element level of the taxonomy that this paper will focus as it allows aggregation of service need for the purposes of identifying whether government investment is both adequate in quantum but also in its targeting. However to give examples of the types of service activity that might make up 'individual support and rehabilitation' as described in the NMHSPF taxonomy, this includes:

'Individual Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well'; individual Support and Rehab linked to early childhood, education and/or employment; individual Support and Rehab linked to enhanced relationships and social participation; and Individual Support and Rehab linked to health management services.

Practical examples of this is assisting people with mental illness in their day to day needs such as shopping or household chores, assisting them to study and get jobs, assisting people to maintain contact with family and friends or assisting people to comply with their medications and attend appointments. These are all activities within the NDIS remit. Group Support and Rehabilitation services provide similar activities except in a group setting, providing for more efficient delivery and greater social contact for participants.

It is useful at this point to compare the taxonomy of services types identified by the expert groups as part of the NMHSPF with the support types envisaged by the NDIS and that are currently available through identified in kind contributing programs.

NDIS Type Supports

Individually Funded Packages (Tier 3)

Section 34 of the Act provides that 'for the purposes of specifying, in a statement of participant supports, the general supports that will be provided, and the reasonable and necessary supports that will be funded, the CEO [of the NDIA] must be satisfied of all of the following in relation to the funding or provision of each such support:

- the support will assist the participant to pursue the goals, objectives and aspirations included in the participant's statement of goals and aspirations;
- the support will assist the participant to undertake activities, so as to facilitate the participant's social and economic participation;
- the support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support;
- the support will be, or is likely to be, effective and beneficial for the participant, having regard to current good practice;
- the funding or provision of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide;
- the support is most appropriately funded or provided through the National Disability Insurance Scheme, and is not more appropriately funded or provided through other general systems of service delivery or support services offered by a person, agency or body, or systems of service delivery or support services offered:

The Act also provides that the National Disability Insurance Scheme rules may prescribe methods or criteria to be applied, or matters to which the CEO is to have regard, in deciding whether or not he or she is satisfied as to the meeting of the principles above. These are contained in the National Disability Scheme (Support for Participants) Rules 2013, and include matters such as value for money, whether the support is effective or beneficial, reasonable with regard to expectations on carers and family and whether the support is appropriate to the NDIS. Importantly the Rules specify that operational guidelines must exist to assess matters relating to decisions about participant supports. As such the range of available operational guidelines regarding supports provides insights to the types of services the NDIS expects to provide. The following table indicates the types of supports for which the NDIA have developed operational guidelines with the ones most relevant to mental health in bold.

Table 2: NDIA Operational Guidelines

SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES STREAM
• Assistive Technology
• Home Modifications
• Motor Vehicle Modifications
• Supports for early childhood
• ***Supports for Employment, Vocational Training and Higher Education***
• ***Supports for Sustaining Informal Supports***
• ***Household Tasks***
• Interface with Child Protection Support and Family Support
• ***Interface with Health***

SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES STREAM

- Interface with Justice
- Interface with School education
- *Interface with transport*
- *Interface with Housing and Community Infrastructure*
- *Interface with Mental Health*
- *Personal Care Supports*
- Prosthetic Limbs
- *Recreation Supports*

It is evident that these supports are entirely consistent with the individual and group support and rehabilitation items in the NMHSPF, although interestingly all of the relevant operational guidelines are silent on the role of peer workers. They are neither explicitly referenced as a type of support, nor as an example of the nature of a support type, but neither are peers excluded as a group who could provide the support. This may be a material consideration when considering the reference to NMHSPF care packages modelling as a method of estimating the numbers to go through the scheme.

Information, Linkages and Capacity Building (previously tier 2)

The NDIA recently released a policy framework that addressed those supports that would be available to individuals who did not meet the criteria for an individualised support package. Access to this group of supports is available for families and carers as well as those who do not meet the threshold for an individualised funding package. The five proposed streams of support under the ILC framework are:

- Information, linkages and referrals
- Capacity building for mainstream services
- Community awareness and capacity building
- Individual capacity building
- Local Area Co-ordination.

The information, linkages and referrals stream largely focuses on assisting people to navigate the system providing information and referral to existing mainstream services and where applicable the NDIS itself. This stream makes specific reference to encouraging peer support although it is not clear if that indicates an intention to fund access to peer workers. It is designed as funding to organisations to deliver programmes rather than as funding filtered through an individual care plan, and driven by client demand. The overlap with NMHSPF is unclear, but it does appear to have some relationship.

The capacity building for mainstream services support is targeted at mainstream organisations to improve their capacity in dealing with people with a disability. It has no obvious overlap with the NMHSPF support types. Similarly the community awareness and capacity building support is aimed at community wide improvement in dealing with people with disabilities and has no obvious overlap with the NMHSPF care package taxonomy.

The individual capacity building supports are aimed at funding organisations to offer one off or low level supports to assist people with a disability. This includes counselling for families and carers and diagnosis specific peer support groups. This stream does have overlaps with the NMHSPF taxonomy meeting some of the need for those outside the criteria for an IFP.

The policy framework does not indicate however the overall budget for the ILC program or the split between the five streams.

The final stream, Local area Co-ordination is a navigation tool for people to make full use of mainstream services and informal services outside the NDIS. It has a heavy focus on prevention activities, community inclusion and the development of networks. It is unlikely to have a significant overlap with the NMHSPF taxonomy however there are some components that are reflected in this stream.

It is important to understand how much funding is going into the ILC program and how it is to be split between the streams, in order to assess how much of the non IFP need will be met by this program.

Mental Health
Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
ABN 57 600 066 635

P 02 6285 3100
F 02 6285 2166
E info@mhaustralia.org
W mhaustralia.org