



***Submission to the Joint Standing Committee
on the National Disability Insurance Scheme
into the provision of services under the NDIS
for people with psychosocial disabilities
related to a mental health condition***

FEBRUARY 2017

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About Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Overview

The National Disability Insurance Scheme (NDIS) has great potential to improve the lives of people with psychosocial disability associated with mental illness. It will provide access to the supports they need to aid recovery and to live meaningful and contributing lives.

Mental Health Australia acknowledges the efforts of the staff of the Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA) who, in implementing the NDIS, have sought to be faithful to the overarching design and structure proposed by the Productivity Commission.



Unfortunately, implementation has presented a range of policy and operational issues for people with psychosocial disability:

- The access criteria (the requirement for a person to provide evidence of a psychiatric condition and to have an impairment that is permanent or likely to be permanent) is difficult to reconcile with contemporary, recovery-focussed mental health management and service delivery. This is a barrier to entry that did not exist under many of the psychosocial support programs that will disappear to make way for the NDIS
- Assessment against the eligibility criteria appears to arrive at inconsistent and unexpected outcomes. The assessment process is not transparent and the review process is not the appropriate vehicle to identify and resolve any inconsistency in the way eligibility is assessed
- There is a major risk of widening gaps in access to services for people who are not eligible for the NDIS, due to the winding down of government programs that currently deliver psychosocial services
- The most obvious sources of referral to the NDIS, i.e. assertive outreach services, general practitioners, mental health nurses and allied mental health professionals, are yet to receive the information and resources they need to assist people to access the NDIS
- Planning processes for people who are eligible for the NDIS are yet to mature to reflect best practice in mental health. Planning for people with psychosocial disability is a specialised task, and many people report receiving NDIS plans that are not fit for purpose or tailored for their individual needs
- The Information, Linkages and Capacity Building (ILC) initiative is not yet filling the gaps in services created by NDIS transition, and is unlikely to do so without substantial additional investment.

At a systems level, roles and responsibilities are still unclear. There is much work still to be done to clarify specifically how Local Area Coordinators (LACs), Primary Health Networks (PHNs) and Local Health Networks (LHNs) will ensure people with psychosocial disability will access NDIS and/or other services, and how they will support the provision of integrated care through the stepped care model recently adopted by the Australian Government.

Further, there appears to be no mechanism to ensure that government funding for mental health services is (at least) maintained so that there is no reduction in access to services for people with severe and complex mental illness as a result of the introduction of the NDIS.

It should be noted that all of the issues discussed in this submission have been raised by Mental Health Australia with the NDIA, DSS and other government representatives on many occasions. Some of the core design problems relating to eligibility, funding and scope were raised with government prior to the Scheme's commencement, and even prior to the passing of the *National Disability Insurance Scheme Act 2013* (the Act). The failure to address these issues, after such a long period of consideration, and after such clear articulation over time, suggests the current governance arrangements for the NDIS, and for the systems that interact with it, are not fit for purpose.

Recommendations

Mental Health Australia makes the following recommendations to address the issues raised in this submission:

- The NDIA should specify which tools (if any) are used to assess psychosocial disability for people making access requests, and describe in detail what safeguards it has in place around the consistent interpretation of the provisions in the Act as they relate to the assessment of psychosocial disability
- The Australian Government should continue to fund community-based psychosocial services for people who do not enter the NDIS
- State and Territory Governments should ensure people who do not enter the NDIS have access to community-based mental health services
- The Australian Government should invest in capacity building activities designed to build knowledge and capability amongst mental health service providers (including primary care practitioners) regarding the respective roles of PHNs, LHNs, LACs and the NDIA
- The National Mental Health Commission should take the lead in keeping governments accountable by tracking mental health expenditure, including spending within and outside the NDIS, on a regular and ongoing basis
- Governments should develop and implement a strategy to provide assertive outreach for every person with severe mental illness and/or complex needs who may be eligible for the NDIS, building on the success of the Partners in Recovery Program
- The Australian Government should invest in research that answers the question “What constitutes optimal psychosocial support for various cohorts?”, whether delivered inside or outside the NDIS
- The Australian Government continue funding respite for carers of people with mental illness who do not enter the NDIS, and where existing supports for NDIS participants will not be funded by the NDIS.

Eligibility criteria for psychosocial disability

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

The National Mental Health Consumer and Carer Forum describes psychosocial disability as:

The disability experience of people with impairments and participation restrictions related to mental health conditions. These impairments and restrictions include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Not all people with a mental health condition will experience a psychosocial disability. Many people with a mental illness will lead fulfilling and productive lives with little support. However, effects of psychosocial disability can be severe and the impact is frequently underestimated both for people with a psychosocial disability and for their carers.¹

¹ National Mental Health Consumer and Carer Forum, *Unravelling Psychosocial Disability – Summary Brochure*, 2011, p1

The legislation for the NDIS presents something of a clash in philosophies when it comes to mental health and the NDIS. The ‘permanent impairment’ requirement in section 24 of the Act may make sense when you consider certain disabilities that result from impairments such as blindness or reduced mobility, which can leave people unable to live and work without support.

The idea of permanence is more problematic for someone with mental illness. Most people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly. Some people who experience severely debilitating mental illness aren’t going to need support and be in the mental health ‘system’ for a long time – only as long as they need for their symptoms to improve. Many consumer “survivors” of severe and persistent mental illness emphasise the importance of hope and a belief in their ability to grow and change for the better as keys to their recovery. On principle then it would seem unreasonable to deny hope to anyone with a severe and persistent mental illness, given the positive effects it can generate.

Further, for any two people with precisely the same diagnosis – of schizophrenia, say, or bipolar disorder – it can be impossible to predict which one might need long-term support, making the idea of a ‘permanent impairment’ difficult to fit with the realities of mental health. That said, many people with psychosocial disability will need, and should expect to receive, support over the long term, and perhaps for a lifetime. These are difficult tensions to reconcile within the policy and legislative framework as it currently exists.

It is possible, in the assessment process for access to the NDIS, to apply the legislation in a way that applies a recovery oriented philosophy² and this is recognised in the NDIA’s fact sheet *Psychosocial disability, recovery and the NDIS*.

However, based on feedback from the mental health sector, there is some concern about inconsistent outcomes of the assessment process, and it is not clear whether this has to do with the ‘permanent impairment’ requirement or other factors.

In its advice for implementing the NDIS for people with mental health issues³, the NDIS Independent Advisory Council found there was “no commonly accepted and used instruments for assessing functional impairments and indicating support needs related to disability due to a psychiatric condition”. The Council highlighted the risk of inconsistent approaches in both eligibility and support needs being determined by the NDIA.

There is a need for greater transparency regarding the assessment mechanism used to assess people with psychosocial disability to better understand whether there are sufficient safeguards around the fair and consistent application of the Act.

In the meantime, the only avenue available to people who have been assessed as ineligible is to seek review of the decision under section 99 of the Act that a person does not meet the access criteria. This is not an appropriate way to redress inconsistency, whether that inconsistency stems from the lack of an appropriate assessment tool, a capability problem within the NDIA, or other factors.

Mental Health Australia therefore urges the Committee to seek clarification from the NDIA as to whether an appropriate tool has been developed to assess psychosocial disability, and whether there are clear safeguards around the consistent interpretation of the provisions in the Act as they relate to the assessment of psychosocial disability.

² The *National framework for recovery-oriented mental health services* was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) on 12 July 2013

³ Independent Advisory Council for the National Disability Insurance Scheme, *IAC advice on implementing the NDIS for people with mental health issues*, 2014

Transition of Commonwealth funded services

b. The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular; whether these services will continue to be provided for people deemed ineligible for the NDIS.

It is evident that not all of the people who had access to psychosocial services under existing community based programs will be able to access the NDIS, either because they have been or will be assessed as ineligible, or they do not apply.

There is a well-founded concern that people with a moderate to high level of impairment resulting from their mental illness will have no access to psychosocial support if all Commonwealth funding for existing community based mental health services is moved to the NDIS. The NDIS understandably focusses on people with substantial disabilities – people who have missed out on adequate support for far too long. Unfortunately, the shift in resource allocation to a different target population means people with less severe or less ‘permanent’ forms of impairment will have substantially reduced access to services they are currently entitled to.

The unintended consequences of transferring funding for existing Commonwealth funded community mental health programs into the NDIS, and most likely a range of state and territory government programs, can only be seen as a policy failure.

A Flinders University evaluation of the NDIS has revealed that the NDIA’s pricing structures may pose a threat to the range of available disability supports. Some disability service providers indicated they would begin ceasing services that are not funded or under-funded under the NDIS, including mental health and community participation programs.⁴

If early intervention and other “temporary” services are no longer available, we will in time see a greater burden on the service system, including additional presentations at emergency departments, increased reliance on crisis accommodation services, and a greater risk of people with mental health issues encountering the criminal justice system. In the context of an insurance scheme which ought to reduce future risks, these arrangements appear misguided.

The Australian Government has estimated that 230,000 Australians with severe mental illness have a need for some form of social support, ranging from low intensity or group-based activities delivered through mainstream social services to extensive and individualised disability support.⁵ The NDIS is projected to cater for only 64,000 people who need psychosocial support.

In addition, PHNs are not permitted to commission psychosocial support services for those with mental illness. This is despite regional Needs Assessments concluding that successful treatment outcomes require a high degree of integration between specialised clinical services and generalist support and recovery programs.

Mental Health Australia recommends that the Commonwealth fill this glaring policy omission and continue funding for community-based psychosocial services for people who do not enter the NDIS.

⁴ K. Mavromaras, M. Moskos & S. Mahuteau, *Evaluation of the NDIS: Intermediate Report*, 2016

⁵ Department of Health. *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. 2015 Page 17

Transition of state and territory mental health services

c. The transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular; whether these services will continue to be provided for people deemed ineligible for the NDIS.

Each State and Territory has made different decisions about how to meet their funding commitments on the NDIS, with different implications for access to mental health services in the long term. Some jurisdictions appear to have withdrawn completely from funding any community-based mental health services outside the NDIS, while others have decided that such investments will be maintained beyond Full Scheme. This is a complex situation and information about the decisions of each government is difficult to interpret. However, it is arguable whether we can claim to have a 'national' Scheme where circumstances vary so significantly from state to state.

Given the size of the population of people with psychosocial support needs who will not be NDIS-eligible (as described above), there is an ongoing need in every state and territory to ensure non-participants have access to community-based mental health services. In the absence of such services, demand for crisis-driven and acute care services will inevitably rise, ultimately at greater cost to governments and for individuals and families.

Funding for mental health services under the ILC

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

Mental Health Australia is confident that a well-designed and appropriately funded system of ILC services (including LAC) can make a vital contribution to improve the interface between the NDIS and mainstream services, help to alleviate some of the fragmentation within the disability system and assist mainstream services to be inclusive of people with disability.

However, these objectives will be hampered by the loss of Commonwealth programs for people who are ineligible for NDIS Individually Funded Packages. A sudden and significant decrease in services available to this cohort would undermine ILC's effectiveness. For example, LACs and PHNs will be unable to refer people with psychosocial disability to appropriate services.

In addition, the uncertainty around availability of services for people with psychosocial disability is heightened by the lack of transparency with which additional programs have been identified as in scope for ILC. The ILC Commissioning Framework states:

State and Territory governments will work with organisations that currently deliver activities that may fit into ILC in the future to let them know what the funding arrangements will be leading up to the start of ILC in their State.⁶

Although Mental Health Australia understands the importance of ensuring funding is invested strategically and inefficiencies are avoided, a concern remains as to whether funding will be withdrawn from successful programs in advance of ILC rolling out in particular locations.

In this context of uncertainty, Mental Health Australia welcomes the government's commitment through the ILC policy framework that ILC could fund "one-off, low level or episodic supports which focus on preventative intervention (for example counselling)."⁷ In particular, Mental Health Australia supports the intention to ensure people get early support which could prevent someone ultimately needing an IFP under the NDIS. However, it is

⁶National Disability Insurance Agency, *ILC Commissioning Framework*, 2016, p30

⁷ National Disability Insurance Agency, *ILC Policy Framework*, p13

unclear what types and volumes of psychosocial support services will be commissioned under ILC and for whom, particularly given ILC will “not fund activities that rightly belong in an NDIS plan or package”.⁸

In addition Mental Health Australia remains concerned about how ILC could adequately fund such services within the limited budget, which has been allocated to fund multiple types of services to be accessed by people with all disability types (\$33 million in 2016-17 growing to \$131 million by 2019-20).⁹ Indeed, the outgoing Chair of the NDIA, Mr Bruce Bonyhady AM, acknowledged these amounts to be insufficient for ILC to reach its goals.¹⁰

Planning process and Primary Health Networks

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

Mental Health Australia supports the intention of the NDIS to provide people with disabilities with more choice and control over how, when and where supports are provided, and acknowledges that an individualised planning process is a core feature enabling NDIS participants to decisions about their support.

Information which has emerged from NDIS trial and transition sites suggests that key features of a planning process which facilitates authentic choice and control for people with psychosocial disability include:

- engagement with mental health consumers in a manner appropriate to their distinctive circumstances
- extensive recovery-focussed pre-planning support
- appropriate engagement by NDIA staff and/or the LAC provider with the participant’s key existing supports, for example mental health carers and/or support workers throughout the planning process
- effective outreach mechanisms including an appropriately informed network of primary health professionals
- access to appropriately skilled NDIA planners who have an understanding of mental health conditions.

Mental Health Australia acknowledges the difficult task faced by the NDIA in meeting ambitious roll-out targets established by the NDIS Intergovernmental Agreements. It appears that in establishing the “First Plan” process the NDIA has attempted to balance its swift roll out with the need to respond to lessons learnt through trial site experiences. Despite the pressures on the NDIA, it is important that the planning process supports mental health consumers to effectively exercise choice and control.

Consultations undertaken to inform a recently released joint report by Mental Health Australia and the NDIA stressed the importance of engaging consumers and carers on their terms and in a manner appropriate to their distinctive circumstances.¹¹ The consultations highlighted that the majority of NDIS participants with psychosocial disability will have had minimal experience with choice and control. Accordingly, significant support may be required to assist a participant to prepare for their first planning meeting. The report noted that this process can take several months to complete.

⁸ National Disability Insurance Agency, *ILC Commissioning Framework*, 2016, p21

⁹ National Disability Insurance Agency, *Community Inclusion and Capability Development Program Guidelines: Implementing Information, Linkages and Capacity Building*, 2016, p. 7

¹⁰ Naomi, W., *NDIS: Outgoing chair Bruce Bonyhady pushes for independent board with disability experience*. ABC News website. 2016

¹¹ National Disability Insurance Agency and Mental Health Australia, *Psychosocial Supports Design Project – Final Report*, 2016, p 17

In addition, the Flinders University evaluation has found that people with mental health and psychosocial disability are more likely to report less choice and control since becoming NDIS participants. This trend is a reported consequence of difficulties navigating the system, a lack of quality services, and a reduced ability to articulate their support needs.¹²

Mental Health Australia therefore welcomes the NDIA commissioning community sector organisations as LACs, given the significant knowledge already residing in the community sector about how to work effectively with people with psychosocial disability. However, Mental Health Australia has also raised concerns about NDIS registered providers being excluded from applying for LAC funding. Many organisations which employ a suitably trained and experienced workforce will not be able to provide LAC services, as they will already be NDIS-registered. Since LAC services were first commissioned, some providers have raised concerns about the lack of awareness by particular LAC providers about psychosocial disability. Providers have also observed support workers being excluded from NDIS planning meetings, even where their contributions would benefit a participant.

Evidence emerged early in NDIS trial sites of the importance of including existing key support people in the NDIS planning process. For example, a report by Psychiatric Disability Services of Victoria stated that “consumers have consistently reported the value of having a support worker or advocate to assist them in the planning process, in trying to establish eligibility and in following up on plans, and that when available it contributed to the successful outcome and their positive experience of the planning process”.¹³ That report also observed that “trusting relationships can play a major role in helping people with psychosocial disability identify and articulate their goals”.¹⁴ In addition, an issues paper developed jointly by Mental Health Australia and Carers Australia clearly outlines the benefits of including mental health carers in the NDIS Planning process, which helps improve the accuracy of the needs assessment (and therefore appropriateness of the plan) and assists to keep informal care arrangements sustainable.¹⁵

In recognition of the importance of trusting and ongoing relationships between participants and providers and/or carers (where these already exist), Mental Health Australia recommends that the NDIA provides guidance to LACs to encourage inclusion of support workers in pre-planning and planning conversations, where potential NDIS participants agree.

It is important to highlight that PHNs do not have a role in the planning process for individual NDIS plans. Their primary role is in regional mental health planning and service commissioning, which excludes the ability to commission psychosocial support services. Perhaps as a result of that government directive, only a few of the Regional Needs Assessments conducted by PHNs to date identify psychosocial services as a pressing need for their communities.¹⁶ This conflicts with information from other parts of the mental health sector, which often draws attention to the ongoing need for such services.

Further, while PHN lead sites are required to develop regional community mental health and suicide prevention plans in collaboration with NDIS providers¹⁷ (of psychosocial services), there is little to be gained by other PHNs planning for psychosocial services when the provider market is solely dependent upon decisions made by the NDIA in respect of participants' plans.

In time, PHNs will be required to promote the use of single multiagency care plans for people with severe and complex mental illness.¹⁸ While this will enable primary health professionals to include psychosocial services in a person's plan, it will also require them to assist people to access the NDIS. Mental Health Australia believes there is a broader need for all PHNs (i.e.

¹² K. Mavromaras, M. Moskos & S. Mahuteau, *Evaluation of the NDIS: Intermediate Report*, 2016

¹³ Psychiatric Disability Services of Victoria, *Learn and Build in Barwon*, 2015, p16.

¹⁴ National Disability Insurance Agency and Mental Health Australia, *Psychosocial Supports Design Project – Final Report*, 2016, p 17

¹⁵ Mental Health Australia and Carers Australia, *Mental Health Carers and the National Disability Insurance Scheme*, 2016

¹⁶ Based on a review by Mental Health Australia on the PHN Needs Assessments conducted in January 2017.

¹⁷ Department of Health, *Mental Health PHN Circular 1*, 12 January 2016

¹⁸ Department of Health, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Primary Mental Health Care Services for People with Severe Mental Illness*. 2016

not just PHNs in stepped mental health care lead sites) to ensure all primary healthcare professionals in their area are able to assist mental health consumers to access the NDIS once NDIS transition reaches their locality.

Mental Health Australia therefore recommends that the Australian Government invest in capacity building activities designed to build knowledge and capability amongst mental health service providers (including primary care practitioners) regarding the respective roles of PHNs, LHNs, LACs and the NDIA.

Mental health consumers, carers and providers have on many occasions raised concerns about NDIA planners' understanding of psychosocial disability. Mental Health Australia would like to recognise the efforts of the NDIA Mental Health Team's work to address this and other important implementation issues. Initiatives such as the establishment of an internal NDIA Community of Practice on psychosocial disability and the provision of training are designed to build the understanding of NDIA staff about psychosocial disability. It is imperative that this work continues, to ensure the planning process results in informed decisions regarding reasonable and necessary supports for people with psychosocial disability.

Spending on psychosocial disability services

f. Whether spending on services for people with a psychosocial disability is in line with projections.

It should be noted here that it is currently unclear what might constitute "optimal spending" on psychosocial support for any given cohort of people, or for any individual. It is therefore possible to argue that even if spending on psychosocial support services was "in line with projections" this may not be desirable. The National Mental Health Services Planning Framework has gone some way to documenting evidence based support packages, but this work is as yet unpublished and untested.

Mental Health Australia therefore recommends that the Australian Government invest in research that answers the question "What constitutes optimal psychosocial support for various cohorts?", whether delivered inside or outside the NDIS.

The NDIS has been funded in part by transferring funding from existing mental health programs progressively into the NDIS. There has never been transparency regarding budgets for, or expenditure on, those programs in Commonwealth budget documents. Therefore, it is impossible to monitor whether the quantum of Commonwealth funding for existing community mental health programs will be maintained as those funds are transferred to the NDIS.

It should be noted that in reality, the Australia Government's mental health reforms are in large part reform of the financial arrangements for mental health services and involve "cost shifting" between Commonwealth departments, the NDIS, PHNs and between governments. Without additional measures to improve accountability, there is a very real risk that there will be a decline in aggregate spending on community-based mental health services.

In fact, such a decline may already be already occurring. Mental Health Australia's analysis comparing the 2014-15 and 2016-17 Australian Government Budget papers shows annual reductions of up to 7.1% in the projected spending for community based mental health services that help people with severe mental illness to live contributing lives. Without more detailed information, it is difficult for non-government stakeholders to understand how spending on community mental health services is changing over time.

Mental Health Australia recommends that the National Mental Health Commission take the lead in keeping governments accountable and tracking mental health expenditure during reform implementation. This should include monitoring to determine:

- How much governments spend on what services in mental health, including at regional levels, and whether expenditure matches budget allocations in practice;
- Whether ongoing reforms inadvertently result in a concentration of service availability for some groups at the cost of gaps in services for others.
- Previous spending, funding allocation, re-allocation and subsequent spending by governments, via line agencies, the NDIS and PHNs from the 15-16 financial year through to July 2019.

Outreach services for psychosocial disability

g. The role and extent of outreach services to identify potential NDIS participants with a psychosocial disability.

The Productivity Commission's report on Disability Care and Support noted that people with disability are over-represented among the homeless, in the criminal justice system, and in boarding houses. The Commission identified that "outreach services will still be required... the NDIS should provide homeless outreach services.... to connect people"¹⁹ to the Agency and a broader range of services. The need for outreach services is critical, with 75 per cent of homeless people in inner Sydney having at least one mental disorder.²⁰

The Partners in Recovery (PIR) program facilitates better coordination of and more streamlined access to the clinical and other service and support needs of people experiencing severe and persistent mental illness with complex needs requiring a multi-agency response.²¹ PIR has enabled organisations to provide assertive outreach services to locate potential clients in the community, rather than waiting for clients to approach a service. PIR organisations have specific strategies for assertive outreach which have shown significant results in reaching and engaging the most hard to reach clients.²²

During the transition to full rollout of the NDIS, with interim block funding arrangements applying during that time, it is difficult to track where, and to what extent, assertive outreach is continuing to be provided.

In the long term, without specific policy and funding arrangements, there is a risk assertive outreach for people with severe mental illness and complex needs will no longer be delivered, either through the NDIS or elsewhere. Assertive outreach takes place before someone accesses the NDIS, so NDIS registered service providers are not be able to charge the NDIA for outreach services (regardless of whether a consumer ultimately becomes an NDIS participant). Further, the very low prices on offer for NDIS supports mean that providers of psychosocial services have no scope to cross-subsidise assertive outreach activities. Without direct funding for assertive outreach, the organisations that regularly work with hard to reach people are unlikely to continue this activity.

Outreach services are not included in the ILC Commissioning Framework or the Community Inclusion and Capacity Development Program Guidelines. Therefore, it would seem that, at this point in time, outreach services can only be delivered through the LAC function; by way of illustration, tender documentation for LAC arrangements in Victoria state that LACs will "[engage in] active outreach programs for those people with disability less connected to

¹⁹ Productivity Commission, *Inquiry Report – Disability Care and Support*, 2011, p233

²⁰ O T. Hodder, M. Teesson, and N. Buhrich, *Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Service Use among Homeless People in Inner Sydney*, Sydney City Mission, Sydney, 1998

²¹ Department of Health and Ageing. *Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative Program. Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16.*

²² Urbis. *Partners in Recovery Annual Report 2014-2015*. July 2015. Prepared for the Department of Health

existing disability supports so that they are aware of the Scheme and they experience a smooth transition to the Scheme”.²³ However, it would also be appropriate that providers of psychosocial services, who have regular and direct contact with people with psychosocial disability, are also funded to undertake assertive outreach with potential NDIS participants and work with them over time until they are ready to make an NDIS access request and/or approach other mainstream services for assistance.

To ensure every person with severe and complex mental illness who may be eligible for the NDIS has an opportunity to access supports, governments must ensure specialised assertive outreach services are delivered throughout NDIS transition and beyond. Future efforts should build on the key features of the PIR Program and the role of PIR support facilitators. Outreach should remain a function of the mental health system, harmonised or integrated with the LAC role.

Provision and continuation of forensic disability services

h. The provision, and continuation of services for NDIS participants in receipt of forensic disability services.

The COAG *Applied Principles for Determining the Responsibilities of the NDIS and Other Service Systems* provide guidance on which system(s) is ultimately responsible for funding which kinds of services. Feedback provided to Mental Health Australia suggests that the Principles relating to the justice system have in practice proved difficult to interpret, with uncertainty about which circumstances would give rise to either the NDIS or forensic mental health services taking responsibility for a particular service.

Mental Health Australia understands the NDIA is aware of this issue and is seeking to develop solutions in collaboration with State/Territory corrective services agencies.

Carer Support

i. Any related matter.

The Mental Health Respite: Carer Support (MHR:CS) Program funded by the Department of Social Services (DSS) provides relief from the caring role, through in-home or out-of-home respite or social and recreational activities; carer support, including counselling, practical assistance, social inclusion activities, and case management; and education, information and access including community mental health promotion.

The MHR:CS Program has been identified as in scope for the NDIS. A note on the DSS website for the program advises that “clients living in a trial site will continue to access their current services, and have their eligibility for the NDIS assessed over time”²⁴. However, given the NDIS is a participant focussed scheme, it is difficult to see how this will work in practice and over the long term.

In addition, the NDIS does not fund respite. The suite of supports for family and carers are not a direct match with the supports provided under the MHR:CS program. Instead the supports focus on the participant while building the skills and capacity of other family members to manage the impact of a participant’s disability on family life.

²³ National Disability Insurance Agency, *Local Area Coordination Tender SoR*, p13&65.

²⁴ <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services#6>

It should be noted that ILC may fund some activities for carers, but there is a caveat in the commissioning framework that emphasises the outcome is for the NDIS participant:

We will also fund some activities that will be targeted at families and carers. But we will need to make sure that those activities deliver an outcome for the person with disability they support. We must do that to comply with the National Disability Insurance Scheme Act 2013.²⁵

This is another unintended consequence of NDIS rollout which to date has not been addressed to the satisfaction of mental health carers. While work is being done by DSS on an 'Integrated Plan for Carer Support Services' and a 'Service Delivery Model', carers are reporting that they are now not receiving supports that they previously had access to.

Mental Health Australia recommends that the Commonwealth continue funding respite for carers of people with mental illness who do not enter the NDIS, or where existing supports are now not covered by the NDIS.

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²⁵ National Disability Insurance Agency. *Information, Linkages and Capacity Building Commissioning Framework*. November 2016. Page 20

Mental Health Australia



Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent,
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