

23 February 2017

Committee Secretary
Joint Standing Committee on the National Disability Insurance Scheme
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email to: ndis.sen@aph.gov.au

Dear Committee Secretary

Re: The provision of services under the National Disability Insurance Scheme for people with psychosocial disabilities related to a mental health condition

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to provide a written submission to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) regarding the inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

The RANZCP has almost 6000 members including more than 4000 fully qualified psychiatrists, many of whom have specific interest and expertise relevant to this inquiry. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

The RANZCP supports the purpose of this inquiry and welcomes the opportunity to contribute. The RANZCP strongly supports the establishment of the NDIS. In vesting choice and control in the hands of consumers, rather than support services, the NDIS will help to encourage person-centred and recovery-oriented approaches to care across the sector. These principles are recognised by the RANZCP to be crucial in the provision of best-practice care.

However, the RANZCP has been concerned at how the NDIS was to account for people with psychosocial disability in its approach, funding and scope. The details of how participants with psychosocial disability will be supported to apply for the NDIS, to develop their individually funded packages (IFPs; if eligible) and/or to achieve suitable outcomes also requires further clarification.

Please see the attached submission which we hope will be of assistance.



If you would like to discuss any of the issues raised in the submission, please contact Rosie Forster, Senior Department Manager, Practice, Policy and Partnerships via

Yours sincerely

Professor Malcolm Hopwood
President

Ref: 0621o



The Royal
Australian &
New Zealand
College of
Psychiatrists

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

February 2017

advocating for equitable access to services

Royal Australian and New Zealand College of Psychiatrists submission

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

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental healthcare. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a binational college has strong ties with associations in the Asia-Pacific region.

The RANZCP has almost 6000 members including more than 4000 fully qualified psychiatrists and nearly 1400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental healthcare in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Introduction

The RANZCP is pleased to provide a written submission to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) regarding the inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. We value the ongoing consultative approach taken by the National Disability Insurance Agency (NDIA) and other stakeholders and we are pleased that the concerns voiced by the RANZCP and others in the mental health sector are being increasingly heard. The Commonwealth Government deserves to be commended for its continued commitment to implementing the NDIS at a time when the imperative is to reduce national spending and the RANZCP looks forward to providing feedback to the Productivity Commission for its upcoming review into NDIS costs to help ensure the economic viability of the NDIS.

The RANZCP has been closely monitoring the design and implementation of the NDIS and has contributed to numerous consultations with the NDIA, including the following:

- [NDIA Personal care and community participation](#), April 2016
- [NDIS Information, Linkages and Capacity Building Commissioning Framework](#), April 2016
- [Independent review of the NDIS Act 2013](#), October 2015
- [NDIS Quality and safeguarding framework](#), April 2015
- [NDIS Information, Linkages and Capacity Building](#), March 2015.

The RANZCP strongly supports the establishment of the NDIS. We believe that the NDIS has the potential to improve the lives of many people and contribute to the formation of a more inclusive and prosperous society overall. In vesting choice and control in the hands of consumers, the NDIS will help to encourage person-centred and recovery-oriented approaches to care across the sector. These principles are recognised by the RANZCP to be crucial in the provision of best-practice care.

However, in order for this potential to be realised, the experience and support needs of consumers with mental illness and their families and carers must be addressed. The RANZCP has been concerned at the capacity of the NDIS to accommodate people with psychosocial disability in its approach, funding and scope, reflecting broad concerns in the mental health sector that there is a fundamental disconnect between the approach of the NDIS and the experience of mental illness. In particular, the RANZCP believes that details of how participants with psychosocial disability will be supported to apply for the NDIS, to develop their individually funded packages (IFPs) and to achieve suitable outcomes all requires further clarification. As such, while the RANZCP broadly supports the NDIS, it maintains that further fine tuning is needed in order to adequately address the psychosocial needs of Australians with disability.

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

The NDIS offers an unprecedented opportunity to improve the lives of people with disability in Australia. However, the RANZCP is concerned that the implementation of the NDIS risks distributing this potential unevenly, thereby continuing the discrimination experienced by people with psychosocial disability. Although the Productivity Commission (2011) estimated that 57,000 people with psychosocial disability would meet NDIS eligibility criteria, research from the National Mental Health Commission (NMHC) and unpublished government modelling from the National Mental Health Service Planning Framework suggest that the number of Australians with severe mental illness is many times this number (NMHC, 2014; Morton, 2016). Although not all of these people will require community support, the RANZCP is concerned that the NDIS is not prepared for the number of people with psychosocial disability who will require support under the NDIS. Under these conditions, the RANZCP is concerned that the access request process may become driven by budgetary considerations, rather than the best interests of applicants. It is therefore essential that eligibility criteria align with the experience of people living with psychosocial disability.

The RANZCP is particularly concerned about the centrality of disability 'permanence' in the eligibility criteria for the NDIS. Although the RANZCP appreciates that eligibility criteria now acknowledge that impairment can vary over time, the language of 'permanence' still does not fit with the recovery-oriented approach of the mental health sector. The permanence of their disability is not something that a significant proportion of people living with mental illness would want to acknowledge. Eligibility criteria that relies on permanence may therefore contribute to many individuals opting out of treatment if that treatment is predicated upon their acceptance of the lifelong nature of their illness. Best-practice mental health care aims to support consumers to arrive at their own definition of well-being using language and definitions that are meaningful to them. The language of empowerment, recovery and ability is emphasised over that of disability, impairment and illness. This approach, which complements the NDIS focus on enabling consumer choice, independence and participation, empowers consumers to work towards aims that are meaningful and achievable for them.

In contrast, access to full supports under the NDIS depends on an applicant's ability to show that their disability is permanent. This contrast in language means that establishing eligibility for consumers with mental illness will require them to straddle two conflicting philosophies and vocabularies related to their impairment. Consumers with significant mental or intellectual impairments may risk exclusion from the NDIS because of the way they understand and describe their situation, despite having high support needs. Given the considerable community investment in establishing a more empowering discourse regarding mental health, the return to the language of 'permanency' and 'disability' is a step backwards.

The RANZCP believes that there needs to be more flexibility within the NDIS eligibility criteria to encompass the lived experience of consumers with mental illness and the language used in best-practice approaches to mental health. Otherwise people with psychosocial disability may require additional supports to apply for the NDIS as their understanding of their disability, and the language which they use to describe it, may disadvantage them in this process.

The RANZCP welcomes provisions for a plan or correspondence nominee to accommodate people with psychosocial disability who may find it difficult to gain access to the NDIS due to their understanding of their illness. However, we are concerned that this may not go far enough, especially when it comes to people who are avoidant of services. In these instances, it may take a long period of assertive engagement and rapport building to encourage the person to engage and consent to assistance. In these scenarios, it would be useful for practitioners such as psychiatrists to be able to refer their patients to the NDIS.

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The RANZCP would also suggest an approach to eligibility that focuses more on functional impairment. For people with psychiatric disability, functional impairment is often a better measure than diagnosis when determining disability permanence. This is because diagnosing mental disorders is often less straightforward than for physical conditions. Mental health diagnoses are also more likely to change over time as the clinician learns more about the consumer, how they respond to various treatments, and the historical and environmental factors that may be impacting upon them. It is unclear how the NDIA will accommodate this complexity or whether a change in diagnosis may change the consumer's access to support.

Feedback from RANZCP members working in NDIS pilot sites indicates that some consumers with severe mental illness such as schizophrenia, severe personality disorder or autism disorder are having difficulty accessing supports because of a lack of understanding of, and/or effective assessment tools for, their impairment and needs. Other people whose diagnoses complicate their eligibility include:

- children and adolescents diagnosed with childhood disorders such as severe dyslexia who encounter difficulties with their eligibility once they turn 18 years of age and their needs change
- people with significant and/or complex comorbidities – for example, someone with mild to moderate physical and psychosocial disabilities may experience significant, lifelong impairment due to the combined and compounding effects of their conditions. While they may have very high support needs due to the combination of impairments, the diagnoses may not be considered severe enough for an IFP when considered individually. In NDIS pilot sites, this has reportedly led to very vulnerable people not being able to access the supports they need.

The RANZCP is also alarmed about the potential for a person aged 65 or over not being able to access services under either the NDIS or the *Aged Care Act 1997*. This is because current interpretations of the *Aged Care Act* mean that age and mental illness alone are not enough to qualify for services. An individual aged 65 and older who develops significant disability but is not considered 'frail' will not be eligible for support through the NDIS nor under the *Aged Care Act*. Such an individual will be at risk of falling through the cracks of the system and being left without any form of support at all.

Finally, more consideration needs to be given to ensuring that young people with mental illness have equitable access to the NDIS. Young people may not be formally diagnosed until later in life or may not yet realise, and perhaps should not yet be expected to consider, that their disability may be lifelong. They may yet have significant needs that are rightfully met under the NDIS.

Recommendations

- **Eligibility criteria which focus on functional impairment over a diagnosis of 'permanent' disability, accompanied by:**
 - **a clear understanding of what functional impairment means with regard to mental illness**
 - **capacity to account for the impact of comorbidities.**
- **Review of the relationship between the NDIS and the *Aged Care Act*.**
- **Evaluation of the accessibility of the NDIS for consumers with severe mental illness.**

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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

Partners in Recovery (PIR) programs and Personal Helpers and Mentors services (PHaMs) currently cater for a wide range of consumers, including people who are likely to fall outside the scope of the NDIS. After the transition, however, these people will still require supports and governments will still be responsible for providing them. Yet there is already evidence of people losing access to these supports due to their transition into the NDIS (Whiting, 2017).

The RANZCP would also note here that levels of impairment among people with psychosocial disability can change regularly, sometimes dramatically and without warning. Under these circumstances, RANZCP consumer representatives have emphasised the importance of having pre-existing supports and linkages. Existing networks can enable early intervention, decrease the need for crisis intervention and lower the risks of hospital admission, housing breakdown, job loss and increasing isolation.

The Information, Linkages and Capacity (ILC) Framework offers an important opportunity to establish such a safety net. Investment is required to ensure the ILC Framework is effective and responsive to the changing needs of participants. With appropriate resourcing and implementation, this has the potential to bolster opportunities for early intervention and, from an economic standpoint, deliver substantial return on investment.

Recommendations

- **Continuation of current levels of funding for PIR programs and PHaMs.**
- **Tracking funding over the transition to ensure that there is no overall loss in funding for services providing support to people with psychosocial disability.**
- **Continued provision of PIR programs and PHaMs to individuals outside the NDIS scope after the transition, whether through:**
 - **the provision of funding streams external to the NDIS, or**
 - **the operation of these programs under the NDIA, encompassing outreach to non-NDIS participants to identify and engage potential NDIS participants while continuing to provide programs to those not eligible for IFPs.**

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

Feedback from trial sites indicates that there is generally a 2- to 4-month delay from application to receiving services due to administrative issues, unavailability of services and/or interagency conflicts of interest. Many transitional services are being held up in anticipation of NDIS funding and some consumers have received no support at all. Wait times for accessing services should be assessed in order to identify ways for streamlining and simplifying the process.

The NDIS was never designed to cover all disabilities and governments must therefore ensure that the transition to the NDIS does not create service gaps for vulnerable people who fall outside the NDIS

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scope but who nevertheless rely on existing community programs. Currently, there is a serious risk that people living with mental illness who are not eligible for NDIS services are going to be left with less support than they have now. This is because NDIS funding agreements between the Commonwealth Government and most jurisdictions commit the majority of funding for existing non-clinical support services to the NDIS. As a result, many community mental health support programs will transition into the NDIS without equivalent programs being offered for those who fall outside its scope, whether this be due to their age, residency status or nature of their disability. This will leave major gaps in services for many people currently supported by existing programs.

The RANZCP is particularly concerned regarding the impact of the NDIS on the future well-being of people with intellectual and developmental disabilities (IDD). There are already reports of services experiencing unprecedented levels of inpatient admissions for children and adolescents with IDD and/or autism spectrum disorder. Without enough beds, young people may be admitted to adult mental health services or general paediatric services, neither of which are likely to be able to manage the symptoms of the often-distressed young person. In these circumstances, young people may become stuck in emergency departments which are even more inappropriate. This can often lead to the young person reaching crisis point and being institutionalised. In contrast, when psychiatrists with expertise in IDD are able to collaborate with the disability service team, the young person can usually be stabilised and returned to their family.

The health system is badly set up for people with IDD and mental health issues. The mental health sector is simply not funded, nor does it have the expertise, to work with people with IDD, except where they have serious mental illness. Neither is the NDIS geared for consumers with complex and severe disability linked to IDD, nor is it disposed to residential respite which is an essential specialist service necessary to support families at risk of burnout.

Therefore, the closures of state-run disability services which currently provide most of the mental health input for people with IDD is concerning. For example, the NSW Department of Ageing, Disability and Home Care has been the primary investor in developing mental health skills in services for people with IDD but as these are increasingly closing, the subspecialty of mental health care for people with intellectual disability is increasingly at risk of being lost. This could leave vulnerable Australians unable to access care. There are also particular fears that the resources for multidisciplinary positive behaviour support will be lost with the potential consequence that families may be unable to care for their family members. This will only increase the strain on emergency departments. The RANZCP is also concerned that the implementation of the NDIS may lead to the privatisation of disability services in some states which is likely to compound these risks.

Specific attention also needs to be given to people whose symptoms are well managed. For these people, there is real concern that they may no longer be able to receive support from the services they are currently accessing if they do not receive an IFP. Although the support they receive may only be occasional, without it, many would struggle to maintain their current levels of well-being.

Recommendation

- **Policies to guarantee that consumers who are not eligible for the NDIS will maintain access to pre-existing supports, both during and after the transition.**

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

The ILC has the potential to improve service access and community integration for people with disability as well as their families and carers, which would lessen marginalisation, improve quality of life and have flow-on benefits for the broader community. It is essential, however, that organisations linked to the ILC are adequately resourced to support this. Housing, education, employment, health, accessibility and transport services are almost universally at capacity and facing funding cuts. It is also well established that the mental health sector is chronically underfunded and unable to meet current demand. Boundary disputes are common as are 'gaps' where no services are available to meet consumer needs. There is a considerable risk that existing services will simply lack the capacity to respond to the increasing demand facilitated through the ILC. Services must be resourced so that they are able to be responsive and to minimise wait times. This will ensure that the increase in referrals via the ILC does not lead to a bottlenecking scenario where demand outstrips supply even more than it already does.

Investment across ILC streams must be guided by the principle of equitable access of all people with a disability when making decisions on investment, as well as design and implementation. The Convention on the Rights of Persons with Disabilities (UN General Assembly, 2007) clearly includes consumers with mental ill health under the definition of disability and emphasises that access to services must be equitable and not on the basis of disability type. The RANZCP therefore urges serious consideration of the ILC's capacity to support people with psychosocial disability.

It is also essential that the ILC adequately accommodate the specific needs of carers. Carers play an essential role in the support of people with psychosocial disability yet carers are too frequently marginalised, excluded and overlooked. It is well established that services for carers are inaccessible, chronically under resourced and often of such poor quality as to be of little benefit. Many carers report feeling frustrated at being left to fill the gaps in the system without any supports for themselves. The ILC must ensure that carers are able to access the supports that they need in a way that is relevant to them.

While the NDIS continues to maintain a focus that could lead to the exclusion of many with psychosocial disability from an IFP, the ILC will be the only way for many consumers to access supports under the NDIS. It is therefore essential that the ILC incorporates a thorough understanding of mental illness and IDD, as well as associated services and support needs. Furthermore, due to the complex nature of quantifying impairment linked to mental illness, some consumers may begin receiving supports under the ILC and then be moved across to an IFP once the full extent of their support needs are understood. The RANZCP would like to see a mechanism for identifying and responding to unmet support needs in a systemic manner. This is particularly important for consumers who are initially found to be ineligible for an IFP due to the incongruence between eligibility criteria and the realities of psychosocial disability.

Rural and remote areas do not have the same level of existing infrastructure and well-functioning nongovernmental organisations (NGOs) as urban areas. The NDIA should support national, well-established NGOs to provide outreach services to rural and remote areas, either by setting up local branches or supporting fledgling NGOs in these areas to develop resources and effective processes. Furthermore, for participants in rural and remote areas, including those of Aboriginal and Torres Strait Islander backgrounds, presentations may be particularly complex. The RANZCP believes that an outcomes-focused approach will need to be balanced with incentives and remuneration for engaging with these populations. It is also important that an outcomes-based approach does not override the imperative for self-determination for Aboriginal and Torres Strait Islander peoples. The RANZCP would therefore encourage the appropriate funding and resourcing for Aboriginal Community Controlled Health Services to build capacity in the disability area, especially in rural and remote locations.

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Where services have capacity, care must be taken to ensure the promises of the ILC can be delivered. As the peak body representing the field of psychiatry, the RANZCP understands the importance of taking an evidence-based approach based on recovery and capacity building. In order for investment to match the aims of the ILC, care must be taken to ensure that funding is targeted at mechanisms that are measurable, accountable, known to work and supported by consumers. Especially given the decentralised model of the ILC, care must be taken to ensure quality and safety standards are met across the board. The RANZCP therefore welcomes the work done by the NDIA in streamlining ILC outcomes and affirms its support of the outcomes in their current state.

The RANZCP is concerned that moving from block funding to grants and outcomes-based funding will risk eliminating small, volunteer and peer-run organisations because only larger, more financially stable organisations will be able to survive the transition. Grants-based funding is likely to lead to uncertainty within organisations and difficulty retaining staff, knowledge and experience. Mentoring and support will be required to assist organisations to negotiate the grants application process, particularly for smaller and consumer-run organisations.

Lessons also need to be learnt from the disability employment sector regarding the impacts of outcomes-based funding. This system can lead to 'cherry picking' of clients who are expected to achieve positive outcomes more quickly, thereby creating a disincentive to working with clients who require more intensive engagement before positive outcomes are achieved. Safeguards should be built into the ILC to counteract the disincentives that outcomes-based performance measurement creates for working with participants with complex and challenging presentations.

Finally, there is currently a significant amount of uncertainty to do with the details of the ILC including outcomes-based performance measurements. It will be essential that open and ongoing lines of communication are established between the NDIA and relevant sectors. Existing services need to be better informed so that they can support consumers with psychosocial disability to understand what the ILC can offer them.

Recommendations

- **Clear definitions of the roles of different service providers.**
- **Referral pathways that are clear and accessible for both practitioners and consumers.**
- **Interim supports for consumers and carers who are linked in with services that are at capacity.**
- **Policies that provide support to consumers to reapply for an IFP, or have their eligibility reassessed, under more suitable conditions.**
- **Support for smaller organisations to negotiate the grants application process.**
- **Self-determination principles to guide services working with Aboriginal and Torres Strait Islander peoples.**
- **Incentives for service provision:**
 - **in rural and remote locations**
 - **for participants with complex and challenging presentations.**

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

It is important to note that in the case of consumers with mental illness, getting the balance right between consumer-driven care and ensuring that the consumers' needs are met can be complex, requiring flexibility and nuance. Consumers with psychosocial disability may have difficulty in identifying their support needs for a number of reasons including the experience of stigmatisation leading to a desire to avoid association with a particular label, a lack of insight into their needs which may be a symptom of the illness itself, or the experience of having a diagnosis change over time which can lead to a lack of faith in the capacity of labels to adequately represent lived experience. In severe cases, a person's lack of insight can be due to anosognosia, a neurological deficit which leads to a lack of awareness that they are sick. Unlike other disability sectors, self-managed care plans have not been introduced in the mental health sector where training, support and education will be required to help consumers accurately identify their support needs and advocate for themselves.

Consumers with psychosocial disability often have very different support needs to those with other forms of disability which often relate to majorly disabling issues not adequately covered under the NDIS. For example, substance abuse disorders are a common comorbidity among people living with mental illness but it is unclear how this will be addressed under the NDIS. The RANZCP is also aware of one consumer with severe mental illness who would greatly benefit from additional psychotherapy sessions which she cannot currently afford. The consumer is currently receiving an IFP which includes various classes worth several thousand dollars but no specific therapeutic supports for her mental illness.

Assessment, plans and reviews need to be flexible to accommodate the often rapidly changing support needs of people with mental illness. Psychiatric conditions can be exceedingly unpredictable in how and when symptoms manifest, how the consumer responds to treatment, and the associated level of impairment. Diagnoses may require regular review as the treating clinician learns more about the consumer, observes how the consumer responds to treatment and learns more about other factors that may be at play. Clarification is required regarding how changes in diagnoses may impact upon eligibility. It will also be important to establish how quickly an IFP can be reviewed to ensure that administrative delays do not compromise the provision of care in times of increased, and unexpected, need.

The unpredictability of mental illness means that it is often difficult to develop a complete understanding of the level of impairment experienced without extended interactions. The model of the NDIS, whereby the consumer is assessed by a person unknown to them, and within a very specific framework, does not lend itself to this. The NDIS should be able to accommodate the inherent complexities of mental illness by ensuring that accurate assessments are gauged over a period of time and with input from treating clinicians. Incorporating more flexibility and nuance would make the NDIS more applicable and relevant to the mental health sector, and enable consumers with mental illness, their families and carers to feel secure in the capacity of the NDIS to support them over their lifetime.

Recommendations

- **IFP assessments to be gauged over a period of time and with input from treating clinicians.**
- **Policies to ensure that IFPs for people with psychosocial disability are broad and flexible.**
- **Supports for people with psychosocial disability when developing IFPs.**
- **Clarification regarding how changes in diagnoses may impact upon eligibility.**

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It is widely acknowledged that the health system, and particular the mental health sector, is fragmented and confusing. Many of the new private service providers under the NDIS lack the experience and networks to make effective linkages for their participants. Families and carers often ask for a list of recommendations from NDIS providers but this is not available. In many cases, initial planning and coordination is falling to NGOs who are poorly remunerated for the considerable amount of paperwork, goal setting and relationship building that is required.

The RANZCP does not believe that providers of services should recommend one NDIS provider over another. Rather, information about the quality of such services should be made available to health professionals so that they can assist their patients to make their own decisions. The RANZCP supports the simplicity of a ratings system, used by participants and other authorised parties, to provide a simple and democratic snapshot of feedback on service providers.

The RANZCP supports the development of an information system that is accessible and user friendly. The Purple Orange project is a good example of how an online platform can be used to empower participants to manage their own care, share information and engage with the NDIS meaningfully. However, people with psychosocial disability generally have much lower than average incomes and rates of school completion and employment. People with psychosocial disability therefore face the double barriers of literacy and lack of access to information technology.

The RANZCP understands that the majority of NDIS communication is online while the proportion of consumers with severe mental illness who have an internet connection at home is thought to be quite low. Consumers with prolonged and severe mental illness are also more likely to lack contact with family, carers and other support networks who could assist them. Consideration of consumers whose preferred method of communication is not online or written is required to ensure that the NDIS is accessible to all. The RANZCP encourages the trial of 'expos', described in the NDIS Quality and Safeguarding consultation paper, to reach this most vulnerable population.

Care coordination would also be greatly improved with better communication with health professionals. There is currently no mechanism for a treating specialist to be informed of NDIS registration nor to provide feedback to the NDIA. RANZCP members have indicated that there have been issues with a lack of communicated information regarding pilot sites, how services will be provided to clients following the wider rollout of the NDIS, and how existing services will be impacted upon. This is the cause of significant anxiety and uncertainty for clinicians. RANZCP members have also reported that NDIA staff turnover and other issues have resulted in inconsistent responses to their feedback. It is essential that communication channels with treating specialists be kept open, given their core role in consumer management and the importance of vesting their expertise and 'on-the-ground' experiences in continuous improvement processes.

There is also scope for greater involvement of mental health social workers, particularly in the private sector, to do more of the practical work which is currently done by 'agency case managers' with no mental health experience. This may be particularly important where consumers do not meet conditions for public case manager allocations.

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Recommendations

- **Capacity building in primary health networks and local health districts including:**
 - mapping service availability across primary, hospital, specialist and tertiary services
 - building resources to support GPs (e.g. the development of clinical pathways in GP software and/or competency frameworks and toolkits).
- **Funding to develop specific capacity within the Health Care Homes trials to include people with psychosocial disability, followed by a comprehensive evaluation.**
- **More work to ensure the accessibility of information platforms including:**
 - consultation to identify preferred ways of accessing and sharing information
 - consideration of telephone lines, outreach workers at community centres, literacy classes and purchase of computer devices.
- **Mechanisms for improved information sharing, communication and collaboration.**
- **Greater involvement of mental health social workers in care coordination.**

Consumers whose impairment is significant enough for them to be eligible for an IFP may have a family member fulfilling an unpaid caring role. One in eight Australians have an unpaid caring role, with 58% of primary carers providing 20–40+ hours of care per week. Carers provide approximately 1.32 billion hours of care per year with an estimated replacement value of \$40.9 million annually (Carers Australia, 2014). Given the important contribution carers make to the community, the economy and their families, the RANZCP believes that carers should have the opportunity for a separate carer assessment under the NDIS so that their individual needs are better understood and catered for.

The RANZCP is concerned that within the consumer's IFP, there is no guarantee that their carer's support needs will be catered for. IFPs are consumer-driven, and therefore will only factor in carers insofar as the consumer perceives they require support. Consumers may not have a full understanding of their carer's support needs, and the carer may not necessarily wish to disclose the full extent of these to their care recipient. It is common for carers to experience mental ill health related to their caring duties. Although it is likely that carers' support needs will lessen as their care recipient receives more comprehensive supports externally, these may or may not resolve naturally as their family member receives more comprehensive supports.

In these instances personalised assessment, treatment and care may be required. Carers should have the option of providing separate input so that their access to necessary supports is not contingent on their capacity to convey these to the consumer. Unless this is addressed, there will be increasing pressures on the ILC to support carers whose needs are not adequately gauged and provided for via the IFP process. The RANZCP maintains that it is essential that carers be more fully integrated into the NDIS model to ensure that they receive targeted supports to meet their specific needs.

Recommendation

- **Separate carer assessments during the planning process.**

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

The RANZCP does not wish to provide a response to this term of reference.

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

The RANZCP believes that outreach services to identify potential NDIS participants will be essential for people with psychosocial disability due to the high prevalence of anosognosia in people with severe mental illness. It is unclear how this cohort will access the supports they need under the NDIS, especially if the language of 'disability' and 'permanence' are not meaningful to them. Even where people with psychosocial disability are able to recognise their conditions, they may approach their diagnosis with ambivalence due to a variety of reasons.

The RANZCP would welcome clarification regarding how the NDIS will accommodate consumers with high support needs but who do not identify that they are unwell. Outreach services will be essential in this regard and may also be useful in ensuring that people who do not meet the eligibility criteria for an IFP may continue receiving services that they are currently receiving, even after they transition into the NDIS.

Consideration should also be given to allowing consumers to be referred to the NDIS in instances where this is the most realistic way to link them with supports. Currently, there are limited options for health providers to directly refer eligible participants to the NDIA. Provisions need to be made for health providers to facilitate such referrals.

Recommendations

- **Outreach services to serve the dual function of identifying people eligible for NDIS supports and continuing the provision of supports to people not eligible for the IFPS but who are currently receiving services which will transition into the NDIS.**
- **Referral pathways to the NDIS from health professionals.**

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

The RANZCP understands that NDIS funding will not be provided to prisoners and young people in detention. This appears to be predicated on the assumption that appropriate services will be provided within custodial settings, funded by state and territory governments. Considering the significant and ongoing underinvestment in prison and youth detention health services, the RANZCP is concerned that individuals whose disabilities render them eligible for NDIS services will lose access to those services while in custody. The RANZCP urges the Commonwealth Government to ensure NDIS funding for people in receipt of forensic disability services.

Furthermore, the RANZCP understands that NDIS funding will only be provided to individuals transitioning back into the community within 3 months of their date of discharge; Oftentimes release is only granted contingent upon supports being in place. If such supports can only be guaranteed within 3 months of the date of discharge, and the date of discharge can only be set when supports are in place,

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this is likely to result in a catch-22 scenario wherein release dates cannot be set without supports, and supports cannot be provided without release dates. In reality, the period of transition often takes much longer than 3 months so this policy is likely to prevent the release and care of individuals seeking release from custody. There are already significant challenges faced by those attempting to reintegrate into the community after very long periods of time and it is therefore essential that their psychosocial needs are adequately met for the full period of transition, not only to facilitate their release, but also to ensure their well-being and recovery, and to decrease recidivism rates which will have substantial flow-on benefits for the community.

Consideration also needs to be given to consumers on existing community treatment orders (CTOs). As services transition to the NDIS, there is a concern that individuals on CTOs will lose access to those services due to the fact that CTOs are not currently accepted by the NDIS retrospectively. As a result, there will likely be a significant number of severely unwell consumers left without services during the transition.

Recommendations

- **NDIS funding for people in receipt of forensic disability services.**
- **NDIS funding for people on existing community treatment orders.**

i. any related matter

It is essential that the registration process for providers ensures clarity of role and responsibility and transparency in communicating this to other stakeholders. Feedback from RANZCP members who work in NDIS trial sites has indicated that there is a lack of clarity regarding the role and responsibilities of NDIS providers. For example, the RANZCP has been informed of an instance where an agency had received NDIS funding to provide accommodation services. The agency was reliant on the private market, however, and was unable to secure anything appropriate for a consumer with severe mental illness. At the same time, pre-existing disability accommodation had ceased to be available, leaving the consumer without secure housing, further impacting on their mental health. In this example, it was unclear to the practitioner and consumer involved as to whether the agency was funded only to provide linkages to existing, mainstream housing, or if the organisation should have had access to direct resources such as housing stock. More clarity and communication is required regarding the resources NDIS-commissioned organisations have at their disposal, what their targeted outcomes are, and how they will be evaluated.

Recommendation

- **Mechanisms for improved information sharing, communication and collaboration.**

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