The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

9 August 2017

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 members

Re: Transitional arrangements for the National Disability Insurance Scheme

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's inquiry into transitional arrangements for the National Disability Insurance Scheme (NDIS).

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 has welcomed 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.

The RANZCP also supports the purpose of this inquiry and welcomes the opportunity to contribute. The RANZCP strongly supports efforts to ensure a smooth transition for the NDIS so that people with psychosocial disability can be provided with optimal services to improve their well-being, independent living and participation in the community, both now and into the future.

However, the RANZCP retains a number of concerns with regard to the transitional arrangements of the NDIS with regard to people with psychosocial disability. These concerns largely relate to the readiness of both people living with mental illness and organisations providing services to people living with mental illness.

Please see the attached submission for detailed responses to questions raised in the issues paper.

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

Yours sincerely

Dr Kym Jenkins
President

Ref: 0808o

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Submission to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into transitional arrangements

August 2017

advocating for equitable access to services

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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 health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has over 6000 members including more than 4000 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 Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to provide a written submission for the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into transitional arrangements for the National Disability Insurance Scheme (NDIS). We value the ongoing consultative approach taken by the National Disability Insurance Agency (NDIA) and other stakeholders and we are pleased that concerns voiced by the RANZCP and others in the mental health sector are being increasingly heard.

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

- Productivity Commission's study into NDIS Costs, March 2017
- Senate Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, February 2017
- 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 supports the principles 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. 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.

a. The boundaries and interface of NDIS service provision, and other non-NDIS service provision, with particular reference to health, education and transport services

Service gaps

Governments must ensure that the transition to the NDIS does not create service gaps for vulnerable people who fall outside the NDIS scope but who nevertheless rely on existing community programs. NDIS funding agreements 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 the nature of their disability. This will leave major gaps in services for many people currently supported by existing programs.

For example, New Zealanders living in Australia are granted Special Category Visas and are therefore not eligible for NDIS services. The transition to the NDIS is therefore likely to deprive many New Zealanders of services to which they previously had services. The same concerns hold for federal services like the Partners in Recovery (PIR) programs and Personal Helpers and Mentors services (PHaMs) which currently cater for a wide range of consumers including people who are likely to fall outside the scope of the NDIS. After the transition, 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).

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

The RANZCP would note here that levels of impairment among people with psychosocial disability can change regularly, sometimes dramatically and without warning. Under these circumstances, the importance of pre-existing supports and linkages cannot be overemphasised. 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.

Recommendations

- **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, whether through:**
  - **the provision of funding streams external to the NDIS, or**
  - **the operation of programs under the NDIS, encompassing outreach to non-NDIS participants.**
- **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.**

Services for prisoners and young people in detention

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 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 also understands that NDIS services will only be provided to individuals transitioning back into the community within 3 months of their date of discharge. Often, release is only granted contingent upon such supports being in place. If these supports can only be provided within 3 months of the date of discharge, and the date of discharge can only be set when supports are in place, 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.

Consideration also needs to be given to consumers currently on community treatment orders (CTOs). CTOs are mechanisms under the mental health acts of each state/territory which are used to compel individuals to receive mental health treatment while in the community. As the NDIS does not accept CTOs retrospectively, individuals on CTOs are at risk of losing access to services during the transition.

Recommendations

- **Provision of supports for people requiring disability services in custodial settings and while on community treatment orders.**
- **Delinking of supports from discharge dates for individuals leaving custodial settings.**

Service roles and responsibilities

Feedback from RANZCP members who work in NDIS trial sites has indicated that there is a lack of clarity regarding the roles and responsibilities of NDIS providers. For example, the RANZCP is aware of an instance where an agency received NDIS funding to provide accommodation services but was reliant on the private market and so was unable to secure appropriate housing 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, impacting their mental health. 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 is required regarding the resources NDIS-commissioned organisations have at their disposal, what their targeted outcomes are, how they will be evaluated, and how they communicate this to practitioners and consumers.

Recommendation

- **Clear definitions of the roles of different service providers and mechanisms to communicate these to participants and stakeholders.**

Care coordination

The mental health sector can be fragmented and confusing, and some new NDIS service providers may lack the experience and networks to make effective linkages for their participants. Instead, initial planning and coordination often falls to nongovernmental organisations (NGOs) who are poorly renumerated for the considerable paperwork, goal setting and relationship building that is required. The RANZCP would support greater involvement of mental health social workers, particularly in the private sector, to do more of the practical work currently done by 'agency case managers' without mental health experience, particularly where consumers do not meet conditions for public case manager allocations.

Care coordination could be further improved with the increased involvement of health professionals. RANZCP members have noted issues with a lack of communication regarding pilot sites, how services will be provided to clients following the wider rollout of the NDIS, and how existing services will be effected. RANZCP members have also reported inconsistent responses to feedback and no mechanism for treating specialists to be informed of NDIS registration or to provide feedback. Open communication channels with treating specialists are essential given their core role in consumer management and the importance of their expertise and 'on-the-ground' experiences for continuous improvement processes. This may be achieved through the establishment of a mental health 'learning network' to provide the sector with a voice and a platform to share ideas and influence the scheme (Williams and Smith, 2014).

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).**
- **Greater involvement of health professionals in care coordination including via establishment of a mental health learning network.**

Outreach services

The RANZCP believes that outreach services to identify potential NDIS participants are essential for people with psychosocial disability due to the lack of insight exhibited by many individuals with severe mental illness. Even where people with psychosocial disability are able to recognise their conditions, they may approach their diagnosis with ambivalence for a variety of reasons. It is unclear how this cohort will access the supports they need under the NDIS. Outreach services will be essential in this regard. Consideration should also be given to allowing health providers to refer consumers 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.

Recommendations

- **Outreach services to identify people who may be eligible for NDIS supports.**
- **Referral pathways to the NDIS from health professionals.**

b. The consistency of NDIS plans and delivery of NDIS and other services for people with disabilities across Australia

Planning process

In the case of consumers with mental illness, getting the right balance 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. Unlike the disability sector, self-managed care plans have not been introduced in the mental health sector so training, support and education are required to help consumers accurately identify their support needs and advocate for themselves.

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 into this process would make the NDIS more applicable and relevant to the mental health sector and enable consumers with mental illness to feel secure in the capacity of the NDIS to support them.

Assessments, 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, how they respond to treatment and other factors that may be at play. While the RANZCP recognises that plans will specify the time and circumstances under which they will be reviewed, 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.

Recommendations

- **Supports to assist people with psychosocial disability with the planning process.**
- **Assessments to be gauged over a period of time and with input from treating clinicians.**
- **Policies to ensure a support package can be reviewed quickly in times of unexpected need.**

Assessment tools

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 spectrum disorder face 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 assessments

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.

Assessment tools may also not be effective in gauging the support needs of people with 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, their 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.

Recommendations

- **Evaluation of the suitability of assessment tools for the identification of support needs for:**
  - **people with severe mental illness**
  - **young adults who have been diagnosed with childhood disorders.**
- **Accounting for the impact of comorbidities in the assessment process.**

Participant supports

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 use disorder is 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 afford. Though currently receiving an IFP, no specific therapeutic supports are provided for her mental illness. This is despite the Productivity Commission's assertion that 'the NDIS may fund… therapeutic supports' (2017, p. 20).

Recommendation

- **Policies to ensure that an appropriate range of supports is provided for people with psychosocial disability.**

System capacity and service delivery

It is 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 NDIS. In addition, housing, education, employment, health, accessibility and transport services are almost universally at capacity and facing funding cuts. 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 NDIS does not lead to a bottle-necking scenario where demand outstrips supply even more than it already does.

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 RANZCP is particularly concerned regarding the impact of the NDIS on the future well-being of people with intellectual and developmental disabilities (IDD). The health system is badly set up for people with IDD and mental health issues. There are already reports of services experiencing unprecedented levels of inpatient admissions, especially for children and adolescents. 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.

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 IDD is increasingly at risk of being lost. The RANZCP is 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. There are also particular fears that the resources for multidisciplinary positive behaviour supports 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.

Recommendations

- **Appropriate resourcing of NDIS services.**
- **Interim supports for consumers who are linked in with services that are at capacity.**

c. The rollout of the Information, Linkages and Capacity Building Program (ILC)

Communication

There is currently considerable uncertainty regarding the details of the ILC including outcomes-based performance measurements. It is 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.

Recommendation

- **Policies to improve lines of communication with relevant sectors.**

Transitioning from the ILC to the NDIS

It is important that the ILC incorporates a thorough understanding of mental illness and IDD, as well as associated services and support needs, as many 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. This is particularly true due to the incongruence between eligibility criteria and the realities of psychosocial disability. The RANZCP would like to see a mechanism for identifying and responding to unmet support needs in a systemic manner.

Recommendation

- **Policies that provide support to consumers to reapply for an IFP, or have their eligibility reassessed, under more suitable conditions.**

Outcomes-based funding

As the peak body representing the field of psychiatry, the RANZCP understands the importance of taking an evidence-based approach to service provision. Care must be taken to ensure that funding is targeted at mechanisms that are measurable, accountable, known to work and supported by consumers.

However, lessons should be learned from the disability employment sector regarding the impacts of outcomes-based funding. 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.

This system can also 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.

Recommendations

- **Support for smaller organisations to negotiate the grants application process.**
- **Incentives for service provision for people with complex and challenging presentations.**

Capacity building in rural and remote areas

Rural and remote areas do not have the same level of existing infrastructure and well-functioning NGOs as urban areas. The NDIA should support NGOs to provide 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.

Recommendations

- **Incentives for service provision in rural and remote locations.**
- **Self-determination principles to guide services working with Aboriginal and Torres Strait Islander peoples.**

References

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