



Joint Standing Committee on the National Disability Insurance Scheme

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

August 2017

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Senator Senator Carol Brown (from 11 Oct 2016)	ALP, TAS
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Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
CALD	Culturally and Linguistically Diverse
CMHA	Community Mental Health Australia
COAG	Council of Australian Governments
D2DL	Support for Day to Day Living in the Community
DoH	Department of Health
FASD	Foetal Alcohol Syndrome Disorder
FPDN	First Peoples Disability Network
GP	General Practitioner
IAC	Independent Advisory Council to the National Disability Insurance Agency
ILC	Information Linkages and Capacity Building
LAC	Local Area Coordination
LACs	Local Area Coordinators
LHNs	Local Hospital Networks
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MHA	Mental Health Australia
MHCC	Mental Health Coordinating Council
MHCSA	Mental Health Coalition of South Australia
MHR:CS	Mental Health Respite: Carer Support
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NMHC	National Mental Health Commission

NMHSPF	National Mental Health Service Planning Framework
NMHSRG	NDIA Mental Health Sector Reference Group
NT	Northern Territory
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Network
PIR	Partners in Recovery
QAMH	Queensland Alliance for Mental Health
QLD	Queensland
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SA	South Australia
SRFs	Supported Residential Facilities
TAS	Tasmania
VCOSS	Victorian Council of Social Service
VIC	Victoria
VMIAC	Victorian Mental Illness Awareness Council

Executive Summary

It is estimated that 64 000 people with psychosocial disabilities related to a mental health condition will become NDIS participants by 2019-2020. For these people the Scheme presents a significant opportunity to increase supports and improve outcomes. However, psychosocial disability differs from physical and sensory disabilities in important ways and presents the Scheme with significant challenges.

Alongside the NDIS, the mental health sector is also undergoing significant parallel reform with the development of the Fifth National Mental Health Plan, which COAG has now adopted. People with mental illness will continue to require services even if they are not participants. Furthermore, the committee recognises that the Scheme will provide services in conjunction with those delivered through other Commonwealth, state and territory governments. The committee acknowledges the commitment made by all governments to provide continuity of support for people with psychosocial disabilities who are not eligible for the NDIS. However, the committee has found there is a need to clarify and make public how they intend to provide these services and address the emerging gaps created by the transition of existing services into the NDIS.

Eligibility

The NDIS eligibility criteria for people with mental illness is a central concern for all stakeholders. The committee found that whilst the current eligibility criteria could be improved to provide greater clarity, the apparent reliance on diagnosis rather than functional needs is likely to result in inconsistent eligibility outcomes for applicants. This is of particular concern given the absence of a validated assessment tool for planners to assess the eligibility of people with psychosocial disabilities. The reported lack of skills and expertise of planners in the mental health field adds to inconsistencies of access to the Scheme and planning outcomes

Planning process

The committee received evidence that the planning process to develop and review NDIS plans has not been operating well and has often resulted in unsatisfactory experiences and outcomes for people with psychosocial disabilities, their families and in some instances particularly their carers. Issues include the development of plans over the phone rather than face-to-face; not involving carers in planning discussions; waiting times and delays; the poor level of planners' knowledge and understanding of psychosocial disability; and lack of flexibility and responsiveness to people's changing needs. Indeed, given the episodic nature of conditions and symptoms experienced by people with a mental health condition, the current approach to the development and review of plans does not readily build in supports to respond to the fluctuating needs of participants.

Assertive Outreach

The committee recognises the critical role advocacy and outreach services can play in identifying and engaging people, their families and carers with NDIS services. In many cases the most efficient way to engage with people in the NDIS process is to work with their families and carers who have long-term, personal and special knowledge of their needs and circumstances. The operational systems in place to provide information about the NDIS and to engage with hard-to-reach cohorts through assertive outreach could be greatly improved. With the transition of Commonwealth and state and territory programs, there is a risk of emerging service gaps in these areas.

Continuity of Support

Given that the majority of people who experience mental ill-health will not access the NDIS for whatever reason, the continued provision of services for people outside the Scheme is particularly important. The transition into the NDIS of Commonwealth programs such as Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Day to Day Living (D2DL) and Mental Health Respite: Carers Support, amongst others, is concerning the committee, as evidence received indicates that a significant number of current clients of those services will not be accessing the Scheme.

The committee also heard of concerns across the sector that services previously delivered by states and territories were being withdrawn before recipients of those services are properly transitioned into the NDIS.

Information, Linkages and Capacity Building (ILC)

The committee is concerned about emerging service gaps, including assertive outreach services, community based group supports, supports for carers, and the availability of services in areas such as remote communities. Some of these services are intended to be delivered through the ILC Framework. However, the ILC is still in its infancy and the current level of funding allocated to support its activities may not match the needs of the community. Furthermore, as the ILC funding is for all disabilities, there is a growing concern that psychosocial disability support services may not be adequately funded through the ILC alone.

Forensic disability services

Finally, the committee looked at the provision and continuation of services for NDIS participants in receipt of forensic disability services. The committee heard that the NDIS has potential to decrease the incarceration rates for people with a cognitive and psychosocial impairment, particularly Aboriginal and Torres Strait Islander people who are overrepresented amongst those in prison with complex disability support needs. Historically, this group has had mostly poor experiences or no contact with existing systems.

However, before the opportunity offered through the NDIS can be realised, access to the NDIS must be readily available and consistent within the criminal justice system. The committee heard some conflicting evidence as to how the NDIS currently supports NDIS participants in custody and what types of services, if any at all, they

can access. There was no clear evidence as to how the process of referring people to become an NDIS participant was taking place within the criminal justice system. Additionally, there was no evidence of the NDIA taking a proactive role in finding a provider of last resort services for NDIS participants, including for those in indefinite detention.

To increase the focus on this cohort, Australians for Disability Justice proposed the establishment of a unit specialising in the interaction of the Scheme with the criminal justice system, which received great support from other stakeholders. The committee supports the creation of such a unit.

Conclusion

The committee received a wealth of information and evidence throughout the inquiry and thanks all those who participated. As a result, the committee has made 24 recommendations, which aim to strengthen the effectiveness of the Scheme to ensure that people with psychosocial disabilities can be appropriately supported.

Recommendations

Eligibility

Recommendation 1

2.63 The committee recommends that the NDIS Act is reviewed to assess the permanency provisions in Section 24 (1) (b) and the appropriateness of the reference to 'psychiatric condition' in 24 (1) (a).

Recommendation 2

2.64 The committee recommends that a review of the NDIS (Becoming a Participant) Rules 2016 should be considered to assess the appropriateness and effectiveness of:

- Including the principle of recovery-oriented practice for psychosocial disability, and
- Clarifying that Rule 5.4 which dictates that a condition is, or is likely to be permanent,¹ does not apply to psychosocial disability, to reflect that people with mental conditions will receive ongoing treatments to aid recovery.

Recommendation 3

2.65 The committee recommends that the Australian Government ensures young people with mental ill-health who are not participants of the Scheme, have access to adequate early intervention services.

Recommendation 4

2.66 The committee recommends the NDIA, in conjunction with the mental health sector, develops and adopts a validated fit-for-purpose assessment tool to assess the eligibility of people with psychosocial disability that focuses on their functional capacity for social and economic participation.

Recommendation 5

2.67 The committee recommends the NDIA monitors eligibility rates for people with psychosocial disability to, a) understand the reasons for a higher rejection rate compared to other disabilities; and b) to build a clearer picture of the size and needs of the people who have been found ineligible for NDIS services.

Recommendation 6

2.68 The committee recommends clients currently receiving mental health services, including services under Commonwealth programs transitioning to the NDIS, namely Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs),

1 Rule 5.4 of the NDIS Rules states that:

An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.

Day to Day Living (D2DL, and Mental Health Respite: Carer Support (MHR:CS), should not have to apply for the NDIS to have guarantee of continuity of supports and access services.

Planning process

Recommendation 7

3.82 The committee recommends the NDIA develops and proactively markets resources and training for primary health care professionals about the NDIS, especially in regards to access and planning processes.

Recommendation 8

3.83 The committee recommends the Department of Social Services and the NDIA collaboratively develop a plan outlining how advocacy and assertive outreach services will be delivered beyond the transition arrangements to ensure people with a psychosocial disability and those who are hard-to-reach can effectively engage with the NDIS and/or other support programs.

Recommendation 9

3.84 The committee recommends the NDIA, in conjunction with the mental health sector, creates a specialised team of NDIS planners trained and experienced in working with people who have a mental health condition as their primary disability.

Recommendation 10

3.85 The committee recommends the NDIA develops an approach to build flexibility in plans to respond to the fluctuating needs of participants with a psychosocial disability, including allowing minor adjustments to be made without the need for a full plan review.

Recommendation 11

3.86 The committee recommends the NDIA reports on the level of engagement of carers in the planning process.

Recommendation 12

3.87 The committee recommends the NDIA publishes the results of its participants and providers pathways review, particularly in the areas related to mental health, and strategies in place to achieve improved outcomes, as well as updates on progress against targets in its Quarterly Reports.

Continuity of Support

Recommendation 13

4.67 The committee recommend the Australian, state and territory governments clarify and make public how they will provide services for people with a psychosocial disability who are not participants in the NDIS.

Recommendation 14

4.68 The committee recommends the Council of Australian Governments (COAG) conduct an audit of all Australian, state and territory services, programs and associated funding available for mental health.

Recommendation 15

4.69 The committee recommends the National Mental Health Commission be appointed in an oversight role to monitor and report on all Australian, state and territory mental health programs and associated funding, including those delivered through the primary healthcare sector.

Recommendation 16

4.70 The committee recommends the Department of Social Services and the NDIA develop an approach to ensure continuity of support is provided for carers of people with a psychosocial disability, both within and outside the NDIS.

Recommendation 17

4.71 The committee recommends the NDIA in collaboration with the Australian, state and territory governments develops a strategy to address the service gaps that exist for rural and remote communities.

Recommendation 18

4.72 The committee recommends the NDIA provides details how it is ensuring a provider of last resort is available for all NDIS participants unable to find a suitable service provider, regardless of their location, circumstances and types of approved supports.

Information, Linkages and Capacity Building (ILC)

Recommendation 19

4.73 The committee recommends the NDIA monitors the psychosocial disability supports, activities and services that are awarded funding through the ILC grant process to be able to identify and address any emerging service gaps as they may arise.

Recommendation 20

4.74 The committee recommends the NDIA undertakes a review of the effectiveness to date of the ILC program in improving outcomes for people with a psychosocial disability.

Recommendation 21

4.75 The committee recommends NDIA considers allocating specific funding for the provision of mental health services through the ILC.

Forensic disability services

Recommendation 22

5.50 The committee recommends the NDIA urgently clarifies what approved supports are available to NDIS participants in custody and how it monitors and ensures NDIS participants access the supports they are entitled to while in custody.

Recommendation 23

5.51 The committee recommends the NDIA establishes an NDIA unit specialising in the interaction of the Scheme with the criminal justice system.

Recommendation 24

5.52 The committee recommends the NDIA develops a specific strategy to deliver culturally appropriate services for Aboriginal and Torres Strait Islander people with disabilities who are in the criminal justice system.

Chapter 1

Introduction

Referral of inquiry and terms of reference

1.1 The Joint Standing Committee on the National Disability Insurance Scheme (NDIS) was established on 1 September 2016. The committee is composed of five Members and five Senators.

1.2 The committee is tasked with inquiring into:

- (a) the implementation, performance and governance of the NDIS;
- (b) the administration and expenditure of the NDIS; and
- (c) such other matters in relation to the NDIS as may be referred to it by either House of the Parliament

1.3 After 30 June each year, the committee is required to present an annual report to the Parliament on the activities of the committee during the year, in addition to other reports on any other matters it considers relevant.

1.4 The committee is also able to inquire into specific aspects of the Scheme. On 30 November 2016, the committee decided to undertake an inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

1.5 The terms of reference for the inquiry are as follows:

1. That the joint committee inquire into and report on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, with particular reference to:
 - (a) the eligibility criteria for the NDIS for people with a psychosocial disability;
 - (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;
 - (i) whether these services will continue to be provided for people deemed ineligible for the NDIS;
 - (c) the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;
 - (i) whether these services will continue to be provided for people deemed ineligible for the NDIS;
 - (d) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework;

- (e) the planning process for people with a psychosocial disability, and the role of primary health networks in that process;
- (f) whether spending on services for people with a psychosocial disability is in line with projections;
- (g) the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability;
- (h) the provision, and continuation of services for NDIS participants in receipt of forensic disability services; and
- (i) any related matter.

1.6 In November 2016 the Senate Community Affairs Committee tabled the report *Indefinite detention of people with cognitive and psychiatric impairment in Australia*. The committee made 32 recommendations, including that the Joint Standing Committee on the NDIS conduct an inquiry into the issue of eligibility and access to the NDIS for people held in prisons and the criminal justice system.¹ The terms of reference of the inquiry cover these issues.

Structure of report

1.7 This report is comprised of five chapters, as follows:

- this chapter (chapter one) outlines the context and administration of the inquiry and provides some background information about psychosocial disability and the NDIS;
- chapter two discusses the eligibility criteria for access to the NDIS;
- chapter three examines the planning process and barriers to access NDIS services;
- chapter four explores issues related to funding and the transition of services to the NDIS, continuity of services, and the scope and level of funding for mental health services under the ILC framework; and
- chapter five considers the provision and continuation of services for NDIS participants in receipt of forensic disability services.

Conduct of the inquiry

1.8 The committee received 131 submissions to the inquiry from individuals and organisations. These submissions are listed in Appendix 1.

1.9 The committee also conducted four public hearings:

- 28 April 2017 in Melbourne;

1 Senate Community Affairs Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, November 2016, p. xviii, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/IndefiniteDetention45/Report (accessed 23 May 2017).

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- 12 May 2017 in Canberra;
 - 17 May 2017 in Penrith; and
 - 16 June 2017 in Canberra.

1.10 Transcripts from these hearings, together with submissions and answers to questions on notice are available on the committee's [website](#). Witnesses who appeared at the hearings are listed in Appendix 2.

Acknowledgements

1.11 The committee would like to thank the individuals and organisations that made written submissions to the inquiry, as well as those who gave evidence at the four public hearings. We are grateful for their time and expertise.

Note on terminology and references

1.12 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to Committee Hansard are to proof transcripts. Page numbers may vary between proof and official transcripts.

Background information

The NDIS and psychosocial disability

1.13 Sections 22 to 25 of the *NDIS Act 2013* detail the criteria for access to the Scheme. To become an NDIS participant a person must:

- have a permanent impairment that significantly affects their ability to take part in everyday activities, or have a developmental delay;
- be aged less than 65 when first applying to enter the NDIS and meet additional age requirements if living in SA or TAS;
- live in Australia in an NDIS area on a specified date;
- be an Australian citizen or hold a permanent visa or a Protected Special Category visa.

1.14 The NDIS defines psychosocial disability as the term used to describe disabilities that may arise from mental health issues. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage. People with a significant disability that is likely to be permanent may qualify for NDIS support².

1.15 With respect to psychosocial disability, the NDIS acknowledges the importance of recovery, which is defined as achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or

2 NDIS, *Psychosocial disability, recovery and the NDIS*, November 2016, p. 1, <https://www.ndis.gov.au/medias/documents/heb/h21/8799160959006/Fact-Sheet-Psychosocial-disability-recovery-and-the-NDIS-PDF-774KB-.pdf> (accessed 23 May 2017).

recovering from mental health issues.³ The NDIS is committed to ensuring that recovery is supported for participants with psychosocial disability through the design and implementation of the NDIS. The NDIS has stated that it will provide:

- choice and control for participants;
- lifetime commitment to supports and funding as required;
- increased independence and social and economic participation; and
- support for a partnership approach.⁴

1.16 The NDIS is designed to be flexible to meet variations of intensity in mental illness ('episodes'). An NDIS plan will account for these possible fluctuations by providing a flexible budget to increase and decrease supports as necessary. A participant's individualised plan will also document their informal supports (from friends and family) along with supports they access from their local community and other government systems.⁵

Estimated numbers of NDIS participants with a primary psychosocial disability

1.17 The original Productivity Commission estimated that there would be 57 000 people with enduring and significant psychiatric disabilities who would meet the NDIS eligibility criteria.⁶

1.18 The Agency estimates that in 2019–20 the total number of expected participants in the NDIS will be approximately 460 000. Of this cohort, around 64 000 participants are estimated to be those with a primary psychosocial disability (13.9 per cent)⁷.

1.19 As of 31 March 2017, across all state/territories 4849 (six per cent⁸) of NDIS participants had psychosocial disability recorded as their primary disability. Compared

3 NDIS, *Completing the access process for the NDIS-Tips for Communicating about Psychosocial Disability*, 5 August 2016, p. 3, https://ndis.gov.au/html/sites/default/files/Completing_the_access_process_for_the_NDIS_Tips_for_communicating_about_...pdf (accessed 23 May 2017).

4 NDIS, *Psychosocial disability, recovery and the NDIS*, November 2016, p. 1, <https://www.ndis.gov.au/medias/documents/heb/h21/8799160959006/Fact-Sheet-Psychosocial-disability-recovery-and-the-NDIS-PDF-774KB-.pdf> (accessed 17 July 2017).

5 NDIS, *Psychosocial disability, recovery and the NDIS*, November 2016, p. 2, <https://www.ndis.gov.au/medias/documents/heb/h21/8799160959006/Fact-Sheet-Psychosocial-disability-recovery-and-the-NDIS-PDF-774KB-.pdf> (accessed 23 May 2017).

6 Productivity Commission, *Disability Care and Support: Productivity Commission Inquiry Report*, No54, 31 July 2011, p. 27, <http://www.pc.gov.au/inquiries/completed/disability-support/report/disability-support-overview-booklet.pdf> (accessed 24 May 2017).

7 National Disability Insurance Agency (NDIA), *Submission 102*, p. 2.

8 NDIS, *National Dashboard as at 31 March 2017*, 31 March 2017, p. 1, <https://www.ndis.gov.au/medias/root/h81/h56/8800927318046/National-Dashboard-as-at-31-March-2017-Accessible-FINAL.pdf> (accessed 23 May 2017).

to 3835 participants (6 per cent) at 31 December 2016,⁹ this represents an increase of 1014 participants in a quarter while the proportions in the context of the overall scheme remain stable.

NDIA Mental health Sector Reference Group (NMHSRG)

1.20 The NMHSRG was established to develop a working partnership between the mental health sector and the NDIA. It provides expert advice from a cross section of the mental health sector to the NDIA about the integration of psychosocial disability and mental health into the Scheme.

1.21 NMHSRG has met quarterly since December 2014 and its purpose is to ensure a strong working partnership between the mental health sector and the NDIA.

1.22 The NDIA has established the NDIA Mental Health Work Plan 2015-16 to address emerging policies and operational issues. The plan is reviewed annually with input from the NMHSRG.

Fifth National Mental Health Plan

1.23 Alongside the NDIS rollout, the mental health sector is undergoing significant parallel reform. The COAG Health Council endorsed the *Fifth National Mental Health and Suicide Prevention Plan 2017–2022* and its Implementation Plan at its meeting on 4 August 2017 in Brisbane.¹⁰

1.24 A consultation draft of the Fifth Plan¹¹ was released on 21 October 2016. The consultation draft focuses on achievable and measurable improvements across seven targeted priority areas:

- Integrated regional planning and service delivery;
- Coordinated treatment and supports for people with severe and complex mental illness;
- Suicide prevention;
- Aboriginal and Torres Strait Islander mental health and suicide prevention;
- Physical health of people living with mental health issues;

9 NDIS, *National Dashboard as at 31 December 2016*, 31 December 2016, p. 1, <https://www.ndis.gov.au/medias/documents/h01/hea/8800417775646/National-Dashboard.pdf> (accessed 23 May 2017).

10 COAG Health Council, *Meeting Communique – 4 August 2017*, <http://www.coaghealthcouncil.gov.au/Portals/0/COAG%20Health%20Council%20Communique%20-%204%20August%202017.pdf>, (accessed 14 August 2017).

11 Australian Government, Department of Health, *Fifth National Mental Health Plan – Draft for consultation*, 21 October 2016, [http://www.health.gov.au/internet/main/publishing.nsf/content/8F54F3C4F313E0B1CA258052000ED5C5/\\$File/Fifth%20National%20Mental%20Health%20Plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/8F54F3C4F313E0B1CA258052000ED5C5/$File/Fifth%20National%20Mental%20Health%20Plan.pdf) (accessed 23 May 2017).

- Stigma and discrimination reduction; and
- Safety and quality in mental health care.

1.25 A national consultation process was held throughout November and December 2016 to inform the development of the Fifth Plan.

Chapter 2

Eligibility criteria

Introduction

2.1 This chapter primarily deals with term of reference (a) the eligibility criteria for the NDIS for people with a psychosocial disability.

2.2 The first part of the chapter focuses on the key issues relating to eligibility criteria, including: the lack of clarity of criteria and guidelines; the criterion of 'permanent impairment' in the context of psychosocial disability; and the reliance on a diagnosis approach.

2.3 The second part of the chapter discusses participation and eligibility rates and touches on the repercussions for people deemed not eligible for NDIS services, which will be discussed in detail in Chapter 4.

Eligibility criteria

Current legislation, rules and guidelines regarding the disability requirements

2.4 Section 24 of the *NDIS Act 2013* stipulates the disability requirements:

(1) A person meets the disability requirements if:

(a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and

(b) the impairment or impairments are, or are likely to be, permanent; and

(c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:

(i) communication;

(ii) social interaction;

(iii) learning;

(iv) mobility;

(v) self-care;

(vi) self-management; and

(d) the impairment or impairments affect the person's capacity for social or economic participation; and

(e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.

(2) For the purposes of subsection (1), an impairment or impairments that vary in intensity may be permanent, and the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime, despite the variation.

2.5 The *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* about the disability requirements state:

5.4 An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.

5.5 An impairment may be permanent notwithstanding that the severity of its impact on the functional capacity of the person may fluctuate or there are prospects that the severity of the impact of the impairment on the person's functional capacity, including their psychosocial functioning, may improve.

5.6 An impairment may require medical treatment and review before a determination can be made about whether the impairment is permanent or likely to be permanent. The impairment is, or is likely to be, permanent only if the impairment does not require further medical treatment or review in order for its permanency or likely permanency to be demonstrated (even though the impairment may continue to be treated and reviewed after this has been demonstrated).

2.6 The NDIS website provides the following details:

You may meet the disability requirements if:

you have an impairment or condition that is likely to be permanent (i.e. it is likely to be lifelong) and

your impairment substantially reduces your ability to participate effectively in activities, or perform tasks or actions unless you have:

◦ assistance from other people or

◦ you have assistive technology or equipment (other than common items such as glasses) or

◦ you can't participate effectively even with assistance or aides and equipment and

• your impairment affects your capacity for social and economic participation and

• you are likely to require support under the NDIS for your lifetime.

An impairment that varies in intensity e.g. because the impairment is of a chronic episodic nature may still be permanent, and you may require support under the NDIS for your lifetime, despite the variation.¹

2.7 In its submission to this enquiry, the NDIA described the evidence required to meet the disability requirements:

Most potential participants with a psychosocial disability will be asked to provide evidence that they have or are likely to have a permanent disability relating to their mental health condition. This needs to be documented by a

1 NDIS, *Access requirements*, <https://ndis.gov.au/people-disability/access-requirements.html> (accessed 25 May 2017).

health professional and in the case of psychosocial disability; this is usually a treating general practitioner or treating psychiatrist. The NDIA will also need evidence/assessments to describe the extent of the functional impact of the mental health condition on the person's everyday living skills.²

Issues arising

Clarity of criteria

2.8 The vast majority of inquiry participants expressed concerns about the lack of clear eligibility criteria for access to NDIS services for people with a psychosocial disability.

2.9 Participants found the disability requirements provided in the NDIS Act difficult to interpret when they are applied to a psychosocial disability related to a mental health condition. The Office of the Public Advocate (Victoria) said in its submission:

Notions that are particularly abstract in this context are those of 'permanency' and 'functional impact', which the National Disability Insurance Agency (NDIA) does not further qualify.³

2.10 Mental Health Australia, the peak, national non-government organisation representing the interests of the Australian mental health sector states:

Clarification of the eligibility criteria for the NDIS re psychosocial disability (currently accepted prevalence figure is 64,000 people at Full Scheme) is the essential starting point. This was made clear in the National Mental Health Commission's (NMHC) Review, which recommended that government 'urgently clarify the eligibility criteria for access to the NDIS' (recommendation 3).⁴

2.11 The Australian Government response to NMHC recommendation 3 reads:

The National Disability Insurance Scheme (NDIS) represents a major advance in terms of funding available for disability support and in terms of giving people with disability the power to choose what works best for them. This includes people who gain entry to the Scheme due to disability arising from mental illness.

The National Disability Insurance Agency (NDIA), Commonwealth and state governments are working together with consumers, carers and peak organisations on a significant work programme to underpin transition arrangements, and to ensure implementation of the NDIS reflects the needs of people with mental illness, their families and carers. The primary

2 NDIA, *Submission 102*, p. 4.

3 Office of the Public Advocate (Victoria), *Submission 7*, p. 5.

4 Mental Health Australia, *Submission 1 – Attachment 1*, p. 2.

mechanism for this work is the NDIA Mental Health Sector Reference Group.⁵

2.12 In 2014, the Independent Advisory Council to the NDIA (IAC) identified the need for 'a more informed evidence base to assist in addressing the complex issues involved in implementing the intent of the NDIS Act in regard to the assessment of eligibility'.⁶ At the time, the IAC noted that there were no accepted criteria for the determination of serious and persistent functional impairments in regards to psychosocial disabilities. In the submission to this inquiry, the IAC reiterated a number of recommendations it had made in 2014, including:

The Agency develops its own working definition and guidelines of permanency of disabilities related to mental health issues.⁷

Permanent impairment requirement

Terminology

2.13 Best-practice mental health care emphasises the language of *empowerment*, *recovery* and *ability* over that of *disability*, *impairment* and *illness*. Inquiry participants were concerned that the language used in the NDIS Act does not fit with the recovery oriented approach of the mental health sector.⁸

2.14 In particular, inquiry participants found the requirement for a person to have an impairment that is permanent or likely to be permanent difficult to reconcile with contemporary, recovery-focussed mental health management and service delivery.⁹

2.15 The committee heard on numerous occasions¹⁰ that some people declined to engage with the NDIS because of the permanent disability requirement and definition of mental illness disability. Tandem, the Victorian peak body representing families and carers of people living with mental health challenges or a psychosocial disability explains:

A reliance on the language of permanence as a requirement to access the Scheme creates barriers for people. Tandem has heard numerous anecdotes

5 Australian Government, *Summary of Actions within the Australian Government Response to Recommendations to the Review of Mental Health Programmes and Services*, November 2015, p. 6, [http://www.health.gov.au/internet/main/publishing.nsf/Content/EDB3AA47E0609E3ACA257F06007F794D/\\$File/actions.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/EDB3AA47E0609E3ACA257F06007F794D/$File/actions.pdf) (accessed 29 May 2017)

6 NDIS Independent Advisory Council, *Submission 125*, p. 3.

7 NDIS Independent Advisory Council, *Submission 125*, p. 4.

8 Royal Australian and New Zealand College of Psychiatrists, *Submission 18*, p. 2.

9 See for example: UnitingCare Wesley Country SA, *Submission 14*, p. 2; Mental Health Australia, *Submission 1*, p. 3; Mental Health and NDIS Facebook Support Group, *Submission 8*, p. 2.

10 See for example: Arafmi Qld Inc., *Submission 10*, p.3; Mr Quinlan; CEO, Mental Health Australia, *Committee Hansard*, 28 April 2017, p.5; Katoomba Neighbourhood Centre, *Submission 84*, p. 3.

from family and carers of the person that they care for declining to engage with the NDIS because they do not view their situation as a 'psychosocial disability' that is 'permanent'.¹¹

Young people

2.16 Orygen, the National Centre of Excellence in Youth Mental Health, raised the issue of the difficulty for young people with a psychiatric disability to enter the NDIS because they are likely not to receive a diagnosis of permanent impairment:

Even for young people experiencing severe and functionally disabling mental ill-health, current NDIS eligibility criteria would exclude access on the basis that it would not be possible (or clinically advisable) to diagnose the illness as a 'permanent' condition. It is therefore problematic that this term is used to define eligibility for the NDIS.¹²

2.17 The Commonwealth Ombudsman also reported receiving 'feedback that suggests a barrier to accessing the Scheme, especially for young people with psychosocial disability, is that medical professionals may be reluctant to assess the person's condition as permanent or likely to be permanent'.¹³

2.18 Similarly, Anglicare Tasmania Inc. raised concerns about the permanent impairment requirement for young people:

Professionals are often reluctant to both diagnose and label symptoms as a specific illness and to confidently state that this is a permanent condition. Many young people living with mental health conditions are likely to be reluctant to consider that their condition is permanent, given the recovery model's emphasis on positive improvements.¹⁴

2.19 At a public hearing, Professor McGorry, Executive Director, Orygen, further explained:

A very important thing in psychiatry is early intervention and recovery—they have been the two big things in the last 20 or 30 years—and changing the pessimism that used to be associated with these illnesses. To have a model that assumes and requires permanent and fixed disability does not really work for us; certainly not in youth mental health. This is what young people have told us.¹⁵

11 Tandem Inc., *Submission 69*, p. 3.

12 Orygen, *Submission 67*, p. 2.

13 Commonwealth Ombudsman, *Submission 4*, p. 4.

14 Anglicare Tasmania Inc., *Submission 98*, p. 7.

15 Professor McGorry, Executive Director, Orygen, *Committee Hansard*, 28 April 2017, p. 3.

Amendments to legislation and rules

2.20 The committee heard on a number of occasions¹⁶ that amendments to the *NDIS Act 2013* in relation to the 'permanent' requirement criterion would enable NDIS to have a recovery-oriented approach aligned with its objectives of maximising independence, social and economic participation at the individual level.

2.21 Dr Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia, explained:

Our view is that there does need to be some change made to the act. One way of dealing with that would be to reference permanency if appropriate support is not received, so that permanency or recovery becomes contingent on the person being able to get support—so that it says that impairment will be permanent if support is not accessible.¹⁷

2.22 Proposed amendments to the NDIS Act in relation to the 'permanent' requirement include:

- Replacing the word permanent with *ongoing, enduring* or *chronic*.
- Considering incorporating into Section 24.1(b): *the impairment or impairments are ongoing, or likely to be ongoing without the person receiving supports intended to build their capacity*.¹⁸

2.23 The committee also received recommendations to amend the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* to, a) include the principle of recovery-oriented practice for psychosocial disability; and b) clarify that Rule 5.4 does not apply to psychosocial disability to reflect that people with mental illness will receive ongoing clinical, medical and other treatments and psychosocial services to aid their recovery.¹⁹

2.24 In contrast, the committee also heard that the NDIS Act has sufficient flexibility. Mary Burgess, Public Advocate (QLD) cited Section 24 (2) that allows for variability within the concept of permanency. In her view, 'the critical issue for people with psychosocial disability in relation to determining eligibility for the NDIS in accordance with the Act, is that of assessing functionality and capacity to participate in Australian society over the long term (Section 24 (1) (c) and (d))'.²⁰

16 See for example: Occupational Therapy Australia, *Submission 57*, p.5; CMHA, *Submission 75*, p.3; Additional information co-authored by Mental Health Australia; Mental illness Fellowship and CMHA, additional information received 19 May 2017, p. 1.

17 Dr Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia, *Committee Hansard*, 12 May 2017, p. 16.

18 Additional information co-authored by Mental Health Australia; Mental illness Fellowship and CMHA, additional information received 19 May 2017, p. 1.

19 Additional information co-authored by Mental Health Australia; Mental illness Fellowship and CMHA, additional information received 19 May 2017, p. 2.

20 Ms Mary Burgess, Public Advocate (Queensland), answers to questions on notice, 25 May 2017 (received 25 May 2017).

Reliance on formal diagnosis

2.25 In the context of psychosocial disability, assessing and predicting functionality over the long term is complex and difficult. Some submitters suggested that this has led to a practice of heavy reliance and focus on a formal diagnosis rather than functionality and the need for support to determine eligibility.²¹

2.26 Mary Burgess, Public Advocate of Queensland, stated:

We are also aware that eligibility decisions made by the NDIA staff are often heavily reliant on diagnosis rather than functionality and the need for support.²²

2.27 The committee heard that another contributing factor leading to the diagnosis type approach to determine eligibility is the reference to 'psychiatric condition' in Section 24 of the NDIS Act. Psychiatric condition is the causal component of later psychosocial disability.²³ According to Mind Australia, no other forms of disability are related to a cause in Section 24 of the NDIS Act.²⁴ Peak organisations such as Mental Health Australia, Mental Illness Fellowship of Australia Inc. and CMHA recommend removing references to psychiatric condition in the NDIS Act.²⁵

2.28 Aftercare, which currently services more than 6 000 clients across NSW, QLD and VIC, argues that the focus on diagnosis disqualifies some people with demonstrable needs under the NDIS:

Our consistent experience over the full period of the operation of the Scheme to date is that the eligibility criteria do not adequately consider the episodic nature of psychiatric disability/mental illness, and the focus on diagnosis rather than physical and psychosocial impact disqualifies many with a demonstrable need for assistance under the Scheme.²⁶

2.29 Many participants²⁷ talked about the episodic nature of conditions and symptoms associated with psychosocial disabilities and how this may exclude people from the Scheme despite their ongoing need for support.

2.30 Anglicare Australia highlighted issues expressed by many participants:

21 See for example: Flourish Australia, *Submission 117*, p.5; Mr Jarrad Smith, NDIA Transition Manager, New England Partners in Recovery, *Committee Hansard*, 12 May 2017, p. 20; Mental Health and NDIS Facebook Support Group, *Submission 8*, p. 4.

22 Mary Burgess, Public Advocate QLD, *Committee Hansard*, 12 May 2017, p. 4

23 Dr Sarah Pollock, Executive Director, Research & Advocacy, Mind Australia, *Committee Hansard*, 12 May 2017, p. 15.

24 Dr Sarah Pollock, Executive Director, Research & Advocacy, Mind Australia, *Committee Hansard*, 12 May 2017, p. 15.

25 Additional information co-authored by Mental Health Australia; Mental illness Fellowship and CMHA, additional information received 19 May 2017, p. 1.

26 Aftercare, *Submission 101*, p. 4.

27 See for example: Australian Red Cross, *Submission 15*, p. 6; Homelessness NSW, *Submission 21*, p.2; JFA Purple Orange, *Submission 25*, p. 7.

In particular the requirement for a psychosocial disability to be both severe and permanent significantly narrows eligibility, contradicts the known episodic nature of many severe forms of mental illness, and directly challenges a recovery framework for treatment.²⁸

2.31 Mind Australia Limited explained the limitations of reliance on diagnosis:

Current practice in assessment of eligibility for people with mental illness relies heavily on diagnosis and evidence from GPs and psychiatrists. As a means of determining disability, this is a blunt instrument because it fails to take into account the complex interplay between symptom severity and individual context over time – including the cumulative impact of episodes of illness on a person's broader life and ability to participate socially and economically.²⁹

2.32 As described by Ms Burgess, the Public Advocate of Queensland, the reliance on diagnosis can also lead to inconsistencies and disadvantage individuals with less acknowledged conditions:

So, in Queensland, we are seeing people with a diagnosis for schizophrenia or depression being more likely to receive NDIS funding than those with less acknowledged conditions such as post-traumatic stress disorder or personality disorders, without consideration of the impacts of these conditions on their functionality.³⁰

2.33 This is confirmed by consumers' groups such as Mental Health and NDIS Facebook Support Group, which has reported instances where applicants have been deemed not eligible to the NDIS solely because their conditions are not on the list of acceptable disabilities and are a medical condition.³¹

Functional impairment

2.34 Overall, participants³² found that the emphasis should be on the assessment of functional impairments and needs to determine eligibility. Whilst many areas of disability do have accepted criteria for the determination of serious and persistent functional impairments, such criteria have not yet been developed in regard to psychosocial disabilities related to a mental health condition.³³

28 Anglicare Australia, *Submission 62*, p. 5.

29 Mind Australia Limited, *Submission 118*, p. 7.

30 Ms Mary Burgess, the Public Advocate of Queensland, *Committee Hansard*, 12 May 2017, p. 4.

31 Mental Health and NDIS Facebook Support Group, *Submission 8*, p. 4.

32 See for example: MHCA, *Submission 116*, p. 3; Royal Australian and New Zealand College of Psychiatrists, *Submission 18*, p. 3; Sunshine Coast and Gympie – Partners in Recovery, *Submission 36*, p. 7.

33 IAC, *Submission 125*, p. 4.

2.35 The IAC and others recommended that the NDIA develop a validated instrument to determine functional impairments and support needs for people with psychosocial disability related to a mental health condition.³⁴

Participation rates

2.36 The estimated number of Australians with severe mental illness requiring community support varies but is, in any case well over 200 000. 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.³⁵

2.37 Using NMHSPF modelling, it is estimated that approximately 290 000 Australians with severe mental illness require community support.³⁶

2.38 As discussed in Chapter 1, in 2019–2020, it is estimated that around 64 000 people with a primary psychosocial disability will be participants in the NDIS.³⁷

2.39 At the end of March 2017, 4849 people with a psychosocial disability had approved plans, accounting for six per cent of Scheme participants.³⁸

Eligibility rates

2.40 To date, eligibility rates for NDIS applicants with a psychosocial disability have been one of the lowest compared to other broad disability categories. Over the life of the Scheme, 81.4 per cent of people with psychosocial disability who lodged an access request have been found eligible for the Scheme. This compares to 97.5 per cent for people with intellectual disability; 98.8 per cent for people with autism and 98.9 per cent for people with cerebral palsy.³⁹

2.41 In 2016–2017, the approval rate for people with psychosocial disability has fallen during the first and second quarter (data not available for third quarter) with only 69.4 per cent approved during Quarter 1,⁴⁰ and 71.3 per cent during Quarter 2.⁴¹

34 See for example: IAC, *Submission 125*, p. 2; Additional information co-authored by Mental Health Australia; Mental illness Fellowship and CMHA, additional information received 19 May 2017, p. 2.

35 Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities – review of Mental Health Programmes and Services*, 2015 p. 17.

36 Mental Health Australia, *Submission 1*, Attachment 1, p. 18.

37 National Disability Insurance Agency (NDIA), *Submission 102*, p. 2.

38 NDIS, *Quarterly Report to COAG Disability Reform Council*, 31 March 2017, p. 18.

39 NDIA, *NDIS COAG Disability Reform Council Quarterly Report*, Version 1, January 2017, p. 56.

40 NDIA, *NDIS COAG Disability Reform Council Quarterly Report*, Version 1, October 2016, p. 45.

2.42 A number of submitters suggested the need for a review into the eligibility rates for NDIS applicants with a psychosocial disability to investigate the high rejection rate of applications for this client group in comparison with applications from people with other primary disabilities.⁴²

2.43 The IAC recommended:

That the Agency monitor patterns of eligibility and ineligibility in relation to functional impairment and a psychiatric condition to build a picture of who is being included and excluded, track compliance with the requirements of the legislation and the consistency of the assessments being undertaken.⁴³

Impact on people deemed not eligible for NDIS services

2.44 One of the key issues for people deemed not eligible for NDIS services is what services will be available once some of the existing Commonwealth, state and territory funded services have fully transitioned into the NDIS.

2.45 Currently, to access continuity of support, clients of Commonwealth programs transitioning to the NDIS need to apply for the NDIS, regardless whether or not they are obviously ineligible for the NDIS.⁴⁴ This is especially important given that service providers have reported that, to date; only some of their existing clients are applying for the NDIS.⁴⁵ This may result in some existing clients losing supports and left without appropriate services.

2.46 The ILC, formerly known as Tier 2, is the component of the NDIS that provides information, linkages and referral to efficiently connect people with disability, their families and carers, with appropriate disability, community and mainstream supports.⁴⁶

2.47 As described by the Sunshine Coast and Gympie – Partners in Recovery, 'the ILC component has been branded as the answer to ensuring continuity of support for those who be ineligible for an IFP'.⁴⁷

2.48 However, there are concerns that the ILC does not have the capacity to provide for what existing services deliver or respond to the needs of people who won't be eligible for the NDIS.⁴⁸

41 NDIA, *NDIS COAG Disability Reform Council Quarterly Report*, Version 1, January 2017, p. 56.

42 See Public Advocate of Queensland. *Submission 93*, p. 11; Australian Red Cross, *Submission 15*, p. 3.

43 IAC, *Submission 125*, p. 4.

44 Committee Hansard, 16 June 2017, pp. 13–14.

45 *Committee Hansard*, 16 June 2017, pp.13 –14.

46 NDIS, *ILC Policy Framework-revised*, August 2015, p. 1.

47 Sunshine Coast and Gympie – Partners in Recovery, *Submission 36*, p. 5.

48 Mental Health Carers Australia, *Submission 116*, p. 4.

2.49 For example, the National Mental Health Commission is 'concerned that the ILC as currently envisaged will not be adequately funded to address the level of need, especially among those with psychosocial disability who do not qualify for a package under the NDIS'.⁴⁹

2.50 Mental Health Coordinating Council noted that there is no quarantined ILC mental health specific allocation and added 'if there were, it would not come close to replacing the Commonwealth mental health programs that are scheduled to be lost to the NDIS'.⁵⁰

2.51 The scope and level of funding for mental health services under the ILC framework are discussed in Chapter 4.

2.52 The RACP expressed concerns that any reduction in services available to people deemed ineligible for the NDIS will likely result in increased pressure and demand upon the mental healthcare system.⁵¹

2.53 The issues relating to the transition of services to the NDIS, the interface between the NDIS and services outside the Scheme as well as emerging service gaps for people not eligible for NDIS services are explored and discussed in Chapter 4.

Committee view

2.54 The committee acknowledges the widespread concerns expressed by stakeholders in relation to the lack of clarity of the eligibility criteria when applied to psychosocial disabilities related to a mental health condition.

Terminology

2.55 The committee agrees that the language of disability used in the NDIS Act and NDIS (Becoming a Participant) Rules does not readily translate into the mental health sphere. An example is the language of permanence which, while a core eligibility criteria for access to the NDIS, can on the surface at least, appear to conflict with a recovery approach, which is the guiding vision and value base for contemporary practice in mental health. Additionally, the committee notes that the language of permanence and disability may detract some people in needs of ongoing support, including young people, to actually engage with the NDIS.

2.56 The committee agrees that Rule 5.4 in the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* should not apply to psychosocial disability to reflect that people with a mental health condition receive ongoing clinical, medical and other treatments and psychosocial services to aid their recovery.

Young People

2.57 The focus on recovery is particularly important for young people experiencing mental ill-health. Organisations supporting young people have long advocated the

49 National Mental Health Commission, *Submission 114*, p. 2.

50 Mental Health Coordinating Council, *Submission 27*, p. 7.

51 The Royal Australasian College of Physicians (RACP), *Submission 17*, p. 2.

need for early-intervention for young people with conditions that will be diagnosed as being permanent. While changes to the permanency criteria in the NDIS Rules may assist participants of NDIS, there is still a significant need for adequate tailored support as early as possible for those young people who will not access the Scheme.

Reliance on formal diagnosis

2.58 The reference to psychiatric condition in Section 24(1) (a) may blur the assessment process for eligibility and lead to a heavy reliance on diagnosis instead of functional needs. Overall, the committee is concerned that, in the context of psychosocial disability, the ambiguity of the language combined with a lack of appropriate tools to assess eligibility could lead to inconsistent interpretations of the NDIS Act and result in inconsistent eligibility outcomes for applicants.

2.59 At operational levels, the adoption of a fit-for-purpose assessment tool to assess the eligibility of people with psychosocial disability would ensure fair and consistent eligibility outcomes.

Review of the Act

2.60 In July 2015, the Australian Government commissioned Ernst & Young to conduct an independent review of the NDIS Act.⁵² COAG considered the review's recommendations and developed a response, which was agreed in December 2016. COAG agreed with recommendation 31 to conduct a further review of the NDIS Act in two-to-three years.⁵³ The committee recommends a review of the NDIS Act as early as possible to provide greater clarity to eligibility criteria and better alignment with the core principles of the NDIS.

Eligibility rates

2.61 The committee is concerned with the relatively high rejection rate of applications for people with a psychosocial disability in comparison with applications from people with other primary disabilities. The committee believes there is value in investigating why ineligibility rates are significantly higher for people with psychosocial disability as the reasons remain unclear.

Requirement to apply for the NDIS to access continuity of support for existing program clients

2.62 Evidence received by the committee strongly suggests that not all existing clients of Commonwealth programs such as Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs) and Day to Day Living (D2DL), which are transitioning into the NDIS, will apply for the NDIS. Those currently receiving support under the Mental Health Respite: Carer Support (MHR:CS) could also be impacted. The committee is concerned that the current requirement for existing clients

52 Ernst & Young, *Independent review of the NDIS Act*, December 2015, https://www.dss.gov.au/sites/default/files/documents/04_2016/independent_review_of_the_ndis_act.pdf (accessed 6 June 2017)

53 Australian Government, *COAG response to the independent review of the National Disability Insurance Scheme Act*, December 2016, p. 7.

of these programs to apply for the NDIS to be able to access continuity of support may have some detrimental consequences. It is likely to result in some existing clients losing psychosocial supports, which would further marginalise a cohort of people who are hard-to-reach and had very little or no interaction with existing services prior becoming clients to these specific programs.

Recommendation 1

2.63 The committee recommends that the NDIS Act is reviewed to assess the permanency provisions in Section 24 (1) (b) and the appropriateness of the reference to 'psychiatric condition' in 24 (1) (a).

Recommendation 2

2.64 The committee recommends that a review of the NDIS (Becoming a Participant) Rules 2016 should be considered to assess the appropriateness and effectiveness of:

- **Including the principle of recovery-oriented practice for psychosocial disability, and**
- **Clarifying that Rule 5.4 which dictates that a condition is, or is likely to be permanent,⁵⁴ does not apply to psychosocial disability, to reflect that people with mental conditions will receive ongoing treatments to aid recovery.**

Recommendation 3

2.65 The committee recommends that the Australian Government ensures young people with mental ill-health who are not participants of the Scheme, have access to adequate early intervention services.

Recommendation 4

2.66 The committee recommends the NDIA, in conjunction with the mental health sector, develops and adopts a validated fit-for-purpose assessment tool to assess the eligibility of people with psychosocial disability that focuses on their functional capacity for social and economic participation.

Recommendation 5

2.67 The committee recommends the NDIA monitors eligibility rates for people with psychosocial disability to, a) understand the reasons for a higher rejection rate compared to other disabilities; and b) to build a clearer picture of the size and needs of the people who have been found ineligible for NDIS services.

54 Rule 5.4 of the NDIS Rules states that:

An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.

Recommendation 6

2.68 The committee recommends clients currently receiving mental health services, including services under Commonwealth programs transitioning to the NDIS, namely Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Day to Day Living (D2DL, and Mental Health Respite: Carer Support (MHR:CS), should not have to apply for the NDIS to have guarantee of continuity of supports and access services.

Chapter 3

Access and planning

Introduction

3.1 This chapter discusses access to NDIS services and explores the establishment and review of plans for NDIS participants with a psychosocial disability.

3.2 It deals with terms of reference e) the planning process for people with a psychosocial disability; and g) the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability.

Access

3.3 Entry to the Scheme begins with an access request lodged through a form or being completed by telephone. The NDIA has 21 days to respond. If the applicant meets the eligibility criteria, the planning process begins. Supports are allocated through a plan, which is prepared through conversations between a planner and the participant.

3.4 The committee heard there were a number of key barriers to access NDIS services. Inquiry participants reported lack of information, unclear referral pathways, emerging service gaps and means of communications used by the NDIA as contributing factors to jeopardising access as well as developments of adequate plans.

Online engagement and phone

3.5 The committee heard that key communication tools (website, *myplace* portal and phone) used by the NDIA can lead to adverse outcomes and contribute to a number of individuals with psychosocial disability missing out on services.¹

3.6 Access to the internet and some degree of digital literacy are required to engage in the NDIS. Accessing information about the Scheme, engaging with the access and planning process as well as managing plans are mostly done online. According to the Commonwealth Ombudsman, this is a source of concern because many people with psychosocial disability do not access the internet for a variety of reasons including lack of access to a computer, cost of services and mistrust of the technology.²

3.7 Ballarat Community Health explained how the need to use online tools is a barrier to accessing the NDIS:

That the eligibility process does rely on participants accessing MyGov, the Portal and using IT skills that they do not have (or lack confidence with) is

1 See for example: Royal Australian and New Zealand College of Psychiatrists, *Submission 18*, p. 9; Commonwealth Ombudsman, *Submission 4*, p. 5; VCOSS, *Submission 50*, p. 21.

2 Commonwealth Ombudsman, *Submission 4*, p. 5.

further isolating and will ensure many do not commence or proceed with NDIS.³

3.8 One Door Mental Health reported that 'there does not appear to be an alternative to or supports for the participants to use the online portal, *myplace*, for those that do not have access to, or are unable to use computers'.⁴

3.9 Central Adelaide Hills Partners in Recovery (CAH PIR) reported that participants found 'there was limited or no promotion or information from the NDIA and that the website is not user friendly'.⁵

3.10 Queensland Program of Assistance to Survivors of Torture and Trauma also commented on the difficulty to navigate the NDIS website and to access information for non-English speakers:

It is not sufficient to have translated material in 10 languages (we work with more than 70 languages each year) tucked away under a sub-heading on the website. People would not be able to access this site if they cannot speak English let alone find the right links.⁶

3.11 As stated on the NDIS website, due to the large number of people entering the Scheme over the next few years, the NDIA offers to undertake most access requests over the telephone.⁷

3.12 Communicating by phone can be extremely problematic for people with a mental health condition. Inquiry participants have reported experiences of people with psychosocial disability not answering or not returning calls for a variety of reasons. Due to the nature of their mental health condition, this includes feeling not comfortable speaking over the phone and not wanting to answer calls from numbers they do not know.⁸ In addition, it can put the participant under undue pressure and excludes the family and carer from the initial and subsequent planning discussions.⁹

Accessibility of information and role of primary health care professionals

3.13 The first professional encounter for many people seeking help for a mental illness is their GP.¹⁰ GPs are often the 'frontline' access point to treatment and can play

3 Ballarat Community Health, *Submission 58*, p. 2.

4 One Door Mental Health, *Submission 74*, p. 9.

5 Central Adelaide Hills Partners in Recovery (CAH PIR), *Submission 30*, p. 6.

6 Queensland Program of Assistance to Survivors of Torture and Trauma, *Submission 79*, p. 7.

7 NDIS, *Access requirements*, <https://www.ndis.gov.au/people-with-disability/access-requirements/completing-your-access-request-form.html> (accessed 27 June 2017).

8 See for example: VCOSS, *Submission 50*, p. 21; VICSERV, *Submission 65*, p. 5; Office of the Public Advocate, *Submission 7*, p. 14.

9 Tandem, *Submission 69*, p. 10.

10 BEING, *Submission 48*, p. 12.

a critical role in identifying potential NDIS participants and providing them with essential information.¹¹

3.14 However, to date, many health professionals and organisations find it difficult to obtain information about how to access the NDIS and navigate the planning process. This leads to health professionals being unable to adequately assist individuals to access or prepare for NDIS assessment. Mental Health Australia said:

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.¹²

3.15 Dr Meyer, Director, Operations Support, Aftercare, reported:

We are seeing a very particular gap around accessibility, and that is in the information and support provided to GPs and other health professionals in assisting people to do the assessments.¹³

3.16 The Queensland Alliance for Mental Health reported that a lack of knowledge of the NDIS amongst GPs and other clinical service providers has resulted in major barriers to access an NDIS package in some areas of Queensland.¹⁴

3.17 The Royal Australasian College of Physicians (RACP) recommended that the NDIS provides information about how physicians and specialists can appropriately refer people with psychosocial disability, especially children to the NDIS.¹⁵

3.18 Similarly, at a public hearing in Penrith, Ms Jaime Comber, Policy Officer with BEING, recommended:

...I think they [NDIS] need to work with health professionals to make sure that that information is getting out there. What we propose in our submission is doing more education with GPs and people who are having the frontline interactions with people.¹⁶

Engagement and assertive outreach

3.19 Outreach services are essential to identifying and supporting people with psychosocial disability. They are often isolated and face other barriers such as a lack of knowledge of services available and negative prior experience with service providers. It is likely that a group of people who are eligible will not access services through NDIS, or will not make full use of allocated plans, without active outreach.

11 Office of the Public Advocate (QLD), *Submission 93*, p. 12.

12 Mental Health Australia, *Submission 1*, p. 3.

13 Dr Isabelle Meyer, Director, Operations Support, Aftercare, *Committee Hansard*, 28 April 2017, p. 16.

14 Queensland Alliance for Mental Health, *Submission 23*, p. 2.

15 RACP, *Submission 17*, p. 4. VCOSS, *Submission 50*, p. 21.

16 Ms Jaime Comber, Policy Officer, BEING, *Committee Hansard*, 17 May 2017, p. 5.

3.20 BEING recommended that the NDIA develops an assertive outreach plan for people with psychosocial disability, particularly regarding how to reach those without regular contact with current Commonwealth funded programs such as PIR and PHaMs.¹⁷

3.21 Many inquiry participants¹⁸ stressed the need for appropriate services to engage with hard-to-reach populations, including CALD, LGBTI and Aboriginal and Torres Strait Islander communities:

Data from the NDIA indicates that people who identify with Aboriginal and Torres Strait Islander heritage or from Culturally and Linguistically Diverse communities are not accessing the Scheme at a rate that is reflective of the needs in these communities. Special attention needs to be paid to ensure that culturally appropriate and safe outreach strategies, processes and other elements of the Scheme are developed in consultation with relevant communities.¹⁹

3.22 The Queensland Alliance for Mental Health gave the example of the NDIS rollout on Palm Island where utilising an outreach model to support the transition was crucial:

Experiences of the NDIS rollout on Palm Island and in some other Aboriginal and Torres Strait Islander communities have uncovered the importance of working with a community to identify tailored ways in which to support the transition utilising an outreach model. Identifying activities appropriate to the community, ensuring appropriate methods for measuring outcomes are employed, appropriately resourcing and acknowledging the importance of family supports are all important aspects of outreach that should be considered for many communities. This includes CALD communities as well as Aboriginal and Torres Strait Islander communities.²⁰

3.23 The issue of funding to deliver assertive outreach was brought to the attention of the committee on several occasions.²¹ Mental Health Australia noted:

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 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

17 BEING, *Submission 48*, p. 12.

18 See for example, VICSERV, *Submission 65*, p. 7; CMHA, *Submission 75*, p. 12; Wellways, *Submission 103*, p. 6.

19 Flourish Australia, *Submission 117*, p. 12.

20 Queensland Alliance for Mental Health, *Submission 23*, p. 6.

21 See for example, Mental Illness Fellowship Australia, *Submission 70*, p. 11; VCOSS, *Submission 50*, p. 6.

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.²²

3.24 Assertive outreach services provided by the NDIS can only be delivered through the Local Area Coordination (LAC) function. However, submitters noted that the current LAC approach does not have the capacity to take on functions such as outreach and advocacy services.²³ The ILC framework and LAC function are discussed in chapter 4.

3.25 According to their submission, the NDIA is currently using the learning from a number of projects to develop an approach for those participants who may be regarded as 'hard to reach'. At the time of writing, no strategy or approach has been made public by the NDIA.²⁴

Advocacy services

3.26 In their submission, the Office of the Public Advocate Victoria highlighted the importance of outreach advocacy so people who are currently not in funded services get access to information and advocacy.²⁵

3.27 This view is shared by many organisations²⁶, including the Victorian Mental Illness Awareness Council (VMIAC), which explained at the public hearing in Melbourne how it has played an active advocacy role for mental health consumers in the NDIS Barwon trial site. Their work includes the development of education resources for consumers as well as a touring musical theatre production -*NDIS: The Musical*. VMIAC recommends that resources and support be made available for advocacy services:

It is our recommendation that the culturally appropriate independent advocacy services be resourced to safeguard vulnerable people—this includes hard-to-reach-and-engage populations including Aboriginal and Torres Strait Islanders, CALD and LGBTI communities—to ensure that the national disability standards continue to underpin and then inform all NDIS activities.²⁷

3.28 Victorian Council of Social Service (VCOSS) members reported that disability advocacy services in the Barwon trial site experience substantial increase in demand that cannot be met. They identified a need for funding independent advocacy

22 Mental Health Australia, *Submission 1*, p. 11.

23 Ballarat Community Health, *Submission 58*, p. 2.

24 NDIA, *Submission 102*, p. 8.

25 Office of the Public Advocate Victoria, *Submission 7*, p. 14–15.

26 See for example, Victorian Mental Illness Awareness Council (VMIAC), *Submission 112*, p.16; Office of the Public Guardian Queensland, *Submission 126*, pp. 4–5; Australian Red Cross, *Submission 15*, p. 8.

27 Mr Turton-Lane, *Committee Hansard*, 28 April 2017, p. 18.

to assist people to access and participate in the NDIS and to help people ineligible for NDIS services to access appropriate services.²⁸

Planning process

3.29 Section 31 of the NDIS Act states that the development of a plan should so far as reasonably practicable be individualised, directed by the participant and maximise participant choice and control.

3.30 The planning process involves discussions about the participant's goals and aspirations and an assessment of function and support needs, before a support package is put together. Once a support package has been put together, the participant and planner decide how the plan will be managed and when the plan will be reviewed. Before the plan is finalised, it must be approved by the CEO of the NDIA.

3.31 The NDIS has developed a range of resources about the planning process and management of plans which are accessible from the NDIS website. This includes an access kit aimed at assisting people with a psychosocial disability entitled *Completing the access process for the NDIS-Tips for Communicating about Psychosocial Disability*.²⁹

Experience, skills and training of staff

3.32 Many inquiry participants expressed concerns about the insufficient knowledge of psychosocial disabilities by NDIS staff, which can impact on access to the Scheme, planning process and quality of plans.³⁰

3.33 The IAC identified major variations in the knowledge and skill base not only of the NDIS teams but more recently in regards to LACs in relation to mental health expertise.³¹

3.34 New England Partners in Recovery noted:

In addition, early experiences in our region of New England NSW suggests that in many locations Local Area Coordinator (LAC) teams and NDIS Planners generally have a low level of understanding of mental health issues. Many of these staff appear to have backgrounds in physical or intellectual disability, and as a result their understanding of mental health, and in particular its episodic nature, is still developing.³²

3.35 The lack of understanding of psychosocial disability by NDIS planners was also noted by Psychiatric Disability Services of Victoria (VICSERV):

28 VCOSS, *Submission 50*, pp. 21 and 22.

29 NDIS, *Access requirements*, <https://www.ndis.gov.au/people-disability/access-requirements.html> (accessed 20 June 2017).

30 National Disability Services (NDS), *Submission 80*, p. 2.

31 IAC, *Submission 125*, p. 5.

32 New England Partners in Recovery, *Submission 111*, p. 3.

Individuals don't always know what they can ask for or how to articulate their disability and it has been reported that NDIA planners do not have an adequate understanding of psychosocial disability and mental illness to support them through the planning process.³³

3.36 Mr Greg Franklin, Administrator, Mental Health and NDIS Facebook Support Group reported:

The experience I have had with NDIS planners is that their backgrounds are very diverse. The highest level of training I have had with any NDIS person in a planning role has been a former occupational therapist. The rest of them have come basically from ADHC, other government departments as they shift to the NDIS and that type of thing. I have been told by an ex-NDIS planner that they got two weeks intensive training, closely supervised training. That was it. As far as access people go, they have very minimal training and absolutely none in mental health.³⁴

3.37 BEING reported that the planning experience is heavily dependent on the NDIA planner and that 'a recurring issue for consumers, carers and support workers was that planners did not have a good understanding of psychosocial disability'.³⁵

3.38 VCOSS members working in the Barwon launch site also reported 'examples of planners lacking relevant knowledge, such as being unaware of the role of peer workers' which resulted in inappropriate plans for some participants.³⁶

3.39 Ms Mary Burgess, the Public Advocate of Queensland talked about how the knowledge and skills of NDIS planners play a critical role in the planning process:

We have also been advised by service providers that the successful transition of people with psychosocial disability into the NDIS and the development of well-constructed plans is heavily reliant on the knowledge and skill of the NDIS planners. Anecdotal reports, including recent media comments from the CEO of the national peak body for disability services, National Disability Services, suggest that capability of planners varies widely and leads in some cases to poorly constructed plans, which then have to be reviewed and altered.³⁷

3.40 Ms Burgess concluded:

In summary, I would respectfully request that the committee consider recommending (...) that key NDIA personnel receive training in the specific needs of people with psychosocial disability and recognise the centrality of the recovery framework in their treatment when interacting

33 Psychiatric Disability Services of Victoria (VICSERV), *Submission 65*, p. 6.

34 Mr Greg Franklin, Administrator, Mental Health and NDIS Facebook Support Group, *Committee Hansard*, 17 May 2017, p. 6.

35 BEING, *Submission 48*, p. 9.

36 VCOSS, *Submission 50*, p. 12.

37 Ms Mary Burgess, the Public Advocate of Queensland, *Committee Hansard*, 12 May 2017, p. 3.

with applicants from this cohort; and, finally, that the NDIA ensure that planners and other key staff, such as local area coordinators, are appropriately experienced and skilled in identifying and addressing issues associated with psychosocial disability.³⁸

Support during the pre-planning and planning stage

3.41 Inquiry participants reported that people with psychosocial disability need and require a significant amount of support to demonstrate their eligibility and prepare for the first planning meeting. There are concerns that without this support available many people with serious mental conditions will miss out.

3.42 The Mental Health Coordinating Council (MHCC) reported that providers in the Hunter trial site, including but not limited to PIR, reported an average of 40 to 60 hours of functional assessment work to support NDIS access. MHCC noted that these activities are currently funded at only up to \$750.³⁹

3.43 Mr Peters, a consumer and user of Neami National services shared his personal experience and explained the importance of having support in the assessment and planning process:

If I had any take-home messages, they would be that it was not my experience that I could do this learning process alone, or walk into a planning meeting with my goals and needs articulated in order to be funded. My firm belief is that there is a definite need for ongoing funding in the current service model to help people reach the stage where they can go into a planning meeting and talk about their needs and goals. Without that capacity building and support helping me to get where I am today I would still be isolated, alone and in bed all day every day.⁴⁰

3.44 Providing pre-planning services is one of the functions of LACs but the Committee did not see any evidence during this inquiry of the effectiveness of LACs in this area. In its NDIS Costs position paper, the Productivity Commission pointed that because of the speed of the rollout it has not been possible for LACs to perform their pre-planning functions as envisaged.⁴¹

3.45 The NDIA is reportedly identifying ways to improve communications to assist people to navigate the NDIS. This includes using the ILC grant process to fund community organisations to provide information and referrals.⁴²

38 Ms Mary Burgess, the Public Advocate of Queensland, *Committee Hansard*, 12 May 2017, p. 4.

39 MHCC, *Submission 27*, p. 10.

40 Mr Peters, Consumer and user of Neami National services, *Committee Hansard*, 28 April 2017, p. 20.

41 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, June 2017.

42 NDIA, answers to questions on notice, received 30 June 2017.

Adequacy of planning meeting

3.46 A number of participants⁴³ expressed concerns about people being contacted by phone by an NDIA representative to undertake an official planning meeting. As discussed previously in terms of access, this often leaves people unprepared and not able to be supported by family, friends or service providers during the assessment process. This can lead to poor outcomes in terms of developing an appropriate plan that meets the needs of an individual.

3.47 Ms Elizabeth Crowther, President, Community Mental Health Australia, explained to the committee how the practice of phoning and sending mail is inadequate:

People have been telephoned and asked over the phone to describe what their life needs are. Many of these people have major cognitive problems just at that time and are unable to engage. The problem we then have is that the person may or may not receive a letter. They do not know what to do with that letter and our experience is that they may appear at a service some nine or 10 months later not knowing what to do with it or where to proceed with that letter. That is currently a major issue. I do not know how that is going to resolve, but resolved it must be.⁴⁴

3.48 MHCSA submitted that people with psychosocial disability are likely to require support during the assessment process:

Phone assessments are problematic – Consumers may not understand that the phone call is actually an assessment, leading to poor outcomes - There is a high degree of social isolation in the cohort eligible due to psychosocial disability (PIR Annual Report, 2016) therefore telephone assessments without significant support is unlikely to result in an effective plan.⁴⁵

3.49 Dr Isabella Meyer, Director Operations Support at Aftercare described to the committee why online and phone communications are not suitable for most consumers:

One of the things that we know about our clients is that less than 24 per cent of them have access to a computer, and a similar number, 27 per cent, own a phone and are engaged in phone calls. For the rest of our clients, this process of accessing forms online and having assessments and planning done over the phone is traumatic, and it is inaccessible to them—they do not do it. If they answer the phone at all, and the request is: 'We're doing your plan now,' they will hang up. We know that. That has been our experience.⁴⁶

43 See for example: Queensland Alliance for Mental Health, *Submission 23*, p. 3; Neami National, *Submission 29*, p. 5; Cohealth, *Submission 43*, p. 8.

44 Ms Elizabeth Crowther, President, Community Mental Health Australia, *Committee Hansard*, 28 April 2017, p. 6.

45 MHCSA, *Submission 109*, p. 7.

46 Dr Isabella Meyer, Director Operations Support, Aftercare, *Committee Hansard*, 28 April 2017, p. 16.

3.50 VICSERV explained that 'phone calls as a means to facilitate engagement can cause significant distress for some individuals and will often result in disengagement.'⁴⁷ In its submission, VICSERV also highlighted how 'non-verbal communication is an essential part of building rapport with people with a psychosocial disability' and concluded:

While using technology plays an important role in increasing access to services, a move away from face-to-face consultations will also mean a lack of rapport and an increase in the number of people who will disengage from services.⁴⁸

3.51 VCOSS members reported a high number of planning meetings occurring over the phone and highlighted some key issues:

Conducting a planning session over the phone may prevent participants with a psychosocial disability from fully understanding or participating in the planning process, and makes assessment more difficult, potentially leading to poorly informed decision making. Members report instances where phone-based planning meetings have resulted in reduced support and some cases where people were unaware the phone conversation constituted their planning meeting until they received their plan in the mail.⁴⁹

3.52 Tandem also noted that planning meeting over the phone 'puts the participant under undue pressure, and actively excludes the family and carer from the planning discussions'.⁵⁰

3.53 At the public hearing held on 16 June 2017 in Canberra, the NDIA reported that 65 per cent of all plans are currently developed in face-to-face conversation and that an individual has always been given the opportunity to book for face-to-face conversation rather than over the phone.⁵¹

The role of carers

3.54 Mental Health Carers Australia (MHCA) and others⁵² are concerned with the lack of engagement by NDIS planners with carers in the planning process. MHCA reported that 'the common experience of mental health carers is that they are not included in the planning process'.⁵³

47 VICSERV, *Submission 65*, p. 5.

48 VICSERV, *Submission 65*, p. 5.

49 VCOSS, *Submission 50*, p. 12.

50 Tandem, *Submission 69*, p. 10.

51 Ms Gunn, Acting Deputy Chief Executive Officer, Participants and Planning, NDIA, *Committee Hansard*, 16 June 2017, p. 17.

52 See for example: Mind Australia, *Submission 118*, p. 11; Mental Health Commission of NSW, *Submission 16*, p. 5; Anglicare Australia, *Submission 62*, Attachment 2, p. 5.

53 Mental Health Carers Australia (MHCA), *Submission 116*, p. 10.

3.55 Tandem has 'heard concerning reports of participants receiving phone calls in which the carer and the family was not involved, pre-warned or consulted'.⁵⁴

3.56 MHCA also reported that 'the majority of carers of NDIS participants consulted as part of the Carers Australia's NDIS Carer Capacity Building Project reported that NDIA staff had not made them aware of the option to have a separate conversation with the planner or of the ability to submit a Carer Statement'.⁵⁵

3.57 Similarly, Mind Australia stated:

Although carers can ask for a separate meeting with planners, our observations are that very few people are aware of this, with the result that carers needs are not taken into account.⁵⁶

3.58 Additionally, as Tandem explained, it is important that carers are present during the planning conversations 'to ensure the planner is provided a holistic and true understanding of the person support needs'.⁵⁷

3.59 VCOSS also highlighted the importance of engaging carers in the planning process as 'this can help to effectively identify the participant's needs and support required'.⁵⁸

3.60 The lack of engagement of carers in the planning process has also resulted in carers 'experiencing reduced access to respite care and other support'.⁵⁹

3.61 The Mental Health Commission of NSW reported that the *Carer Recognition Act 2010* makes it clear that 'Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers' and recommended:

This needs to be fully recognised during the planning process as carers will inevitably be a key component in the implementation of any individual package.⁶⁰

3.62 VCOSS recommended engaging carers and family members in the planning process to 'better identify the support needed for individuals and their carers'.⁶¹

Poor communication, delays and other issues

3.63 Submitters reported difficulty to contact NDIS staff and a lack of responsiveness of NDIS planners during the planning process.⁶²

54 Tandem, *Submission 69*, p. 10.

55 Mental Health Carers Australia (MHCA), *Submission 116*, p. 6.

56 Mind Australia, *Submission 118*, p. 11.

57 Tandem, *Submission 69*, p. 11.

58 VCOSS, *Submission 50*, p. 13.

59 VCOSS, *Submission 50*, p. 13.

60 Mental Health Commission of NSW, *Submission 16*, p. 5.

61 VCOSS, *Submission 50*, p. 5.

3.64 Mental Health Carers NSW Inc. reported that carers and support workers find it difficult to contact NDIS planners, who often do not return phone calls or meet agreed deadlines.⁶³

3.65 BEING explained some of the communication issues:

One recurring problem appears to be difficulty reaching NDIA staff. Many survey respondents commented on the long phone hold times, the long wait to find out application results, and NDIS planners not returning calls.⁶⁴

3.66 The Commonwealth Ombudsman has received a number of complaints from people with psychosocial disability, covering a range of issues pertaining the planning process:

The bulk of these complaints reflected similar issues as those complaints received from people with other disabilities including delays, poor communication, dissatisfaction with plans and planning staff, and difficulties with the review process.⁶⁵

3.67 Capital Health Network reported delays of up to 12 weeks before plans have been approved.⁶⁶

3.68 VCOSS members in the Barwon launch site report 'delays of between four and six months between when a participant is assessed as eligible and their first plan being receive' with people 'unable to access funded mental health services during this transition period'.⁶⁷

3.69 Similarly, Collaboration in Mind (CiM) stated 'the delay, sometimes a matter of weeks, between approval of a plan and receipt of the plan is leaving participants without access to support'.⁶⁸

Annual plan and plan reviews

3.70 Usually, a plan is established for twelve months and plan review occurs as part of the planning cycle. However, unexpected plan reviews can be triggered if the Scheme participant requests a plan review or changes their statement of goals and aspirations. Currently, any changes to a plan require a full plan review.

3.71 Given the episodic nature of conditions and symptoms, concerns have been raised by participants that the annual plan approach does not build in supports to intervene early and prevent relapse. For example, the Benevolent Society stated:

62 See for example: Mr Chris Redmond, CEO, Woden Community Service, *Committee Hansard*, Friday 12 May, p. 34; Ms Marilyn Gale, *Submission 59*, p. 2; Mr David Lamborn, *Submission 90*, p. 1.

63 Mental Health Carers NSW Inc., *Submission 64*, p. 4.

64 BEING, *Submission 48*, p. 4.

65 Commonwealth Ombudsman, *Submission 4*, p. 4.

66 Capital Health Network, *Submission 45*, p. 2.

67 VCOSS, *Submission 50*, p. 10.

68 Collaboration in Mind (CiM), *Submission 94*, p. 6.

We also have concerns that the NDIS planning process will be unable to accurately measure and plan annually for needs which are sporadic in nature.⁶⁹

3.72 This view was supported by Ms Meagher of the IAC:

There is an argument that all disabilities are also, to some extent, episodic. When we look at the issues of permanency, they have to be moderated by the understanding of episodic conditions, how extreme or not those episodes could be and whether as an agency we are responsive to those fluctuating needs. That would be amongst the work we need to do into the future to determine how flexible plans can be—not just for people with psychosocial disabilities arising from mental illness, but also for a range of disabilities.⁷⁰

3.73 Many participants⁷¹ found that the rigidity of the NDIS review process as well as long delays in accessing reviews, do not allow for responsive plans and support to be put in place for participants when crises occur or circumstances suddenly change.

3.74 As stated by National Disability Services (NDS) and other participants,⁷² the current average three-month wait for a plan review is not appropriate for people who have a sudden increase in their need for support.⁷³

3.75 The NDIA is aware of the concerns raised about current planning processes and practices. On 6 June, the NDIA announced it has undertaken a participant pathway review to deliver a significantly upgraded quality of participant and provider experience in a way that remains consistent with maintaining the Scheme's financial sustainability.⁷⁴

3.76 Overall, the committee heard that there is need to put greater emphasis on the pre-planning and planning stage to achieve good outcomes and quality plans. Mental Health Australia and others stated that as result of poor planning process many people reported receiving NDIS plans that are not fit for purpose or tailored to their individual needs.⁷⁵

69 The Benevolent Society, *Submission 106*, p. 4.

70 Ms Meagher, IAC member, *Committee Hansard*, 16 June 2017, p. 2.

71 See for example: Partners in Recovery Tasmania, *Submission 97*, p. 12, Anglicare Tasmania, *Submission 98*, p. 10, RANZCP, *Submission 18*, p. 8.

72 See for example: VICSERV, *Submission 65*, p. 7; Anglicare Tasmania, *Submission 98*, p. 11.

73 NDS, *Submission 80*, p. 3.

74 David Bowen, CEO, NDIA, *Participants and providers work with the NDIS to improve processes*, 6 June 2017. <https://www.ndis.gov.au/news/ceo-message-6june.html> (accessed 20 June 2017).

75 Mental Health Australia, *Submission 1*, p. 3.

Committee view

Information and assertive outreach

3.77 Given the critical role that GPs and other primary health care professionals can play in identifying and referring people with psychosocial disability to NDIS services, the committee recommends the NDIA develops and proactively markets resources and training for health professionals, especially about the NDIS referral pathways, access and planning processes.

3.78 The committee acknowledges the critical role assertive outreach and advocacy services can play in identifying and engaging individuals with psychosocial disability with NDIS services. With the transition of services such as PIR and PHaMs it is important to ensure that service gaps do not emerge in the area of assertive outreach and advocacy services. Given the reported high number of people with psychosocial disability who do not want or cannot utilise phone or online services, the NDIA must consider other ways to reach and communicate, including proactively using assertive outreach services to facilitate access to the NDIS.

Skills and expertise of planners

3.79 While mental health consumers, carers and providers have on many occasions raised concerns about NDIA planners' understanding of psychosocial disability, the committee recognises the efforts of the NDIA Mental Health Team work's to address this important issue. Initiatives such as the establishment of an internal NDIA community of practice on psychosocial disability and the provision of training for staff must continue to ensure the planning process results in providing the necessary supports for people with psychosocial disability. Given that participants with psychosocial disability as their primary disability are expected to account for about 13.9 per cent of all NDIS participants by 2019–20, the NDIA should consider having a specialised team of NDIS planners for people with psychosocial disability. This would ensure better plan outcomes for participants, less need for reviews and ultimately contribute to the sustainability of the Scheme.

Planning process

3.80 Overall, the committee believes the planning process has not been operating well for people with psychosocial disability and has resulted in many cases with less than satisfactory experiences and outcomes for participants. Furthermore, the reported delays experienced by participants in getting a planning meeting, receiving their approved plan or reviewing their existing plan are a cause of great concern for the committee. Given the episodic nature of mental health conditions, an agile planning and review process is crucial to ensuring that participants have continuity of appropriate support. Notwithstanding the challenges of the rollout schedule, the committee urges the NDIA to continue reviewing its current practices to address operational issues around meetings taking place over the phone, waiting times and delays and lack of responsiveness to people's changing needs.

3.81 As discussed in the general issues report, the committee acknowledges that the NDIA is currently investigating the ways in which it can improve its participant and provider experience. The committee expects that the pathways review currently

being undertaken will be published and made accessible to all those involved in the Scheme. Those areas identified, particularly related to mental health as requiring improvement should be incorporated into the NDIA's Quarterly Reports and progress against those targets tracked over time.

Recommendation 7

3.82 The committee recommends the NDIA develops and proactively markets resources and training for primary health care professionals about the NDIS, especially in regards to access and planning processes.

Recommendation 8

3.83 The committee recommends the Department of Social Services and the NDIA collaboratively develop a plan outlining how advocacy and assertive outreach services will be delivered beyond the transition arrangements to ensure people with a psychosocial disability and those who are hard-to-reach can effectively engage with the NDIS and/or other support programs.

Recommendation 9

3.84 The committee recommends the NDIA, in conjunction with the mental health sector, creates a specialised team of NDIS planners trained and experienced in working with people who have a mental health condition as their primary disability.

Recommendation 10

3.85 The committee recommends the NDIA develops an approach to build flexibility in plans to respond to the fluctuating needs of participants with a psychosocial disability, including allowing minor adjustments to be made without the need for a full plan review.

Recommendation 11

3.86 The committee recommends the NDIA reports on the level of engagement of carers in the planning process.

Recommendation 12

3.87 The committee recommends the NDIA publishes the results of its participants and providers pathways review, particularly in the areas related to mental health, and strategies in place to achieve improved outcomes, as well as updates on progress against targets in its Quarterly Reports.

Chapter 4

Funding and services

Introduction

4.1 This chapter focuses on the transition of Commonwealth, states and territories funded services to the NDIS. It investigates the continuity of services and the risk of emerging service gaps. Finally, this chapter discusses the scope and level of funding for mental health services under the ILC framework.

4.2 It deals with terms of reference:

- (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;
- c) the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular;
 - i. whether these services will continue to be provided for people deemed ineligible for the NDIS; and
- (d) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework.

4.3 For people living with a psychosocial disability, the service landscape remains complex and fragmented as services are both cross-sectoral (health and disability) and cross-jurisdictional (Commonwealth and state/territory). It is important to note that alongside the NDIS rollout, the mental health sector is undergoing significant reform with the development of the Fifth National Mental Health Plan.

4.4 A number of Commonwealth, state and territory services and funding are being transferred into the NDIS, which currently provide services for clients both in and out of scope for the NDIS. The Australian, state and territory governments have agreed to provide continuity of support for people who are not eligible for the NDIS.¹

4.5 The NDIS is meant to work collaboratively and alongside mainstream services, not replace them. As the NDIA stated:

The NDIS does not replace the mental health system and does not replace community based support or medical clinical care for people living with mental health conditions, but, rather, must be designed to work collaboratively with these sectors. We continue to work to do this.²

4.6 In practice, many inquiry participants reported confusion and uncertainty about what services and supports will continue to be funded and/or funded for

1 Intergovernmental Agreement for the NDIS Launch, 7 December 2012, p. 11.

2 Ms Gunn, Acting Deputy Chief Executive Officer, Participants and Planning, NDIA, *Committee Hansard*, 16 June 2017, p. 16.

individuals with a psychosocial disability who are ineligible for the NDIS. This is partly because the roles of the Australian and state and territory governments in relation to NDIS and residual or ongoing service systems are not clear or nationally consistent. Indeed, the extent to which existing services are transitioning to the NDIS varies between jurisdictions as do the implementation timelines.³

Commonwealth programs

Transition to the NDIS of Commonwealth funded services

4.7 The NDIS will eventually replace a range of Commonwealth funded disability programs for people with a psychosocial disability. The funding for the following programs is gradually transitioning into the NDIS:

- Partners in recovery (PIR) funded by the Department of Health;
- Support for Day to Day Living in the Community (D2DL) funded by the Department of Health;
- Personal Helpers and Mentors (PHaMs) funded by the Department of Social Services; and
- Mental Health Respite: Carer Support (MHR:CS) funded by the Department of Social Services.

4.8 Not all of the people who had access to psychosocial services under these community based programs will become NDIS participants. Some have been or will be assessed as ineligible and some will not apply to become an NDIS participant.

4.9 A number of service providers and organisations,⁴ including Mental Health Australia (MHA) estimate that about 70 per cent of PIR participants and 60 per cent of D2DL participants will be eligible for the NDIS.⁵

4.10 In the case of PHaMs, MHA submitted that the Commonwealth government indicated that while PHaMs is 100 per cent in scope for NDIS, it is hard to estimate what the actual rate of eligibility for PHaMs participants will be because PHaMs does not specify an older age limit so it is conceivable that a number of existing participants will be excluded on the basis of age.⁶

4.11 Other submitters were also concerned that not all PHaMs clients will become NDIS participants.⁷ For example, Anglicare Australia reported:

3 National Mental Health Commission, *Submission 114*, p. 3.

4 See for example: Mental Health Coordinating Council (MHCC), *Submission 27*, Attachment 1 p.35; Sunshine Coast and Gympie - Partners in Recovery, *Submission 36*, p. 4; Wide Bay Partners in Recovery Consortia, *Submission 51*, p. 7.

5 Mental Health Australia, *Submission 1 Attachment 1*, p. 23.

6 Mental Health Australia, *Submission 1 Attachment 1*, p. 22.

7 See for example: YFS, *Submission 47*, p. 2; Mental Health Council of Tasmania (MHCT), *Submission 52*, p. 4.

It is already clear that there are major gaps between the expectation of the number of people being serviced through the Commonwealth PHaMs and PIR programs who will be able to access the NDIS, and the reality. For example, Anglicare South Australia report:

...PHaMs has been classified as 100% in-scope for NDIS, however, a participant audit of our PHaMs services indicate that the clinical 'psychotic' disorders anecdotally deemed 'in-scope' for NDIS such as schizophrenia, bipolar and schizo affective disorder account for approximately 30% of participant's diagnosis.⁸

4.12 The Commonwealth government has made a commitment that no existing programme clients will be disadvantaged in the transition to the NDIS and will provide continuity of support to existing clients who are not eligible for the NDIS.⁹

4.13 The Department of Social Services made the following statement:

The Commonwealth committed to provide continuity of support for any existing participants who do not meet the definitions of eligibility under the Act, including those aged over 65 years of age. In practice, the focus of PHaMs, Partners in Recovery and Day to Day Living providers is on providing service continuity until full scheme by supporting clients to access the NDIS, and until they have approved NDIS plans in place. Providers have funding for service continuity up until 30 June 2019, and the Departments of Social Services and Health and the National Disability Insurance Agency continue to work with providers who have clients that may require more support to engage with the NDIS. Formal continuity of support arrangements post full scheme are still to be determined, noting policy is expected to be finalised by the end of 2017.¹⁰

4.14 Many inquiry participants are concerned that the gap created in service provision by the transition of PIR, PHaMs, and D2DL programs into the NDIS is significant. Service providers find there is little information available as to how some people will access services once the funding transition is complete and believe funding will not be adequate or appropriately targeted to cover this emerging gap.¹¹

4.15 Additionally, as discussed in chapter 2, to access continuity of support, program clients need to apply for the NDIS, regardless whether or not they are obviously ineligible for the NDIS. This may result in some existing clients losing supports and left without appropriate services.

8 Anglicare Australia, *Submission 62*, p. 5.

9 Department of Social Services, *Transition of Commonwealth programs to the NDIS*, <https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/national-disability-insurance-scheme/transition-of-commonwealth-programs-to-the-national-disability-insurance-scheme-ndis> (accessed 18 July 2017).

10 Department of Social Services, answers to questions on notice, 16 June 2017 (received 30 June 2017).

11 See for example, One Door Mental Health, *Submission 74*, p.6; VICSERV, *Submission 65*, p.4.

Emerging service gaps

4.16 Inquiry participants explained that the role of PIR is much broader than individual care-coordination that may now be incorporated into an individual package under the NDIS. PIR is also about building community capacity by drawing together organisations and agencies to work innovatively together to both close gaps in traditional service delivery and referral pathways, as well as to wrap around particular individuals.¹²

4.17 As described by participants,¹³ both PIR and PHaMs programs support recovery in mental illness and psychosocial disability using a wrap-around approach that facilitates coordination of care and an integrated approach to treatment and support.

4.18 According to Woden Community Services Inc., the transition of funded services to the NDIS such as PIR and PHaMs 'has left a huge hole in the service delivery continuum for people with illness. There are now fewer options for people and for service to refer to for support'.¹⁴

4.19 Similarly, Ms Marilyn Gale is concerned with emerging service gaps:

PIR currently coordinates care for the most complex mental health clients, in the community. Who will support these clients in the future to ensure they have supports in place and to intervene early, to prevent relapse? Clinical services do not and will not have capacity to do this work and in fact, I believe the absence of PIR and other community mental health services will prove to a heavy burden on clinical services.¹⁵

4.20 As described by Mr Quinlan, the CEO of Mental Health Australia, PIR is also an active outreach program which actively engages and finds people who are hard to reach:

Part of the great benefit of programs like Partners in Recovery,(...) was that it was actually a really active outreach program. It went to find people who might not otherwise be in contact with the system.¹⁶

4.21 Assertive outreach undertaken by PIR has enabled the identification of people eligible for the NDIS who were previously not engaging with service providers.¹⁷ A major concern raised by participants is that once full transition to the NDIS occurs and PIR block funding disappears, the availability of appropriately skilled workers with

12 Mental Health Commission of NSW, *Submission 16*, p. 3.

13 See for example: Office of the Public Advocate (Queensland), *Submission 93*, p. 9; Woden Community Services Inc., *Submission 42*, p. 4; Grand Pacific Health, *Submission 55*, p. 1.

14 Woden Community Services Inc., *Submission 42*, p. 8.

15 Marilyn Gale, *Submission 59*, p. 1.

16 Mr Quinlan, CEO, Mental Health Australia, *Committee Hansard*, 28 April 2017, p. 5.

17 Mental Health Commission of NSW, *Submission 16*, p. 6.

sufficient time to undertake assertive outreach and engagement work will be virtually non-existent.¹⁸

4.22 Many service providers such as Aftercare are concerned that in some communities where there may not be sufficient eligible clients for the NDIS, service providers will not be in a position to continue operating. This will particularly impact regional, rural and remote communities.¹⁹

4.23 Cohealth argues that 'even for people eligible for the NDIS some important support services (e.g. groups) may no longer be available as agencies find that, under a market model, it is not financially viable to provide them'.²⁰

Support to carers

4.24 ABS data estimates that 194 000 primary carers care for someone who with a psychosocial disability. This represents about a quarter of the primary carer population.

4.25 The MHR:CS program supports carers whose health and wellbeing, or other impediments, are negatively impacting their ability to provide care to people with mental illness. Support assists carers and their families to continue in their caring roles, improve their health and wellbeing and participate socially and economically in the community. MHR:CS has been identified as a service in scope for NDIS.²¹

4.26 Mind Australia and others are concerned that with half of the funding for MHR:CS in scope for NDIS, many people who are caring for someone outside of the NDIS will no longer be able to access the supports they need.²²

4.27 Mental Health Australia noted that 'the NDIS does not fund respite',²³ and that 'the suite of supports for family and carers are not a direct match with the supports provided under the MHR:CS program'.²⁴

4.28 There is also great uncertainty about how funding for carers under the NDIS will work. For carers of participants in the NDIS, they can be provided supports only if the participant agrees and this is determined as part of the planning process. As Ms Cresswell, the CEO of Carers Australia explains:

We have heard different estimates of how many people will be eligible for NDIS packages, but we do know that their carers are not eligible for

18 New England Partners in Recovery, *Submission 111*, p. 7.

19 Dr Meyer, Director, Operations Support, Aftercare, *Committee Hansard*, 28 April 2017, p. 17.

20 Cohealth, *Submission 43*, p. 4.

21 Department of Social Services, *Mental Health Respite: Carer Support*, <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/mental-health-respite-carer-support> (accessed 3 July 2017).

22 See for example: Mind Australia Limited, *Submission 118*, p.10; Carers Australia, *Submission 99*, p. 7.

23 Mental Health Australia, *Submission 1*, p. 12.

24 Mental Health Australia, *Submission 1*, p. 12.

support. (...) There is not funding support for carers under the NDIS, so for those carers whose people have a package there will be some relief, some support, for their person. That is great, but they still need to access support in their own right. For those carers whose people are not funded under the NDIS it is a double whammy, as their people are losing their support and the carers are losing their support.²⁵

4.29 In its submission, Carers Australia stated that MHR:CS funding 'will not only be lost to mental health carers of people who are eligible for NDIS packages, but also to those caring for someone who is not eligible for the NDIS'.²⁶

4.30 Mental Health Australia noted that 'While work is being done by DSS on an 'Integrated Plan for Carer Support Services' and a 'Service Delivery Model',²⁷ carers are reporting that they are now not receiving supports that they previously had access to' and recommended:

The Australian Government continues 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.²⁸

Primary Health Networks

4.31 Primary Health Networks (PHNs) were established in July 2015 with the aim to increase the efficiency and effectiveness of health services. PHNs replaced the previous Medicare Locals. One of the six key priorities for PHNS is mental health.²⁹

4.32 As part of the mental health reforms, PHNs play a key role in the reform process through the planning and commissioning of primary health services at a regional level, supported by a flexible funding pool for mental health and suicide prevention services. However, PHNs do not have the ability to commission psychosocial support services.

4.33 At this stage, the role of PHNs in NDIS planning processes lacks clarity. The role of PHNs seems to be more about assessment as PHNs do not have a role in the planning process for individual NDIS plans.³⁰

4.34 Inquiry participants reported that, to date, there has not been a lot of interface between PHNs and the NDIS.³¹ However, with PHNs taking on a greater role in local implementation of national mental health reforms, the way in which PHNs will

25 Ms Cresswell, CEO Carers Australia, *Committee Hansard*, 28 April 2017, p. 31.

26 Carers Australia, *Submission 99*, p. 7.

27 Mental Health Australia, *Submission 1*, p. 13.

28 Mental Health Australia, *Submission 1*, p. 4.

29 Australian Institute of Health and Welfare, *Primary Health Network (PHN) data*, <http://www.aihw.gov.au/primary-health-care/phn/> (accessed 29 June 2017).

30 Mental Health Australia, *Submission 1*, p. 9.

31 MHCC, *Submission 27*, p. 9.

interface with social care providers and the NDIS will become important in addressing both individual and population wide mental health needs.³²

4.35 Work by the NDIA and the NDIA Mental Health Sector Reference Group (NMHSRG) is underway to better understand the interface between PHNs and the NDIS.³³

4.36 The NDIA is liaising closely with the Department of Health to develop working relationships with PHNs at a local, state/territory and national levels to understand the impact and opportunities that their planned regional commissioning of primary health and mental health services will have for access to services.³⁴

4.37 Several participants suggested that PHNs could play a role in educating and supporting GPs in understanding the NDIS and how to meet the needs of patients who want to test their eligibility for, or are participants in, the Scheme.³⁵

Transition to the NDIS of States and Territories funded services

4.38 Funding of the NDIS has involved bi-lateral agreements between individual state and territory governments and the Commonwealth Government. The inclusion of mental health program funding in those financing arrangements has not been uniform: in some states existing mental health funding has been added to a state's contribution to the NDIS; in others it has not.

4.39 Mental Health Australia and other organisations raised questions about how continuity of services will be guaranteed and monitored and ultimately, who will be responsible for ensuring that community support system exists for those who do not qualify for the NDIS:

The concern is about what happens to the services transferred into the NDIS, which currently provides services for clients out of scope for the NDIS. How will the continuity of service guarantee be monitored and which jurisdiction is responsible for rectifying poor outcomes? Who is responsible for ensuring that a community support system exists for those who do not qualify for the NDIS? ILC may address these questions but it is unclear at present how the ILC will do it. There are also concerns that the ILC does not have capacity to adequately fund services within its current limited budget.³⁶

32 MHCC, *Submission 27*, Attachment 3, p. 7.

33 NDIS, *NMHSRCG Communique*, October 2016, <https://www.ndis.gov.au/NMHSRG-October-2016.html> (accessed 29 June 2017).

34 NDIA, *Submission 102*, p. 7.

35 See for example: Mental Health community coalition ACT, *Submission 82*, p. 16. Flourish, *Submission 117*, p. 11.

36 Mental Health Australia, *Submission 1*, p. 8.

Emerging service gaps

4.40 Inquiry participants identified a risk of service gaps because of the uncertain future of state and territory programs. There is a risk that highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. For example, the Mental Health Coalition ACT reported:

One of the consequences of the transition of ACT Government funded community managed mental health services to the NDIS has been the loss of group-based programs and drop-in style social participation supports. These services were not viable within the NDIS framework.³⁷

4.41 In South Australia, Supported Residential Facilities (SRF's) provide unique, specialised accommodation, supervised care, medication prompting and administration which the NDIS care models do not cater for. SRF's are currently outside the NDIS arrangements for accommodation and support. It is likely that people in SRF's are not going to fit into the expectations and environments provided by small group homes as outlined in the NDIS. The Central Adelaide Hills Partners in Recovery reported that a loss of SRF's will potentially expose 1100 people to homelessness in the very short term.³⁸

4.42 Tandem reported that state funded organisations have been unable to provide the same breadth, quantity and quality of services that they offered previously because of funding uncertainties and the pricing structures.³⁹

4.43 The other risk commonly cited by participants is the closure of some services or decrease of quality of services due to the NDIS pricing framework.⁴⁰ For example, CMHA reported:

A key tension arising relates to the financial viability of the pricing of services and supports under the NDIS. Although NDIS pricing does not officially set mental health sector workers' wages; NDIS pricing does have an extremely significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders argued that the pricing is not sufficient to purchase a suitably skilled workforce that engages in complex 'cognitive behavioural interventions' as well as direct personal care.⁴¹

37 Mental Health Community Coalition ACT, *Submission 82*, p. 11.

38 Central Adelaide Hills Partners in Recovery, *Submission 30*, p. 5.

39 Tandem, *Submission 69*, p. 9.

40 See for example: Mental Health Community Coalition ACT, *Submission 82*, Attachment 3 p. 5; QAMH, *Submission 23*, p. 7.

41 CMHA, *Submission 27*, Attachment 1, p. 1.

Rural and remote challenges

4.44 The other issue often raised is the lack of services in rural and remote areas and how this may impact access to the NDIS and support services, especially given the change to a market-based system.⁴²

4.45 Access to mental health services is an ongoing challenge for people living in regional, rural and remote areas due to a lack of or limited services available. This is particularly the case in remote Aboriginal and Torres Strait Islander communities.

4.46 The Benevolent Society outlined some of the issues pertaining to access to services in remote areas:

Access to services under the NDIS for people living in remote and regional areas continues to be an issue. In these early stages of the NDIS, the market has not yet grown to meet the emerging needs of the sector, so in many isolated areas there are few if any providers of the mental health services people need. Service providers may need to travel large distances to meet the needs of all clients. Currently, the arrangements to compensate providers who need to travel large distances to consumers are inadequate.⁴³

4.47 Members of the NT Mental Health Coalition reported that the NDIS is posing significant strain on small to medium services that do not have resources to redevelop organisational systems and structures to operate sustainably within a market-based service economy. There is a concern that this will result in organisation closures and lead to a market of larger, one-size-fits-all service organisations, reducing quality of services and limiting choice for consumers—especially those living in very remote communities.

4.48 The Bilateral Agreement between the Commonwealth and Northern Territory states that the NDIA is responsible for ensuring provider of last resort services are in place for all participants in the NT, where other services are not operational.⁴⁴ However, there is a lack of detailed information around what 'provider of last resort' options might look like in practice. This is causing angst throughout the NT mental health sector.⁴⁵

4.49 The NDIA acknowledges the challenges to address the service gaps that exist for rural and remote communities as well as the emerging issues in relation to 'price caps'. The NDIA has developed a rural and remote strategy,⁴⁶ and says it is working

42 See for example: CMHA, *Submission 75*, p. 23; National Disability Services (NDS), *Submission 80*, p. 4.

43 The Benevolent Society, *Submission 106*, p. 5.

44 *Bilateral Agreement between the Commonwealth and Northern Territory for the transition to an NDIS*, Schedule K, 5 May 2016.

45 NT Mental Health Coalition, *Submission 71*, p. 6.

46 NDIA Rural and Remote Strategy 2016–2019, February 2016, p. 3.
<https://www.ndis.gov.au/medias/documents/h2c/hb0/8800389824542/Rural-and-Remote-Strategy-991-KB-PDF-.pdf> (accessed 18 July 2017).

with state governments to find more innovative ways to deliver services and grow the capacity for localised delivery of services.⁴⁷

4.50 Solutions put forward include the establishment of an NDIS Community of Practice for rural areas to encourage information sharing and assist communities to learn from one another about successes in delivering NDIS in their communities.⁴⁸

4.51 Aboriginal Community Controlled Health Services (ACCHS) could have a role in building capacity in the disability area in rural and remote locations. The RANZCP recommends appropriate funding and resourcing to be allocated to ACCHS to undertake this role.⁴⁹

Scope and level of funding for mental health services under the Information Linkages and Capacity Building (ILC) framework

4.52 The NDIS website provides the following information about the ILC:

The focus of ILC will be community inclusion—making sure people with disability are connected into their communities. ILC is all about making sure our community becomes more accessible and inclusive of people with disability. We want to do this in two ways:

1. Personal capacity building—this is about making sure people with disability and their families have the skills, resources and confidence they need to participate in the community or access the same kind of opportunities or services as other people.
2. Community capacity building—this is about making sure mainstream services or community organisations become more inclusive of people with disability.

Unlike the rest of the NDIS, ILC won't provide funding to individuals. We will provide grants to organisations to carry out activities in the community. Many of the activities that we will fund in ILC will be open to both people with disability and families. Through ILC we will also support people who have an NDIS plan as well as those who do not.⁵⁰

4.53 The vast majority of ILC funding is allocated to Local Area Coordination.⁵¹ As described in the ILC Commissioning framework, LACs play a central role in the delivery of ILC:

47 Ms Gunn, Acting Deputy Chief Executive Officer, Participants and Planning, NDIA, *Committee Hansard*, 16 June 2017, p. 18.

48 Beyondblue, *Submission 34*, p. 9.

49 RANZCP, *Submission 18*, p. 6.

50 Australian Government, NDIS, <https://www.ndis.gov.au/ILC-FAQ-People-with-Disability.html> (accessed 4 July 2017).

51 NDIS, *Working together – Local Area Coordination and Information, Linkages and Capacity Building* p. 1. <https://www.ndis.gov.au/communities/local-area-coordination.html> (accessed 18 July 2017).

- they work directly with people who have an NDIS plan by connecting them to mainstream services, community activities and putting their plans into action;
- they provide some short-term assistance to non-NDIS participants and connect them to mainstream services and community activities; and
- they work with the local community to ensure it is more accessible and inclusive for people with disability.⁵²

Level of funding

4.54 Most inquiry participants support the goals of ILC. However, there are widespread concerns that the allocated funding is insufficient to fill the gap for people with a mental condition and their carers who are ineligible for NDIS plans. In practice, the question is how ILC can adequately fund psychosocial services within a limited budget, which has been allocated to fund multiple types of services to be accessed by people with all disability types?⁵³ Overall, participants feel that the ILC is not yet filling the gaps in services created by NDIS transition, and is unlikely to do so without substantial additional investment.⁵⁴

4.55 The short-term competitive grant mechanism being used to fund ILC activities is a cause of concerns. It provides no certainty of continuity of services and may result in some programs not being consistently offered across time and regions. For example, the Victorian Council of Social Service (VCOSS) noted that the nature of ILC grant-based funding, means coverage of programs across Victoria and Australia overall may be inconsistently offered and time-limited.⁵⁵

4.56 Flourish Australia and other participants argue that the level of funding for the ILC program, and the short-term nature of the grants to be provided, should be revisited, given its important and ambitious aims.⁵⁶

4.57 To ensure that provision of mental health services is adequately provided through ILC, the Office of the Public Advocate (QLD) and other organisations recommends that a proportion of ILC funding is quarantined specifically for the provision of mental health ILC services.⁵⁷

52 NDIS, *Information, Linkages and Capacity Building Commissioning Framework*, November 2016, p. 12.

53 \$33 million in 2016–17 growing to \$132 million by 2019–20, Mental Health Australia, *Submission 1*, p. 8.

54 See for example: Sunshine Coast and Gympie - Partners in Recovery, *Submission 36*, p. 5; VCOSS, *Submission 50*, p. 17; Mental Illness Fellowship of Australia, *Submission 70*, p. 12.

55 VCOSS, *Submission 50*, p. 17.

56 Flourish Australia, *Submission 117*, p. 10.

57 Office of the Public Advocate (QLD), *Submission 93*, p. 8.

Emerging gaps

4.58 Assertive outreach services are not included in the ILC Commissioning Framework or the Community Inclusion and Capacity Development Program Guidelines.

4.59 Assertive outreach services can only be delivered through the LAC function. However, with the pressure of the rollout, it appears that LACs are focusing on the transition of clients to the NDIS rather than undertaking assertive outreach activities and community development work.⁵⁸

4.60 The issue of support for family and carers was also raised. Service providers such as Tandem argue that the ILC framework does not have the resources, scope or capacity to deliver the services required to adequately support families and carers.⁵⁹

Committee view

Service landscape

4.61 The committee is concerned that for people living with a psychosocial disability the service landscape remains complex and fragmented as services cross both sectors and jurisdictions. Clearly there is a complex intersect between psychosocial disability services and the mental health sector. At present, consumers, their families, carers and service providers, face confusion and uncertainty about what psychosocial support programs will be available to people outside the NDIS, especially once the transition period has ended.

4.62 The committee has identified the need for a national audit and mapping of all Australian, state and territory services and associated funding available for mental health, to ensure existing and emerging service gaps are detected and addressed accordingly. Additionally, consideration should be made for the National Mental Health Commission to have an ongoing monitoring role of all Australian, state and territory mental health programs, including those delivered through primary healthcare sector.

4.63 The recent budget announcement of \$80 million over four years to provide mental health services for people outside the NDIS,⁶⁰ is likely to alleviate some of the concerns around availability and access to services in the short term. Notwithstanding, the commitment of continuity of support by governments and recent budget announcements does not appear to provide a mechanism to guarantee that funding for mental health services is maintained and these services will continue to be delivered.

4.64 The committee acknowledges the particular role that carers and families have in the support of people with psychosocial disabilities. The Committee supports the view that there is a need for greater clarity around the continuity of support for carers under the NDIS. As the NDIS does not include direct provision of respite support for

58 MHCC, *Submission 27*, p. 7.

59 Tandem, *Submission 69*, p. 9.

60 This is contingent on states and territories contributing a similar amount.

carers, the provision of support for carers appears to only be available if it is included in the participant's plan. Whilst the Committee acknowledges that elements of the MHR:CS fall within the ILC scope, it is not yet clear how some supports, such as recreational respite activities, will be funded and supported. It is too early to assess how this is affecting carers but there is already anecdotal evidence suggesting that some carers will no longer access the level of support they require and had been provided with through the MHR:CS program.

4.65 At systems levels, there is a lack of clarity on how LACs, PHNs and LHNs will ensure people with a psychosocial disability will access NDIS and/or other services. With PHNs not able to commission psychosocial services this may also create a gap in meeting the support needs of some communities, especially in regional, rural and remote areas. The Australian, state and territory governments should urgently clarify and make public how they intend to provide services and funding for ensuring continuity of support and services for people with a psychosocial disability beyond the supports provided through the NDIS. Finally, the NDIA should provide details about the arrangements it has put in place for ensuring a provider of last resort services is available for all NDIS participants unable to find a suitable service provider.

ILC

4.66 The ILC is a key component of the NDIS, especially during the transition period when it is critical to have structures in place to ensure people with a psychosocial disability are adequately connected with the appropriate services. To some extent, the ILC has been branded as the answer to ensuring continuity of support for those who will be ineligible for NDIS services. The ILC is still in its infancy and the outcomes it will be able to achieve are still unknown and untested at this stage. However, it seems that the level of funding that has been allocated may not match the needs of the community. Additionally, with the current focus of LACs on facilitating the access process to the NDIS and supporting NDIS participants to locate supports, it is unclear to what extent LACs have the capacity to support individuals with a mental health condition who are not eligible for the NDIS. Furthermore, it is unclear how LACs will engage in active outreach to engage hard-to-reach individuals. The Committee is also concerned with widespread reports of LACs lacking skills and expertise in the area of psychosocial disability and mental health care.

Recommendation 13

4.67 The committee recommend the Australian, state and territory governments clarify and make public how they will provide services for people with a psychosocial disability who are not participants in the NDIS.

Recommendation 14

4.68 The committee recommends the Council of Australian Governments (COAG) conduct an audit of all Australian, state and territory services, programs and associated funding available for mental health.

Recommendation 15

4.69 The committee recommends the National Mental Health Commission be appointed in an oversight role to monitor and report on all Australian, state and territory mental health programs and associated funding, including those delivered through the primary healthcare sector.

Recommendation 16

4.70 The committee recommends the Department of Social Services and the NDIA develop an approach to ensure continuity of support is provided for carers of people with a psychosocial disability, both within and outside the NDIS.

Recommendation 17

4.71 The committee recommends the NDIA in collaboration with the Australian, state and territory governments develops a strategy to address the service gaps that exist for rural and remote communities.

Recommendation 18

4.72 The committee recommends the NDIA provides details how it is ensuring a provider of last resort is available for all NDIS participants unable to find a suitable service provider, regardless of their location, circumstances and types of approved supports.

Recommendation 19

4.73 The committee recommends the NDIA monitors the psychosocial disability supports, activities and services that are awarded funding through the ILC grant process to be able to identify and address any emerging service gaps as they may arise.

Recommendation 20

4.74 The committee recommends the NDIA undertakes a review of the effectiveness to date of the ILC program in improving outcomes for people with a psychosocial disability.

Recommendation 21

4.75 The committee recommends NDIA considers allocating specific funding for the provision of mental health services through the ILC.

Chapter 5

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

Introduction

5.1 The final chapter of this report deals with term of reference (h) the provision and continuation of services for NDIS participants in receipt of forensic disability services.

5.2 The vast majority of people with disabilities who come into contact with the criminal justice system have some form of cognitive disability, including intellectual disability; mild to borderline intellectual disability; acquired brain injury and foetal alcohol spectrum disorders.¹ The overwhelming majority of these individuals also experience a range of psychosocial disabilities related to mental health impairments. The combination of these issues impacts significantly upon the person's daily functioning, very often resulting in compounding social disadvantage and complex support needs.²

5.3 People with psychosocial disabilities are overrepresented in the criminal justice system. This is often directly related to the interacting factors of disability, disadvantage, discrimination, isolation and lack of appropriate supports available to this group. The continuing lack of access to appropriate service provision directly contributes to the criminalising of and disproportionate representation of people with cognitive disability in prison.³ For many, if they had received appropriate psychosocial and other disability supports earlier in their life they may never have come into contact with the criminal justice system. They are an exceptionally marginalised and vulnerable population who often end up cycling in and out of prison and may end up in indefinite detention.⁴

5.4 There is no reliable data to estimate the number of people with a cognitive impairment who are in the criminal justice system because each jurisdiction measures disability differently. Estimates provided to the committee suggest that somewhere between 20 per cent and 25 per cent of people in the criminal justice system have a cognitive impairment. This goes to over 50 per cent in the youth justice system.⁵

5.5 Aboriginal and Torres Strait Islander people in particular are significantly overrepresented amongst those in prison with complex disability support needs. For

1 Australians for Disability Justice, *Submission 121*, p. 7.

2 Australians for Disability Justice, *Submission 121*, p. 7.

3 Australians for Disability Justice, *Submission 121*, p. 12.

4 Australians for Disability Justice, *Submission 121*, p. 3.

5 Professor Leanne Dowse, Chair in Intellectual Disability, School of Social Sciences, University of New South Wales, *Committee Hansard*, 28 April 2017, p. 35.

example, in Queensland, 73 per cent of Aboriginal and Torres Strait Islander men and 86 per cent of Aboriginal and Torres Strait Islander women in Queensland jails have some form of mental impairment.⁶

5.6 There are two common pathways into detention for people with complex disability needs. The first one is a conviction for lesser crimes. Generally, their disabilities are not recognised or taken into account during the course of justice. This is often due to the lack of available expertise to identify the impairment; masking of the impairment or lawyers advising their client not to identify as a person with impairment due to the fear of indefinite detention.⁷

5.7 The second pathway into and out of detention is via state and territory Mental Impairment legislative processes. The Mental Impairment / Unfit to Plead pathway is an alternative pathway through the criminal justice system and is designed specifically for people who are assessed as mentally impaired and as a result are found unfit to plead. People who are deemed unfit to stand trial may become subject to a forensic or criminal order. The court, or mental health review tribunal, will assess that person's risk to themselves or others and the need for ongoing treatment, and can impose forensic orders to detain the person in a prison, hospital or mental health care facility. In some cases they may be allowed to live in the community in a designated location.⁸ An unintended but highly significant consequence of the Mental Impairment / Unfit to Plead pathway for people with complex disability support needs is indefinite detention.

5.8 Historically, people with disabilities who are in the criminal justice system have had mostly poor experiences or no contact with existing support systems. As described by Australians for Disability Justice, access to the NDIS may be an opportunity to decrease incarceration rates for people with a cognitive and psychosocial impairment, particularly for Aboriginal and Torres Strait Islander people who are overrepresented amongst those in prison with complex disability support needs.

5.9 To date, there is no data available on the number of people incarcerated who are NDIS participants or in the process of applying to become participants.

Access to NDIS services for NDIS participants in prison

5.10 The NDIS (Supports for Participants) Rules 2013 state that the NDIS in relation to a person in custody will be responsible for reasonable and necessary

6 Australians for Disability Justice, *Submission 121*, p. 34.

7 Australians for Disability Justice, *Submission 121*, p. 17.

8 Senate Community Affairs Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, November 2016, p. 13.

supports other than the day-to-day care (including supervision, personal care and general supports). The NDIS will also be responsible for transition supports.⁹

5.11 In their submission, the NDIA stated:

For people in a custodial setting (including remand) the only supports funded by the NDIS are those required due to the impact of the person's impairment/s on their functional capacity and additional to reasonable adjustment, and are limited to:

- aids and equipment;
- allied health and other therapy directly related to a person's disability, including for people with disability who have complex challenging behaviours;
- disability specific capacity and skills building supports which relate to a person's ability to live in the community post-release;
- supports to enable people to successfully re-enter the community; and
- training for staff in custodial settings where this relates to an individual participant's needs.

Where a person is remanded in custody, NDIS funding for reasonable and necessary supports in the participant's plan will continue to be available to the person when they are released.¹⁰

5.12 As noted by the Office of the Public Advocate (VIC), given the relatively early stages of the NDIS rollout, it is difficult to fully assess the operations of the NDIA in relation to forensic services and their patients. At this stage, it is impossible to evaluate the impact of the Scheme on this cohort.¹¹ However, the NDIA reported that supports are currently being delivered within correctional facilities:

Whilst it is not possible to provide a national figure at this stage, the Vic West regional office in the Barwon region of Victoria confirm that there are at least 12 NDIS participants incarcerated within local facilities in the Vic West region. The NDIA funds reasonable and necessary supports to each participant based on their needs and in line with the COAG principles between the NDIS and mainstream service systems, particularly the mental health and justice sectors. Some supports are currently being delivered within correctional facilities while some participants who are on day release may have funded supports outside delivered outside the facility to enable successful transition into community life.¹²

9 The NDIS (Supports for Participants) Rules 2013, Section 7.24 and 7.25, https://www.legislation.gov.au/Details/F2013L01063/Html/Text#_Toc358793053 (accessed 6 July 2017).

10 NDIA, *Submission 102*, p. 9.

11 Office of the Public Advocate (VIC), *Submission 7*, p. 15.

12 Letter to Hon Kevin Andrews MP from Louise Clanville, Deputy CEO – Governance and Stakeholder Relations, NDIA, additional information received 14 June 2017, p. 1.

5.13 Nonetheless, there seems to be some lack of clarity and confusion around the supports the NDIA provides to NDIS participants in custody. The committee received evidence suggesting that the NDIA currently stops any individualised package upon an individual being taken into custody.¹³

5.14 For example, Ms Alison Churchill, CEO, Community Restorative Care, stated:

I am not aware of any jurisdiction where an NDIS package is currently following somebody into a correctional centre.¹⁴

5.15 Similarly, the Mental Health Commission of NSW reported:

The Commission understands that the NDIA currently stops any individualised package upon an individual taken into custody, and that the NDIA will only engage in planning for community based supports once the individual has a known release date, and is within 6 months of that date.¹⁵

NDIS participant and indefinite detention

5.16 The case of an NDIS participant in indefinite detention was also brought to the attention of the committee by Ms Pearce, the Public Advocate of Victoria at a public hearing in Melbourne on 28 April 2017. The following account of events raises important issues around the role and responsibility of the NDIA to provide reasonable and necessary supports and to ensure a provider of last resort service is allocated when no providers are prepared to work with a participant. Additionally, it raises the issue of NDIA's ability to be responsive and deal with complex issues in a timely and effective manner. Ms Pearce reported:

Ms Z has been on remand for over 12 months. She is being held in a prison mental health unit and is in lockdown 23 hours a day in part due to her distressing behaviours. While she has a diagnosis of autism, she has also spent time in mental health services in the community as well as in the Thomas Embling Hospital, which is a Victorian high-security mental health forensic service. Recently a jury found her unfit to stand trial and her charges are at the minor end of offending. The presiding judge has expressed concern about her lengthy incarceration in onerous conditions, that the systems are not meeting her needs and that she remains incarcerated. She is allowed out of her cell for one hour a day and, not surprisingly, she is extremely distressed. When she is returned to her locked cell she spends hours and hours just screaming, vocalising her distress. If she had accommodation and supports, it is absolutely clear, she would be released. No-one wants to prosecute this case but there are no options for her. Her basic care needs are difficult to meet in a prison setting.(...) She

13 See for example: Mental Health Carers NSW, *Submission 64*, p. 10; Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 18*, p.11; Mr James Condren, *Submission 128*, p. 1.

14 Ms Alison Churchill, CEO, Community Restorative Care, *Committee Hansard*, 28 April 2017, p. 47.

15 Mental Health Commission of NSW, *Submission 16*, p. 7.

urgently needs to be transitioned to a residential environment with appropriate, ongoing clinical and therapeutic supports. The inability to identify an appropriate service provider and her behavioural presentations make it very difficult to successfully transition her to an alternative, community based environment. (...) The really good news in terms of Ms Z's circumstances is that NDIS has cut through all of that. She is, in fact, an NDIS participant. However, there is a limit as to what can be implemented while she remains in prison, in part because of the NDIS rules and the interface with the justice system. Only support coordination has been funded thus far, and other funded supports will not be available until there is a release date. Multiple agencies have so far declined to accept a referral to provide support coordination for this complex client.(...) There are no choices when there are no providers prepared to work with her. In order to ensure people with complex presentations who are involved with the criminal justice system can participate in and benefit fully from the scheme, the NDIS must be more flexible and responsive in its approach.¹⁶

5.17 At a public hearing on 12 May 2017, the committee was provided with a progress update on Ms Z's case. Ms Pearce reported:

(...)We do believe we may now have a case planner, but they are looking to see whether their services match the needs of this individual. This is one of the issues for people in the criminal justice system who are eligible participants—many of them will have high and complex needs, but, in a market driven environment, service providers can choose who they wish to provide services to. The NDIS still is unwilling to engage in any kind of service planning (...) But, without the involvement of the NDIA in a more proactive way than simply writing to my office and saying, 'This is what we are prepared to fund,' we are just not getting the cooperative, coordinated working relationships that we need to ensure that there is a smooth transition from one service system to another.¹⁷

5.18 The committee invited Ms Pearce to provide a further update on 28 July 2017. Ms Pearce reported:

(...)In May we found an agency who was able to do that, and at the moment her plan includes funding for specialist support coordination, and as I said, this is now being provided. A proposal has also been developed for a plan that includes post-release supports. An NDIS funded provider has prepared a proposal for a staged transition from prison, which includes a detailed explanation of the types of supports Ms Z will require to safely transition from her current restrictive environment to independence within the community. The plan is quite substantive. (...)As I understand it, the proposal now sits with the NDIA. Since my last appearance before you, the NDIA has been more engaged. They were given the proposal in June and have informed me that it is still under consideration and that approval is yet to be confirmed. In the meantime we've mostly relied on the hard work and

16 Ms Pearce, Public Advocate (VIC), *Committee Hansard*, 28 April 2017, p. 48.

17 Ms Pearce, Public Advocate (VIC), *Committee Hansard*, 12 May 2017, p. 5.

goodwill of agencies like the one who prepared the proposal. For instance, a service provider included in the plan—the same agency that would provide the support for Ms Z in her house—is proactively collaborating with the prison. The prison has agreed to bend their protocols around transitioning in order to allow the agency to enter the prison and begin engaging with Ms Z in preparation for discharge. (...) As mentioned, we are very thankful for the attention you've paid to this case. It has certainly been a factor in the gains that have been made. However, despite recent progress, all parties are now at a standstill until the NDIA approves the plan. In other words, the case is progressing, but unfortunately not quickly enough to prompt her release from prison.¹⁸

Becoming an NDIS participant while in custody

5.19 While in custody, people can make an access request to the NDIS and engage in the planning process to develop a plan.

5.20 The committee received conflicting information regarding process, availability of planners and coordination for the implementation of plans in such circumstances.

5.21 The committee heard that it is the correctional centre staff who are currently holding the responsibility for completing access requests to the NDIS. However, when packages are developed and funded submitters reported that it remains unclear whose role it is to assist in the implementation of the plan for the individual in custody.¹⁹

5.22 The NDIA reported that during the Barwon trial, the NDIA staff worked collaboratively with Corrections Victoria, local Correctional facilities, Disability Liaison Officers and the Victorian Government Department of Health and Human Services to streamline access and planning processes for eligible NDIS participants who were incarcerated. This has included NDIS planning taking place inside the facility; funded supports with the aim of supporting a successful transition to the community; and maintaining engagement with existing support workers following incarceration.²⁰

Barriers to participation

5.23 As previously discussed in this report, one major barrier is that people may not see or wish to acknowledge their impairments. They are very unlikely to seek out NDIS support of their own initiative and will often initially be suspicious of suggestions to obtain NDIS assistance.²¹

5.24 Mr Simpson from the New South Wales Council for Intellectual Disability reported:

18 Ms Pearce, Public Advocate (VIC), *Committee Hansard*, 28 July 2017, p. 2.

19 Ms Churchill, CEO, Community Restorative Centre, *Committee Hansard*, 28 April 2017, p. 47.

20 Letter to Hon Kevin Andres MO from Louise Clanville, Deputy CEO – Governance and Stakeholder Relations, NDIA, additional information received 14 June 2017, p. 1.

21 Australians for Disability Justice, *Submission 121*, p. 26.

(...)this group is unlikely to seek out NDIS support of their own initiative. They are living isolated lives. They will not be aware of the NDIS. They will be initially suspicious.²²

5.25 Furthermore, many people with cognitive or psychiatric disability may not have the skills or the supports required to know about the NDIS, go through the process of becoming a participant and adequately represent their needs in a planning meeting. This brings up the importance of availability of trained staff and assertive outreach services being available in prison settings.

5.26 NDIA reported that staff have provided training to case managers and prison staff about the NDIS and have developed working arrangements with the Victorian Department of Justice.²³ However, submitters argue that relevant staff with specific skills are needed within the criminal justice system to effectively engage and work with people with complex disability support needs.²⁴

Proposal to establish an NDIA criminal justice unit

5.27 Following discussions at public hearing on 28 April 2017, the Australian for Disability Justice group and others have put forward the proposal of creating an NDIA criminal justice unit, which would:

- Provide expertise to the NDIA around the interface of criminal justice and disability
- Develop expertise in planning and funding for people with disabilities in the context of the interaction of the national disability system and the state and territory justice systems as well as other mainstream agencies with inter sectoral responsibilities
- Act as the NDIA point of contact for state and territory criminal justice systems in the context of people with disabilities
- Ensure people with disabilities in the criminal justice system have access to the full range of disability supports and protections provided through the NDIS²⁵

5.28 On 12 May, Ms Pearce, the Public Advocate (VIC) voiced her support for such initiative:

In Melbourne, the committee asked whether speakers were in favour of the implementation of an NDIA unit specialising in the interaction of the

22 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 28 April 2017, p. 36.

23 Letter to Hon Kevin Andres MO from Louise Clanville, Deputy CEO – Governance and Stakeholder Relations, NDIA, additional information received 14 June 2017, p. 1.

24 Australians for Disability Justice, *Submission 121*, p. 4.

25 Australians for Disability Justice, *Submission 121*, Supplementary Submission 3, p. 2.

scheme with the criminal justice system. I would like to reiterate my support for this initiative.²⁶

Aboriginal and Torres Strait Islander peoples with disabilities in prison

Overrepresentation in the criminal justice system

5.29 Aboriginal and Torres Strait Islander people are significantly overrepresented amongst those in prison with complex disability support needs. They are also significantly more likely to be very poor, come from places of high socio-economic disadvantage, have low levels of education, be unemployed, have experienced violence and abuse and have earlier and more police and criminal justice events as both victims and offenders.²⁷

5.30 Aboriginal and Torres Strait Islander people with a cognitive impairment are also overrepresented amongst people held in indefinite detention.²⁸ This was reported in the Senate Community Affairs Committee report *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, which suggested that as many as 50 per cent of the people currently detained indefinitely without charge in prison are Aboriginal and Torres Strait Islander peoples.²⁹

5.31 Sisters Inside, an advocacy group for the human rights of women in the criminal justice system, reported that Aboriginal and Torres Strait Islander women are the fastest growing prison population in Australia. A significant proportion of these women have cognitive disabilities as well as an undiagnosed mental health condition.³⁰

5.32 One of the reasons cited for this overrepresentation is the lack of appropriate early diagnosis and culturally responsive support available for Aboriginal and Torres Strait Islander children and young people with cognitive impairment.³¹

5.33 The FPDN explained that the first time many Aboriginal and Torres Strait Islander people with cognitive impairment are diagnosed is upon entering the criminal justice system and that without access to holistic disability support, Aboriginal and Torres Strait Islander people with cognitive impairment are at a much greater risk of entering a cycle of offending and imprisonment.³²

26 Ms Pearce, Public Advocate (VIC), *Committee Hansard*, 12 May 2017, p. 5.

27 Australians for Disability Justice, *Submission 121*, p. 20.

28 FPDN, *Submission 100*, p. 3.

29 Senate Community Affairs Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, p. 21.

30 Sisters Inside, *Submission 49*, p. 3.

31 FPDN, *Submission 100*, p. 4.

32 FPDN, *Submission 100*, p. 4.

Access to the NDIS

5.34 The committee heard on many occasions that there is currently a lack of culturally appropriate tools and supports, including provision of interpreters, for Aboriginal and Torres Strait Islander people to access and navigate the NDIS.³³

5.35 For example, the Office of Public Guardian (NT) outlined the finding of a review of the Barkly trial site in the NT. Low levels of cultural competence amongst NDIS staff, the bureaucratic nature of the NDIS process, and the lack of information provided in an accessible way to Indigenous clients (including providing for individuals with literacy issues), resulted in resistance amongst Aboriginal and Torres Strait Islander people to engage. Additionally, remoteness provided a barrier to accessing information and resources about the NDIS Scheme. The Office of Public Guardian (NT) concluded:

These findings demonstrate that without improvements in the approach to engagement with all clients with mental illness, and particularly indigenous clients with mental health issues, there is a considerable risk that they will be left behind.³⁴

5.36 The FPDN noted that for many Aboriginal and Torres Strait Islander people with cognitive impairment and complex support needs, the access to the NDIS can be challenging and recommended that this group have access to an advocate or support person to assist with the NDIS application process, including within the criminal justice system.³⁵

5.37 Another issue raised was that many Aboriginal and Torres Strait Islander people with cognitive impairment may be unwilling to identify as disabled and may not recognise their own needs for assistance. It can also be due to cultural factors. For example, in some Aboriginal and Torres Strait Islander languages, there is no comparable word for disability.³⁶

5.38 Overwhelmingly, inquiry participants highlighted the need for culturally safe planning services to help Aboriginal and Torres Strait Islander people to access the NDIS.³⁷

Initiatives and suggested strategies for better outcomes

5.39 The NDIA has recognised that engaging with Aboriginal and Torres Strait Islander communities has been challenging and requires further work.³⁸

33 See for example, Brisbane South PHN, *Submission 63*, p. 1; NT Mental Health Coalition, *Submission 71*, p.3; NT Council of Social Services, *Submission 85*, p. 4.

34 Office of the Public Guardian, *Submission 87*, p. 1.

35 FPDN, *Submission 100*, p. 6.

36 FPDN, *Submission 100*, p. 7.

37 See for example: VCOSS, *Submission 50*, p. 22; Brisbane South PHN, *Submission 63*, p. 1; CMHA, *Submission 75*, p. 13.

38 NDIA, *Submission 102*, p. 5.

5.40 To address current challenges and advancing Aboriginal and Torres Strait Islander participant representation in the NDIS (currently at 6 per cent), the NDIA has developed an Aboriginal and Torres Strait Islander Engagement strategy aimed to develop a collaborative planning and working model to inform practice which can meet the needs of Aboriginal and Torres Strait Islander peoples with a disability, their families, carers and communities.³⁹

5.41 The NDIA has identified 10 key engagement priority areas for Aboriginal and Torres Strait Islander peoples with a disability,⁴⁰ these are:

- Communication and sharing of information
- Cultural competency
- Sharing Best Practice
- Local solutions
- Participant-centric design
- Market enablement
- Leveraging and linking
- Cultural Leadership
- Supporting internal infrastructure
- Tracking progress

5.42 Inquiry participants suggested a number of initiatives to help make the NDIS services more accessible including:

- Support for Aboriginal controlled organisations to continue providing culturally appropriate mental health services;⁴¹
- Appropriate funding and resourcing for ACCHS to build capacity in the disability area, especially in rural and remote locations;⁴²
- Higher proportion of skilled Aboriginal workers in the NDIS workforce;⁴³
- Targeted outreach services.⁴⁴

39 NDIA, *Aboriginal and Torres Strait Islander Engagement Strategy*, 2017, <https://www.ndis.gov.au/medias/documents/hcb/h31/8800389759006/Aboriginal-and-Torres-Strait-Islander-Strategy-3MB-PDF-.pdf> (accessed 10 July 2017).

40 NDIA, *Aboriginal and Torres Strait Islander Engagement Strategy*, 2017, p. 17.

41 Australian Red Cross, *Submission 15*, p. 15.

42 RANZCP, *Submission 18*, p. 6.

43 CMHA, *Submission 75*, p. 12.

44 Wellways, *Submission 103*, p. 6.

5.43 Australians for Disability Justice suggested strategies to reduce the negative experience in the criminal justice system of Aboriginal and Torres Strait Islander peoples with complex disability support needs:

- Development of cultural inclusive safety principles that are formed by Indigenous Australians with cognitive impairments and mental health disorders, their families and communities;
- Translation, interpreting and plain language services to enable Indigenous Australians with cognitive disability to access information; and
- Involvement of community Elders in creating pathways back into community for Indigenous Australians who have complex disability support needs and have been in prison.⁴⁵

5.44 The need for strong collaborative relationships between the NDIS and justice, health, housing and other relevant mainstream services was also highlighted by participants.⁴⁶

Committee view

Provision of reasonable and necessary supports

5.45 The committee has received numerous reports during the course of the enquiry about NDIS participants having their disability supports funded through the NDIS suspended while in custody. This is a cause of concern for the committee as the NDIA has a statutory responsibility to provide reasonable and necessary supports and transition supports while an NDIS participant is in custody.

5.46 In light of the reported case of Ms Z in indefinite detention, the committee believes it is imperative that the NDIA takes a more proactive and collaborative approach to fulfil its responsibility of ensuring a provider of last resort is found in all circumstances. The committee is also aware that, in Queensland, *The Mental Health Act 2016 (Qld)* now allows Magistrates to refer defendants who are unfit for trial to expressly named support services, including the NDIA. The NDIA must develop a strategy to ensure people in custody, including in indefinite detention, have access to an NDIA planner and be provided with NDIS services.

NDIA criminal justice unit

5.47 The NDIS can make a real difference in the incarceration rate of people with a cognitive impairment. The committee heard a positive story of a man who prior getting into the NDIS went to court 50 times over the 2½ years leading up to his NDIS package. Since he had his NDIS package, he has only been to court twice and is now doing well.⁴⁷ Therefore, it is important that people are referred to the NDIS and that

45 Australians for Disability Justice, *Submission 121*, p. 21.

46 Australians for Disability Justice, *Submission 121*, p. 29.

47 Ms Cootes, Executive Officer, Intellectual Disability Rights Service In., *Committee Hansard*, 28 April 2017, p. 51.

the interface between the NDIA and the criminal justice system works effectively. The committee supports the proposal of an NDIA criminal justice unit. This has potential to address critical issues, which have been brought to the attention of the committee, including for people in indefinite detention.

Engaging with Aboriginal and Torres Strait Islander peoples

5.48 The recent work undertaken by the NDIA in developing an Aboriginal and Torres Strait Islander Engagement strategy is a positive step in addressing some of the critical issues raised throughout the course of this inquiry in relation to Aboriginal and Torres Strait Islander peoples' access to the NDIS, the current lack of culturally appropriate services, the need for targeted outreach services and the lack of services due to thin markets in rural and remote Aboriginal and Torres Strait Islander communities.

5.49 It is too early to assess the effectiveness of the strategy, which has only been completed in early 2017. However, it remains imperative that the NDIA works collaboratively with Aboriginal and Torres Strait Islander communities and service providers to realise the goals for the strategy. With the high rate of Aboriginal and Torres Strait Islander peoples with disabilities in the criminal justice system, the committee recommends the NDIA develops a specific strategy to ensure early intervention and culturally appropriate services are delivered for this group by specialised trained staff.

Recommendation 22

5.50 The committee recommends the NDIA urgently clarifies what approved supports are available to NDIS participants in custody and how it monitors and ensures NDIS participants access the supports they are entitled to while in custody.

Recommendation 23

5.51 The committee recommends the NDIA establishes an NDIA unit specialising in the interaction of the Scheme with the criminal justice system.

Recommendation 24

5.52 The committee recommends the NDIA develops a specific strategy to deliver culturally appropriate services for Aboriginal and Torres Strait Islander people with disabilities who are in the criminal justice system.

Hon Kevin Andrews MP
Chair

Senator Alex Gallacher
Deputy Chair

Appendix 1

Submissions and additional information

Submissions

- 1 Mental Health Australia
Supplementary information
Attachment 1 'The implementation and operation of the psychiatric disability elements of the NDIS: A recommended set of approaches', David McGrath consulting
Attachment 2 'Draft position statement', Mental Health Australia
- 2 Community Living Association Inc.
- 3 Mental Health Foundation Australia (Victoria)
- 4 Commonwealth Ombudsman
- 5 NSW Disability Council
- 6 Ms Karen Segal
- 7 Office of the Public Advocate (Victoria)
- 8 Mental Health and NDIS Facebook Support Group
Supplementary information
Supplementary submission
- 9 Miss Kathryn Gilbert
- 10 Arafmi Qld Inc.
- 11 NT Shelter Inc.
- 12 Confidential
- 13 Office of the Guardian for Children and Young People
- 14 UnitingCare Wesley Country SA
- 15 Australian Red Cross
Supplementary information
Attachment 1 'Australian Red Cross Strategy 2020'
- 16 Mental Health Commission of NSW
- 17 The Royal Australasian College of Physicians (RACP)
- 18 The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- 19 Multiple Sclerosis Australia
- 20 Mr Grenville Duckworth
- 21 Homelessness NSW

- 22 Launch Housing
- 23 Queensland Alliance for Mental Health
- 24 Ethnic Community Services Co-operative
- 25 JFA Purple Orange
- 26 Victorian Alcohol & Drug Association (VAADA)
- 27 Mental Health Coordinating Council (MHCC)
Supplementary information
Attachment 1 'Developing the workforce', MHCC, 2015
Attachment 2 'Navigating the NDIS: Lessons Learned through the Hunter trial', MHCC, July 2016
Attachment 3 ' Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform', MHCC, July 2016
- 28 Queensland Nurses' Union
- 29 Neami National
- 30 Central Adelaide Hills Partners in Recovery (CAH PIR)
- 31 Name Withheld
- 32 Hunter Primary Care
- 33 Stepping Stone Clubhouse
- 34 Beyondblue
- 35 Department of Developmental Disability Neuropsychiatry, UNSW Sydney
- 36 Sunshine Coast and Gympie - Partners in Recovery
- 37 Inner South Community Health
- 38 Queensland Mental Health Commission (QMHC)
- 39 Merri Health
- 40 National LGBTI Health Alliance
- 41 The Butterfly Foundation
- 42 Woden Community Service Inc
- 43 Cohealth
- 44 Barnardos Australia
- 45 Capital Health Network
- 46 ADACAS
Supplementary information
Attachment 1 Additional information
Attachment 2 NDIS evidence of disability form

Attachment 3 EoD client questionnaire, February 2016

- 47 YFS Ltd
- 48 BEING
- 49 Sisters Inside Inc
- 50 Victorian Council of Social Service (VCOSS)
- 51 Wide Bay Partners in Recovery Consortia
- 52 Mental Health Council of Tasmania (MHCT)
- 53 The Council to Homeless Persons
- 54 NSW Council for Intellectual Disability
- 55 Grand Pacific Health
- 56 Centre for Excellence in Child and Family Welfare
- 57 Occupational Therapy Australia
- 58 Ballarat Community Health
- 59 Ms Marilyn Gale
- 60 ACT Human Right's Commission
- 61 Australian Society of Rehabilitation Counsellors Ltd. (ASORC)
- 62 Anglicare Australia

Supplementary information

Attachment 1 Additional information from Anglicare SA

Attachment 2 Additional information from Anglicare Sydney Mental Health Supplement

Attachment 3 Anglicare response to: Fifth National Mental Health Plan Draft for Consultation

- 63 Brisbane South PHN
- 64 Mental Health Carers NSW (MHCN)
- 65 VICSERV (Psychiatric Disability Services of Victoria)
- 66 EMPHN PIR services (Eastern, Inner East and Northern Melbourne Partners in Recovery Consortiums)
- 67 Orygen, The National Centre of Excellence in Youth Mental Health
- 68 Mission Australia
- 69 Tandem Inc.
- 70 Mental Illness Fellowship of Australia
- 71 NT Mental Health Coalition
- 72 Challenge Community Services

- 73 Department of Social Services (DSS)
- 74 One Door Mental Health
- 75 Community Mental Health Australia (CMHA)
- Supplementary information*
- Attachment 1- Letter to CMHA from NT Minister for Health
- Additional information – Letter to CMHA from NSW Minister for Mental Health
- Additional information – Letter to Hon Kevin Andrews MP from CMHA
- Additional information – Letter to CMHA from Queensland Minister for Health
- Additional information –Letter to CMHA from ACT Minister for Health
- 76 HealthWest Partnership
- 77 Australian Lawyers Alliance
- 78 Hume and Loddon Mallee Murray Partners in Recovery
- 79 Queensland Program of Assistance to Survivors of Torture and Trauma
- 80 National Disability Services (NDS)
- 81 Toowoomba Clubhouse
- 82 Mental Health Community Coalition ACT (MHCC ACT)
- Supplementary information*
- Attachment 1 –Letter to MHCC ACT from NDIS
- Attachment 2 –Letter to Minister for Health from MHCC ACT
- Attachment 3 – Presentation by Leith Felton-Taylor, MHCC ACT
- 83 Australian Psychological Society (APS)
- 84 Katoomba Neighbourhood Centre, Inc.
- 85 NT Council of Social Services
- 86 Rainbow Territory
- 87 Office of Public Guardian (NT)
- 88 Stress Management Institute
- 89 Autism Aspergers Advocacy Australia
- 90 Mr David Lamborn
- 91 McAuley Community Services for Women
- 92 Public Health Association of Australia
- 93 Office of the Public Advocate (Queensland)
- 94 Collaboration in Mind (CiM)

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- 95 TEAMhealth
 - 96 The Salvation Army of Australia
 - 97 Partners in Recovery Tasmania
 - 98 Anglicare Tasmania
 - 99 Carers Australia
 - 100 First Peoples Disability Network (FPDN)
 - 101 Aftercare
 - 102 National Disability Insurance Agency (NDIA)
 - 103 Wellways Australia
 - 104 Victorian Healthcare Association
 - 105 Dr Jean Graham
 - 106 The Benevolent Society
 - 107 Suncorp
 - 108 ACT Mental Health Consumer Network
 - 109 Mental Health Coalition of South Australia (MHCSA)

Supplementary information

Attachment 1 – Discussion Paper: Community-based Psychosocial Rehabilitation: A Casualty of the NDIS? By MHCSA

- 110 People with Disability Australia (PWDA)
- 111 New England - Partners in Recovery
- 112 Victorian Mental Illness Awareness Council (VMIAC)
- 113 Mental Health Complaints Commissioner
- 114 National Mental Health Commission
- 115 National Rural Health Alliance
- 116 Mental Health Carers Australia (MHCA)
- 117 Flourish Australia
- 118 Mind Australia
- 119 Queensland Advocacy Incorporated
- 120 Youth Disability Advocacy Service
- 121 Australians for Disability Justice

Supplementary information

Additional information – Letter to Hon Kevin Andrews MP from Australians for Disability Justice

Supplementary submission, May 2017

Supplementary submission, 19 June 2017

- 122 Australian Services Union
- 123 Victoria Legal Aid
- 124 Victorian Department of Health and Human Services
- 125 NDIS Independent Advisory Council
- 126 Office of the Public Guardian Queensland
- 127 Australian Healthcare and Hospitals Association
- 128 Mr James Condren
- 129 Queensland Health
- 130 Hon Leesa Vlahos MP
- 131 Name withheld

Tabled documents

- 1 CMHA: Statement (public hearing, Melbourne, 28 April 2017)
- 2 VMIAC: Membership brochure (public hearing, Melbourne, 28 April 2017)
- 3 Aftercare: Brochures about Aftercare, (public hearing, Melbourne, 28 April 2017)
- 4 Opening statement from Mental Health Commission of NSW (public hearing, Canberra, 12 May 2017)

Additional information

- 1 Additional information received from the Department of Social Services on 23 February 2017
- 2 Additional information received from the NDIA on 23 February 2017
- 3 Additional information received from Flourish Australian on 12 May 2017
- 4 Additional information received from Mental health Australia, Mental Illness Fellowship and CMHA on 19 May 2017
- 5 Letter to Hon Kevin Andrews MP Chair JSC received from Deputy CEO NDIA on 14 June 2017
- 6 Additional information received from ASU member Ms Bianca Villella on 14 June 2017
- 7 Additional information received from NDIA on 18 July 2017

Answers to questions on notice

- 1 NSW Department of Family and Community Services: Answers to questions taken on notice from public hearing 17 May 2017 (received 3 July)
- 2 NSW Department of Family and Community Services: Answers to questions taken on notice from public hearing 17 May 2017 – Attachment 1 (received 3 July)

-
- 3 NSW Department of Family and Community Services: Answers to questions taken on notice from public hearing 17 May 2017 –Attachment 2 (received 3 July)
 - 4 NDIA: Answers to questions on notice from public hearing 16 June 2017 (received 30 June 2017)
 - 5 NDIA: Answers to questions on notice from public hearing 16 June 2017 (received 30 June 2017)
 - 6 NDIA: Answers to questions on notice from public hearing 16 June 2017 – Attachment 1 (received 30 June 2017)
 - 7 NDIA: Answers to questions on notice from public hearing 16 June 2017 – Attachment 2 (received 30 June 2017)
 - 8 NDIA: Answers to questions on notice from public hearing 16 June 2017 (received 30 June 2017)
 - 9 NDIA: Answers to questions on notice from public hearing 16 June 2017 – Attachment 1 (received 30 June 2017)
 - 10 NDIA: Answers to questions on notice from public hearing 16 June 2017 – Attachment 2 (received 30 June 2017)
 - 11 NDIA: Answers to questions on notice from public hearing 16 June 2017 (received 30 June 2017)
 - 12 IAC: Answers to question on notice from public hearing 16 June 2017 (received 30 June 2017)
 - 13 Department of Social Services: Answers to question on notice from public hearing 16 June (received 30 June 2017)
 - 14 Office of the Public Advocate (Queensland): Answers to question on notice from public hearing 12 May 2017 (received 25 May 2017)
 - 15 Wide Bay Partners in Recovery: Answers to question on notice from public hearing 12 May 2017 (received 5 June)
 - 16 Sunshine Coast and Gympie Partners in Recovery: Answers to question on notice from public hearing 12 May 2017 (received 5 June 2017)
 - 17 BEING: Answers to question on notice from public hearing 17 May 2017 (received 31 May 2017)
 - 18 Department of Health: Answers to question on notice from public hearing 16 June 2017 (received 19 July 2017)

Appendix 2

Public hearings

Melbourne VIC, 28 April 2017

Aftercare

Dr Isabelle Meyer, Director, Operations Support

Ms Sylvia Grant, New South Wales Operations Manager

Australians for Disability Justice

Mr Patrick McGee, Co-Convenor

Australian Lawyers for Human Rights

Dr Emma Phillips, Member, Disability Rights Sub-Committee

Carers Australia

Ms Ara Cresswell, Chief Executive Officer

Community Mental Health Australia

Ms Amanda Bresnan, Executive Director

Ms Elizabeth Crowther, President

Community Restorative Centre

Ms Alison Churchill, Chief Executive Officer

Dr Mindy Sotiri, Program Director

Deaf Indigenous Community Consultancy

Ms Jody Barney, Consultant

Developmental Disability WA

Ms Taryn Harvey, Chief Executive Officer

Endeavour Foundation Queensland

Mr Simon Wardale, Manager, Specialist Behaviour Service

Individuals

Dr Matthew Frize, Private capacity

Intellectual Disability Rights Service Inc., New South Wales

Ms Janene Cootes, Executive Officer

La Trobe University

Professor Patrick Keyzer, Chair of Law and Public Policy, La Trobe Law School

Mental Health Australia

Mr Frank Quinlan, Chief Executive Officer

Mr Joshua Fear, Director, Policy and Projects

Mental Health Carers Australia

Ms Jenny Branton, Executive Officer

Mental Illness Fellowship of Australia

Mr Tony Stevenson, Chief Executive Officer

Neami National

Mr Arthur Papakotsias, Chief Executive Officer

Mr David Peters, Consumer, Service user

New South Wales Council for Intellectual Disability

Mr Jim Simpson

Office of the Public Advocate

Ms Colleen Pearce, Public Advocate

Orygen

Professor Patrick McGorry, Executive Director

Queensland Advocacy Inc.

Mr Nick Collyer, Systems Advocacy

Supreme Court of Victoria

Ms Miranda Bain, Director Strategy, Government and Community Relations, Funds in Court

University of Melbourne

Ms Rikki Mawad, Assistant Director, Tasmanian Law Reform Institute; Coordinator, Melbourne University Disability Justice Consortium, Melbourne Law School

Dr Piers Gooding, Postdoctoral Research Fellow, Melbourne Social Equity Institute, Melbourne Law School

Mr Jesse Young, Research Fellow, School of Population and Global Health

University of New South Wales

Associate Professor Leanne Dowse, Chair in Intellectual Disability, School of Social Sciences

Victorian Mental Illness Awareness Council

Ms Ella Kingsley, NDIS Lead

Mr Neil Turton-Lane, Consumer Liaison Manager

VICSERV Psychiatric Disability Services of Victoria

Ms Larissa Taylor, NDIS Engagement Manager

Canberra ACT, 12 May 2017

Witnesses

ACT Disability, Aged and Carer Advocacy Service

Mrs Fiona May, Chief Executive Officer

Ms Lauren O'Brien, Advocate

Bus Association Victoria

Mr Peter Kavanagh, Government Relations Manager

Bus Industry Confederation

Mr Michael Apps, Executive Director

Flourish Australia

Ms Pamela Rutledge, Chief Executive Officer

Ms Joanna Quilty, General Manager, NDIS Transition

Mental Health Commission of NSW

Mr John Feneley, Commissioner

Mind Australia Ltd

Dr Gerry Naughtin, Chief Executive Officer

Dr Sarah Pollock, Executive Director, Research and Advocacy

National Rural Health Alliance

Mr David Butt, Chief Executive Officer

Ms Fiona Brooke, Senior Policy Adviser

New England Partners in Recovery

Mr Jarrad Smith, NDIS Transition Manager

Office of the Public Advocate, Queensland

Ms Mary Burgess, Public Advocate

Office of the Public Advocate, Victoria

Ms Colleen Pearce, Public Advocate

Sunshine Coast and Gympie Partners in Recovery

Miss Candice Lee Thomson, Coordinator

Tasmanian Bus Association

Mr Geoff Lewis, Executive Director

Wide Bay Partners in Recovery

Ms Sarah James, Coordinator, Lead Agency—Central Queensland, Wide Bay, Sunshine Coast Primary Health Network

Woden Community Service

Mr Chris Redmond, Chief Executive Officer

Ms Pamela Boyer, Director, Mental Health and Housing

Penrith NSW, 17 May 2017

Witnesses

Australian Services Union

Ms Linda White, Assistant National Secretary

Mr Angus McFarland, Assistant Secretary, ASU NSW and ACT (Services) Branch

Mr Bernard Davey, Member

Ms Harriette Farrance, Member

Mr Philip Jones, Member

Mr Jon Mills, Member

Ms Janine Saligari, Member

Mrs Jodi Stuart, Member

Ms Bianca Villella, Member

Being - Mental Health and Wellbeing Consumer Advisory Group

Ms Jaime Comber, Policy Officer

Department of Family and Community Services, New South Wales

Ms Samantha Taylor, Executive Director NDIS Implementation

Department of Premier and Cabinet, New South Wales

Ms Janet Schorer, Executive Director NDIS Reform Group

Disability Council NSW

Mr Jake Fing, Council Member

First Peoples Disability Network

Mr Scott Avery, Policy and Research Director

Mental Health and NDIS Facebook Support Group

Mr Greg Franklin, Administrator

People with Disability Australia

Mrs Kate Finch, Manager, Systemic Advocacy

Canberra ACT, 16 June 2016

Witnesses

Department of Health

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Anthony Millgate, Assistant Secretary, Mental Health Services Branch, Health Services Division

Department of Social Services

Mr John Riley, Acting Group Manager, National Disability Insurance Scheme Market Reform Group

Ms Anne-Louise Dawes, Branch Manager, Program Transition Branch

Ms Joanne Llewellyn, Director, Carer and Mental Health Transition

National Disability Insurance Agency

Ms Stephanie Gunn, Acting Deputy Chief Executive Officer, Participants and Planning

Ms Deborah Roberts, Director, Mental Health

Mr Eddie Bartnik, Expert Advisory Mental Health

National Disability Insurance Agency Independent Advisory Council

Professor Rhonda Galbally, Principal Member

Ms Janet Meagher AM, Member

Dr Gerry Naughtin, Council member

