Submission to the Productivity Commission's study into NDIS costs

One Door Mental Health

Executive Summary

As a grass roots community mental health organisation, One Door is well placed to provide feedback on a number of issues relevant to the costs, efficiency and sustainability of the National Disability Insurance Scheme (NDIS). One Door can make comment on the impacts of NDIS policy, the costs to providers and the NDIA and suggested causations for emerging cost related issues with regards to the provision of the NDIS for people living with a mental illness.

In Australia, mental health has been, and continues to be, grossly under-invested in despite the clear economic and societal benefits of investment. The NDIS has great potential to address the unmet need for focused support for those with a complex and chronic psychosocial disability.

However, for the NDIS to reach its potential, unintended consequences created by emerging issues with implementation must be addressed in a timely manner to ensure continuity of service, to prevent market exit and to uphold quality of service.

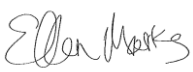
The speed at which the NDIS has been rolled out, coupled with the removal of funding for key psychosocial programs that also support those who are not eligible for an NDIS package, has created a state of unprecedented uncertainty for those living with a mental illness and service providers.

The current approach to implementation of the NDIS has the potential to exacerbate fragmentation of the mental health system. It is important to move towards an agile and mobile system that provides psychological continuity for consumers and carers at all levels of need. To do this One Door recommends that policy makers and the NDIA consider:

1. Quarantining of funding for services for those who are not eligible or who do not apply.
2. Clarification of eligibility criteria.
3. Improvements to pre-planning and planning supports.
4. Engagement with consumers, carers and organisations with established relationships with consumers and carers.
5. Addressing the absence of interface between mainstream services and the NDIS.
6. Engagement of a provider of last resort.

One Door would welcome the opportunity to provide further input towards improvements to NDIS implementation.

Yours sincerely,



Dr Ellen Marks
General Manager, Advocacy and Inclusion
Ellen.marks@onedoor.org.au
T 02 98792600

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Locked Bag 5014 | Gladesville NSW 1675
Tel: 02 9879 2600 | Fax: 02 9879 2699
ABN: 58 903 786 913 | www.onedoor.org.au

About One Door Mental Health

One Door is a specialist mental health recovery organisation, with a 32 year history, committed to improving access to services and the circumstances of people living with severe and complex mental illness.

One Door delivers trauma-informed recovery-oriented psychosocial support programs for carers and consumers. We provide psychosocial community mental health programs, specialist mental health Disability Employment Services (DES), care coordination, housing, clinical and peer supported services. Each year, 10 000 people, across 33 sites in NSW and ACT, access our services.

Many of the programs that are fundamental to our ability support people in their recovery are among those whose funding is currently transitioning into the NDIS. This includes crucial services provided through the Personal Helpers and Mentors program (PHaMs), Partners in Recovery (PIR), Day to Day Living (D2DL) and Mental Health Respite Carer Services (MHR-CS).

One Door delivers services and coordinates community psychosocial care for people across silos of sectors, funding and policy through building relationships and trust with other providers, funding bodies and most importantly, individuals and the communities they live in.

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Scheme Costs

The NDIS is currently experiencing a higher than anticipated rate of entry into the scheme, coupled with lower than expected rates of exit. Pressure to meet enrolment targets has the potential to exacerbate implementation issues and costs currently being experienced by providers, participants and carers.

Additional cost pressures that may arise with the roll-out of the NDIS include:

- Cost pressure arising from the inability to meet the target number of enrolments resulting in the need to extend block funding for programs transitioning to the Scheme, such as PIR, PHaMs, D2DL and MHC-RS in order to meet a no disadvantage guarantee.
- Increased prevalence of psychosocial disability as a result of service gaps created by funding transition from community psychosocial programs into the NDIS.
- Pressure to meet target enrolments with the potential to result in the necessity to introduce private providers for eligibility assessment.
- Increased utilisation of plans when both participants and LACs gain experience with the availability of supports and those most appropriate.

Higher than anticipated entry into the NDIS may be occurring as a result of previously unmet need for services for people with severe and permanent disability. It is plausible that some of this unmet need consisted of people with psychosocial disability who were not previously being fully serviced by the mental health sector, or did not identify themselves as being disabled.

It is unclear how expected numbers of people exiting the scheme would have been calculated other than factoring in mortality rates, given that those entering the scheme are entitled to life-long support based on the principle of the likelihood of permanence of the disability as an essential criteria for eligibility.

If scheme exit is anticipated as a result of improvement of function, the expectations of such a short-term of intervention for such improvements, is unrealistic. Exit from the scheme based on functional improvements of participants will require that supports outside the NDIS are available and the interface with mainstream services improved. This reflects that the nature of a fee-for-service model under the NDIS does not incentivise the use of recovery based models.

For those living with a psychosocial disability, approximately 12% will also have significant chronic physical health comorbidities[1]. Disparities in healthcare provision contribute to poor physical health outcomes for those with a severe mental illness, with physical health needs often ignored in those with a severe mental illness[2]. Such physical health comorbidities can be a significant barrier to improvements in functional outcomes which often remain unaddressed by both mainstream Health services and NDIS supports.

Recommendations:

- Address barriers to plan utilisation as discussed below including physical comorbidities

Scheme Boundaries

[1] Australian Institute of Health and Welfare 2012. Comorbidity of mental disorders and physical conditions 2007. Cat. no. PHE 155. Canberra: AIHW.
[2] Lawrence D, Kisely S (2010). Inequalities in healthcare provision for people with severe mental illness. J Psychophamacol; 24(4 Suppl):61-8.

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Eligibility Criteria

There is a lack of clarity with regards to eligibility criteria for people with psychosocial disability, which has been highlighted by many organisations including the Mental Illness Fellowship of Australia (MIFA)[3], Mental Health Australia (MHA)[4], One Door Mental Health[5] and the National Disability Service (NDS)[6].

This problem is exacerbated by the division between fundamentals of mental health and the NDIS – problems such as the disconnect between NDIS design and Recovery Oriented Practice, the disconnect between NDIS eligibility criteria (of a permanent and severe functional impairment) and fluctuating and episodic needs of many people with severe mental illness. It is also exacerbated by the difficulty in predicting the long-term outcome of a mental illness.

Current eligibility criteria used by the NDIS lacks clarity in relation to psychosocial disability and the judgements made on the likelihood of permanence of disability based on the "condition". For some people with a well-established medical history of impairment this may be easy. However, for others, demonstrating this, in the face of stigma-based assumptions of the permanence of the illness, this may be challenging despite their level of need for access to the Scheme.

In the DSS Guide to Social Security Law[7] provides insightful guidance for assessing the permanence of a condition, which is missing in the National Disability Insurance Act 2013 section 24(1), described as:

"If for example, specialist advice is that a person would benefit from treatment with long-term psychotherapy but that significant functional improvement is not expected to occur for many years, then the mental health impairment may be considered permanent and rated accordingly."

Further,

"If reasonable treatment has not been undertaken, it should be determined whether the person has a reasonable medical or other compelling reason for not doing so. For example, the person may have a psychotic illness that impairs their insight and ability to make sound judgements and this may affect their compliance with treatment. Such a person's mental health impairment could then be considered stable and permanent if it is unlikely that any significant improvement will occur within 2 years."

One Door supports changes to eligibility criteria for psychosocial disability that recognise enduring chronic or episodic, complex illness characterised by significant disabilities resulting from any diagnosed psychosocial condition which is unlikely to significantly improve over a two year period.

As proposed by MIFA[3] and Mental Health[4] Australia, evidence of disability could be:

- *Frequent hospitalisation for mental illness*
- *Current or recent history of being on the caseload of public mental health services*
- *Minimal employment in recent years*

[3] Mental Illness Fellowship of Australia (2017). Submission 70, The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.
[4] Mental Health Australia (2017). Submission 1 - Attachment 2, The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition
[5] One Door mental Health (2017). Submission 74, The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.
[6] National Disability Service (2017). Submission 80, the provision of services for people with psychosocial disabilities related to a mental health condition. www.nds.org.au/images/news/NDISandPyschosocialDisabilityFebruary2017.pdf
[7] DSS Guide to Social Security Law. 3.6.3.50 Guidelines to Table 5 - Mental Health Function. Version 1.230, released January 2017. Accessed at: http://guides.dss.gov.au/guide-social-security-law/3/6/3/50

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- *Poor physical health*
- *Insecure housing*
- *Extreme social isolation*

More effort should be made to inform key stakeholders and coordinators about the boundaries of current eligibility criteria. Clearer guidelines should also be provided for assessors in order to ensure that stigma does not influence judgements of the permanence of disability based on a person's diagnosis. According to MIFA's submission to the Joint Standing Committee on the NDIS[3]:

"*There is already evidence of diagnoses-related decision-making both anecdotally from our member service providers, and in trial site evaluations which showed that those with PTSD, depression & mood disorders are more likely to be declined a package*[8]."

The speed of the NDIS roll-out is a significant factor affecting eligibility assessment processes. There has been little engagement with health professionals involved in providing medical evidence of disability to align reports and evidence with the information required by the NDIA to assess eligibility. This has resulted in appeal and review of decisions[6]. For example, effort could be made to inform consulting psychiatrists about the eligibility criteria, functional impairment and symptom description.

Additional aspects of eligibility criteria affecting participation include the requirement for a psychosocial diagnosis for access to the Early Childhood Early Intervention (ECEI) section of the NDIS. In One Door's experience, health professionals are reluctant to diagnose children with a mental illness, particularly as there is significant difficulty of identifying early prodromal symptoms in mental illnesses such as schizophrenia, which will inhibit them accessing the NDIS.

Recommendations:

- Address divisions and disconnects between mental health services and the NDIS
- Improve clarity of criteria for eligibility of people with psychosocial disability
- Engage with health professionals involved in providing medical evidence eligibility for the NDIS

Plan Utilisation and Navigating the Planning Process

Alarmingly, the NDIA annual report indicates that the NDIA has had no intention of addressing under-utilised supports during the trial period in order to stay within budget:

"*Committed support in trial exceeds the funding envelope in 2014-15 and 2015-16. However, as not all committed support is being utilised, an actual deficit will not arise. That is, the Scheme will be within the budget for the three years of trial.*"[9]

The incentive for the NDIA to improve utilisation at the expense of remaining within budget is poor. However, it can be anticipated that utilisation of plans will increase when both participants and planners gain experience with the availability and appropriateness of supports.

There will be a number of people who require more intensive support for decision-making in the planning process (and the application process). Currently, service providers are providing unpaid

[8] Partners in Recovery and NDIS Interface: A Data Report from the Hunter and Perth Hills Trial Sites (2015). Accessed at: https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf
[9] NDIA Annual Report 2015-16, Geelong.

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support in this area. However, as program funding transitions to the NDIS, the capacity and willingness of organisations to undertake this support function will decrease because it will not be remunerated. This will potentially exacerbate the lack of Local Area Coordinators (LACs) capacity to support participants in the scheme.

One Door has identified four main aspects which contribute to poor plan utilisation:

1. Inadequate plans are created without pre-planning and support

In order to create an effective plan that meets the needs of a person with a psychosocial disability frequent review is needed, as well as a good understanding of the nature of the person and their unique experience of mental illness. In our experience the following issues are preventing people with a psychosocial disability from access to the supports they are entitled to under the NDIS:

- Lack of engagement with local providers who have established trusting relationships with participants to assist with the planning process[10].
- Plans are approved that are inadequate or inappropriate to client needs, particularly for those unable to advocate for themselves.
- Lack of mental health knowledge/expertise of Planners (and LACs).
- Poor engagement with consumers for decision making regarding their package.
- Failure to plan for provision of supports that the participant accesses currently, which will not be able to be provided without NDIS funding.
- There is evidence that some NDIS-eligible individuals and their carers may not have the knowledge and skills to negotiate plans.

2. Lack of support offered through Coordination of Supports (COS)

It is estimated that the NDIA will spend $770 million on COS, which is the fourth largest category of money invested by the NDIA. COS is one of the most important levers the NDIA has at its disposal, particularly as moving from plan approval to implementation can involve in excess of 100 small decisions. Outcomes of the NDIS trial sites have shown that COS inclusion in packages is particularly important to assist consumers and carers to navigate the system[11].

Currently, our clients are experiencing a "chocolate wheel" approach to COS, where the logic of supports approved appear similar to a game of chance:

- In our experience, participants are being encouraged to self-manage plans when they are incapable of doing so.
- COS has not been included in a number of participants packages who need help to coordinate support. Where no COS is included, LACs are funded for 10hrs per year to coordinate support, however this is rarely expended.
- Participants are not being given choice of provider of COS.
- Guidance from the NDIA on what COS should look like has been inadequate.
- The intention that COS is a capacity building support, raises concerns that COS will only be funded for the first year of an NDIS plan, or reduced in subsequent funded years. If so, engagement and empowerment of participants and carers will need to be significantly improved.

[10] Civil Society NDIS Statement to the Council of Australian Governments (COAG) and the National Disability Insurance Agency. Call for stronger engagement with people with disability in the NDIS. December 2016.
[11] Carers NSW (2014). The NDIS One Year In: Experiences Of Carers In The Hunter Trial Site. Accessed at https://www.carersnsw.org.au/Assets/Files/NDIS%20Issues%20Paper%20DSN%20FNL%203%20Oct%2014.pdf

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- Lack of mental health knowledge/expertise of LACs which has resulted in poor engagement of consumers in decision making regarding their supports.

3. ***Barriers created by ineffective administrative processes***

Current administrative processes, with significant failings, make it difficult for reimbursement of self-managing participants. Administrative processes are effecting plan utilisation as shown in both South Australian and Tasmanian data:

"*Participants are processed as 'eligible' quickly, the data shows that they have the long wait times of 115-128 days until an approved plan is finalised*"[12]

Transparency of information about the care of a person needs to be a priority. As One Door understands, the information contained in the portal used by the NDIA is different to the information being provided (with significant delays) to LACs, and there is no information is provided to external providers of community supports. Information that should be included to improve transparency includes supporting evidence used in the application process to help inform providers and LACs of the person's needs.

4. ***Availability of appropriate supports and the presence of service gaps (discussed further below)***

Recommendations:

- Further train Planners and LACs to improve understanding of psychosocial disability.
- Ensure that COS is included in plans where needed.
- Recognition of supports that are already provided to a participant in NDIS plans.
- Ensure transparency and consistency of information shared between the NDIA, LACs and service providers.

Significant Gaps in Service

The impact of full NDIS roll-out is likely to be significant and wide ranging. We anticipate an increase in poverty levels, hospitalisations and deterioration of mental state and community participation for those clients unable to access the NDIS, as well as an increased demand on the NDIS in the future.

There are a number of categories of people who will experience gaps in service:

Services for those without an NDIS package

This group of people includes:

- *Those who are not eligible for the NDIS*
- *Those who most likely have a permanent disability but are rejected by the NDIA (e.g. insufficient medical evidence supplied, poorly trained NDIS assessors in the area of psychosocial disability, and those who do not have an advocate to attend meetings)*
- *Those with no history of formal contact with health services and unable to demonstrate disability (e.g. those extremely marginalised and disabled)*

[12] Joint Standing Committee on the National Disability Insurance Scheme (2015). Progress report on the implementation and administration of the National Disability Insurance Scheme

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- *Those who can't or won't apply (e.g. those with anosognosia, previous trauma from experiences with government services or those that are unsupported in the application process*

Commonwealth funding for essential psychosocial services provided through PHaMs, PIR and D2DL is being withdrawn in order to fund the NDIS. Funding to these programs is progressively transitioning towards zero. In 2016-17 funds for this program to One Door were cut by 6.1%, which will increase to 30% in 2017-18 and 71% in 2018-19.

Once funding transition is complete, these programs will cease to exist in their current form. Only those who receive an NDIS package will be eligible to receive services planned for in their NDIS package. There are no replacement supports or equivalent programs available for those who do not receive and NDIS package. One Door estimates that in 2016-17 alone, funding cuts will result in the loss of 8 staff, who would otherwise provide support to over 144 clients.

Mental Health Australia's population profiling estimates a population of 502,000 adults with severe mental illness in Australia, of whom approximately 290,000 will require some form of NDIS-like community support- 5 times the Productivity Commission's original estimate[13]. Such supports can be defined as "non-clinical community based services designed to assist those with a mental illness to participate in their communities and have meaningful and contributing lives." They are similar to supports provided under PIR, PHaMs and D2DL which will no longer be available for people without an NDIS package.

One Door estimates that between 50-75% of those accessing the PHaMs program will receive an NDIS package of an unknown amount. While recognising that this is just an estimate based on our experience, our estimate leaves a potential 25-50% of people without service. One Door is also aware that some providers are reducing the amount of service provided to those who are not eligible for the NDIS in order to maximise the potential to gain clients with NDIS packages.

One Door and others[3] believe that funding transitioning to the NDIS from psychosocial programs should be quarantined.

Of concern is the loss of outreach to those who may qualify for an NDIS package but are unable or unwilling to apply and for those who are outside of mainstream services. Approximately 46% of Australians living with a mental illness do not access treatment services[14].

Prior to the roll-out of the NDIS, outreach was a critical component of work completed by the community mental health sector through programs such as PIR, which will no longer be funded.

Those organisations and service providers who are best positioned to undertake outreach in their local area should be funded to do so. Non-government organisations, such as One Door, have worked over many years to establish trust and relationships with vulnerable communities and therefore should be considered as key to outreach and appropriately funded to do so.

Services for those with an NDIS Package

This group of people includes those with an NDIS package, but:

- *No services, for example in regional and remote Australia*
- *No coordination of supports and therefore unable to use their package*

[13] Mental Health Australia's Submission 1: McGrath, D. (2016). The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches
[14] Whiteford HA, Buckingham WJ, Harris MG, et al. Estimating treatment rates for mental disorders in Australia. Australian Health Review 2014; 38(1): 80-5.

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- *The package is inadequate*
- *The package contains inappropriate supports*
- *Providers unwilling to provide services due to complexity of needs under a fixed-price system*
- *Absence of culturally appropriate services*[15,16]

Full roll-out of the NDIS will fundamentally change the way community mental health is delivered to those with an NDIS package. For example, the provision of center-based services is incompatible with the funding model provided through the NDIS. Center-based services require steady streams of income in order to maintain workforce and property leases. Furthermore, providing fixed plan supports will change the ability of participants to access the service flexibly as they have been able to in the past. For example, if a participant had previously attended the center 5 days a week, they will be restricted to attendance within prearranged appointment times and limited to accessing the service to that amount funded through the NDIS package.

Evaluation of the NDIS trial sites by the Independent Advisory Council concluded that service gaps exist for those living in regional areas due to lack of providers[17]. Sparse population density in regional areas limits both financial sustainability and workforce availability. Typically services to those living where commercial drivers are less apparent are provided by small, not-for-profit (NFP) organisations. The NDIS is proving challenging for small regional service providers due to the need for upfront capital investment in order to train workforce and restructure service provision.

Full NDIS roll-out also has implications for the quality of service provided as a result of changes to the workforce. While the NDIS does not directly set the amount a service provider can pay an employee, the amount provided for a service under the NDIS is too low to maintain the current level of skill in the workforce. The low cost of support service items provided through the NDIS is likely to exacerbate both workforce shortages and result in deskilling of the current workforce. Provisions for basic support items allow for the attraction of only minimally qualified staff, which will result in reductions in the quality of services that can be provided.

Carers

The NDIS roll-out will change the way carer services, including much needed respite, are provided. In 2009, the Mental Health and Carer Respite Services (MHC-RS) was introduced after many years of organisations such as One Door advocating for the needs of mental health carers. With the transition to the NDIS this program will now disappear (as well as the On Fire! program for young carers).

Respite for carers of a participant in the NDIS will only be provided indirectly through coordination of participant activities with carer needs. No active respite, with a focus on carer wellbeing, will be provided.

Carer needs should always be a consideration when planning NDIS packages for people living with a mental illness. However independent funding for carers from the NDIS recipient's supports is needed and should be funded outside the NDIS.

[15] Diversitat Disability Findings Report. Accessed at: http://www.diversitat.org.au/documents/Settlement/Diversitat_Disability_Findings_Report.pdf
[16] Indigenous Australians and the National Disability Insurance Scheme. Accessed at: http://press-files.anu.edu.au/downloads/press/p298291/html/ch01.xhtml?referer=250&page=8
[17] Independent Advisory Council report 2015. Response to the Joint Standing Committee on the National Disability Insurance Scheme on gaps in service. Accessed at: http://bit.ly/2mFHzDq

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Recommendations:

- Quarantine funding for psychosocial support programs for those not eligible for the NDIS or who will not apply.
- Recognise carer needs both when planning NDIS packages and through quarantining of MHC-RS funding.
- Service gaps for regional areas should be addressed in partnership with the local communities including addressing the need for a provider of last resort.

The Interface with Mainstream Services

There is evidence of lack of coordination between the NDIS and mainstream services, particularly the interface between housing, education, employment and health services[17].

In our experience, there has been little attempt at NDIS service integration with mainstream services, including engagement through PHNs or LACs. Primary Health Networks (PHNs) and LACs do not have the capacity or understanding of psychosocial disability to perform this function[18]. Furthermore, the referral process back to mainstream services for people ineligible for the NDIS is, in practice, not transpiring.

Mechanisms for communication and service integration at the interface of Health and the NDIS need to be carefully considered. Currently, it is not clear how mainstream clinical services will be included in the planning and care of patients who are also accessing the NDIS. Furthermore there have been little attempts, to our knowledge, to include formal health services in education and training surrounding the NDIS.

Service gaps as a result of lack of clarity of the current split of services are also emerging. The delineation of supports funded by Health and those funded by DSS does not provide clear lines of responsibility for those who are in-patients of hospitals, such as forensic consumers.

In Australia, people who have been found unfit to be tried for an offence, or people who have gone through a criminal trial or special hearing and are “not guilty on the grounds of mental illness” are known as forensic consumers.

Forensic consumers are kept in a prison or a hospital for recovery and rehabilitation with the goal of integration back into the community. The process of integration back into the community begins with day leave (funded by NSW health) and gradually overnight leave (previously funded by the NDIS for eligible participants).

When the Treating Team is satisfied with the progress made during overnight leave, they will submit an NOI for conditional discharge.

The NDIA is no longer funding overnight leave for forensic consumers without a conditional release date. However, no forensic consumer will be granted conditional release without having completed overnight leave. Without NDIS funding for overnight leave, forensic consumers will not be able to be integrated back into the community.

[18] Department of Health (2016). PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care. Accessed at: http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF

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It is One Door's belief that these supports should be included in an NDIS package as they represent fundamental community supports for an individual, delivered in a community setting rather than an in-patient setting.

Information, Linkages and Capacity Building (ILC)

The intention of the $132 million (2019/20) ILC funding was initially thought to be to provide a 'tier 2' of service to ensure that those who are ineligible for an NDIS package receive service. However, it is clear that ILC is not intended for this purpose and 'tier 2' remains unfunded.

Instead, the ILC will form an important interface between the NDIS and mainstream services. However it is not clear how this will be achieved and how both LACs and PHNs will be involved in this process[19,20].

The amount of funding provided through ILC and the short-term nature of the grants awarded may also impact on the willingness of organisations to tender for ILC grants.

Recommendations:

- Develop a strategy to address the lack of interface between the NDIS and mainstream services
- Clarify terms of funding under the 2014 Bilateral Agreement (NSW) for forensic consumers
- Clarify the overlap between ILC and individually funded packages, LAC functions, and ILC outcomes (particularly the 'individual capacity building' outcome of ILC).

Sector Readiness

Financial sustainability

The NDIS continues to fundamentally change the way community psychosocial supports are delivered. Many providers delivering psychosocial support services are not-for-profit organisations currently funded by a mixture federal and state-based grants, fundraising, philanthropy (and potentially through provision of NDIS services to clients).

The speed with which the roll-out has occurred has placed significant financial strain on providers, particularly small providers, as a result of needing to move from the relative stability of block-funding arrangements to the uncertainty of unknown revenue through fee-for-service. Recent evidence supports this, as 32% of small organisations have reported a decline in income in areas with the NDIS roll-out, compared with 6% of large providers[21]

Concerns exist with the potential for negative impacts of market-exit of small NFP organisations on responsiveness, quality, access and reduced investment in research and innovation. In cases where fee-for-service items are delivered without linkage to outcomes or quality of service, it is possible that principles of practice will shift from recovery focused, to one based on unit delivery and competition, without necessary supports that allow the scheme to empower choice and control.

[19]The Productivity Commission. National Disability Insurance Scheme Costs Issues Paper. 2017
[20] The Department of Health. PHN primary mental health care flexible funding pool. Implementation guidance primary mental health care services for people with a severe mental illness. Accessed February 2017 at http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/4PHN%20Guidance%20-%20Severe%20mental%20illness.PDF
[21] National Disability Services. Stat of the Disability Sector Report 2015. Accessed at: https://disabilitysectorreport.nds.org.au/images/State-of-the-disability-sector-report-2015.pdf

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Statistics from the National Disability Services[21] give an indication of the impact of the shift from block-funding to fee-for-service environment on care providers:

- 42% feel that the risks the NDIS presents to their small organisation outweighs the opportunities
- 44% of all small organisations have insufficient financial resources
- 47% of small organisations experienced increased demand for their services
- 17% report less income

The ability of providers to remain viable in the NDIS market is clearly highly variable. A recent Curtin University study found that 42% of providers were generating a profit of less than 3%, with 16% of organisations with an asset ratio of below (compared to a healthy ratio of 1.9)[22].

A major influence on the financial viability of smaller providers is the prices for services set by the NDIA. There is some evidence that the disability sector may not be prepared for a market-price setting mechanism. The NDS report indicates that 67% of providers "are concerned they will not be able to provide services at the prices being offered under the NDIS" [21]. Despite this, the NSW NDIS Market Position Statement (2016) does not consider the market for psychosocial disability support, rather focuses on traditional disability service providers.

Key strategic challenges many organisations are facing also include the necessity for significant upfront capital investment to recruit and train a workforce able to deliver lower cost services (see discussion of workforce issues below), and implement mobility within the sector. Importantly, organisations have also been required to invest significant unpaid contributions in order to provide information and training to carers and consumers in the application process, who would otherwise have found the complexity of the scheme prohibitive.

Corporatisation of services

The Productivity Commission identified that current reforms have introduced "corporatisation" of the community mental health sector, which has previously been dominated by charity[23]. Previously, organisations collaborated towards a common goal of improved health outcomes for those who access services. In the current environment these organisations are now competitors for NDIS business.

One Door believes the introduction of market-based prices in the community mental health sector has the potential to result in:

- Loss of values driven by principle rather than profit.
- A reduction in investment in workforce.
- The introduction of competitive behaviours between providers who previously operated as collaborators.

Workforce

[22] Gilchrist, D. J. and P. A. Knight, (2016), Australia's Disability Sector 2016: Report One - Financial Sustainability and Summary of Key Findings, A Report for the Research Data Working Group, Sydney

[23] The Productivity Commission (2016). Inquiry into introducing competition and informed user choice into human services. Accessed at: http://www.pc.gov.au/inquiries/current/human-services/reforms/issues

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Many workers who provide NDIS services are inextricably linked to grant-based community mental health services. The community mental workforce is likely to undergo significant de-skilling in the coming years with the introduction of the NDIS.

While the NDIS does not directly set the amount a service provider can pay an employee, the amount provided for a service under the NDIS is too low to maintain the current level of skill in the workforce. For example, highly skilled workers currently employed in the PIR program are employed on a much higher pay scale than those prices set for support through an NDIS package. These workers will likely chose to exit the community mental health sector

It is critical that further pressure is not exerted by reforms to community services in order to maintain the skill level of the workforce and ultimately the quality of service that a consumer can access.

Recommendations:

- Further consider pricing for NDIS supports and the financial viability of service providers
- Further consider pay provisions under the NDIS and its impact on the workforce skill level
- Develop a National Workforce Strategy

Governance and administration of the NDIS

A Provider of last resort

A provider of last resort is crucial for the provision of services to those who are seen as less commercially appealing due to complex needs and for those living in regional/remote Australia. A fixed price scheme such as the NDIS does not incentivise service provision to these people.

One Door does not support the NDIA as a provider of last resort for those living with a psychosocial disability. One Door has concerns with the level of expertise and understanding of psychosocial disability within the NDIA, and a provider of last resort would be best outsourced to a private provider with values driven philosophy to support and individual's recovery journey.

Recommendations:

- Establish providers of last resort that are independent of the NDIA

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