Joint Standing Committee on the National Disability Insurance Scheme Inquiry into Market Readiness

Introduction

Community Mental Health Australia (CMHA) would like to thank the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) for the opportunity to make a submission to the Market Readiness inquiry. CMHA would welcome the opportunity to address the Committee when hearings are held as a part of the inquiry process.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

Key issues for the community mental health sector with market readiness include market viability, the price structure of the NDIS and adopting the recovery approach of the sector within the NDIS structure. The CMHA and Mental Illness Fellowship of Australia (MIFA) joint submission to the McKinsey and Company Independent Pricing Review 2017[1] noted that sector wants to work with the National Disability Insurance Agency (NDIA) to better understand how a recovery approach can contribute to greater impact and cost efficiencies for people with psychosocial disability who are eligible for the NDIS.

A central issue for including psychosocial disability in the NDIS has been that psychosocial disability support does not fit easily into the current pricing structures of the NDIS. The sector has developed responsive recovery-oriented models of support over many years, and has developed a workforce that is appropriately qualified and skilled to deliver this support. A recovery approach is aligned to the objectives of the NDIS. Supporting a person with psychosocial disability to build their resilience, strengthen their natural supports from family and friends, and develop their connections with the community, will lead to an increase in community participation and contribution, and a reduction in life-time support needs.

[1] CMHA and MIFA, Submission to the Independent Pricing Review 2017: McKinsey and Company, http://cmha.org.au/wp-content/uploads/2017/04/171016-NDIS-Independent-Pricing-Review-submission-CMHA-MIFA.pdf

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

Developing a system of viable psychosocial support for people with severe and enduring mental illness within the NDIS requires an understanding of the key needs of people with psychosocial disability. These include:

- the need to take time to develop a comprehensive recovery plan;
- for capacity building, wrap-around support across many life domains and systems that can be flexible and responsive; and
- to have access to infrastructure and transport that meets their needs and be supported by well-trained and supervised staff.

Best practice requires a broader understanding of how supports to people with psychosocial disability are provided to ensure the best outcomes for people, and the ongoing viability of service providers.

CMHA's submission to the Market Readiness inquiry will address the terms of reference that are relevant to the community managed mental health sector.

a. the transition to a market based system for service providers;

The Mind the Gap project and report undertaken by University of Sydney in partnership with CMHA[2] found that in some instances NDIS participants were unable to implement NDIS plans as the services were not available. The project engaged with over 60 stakeholders across consumers, carers and service providers in Western Australia, the Northern Territory, Queensland, New South Wales, the ACT and Victoria. Stakeholders described a frequent inability to find an available provider for services. This was particularly in the following contexts:

1. Missing services - The services that stakeholders highlighted as particularly hard to find NDIS approved providers for included psychology, short term respite, particularly those able to deal with complexity of health-related needs, hoarding and squalor services with an understanding of mental health and trauma-related needs.
2. Weekend services - Stakeholders said that trying to find weekend services for people was even more challenging because providers could not make weekend services financially viable.
3. Rural and remote services - While this lack of providers was a national issue, it was particularly emphasised in rural and remote contexts often no service providers existed at all. Where services did exist, the market was so thin that consumers had no choice of provider. Stakeholders explained that their organisations had decided not to provide services in rural and remote environments because they were unable to provide quality, safe service within the pricing structures. Some of the reluctance to work in rural and remote regions was blamed upon the slow roll out of the scheme and thus not a work-load high enough to make it viable. The lack

[2] Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Final Report: Stakeholder identified gaps and solutions. January 30th, 2018. The University of Sydney, Sydney Policy Lab and Community Mental Health Australia.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

of recognition of the extensive time involved in travel in rural and remote regions within NDIS pricing structures also greatly impacted on the ability to deliver financially viable service.

4. Appropriate staff not available - Another reason for the lack of providers, providers withdrawing services, and providers saying they were at capacity and thus not available for service, was the difficulty finding and retaining quality staff with the level of skill required within the pricing structure. A particular lack in terms of service provider staff is Aboriginal workers. There were many stories of Aboriginal clients not engaging with the NDIS or activating their plans because they were unable to be connected to Aboriginal provided services.
5. Lack of service funding for travel – This meant that organisations would not/could not accept clients that lived further than 20 minutes away. This is creating particular difficulty for those living in more rural or remote communities including many Aboriginal clients.

The lack of services described above repeatedly came down to a lack of financial viability of providing services within the costing structure of the NDIA. Even if the services they were seeking for clients were available, providers struggled and often were unable to find people/organisations to provide services within the funding structure. Services highlighted included cleaning, support workers, self-care and gardening. Stakeholders also reported that only a small percentage of organisations who had registered to provide services within NDIS were in fact actively doing so.

A further issue was inflexibility and errors in the on-line NDIS systems as well as un-scrupulous organisations resulting in people not being able to access the supports detailed in their plan because other services have stepped in and drawn down on the same line items, leaving the person with no funds to engage with other organisations or services.

Some of stakeholders described the non-government service provision system being on the brink of collapse. Below are the issues that were described by the providers engaged in the Mind the Gap project:

1. Collapsing, merging and avoiding the NDIS - Smaller non-government organisations described collapsing and merging. They also repeatedly talked about waiting to see how things go before offering services through the NDIS or choosing not to engage with the NDIS at all.
2. Running at a loss. All non-government stakeholder organisations providing services through the NDIS described running at a loss that was not sustainable. All organisations described covering these additional costs by drawing on reserves and donations with an understanding that there was a time-limit before the organisation would 'step away' from engagement with the NDIS scheme. The larger organisations had established that they could 'carry' this financial burden for two years, for others the time-frame was much shorter. Further points on this were:
    i. They commonly described offering and providing 'free' or unfunded services to many clients because they were not in the NDIS and no other funded services were available.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

ii. They commonly described providing unfunded service to support people in the pre-planning and application phases due to many having no support allocated, and those within programs transitioning and having insufficient hours of support provided.

iii. They commonly described paying their NDIS service delivery staff more than the hourly rate 'allocated' within the NDIS pricing structure in order to maintain staff quality, mental health knowledge and skill.

iv. They commonly described providing more services to clients than was allocated in NDIS approved plans and to 'plug' gaps in services available and, as above, covering the costs for these 'extensions' of service while understanding this was not sustainable long-term.

v. The extent of un-funded work is impacted by delays and complexity for people along the NDIS journey. Stakeholders described continuing to provide un-funded services at the various points of delay for both ethical reasons and in the hope that they would be 'reimbursed' later.

3. Losing a talented mental health work-force. All organisations described the distress of 'shedding' talented, well trained staff that they had invested time and resources in building and training. Stakeholders have consistently raised concerns around the lack of understanding within the NDIS structure of the qualifications and expertise required to provide services and support or people with psychosocial disability. This once talented workforce is being replaced by an increasingly un-skilled, inexperienced, casualised and unstable workforce. Staff retention was a challenge repeatedly raised.
4. Staff training and supervision reduced to risky levels. All stakeholders talked about having to drastically reduce the quality of staff training, support, supervision and services to try and get closer to alignment with the NDIS funding model. They described radically changing, or in some cases ceasing, staff induction, orientation, supervision, support and training. Typically, these were now delivered as on-line modules with limited or no capacity to confirm completion.
5. Poor communication between NDIA and organisations. Communication from the NDIA national office, NDIA regional offices and LACs has been raised as on ongoing issue for stakeholders which frequently causes confusion; incorrect information or interpretations of information; and a lack of clarity on who is responsible for what. Stakeholders described that a risk to staff arising from poor training and supervision was exacerbated by poor communication between NDIA staff and service provider organisations. This meant that sometimes information about complex behaviours or people's histories of violence were not shared with providers.
6. Bending and breaking rules to survive: Stakeholders invariably described their organisations 'bending the NDIS rules' to survive financially, or to extend the time before they would withdraw from the NDIS. This had a negative impact on their culture and morale and created a growing sense of need for secrecy rather than cross-organisational connection, collaboration and sharing (hiding clearly questionable but deemed essential-to-survival practices).

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

7. Lamenting the loss of a person-centred model for this new business-driven model. Stakeholders believed that a very different culture was now driving the community managed or non-government mental health system across the country, with a business model rather than people at the centre. Funding, and thus opportunity, for organisations to connect, collaborate and build integration has been lost. This also impacted on capacity to develop relationships and partnerships beyond the community-mental health sector, such as with Aboriginal organisations and communities.

A copy of the Mind the Gap report has been provided to the Committee separately to this inquiry.

b. participant readiness to navigate new markets;

CMHA addressed the issue of what participants need to make the most of the NDIS in the submission to the NDIS Costs – Productivity Commission Position Paper[3]. The Position Paper raised the issue of assistance to NDIS participants to implement plans, including through support coordination. CMHA noted that the point has been made in several forums that many people, particularly people with psychosocial disability, will require support coordination over their lifetime. This may vary in the level of need, however, this need will always be there. This has been an issue with the WA NDIS, which had only allowed for episodic coordination but had recognised that ongoing coordination was required and reflected this in the price framework. Noting that WA have announced they will join the national scheme. At a Federal level, a balance must be struck between the expectation of the NDIS to build capacity and leaving participants without sufficient support coordination.

This is not something that has been well recognised through the NDIS and particularly through the provision of support coordination via LACs. Where it is needed, support coordination must be provided to participants, and this should be done in consultation with providers who know the participants needs. It is likely to also require a change in process for the NDIA and the LACs in recognising the centrality of this type of support, and expertise in areas such as mental health when these supports are being assessed.

The Position Paper discussed the potential role for peer workers to assist people in navigating the NDIS. Peer workers are a central part of the community managed mental health workforce and CMHA has been raising the issue of their inclusion in an NDIS disability workforce for some time. In addition, the NDIS Independent Advisory Council (IAC) is developing advice on the inclusion of peer workers in the NDIS. The NDIS currently does not adequately recognise the role or expertise of a peer workforce, and CMHA would support the inclusion of processes to support a peer workforce. However, peer workers should not just be restricted to intermediary or support roles – they should be able to support

[3] CMHA (2017), National Disability Insurance Scheme (NDIS) Costs – Productivity Commission Position Paper, http://cmha.org.au/wp-content/uploads/2017/04/CMHA-submission-PC-NDIS-Costs-Position-paper.pdf

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consistent with peer work principles and practices and be supported as part of the overall NDIS workforce and recognised as such.

Service providers in Victoria have reported positive outcomes when Support Coordination is provided for people with psychosocial disability, particularly for those who require capacity building to help them engage with their disability supports. It is recommended that Support Coordination be offered as an ongoing line item.

The Mental Health Coordinating Council have provided the following narrative from their NDIS online resource 'reimagine today' [4] with regards to participant involvement to achieve positive outcomes from the NDIS:

> Erika is an NDIS participant with psychosocial disability now on her fourth plan. Erika's NDIS third plan included an aspiration to develop a 'safety' (i.e., wellbeing) plan including NDIS funded education for family and service providers to implement it. Feedback is that a 'crisis prevention' (i.e., advance planning) procedure with the local public mental health and primary care providers has now been developed and is working well.

c. the development of the disability workforce to support the emerging market;

A central part of delivering quality psychosocial supports is the workforce, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of reforms that are impacting mental health, including the NDIS. CMHA's 2017-18 Federal Pre-budget Submission[5] recommended a National Mental Health Workforce Strategy be undertaken to develop, support and maintain the mental health workforce. This should include the community mental health sector, the mental health peer workforce, and the primary health workforce.

CMHA's 2018-19 Federal Pre-Budget Submission[6] notes that the Implementation Plan for the Fifth National Mental Health and Suicide Prevention Plan includes the development of a Workforce Development Program to guide strategies to address future workforce supply requirements and assist with recruitment and retention of staff. The inclusion of the community mental health workforce in this Program will be vital, as the various reforms are having an impact on the workforce in community-managed mental health sector. For example, the development of the new disability workforce through the NDIS is not funded and therefore quality is being impacted. This is noted in the Productivity Commission report on NDIS Costs.

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[4] Further information on participants making the most of the NDIS, the resource is available at http://reimagine.today/step-5/thinking-about-my-plan/

[5] CMHA (2016), Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, http://cmha.org.au/wp-content/uploads/2017/06/CMHA-2017-18-Federal-Pre-budget-Submission.pdf

[6] CMHA (2017), Community Mental Health Australia 2018-19 Federal Pre-Budget Submission, http://cmha.org.au/wp-content/uploads/2017/12/CMHA-2018-19-Federal-Pre-budget-Submission-Final.pdf

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There is an impact from the NDIS pricing structure and its relationship to qualified mental health staffing. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, and therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. The key issue is the community-managed mental health sector not only being prepared, but supported to make the transition to the NDIS. CMHA outlined issues identified by the states and territories about market viability in the submission to the Committee's inquiry into the Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition[7], and in the submission to the Productivity Commission NDIS Costs Inquiry[8]. In summary, these issues included:

- The withdrawal of block-funding without adequate transition was impacting the capacity to support people to engage with and access the NDIS.
- It was a 'one-sided market" with fixed prices, supports strictly defined, administrative burdens increased, and a significant information gap.
- Funding is often sufficient only to cover staff salaries at a comparatively junior level (CSW 3 and below). This makes it difficult to retain staff with degree qualifications who are required to effectively deliver programs for consumers with complex needs. The amounts set out in the NDIS Price Guide are not enough to fund complex case coordination or skilled staff particularly once expenses such as developing individual case plans and group programs, travelling time, making and following up referrals and so on have been removed.
- For service providers who are juggling clients with packages and clients without packages there is also a moral and financial dilemma. To survive, providers need to take the NDIS clients attached to higher value packages but this means that other individuals are at risk of delayed or no access to supports.

An issue that has been raised by all state and territories is a high risk of seeing significant market failure across the sector. The NDIS may potentially be faced with an exponentially growing level of disability while at the same time community-based rehabilitation services are experiencing loss of funding, loss of qualified mental health staff and the capacity to provide services the impact of pricing on the development of the market. The possible impacts on the community-managed mental health workforce are:

[7] CMHA (2017), Joint Standing Committee on the NDIS – The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, http://cmha.org.au/wp-content/uploads/2017/06/CMHA-submission-to-Joint-Standing-Commitee-on-NDIS-inquiry-into-mental-health-the-NDIS-Final.pdf

[8] CMHA (2017), National Disability Insurance Scheme (NDIS) Costs – Productivity Commission Issues Paper, http://cmha.org.au/wp-content/uploads/2017/06/Community-Mental-Health-Australia-submission-to-Productivity-Commission-NDIS-Costs-Issues-Paper.pdf

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e: abresnan@cmha.org.au **w:** www.cmha.org.au

- The exclusion of participants with higher needs that require higher levels of staff support from these services, and the withdrawal of service providers.
- The loss of existing skilled and qualified staff and a de-skilling of the workforce. In time providers may well opt to hire the lower-skilled staff they can afford to be able to offer NDIS services. This will impact on recovery-focused psychosocial rehabilitation supports which will develop into generalist disability supports.
- Service providers may choose to only provide low-priced supports if the NDIS participant also purchases higher-priced supports from them, effectively aiming to some degree offset losses on support with profits on another. This limits choice and control and undermines the objectives of the NDIS.
- Withdrawal of service providers altogether from the market. Some service providers, particularly in rural and remote areas, are at the point of imminent withdrawal from the market due to unacceptable losses, which are drawing on already small reserves.

CMHA was pleased to see the Productivity Commission in the NDIS Costs Position Paper note the need for the long-term development of the workforce, however this should include the involvement of all levels of government as the Commonwealth and State and Territory Governments will be impacted by the changes to the workforce that will be brought about by the NDIS.

The CMHA NDIS Workforce Scoping Paper describes seven findings and makes ten recommendations in relation to early identification of NDIS workforce impacts on the community managed mental health sector (see Attachment 1)[9]. Finding 1 states that 'the NDIS has affected the nature of work performed' and is important to the Productivity Commission's costs inquiry and Recommendation 1, to 'Undertake community mental health sector role mapping (i.e., skills, qualifications and pricing) and identify appropriate supports pricing'. This is because roles, functions and pricing for NDIS non-government psychosocial disability support services will be challenging to ascertain without consideration of the complimentary workforce contributions of public mental health and primary health care work settings. The Department of Health National Mental Health Service Planning Framework has undertaken some related workforce considerations that is not yet been publicly released.

CMHA's submission to the NDIS Costs – Productivity Commission Position Paper with regards to 'Market, provider and participant readiness' recommended that particular approaches to encourage a greater supply of disability supports over the NDIS transition period could include:

- Co-operative enterprises developed and led by people with disabilities (within mental health these are often called consumer operated services and programs)

[9] Community Mental Health Australia (2015). Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project. Sydney: Mental Health Coordinating Council.

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e: abresnan@cmha.org.au w: www.cmha.org.au

- Empowering local community driven, social enterprise based customised solutions.
- Embracing a broad diversity of supply solutions.
- Encouraging types of alternative business models to generate viable employment and business solutions for people with disability and to retain the concept of participants owning and driving their own solutions.
- Providing clear market incentives for new entrants. Businesses outside the sector, especially from sectors that provide similar supports such as health and aged care can bring their experience and learnings into the disability marketplace in many cases for the first time.
- Provide block funding to service providers to enable them to train the very low level of disability support worker so that they can provide psychosocial supports at an acceptable level, or increase the hourly rate of supports substantially to enable providers to generate enough revenue to achieve the same.

d. the role of the NDIA as a market steward;

The Productivity Commission in the NDIS Costs Position Paper recommended that:

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA's power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.[10]

The body tasked with price regulation for scheme supports should:

- collect data on providers' characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.[11]

[10] Productivity Commission (2017) National Disability Insurance Scheme (NDIS) Costs, Productivity Commission Position Paper, June 2017. Commonwealth of Australia: Canberra

[11] Ibid

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e: abresnan@cmha.org.au w: www.cmha.org.au

The final report on the Productivity Commission NDIS Costs inquiry reiterated the need for ongoing independence in pricing stating that a body responsible for regulating the price of supports should set price caps in a manner that is:

- transparent with public consultation and publicly available information
- evidence-based
- supported by clear and limited legislative authority
- independent
- timely[12]

It recommended that the proposed NDIS Quality and Safeguards Commission, upon commencement in 2018, be given the authority to monitor, review and report on price caps, and have the power to set price caps transferred to its responsibility by 1 July 2020.[13] CMHA supports the recommendation to transfer price regulation powers to an independent body by 1 July 2019. CMHA included establishing an independent price regulation body for the NDIS as a recommendation in the 2018-19 Federal Pre-Budget Submission[14] and that this should occur as a matter of priority.

CMHA acknowledges and welcomes the Independent Price Review that was announced and is being undertaken by an independent consultant for the NDIA. However, there will remain a significant conflict of interest for the NDIA in being the body that establishes and monitors price, and determines, reviews and monitors NDIS participant plans. It is vital that the regardless of what eventuates with the independent price monitor, the full report and results of the Independent Price Review are made publicly available.

CMHA received a response from the Department of Social Services to CMHA's 2018-19 Federal Pre-Budget Submission. A copy of the letter is attached separately to this submission. The response stated:

> The Government does not consider the introduction of an independent price regulator is required at this time. The NDIA considers that the introduction of an independent price regulator would adversely affect the NDIA's ability to contribute to effective market stewardship.

The response states further:

> This remains in the best interests of participants, whose ability to access reasonable and necessary supports to underpin their having a better life, depends on the development of a vibrant disability supports marketplace.

[12] Productivity Commission (2017) National Disability Insurance Scheme (NDIS) Costs, Productivity Commission Study Report, October 2017. Commonwealth of Australia: Canberra
[13] Ibid
[14] CMHA (2017), Community Mental Health Australia 2018-19 Federal Pre-Budget Submission, http://cmha.org.au/wp-content/uploads/2017/12/CMHA-2018-19-Federal-Pre-budget-Submission-Final.pdf

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As noted above, CMHA considers that while the NDIA has the dual responsibilities of setting prices and the amounts contained in participant's packages, there remains a significant conflict of interest. The best interests of participants and having a vibrant marketplace will be dependent on the Government and the NDIA listening to the expertise of agencies such as the Productivity Commission, the experiences of the sector in the transition process and the experiences of participants, not who retains control on setting the price.

A response to a Question on Notice from the 2017-18 Supplementary Budget Estimates Hearings about whether the NDIA disagreed that there was a conflict of interest in setting the price and managing the scheme as identified by the Productivity Commission and others in the sector, noting this was raised by many people through the processes of the Joint Standing Committee on the NDIS. The response from the NDIA included the following statements:

> The Productivity Commission (PC) raised an important challenge for the National Disability Insurance Scheme (NDIS) in undertaking its market stewardship role alongside its administration of the Scheme.
>
> The NDIA recognises that price regulation is not a lever to manage NDIS spending. Maximum prices are set with reference to the efficient costs of service delivery, which the NDIA can influence but does not control.

The above statement demonstrates a conflict in itself in that while there is specific recognition that price regulation should not managed spending, the NDIA are stating efficiency is setting the maximum price, not the demonstrated needs and complexity of participants. Also stating the NDIA can 'influence' but not 'control' the price seems to ignore the fact that the price they set does control the price paid and established for services and what is able to be provided within those parameters. As noted earlier, CMHA and others in the sector want to work with the NDIA to address these issues, but for that to occur the assumption that service providers are somehow the enemy must end.

e. market intervention options to address thin markets, including in remote Indigenous communities;

The Productivity Commission inquiry into Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform identified remote Indigenous communities as one of the target areas for competition. CMHA's submission to the second stage of the inquiry – the Study Report - questioned the rationale for including services to remote Indigenous communities for consideration is unclear. CMHA agreed with the Productivity Commission's comments that these areas are underserviced, particularly in mental health, and that there are fragmented and complex funding arrangements which create difficulties. The Productivity Commission should be looking at how to build the capacity of existing local services in remote Indigenous communities, and developing an understanding of current services to then identify the gaps and improve quality, equity, efficiency,

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

accountability and responsiveness via this pathway. In remote Indigenous communities adding, building and investing in local people to develop and deliver programs and services needs to be highlighted. This is the same approach which should be taken with the NDIS in other thin markets including in rural and remote areas in general, along with examining best practice.

CMHA submitted an is an addendum to the Study Report submission which highlighted an example of a best practice community-led mental health program model. The example was of a community-developed and community-led mental health program in a community in East Arnhem called Galiwin'ku. Galiwin'ku, a Yolngu community of approximately 2500 people, situated on Elcho Island. The health service – Ngalkanbuy – was managed by the local council until 2008 when Miwatj Health Aboriginal Corporation took over management. Ngalkanbuy provides a 24/7 service and is characterized by the prominent role of local Yolngu in its staffing profile.[15] The Healthy Minds team runs the mental health program. This team undertakes activities such as monthly and fortnightly injections and supervised daily administration of oral medication. The team works collaboratively with families, with much of their work undertaken in the community (rather than in the clinic). They respond to acute situations and people with chronic mental health conditions, this includes responding to overnight emergencies.[16]

The Productivity Commission's Final Report of the competition inquiry acknowledge that effective service provision in remote Indigenous communities required strategies that suit particular circumstances, builds local capacity and enables the communities themselves to influence the services they receive. CMHA reiterated that a better approach would be looking at how you can build the capacity of existing local services and develop an understanding of current services to then identify the gaps, and improve quality, equity, efficiency, accountability and responsiveness via this pathway.

f. the provision of housing options for people with disability, with particular reference to the impact of Specialist Disability Accommodation (SDA) supports on the disability housing market;

The NDIS (Specialist Disability Accommodation) Rules 2016, which came into effect in March 2017, were very much focused on group or congregate living. For any people living with a disability, including people with psychosocial disability, this offers little in terms of 'choice and control' by turning the focus to one type of housing and assumes all people with disability will or will want to live in groups houses. Utilising and amending planning regulations and laws to act a means of encouraging developers to diversify accommodation for people with a disability, may be one means of creating a market or changing the market. This would require the NDIA and Federal Government to work with state, territory and local governments, where the controls for planning laws exist.

[15] Ngalkanbuy health service at Galiwin'ku, Miwatj Health Aboriginal Corporation, http://miwatj.com.au/what-we-do/clinical-services/at-galiwinku/, Accessed 8 February 2017
[16] Ibid

Room 1.06, Level 1, Griffin Centre
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t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

g. the impact of the Quality and Safeguarding Framework on the development of the market;

As noted in (d), the final report on the Productivity Commission NDIS Costs inquiry reiterated the need for ongoing independence in pricing stating that a body responsible for regulating the price of supports, and recommended that the NDIS Quality and Safeguards Commission (the Commission), upon commencement in 2018, be given the authority to monitor, review and report on price caps, and have the power to set price caps transferred to its responsibility by 1 July 2020. The potential wider role for the Commission and the Safety and Quality Framework in terms of price setting or being a part of market stewardship will be dependent on government taking forward this particular recommendation of the Productivity Commission.

With regards to the Quality and Safeguarding Framework (the Framework) and how it is implemented and monitored through the processes of the Commission, it's impact on the market around achieving safety and quality will be dependent on the extent to which it will provide independent oversight and achieve national consistency. This includes how the Commission will fit with existing state and territory schemes such as the ACT Human Rights Commission; Ombudsman offices; Official or Community Visitors; and Public Advocates. There is currently a lack of clarity around this issue.

Under the processes being developed to implement the various aspects of the Framework registered providers will be required to have processes in place, for example, to receive and manage complaints and to provide training on the new processes. These requirements add further compliance costs for providers in addition to those associated with the Code of Conduct and Provider and Worker Screening, and the NDIS does not currently include training and compliance costs in its price structure for providers. The community managed mental health sector is being impacted by, and under extreme pressure to work to adapt to, the implementation of the NDIS and its price structure, and the new compliance measures will add further pressure and impact on service delivery. How these changes are implemented by the Commission and the support that is provided by the Commission, for example in the form of training, guidance and other support, will impact on how the services are supported through the transition and how the market develops.

h. provider of last resort arrangements, including for crisis accommodation; and

CMHA believes that clarity around the arrangements for a provider of last resort need to be determined as a matter or priority between the Federal and State and Territory Governments. This is directly linked to the continuity of support provision – as services a withdrawn or transferred to the NDIS, for example Victoria which has removed all community mental health funding and the transfer of federally funded mental health programs to the NDIS, there will be significant gaps across the spectrum of community mental health services for people both eligible and not eligible for the NDIS. The dual impacts of the loss of programs and funding with the potential withdrawal of services for people with psychosocial disability in the NDIS is an issue that must be confronted along with who will be the provider of services when those services no longer exist.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

CMHA supports the point made by the Productivity Commission in the NDIS Costs Position Paper that the NDIS was not expected to fill all service gaps. We also do not want to create a situation where some people receive a high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not. The NDIS was never meant to and cannot replace the mental health system. As CMHA stated in several submissions and forums, the interface between the NDIS and mainstream services and the gaps that will be created for mental health in the transition to the NDIS are some of the most significant and concerning issues for the community-managed mental health sector.

CMHA agrees with the recommendation of the Productivity Commission in the NDIS Costs Position Paper that until the interface issues and associated boundaries are settled, it is important that governments do no withdraw from services too quickly. CMHA agrees with the point made by the Productivity Commission in the NDIS Costs Position Paper that with the agreement between the Commonwealth and State and Territory Governments to provide continuity of support, there is considerable confusion and uncertainty about what this actually means in practice. The experience of the community managed sector is that it simply shifts the responsibility to provide support to the sector without any funding to do so and this is not sustainable. This is where providers may withdraw from and the provider of last resort may be required. CMHA also supports the recommendation that the NDIA should report on boundary issues and that there should also be mandatory reporting by all governments on the number of people covered by disability support programs pre- and post-NDIS.

In addition, the Federal Government has said that if Commonwealth mental health program clients 'choose' not to make an NDIS access request there will be no continuity of support and these people's needs will be the responsibility of state and territory governments. Where a person's 'choice' is linked to their psychosocial disability (i.e. cognitive behavioural impairments), this cost-shifting stance is of great concern and not consistent with Australia's obligations under the UN Convention on the Rights of Persons with Disability.

To date, there has been no clear articulation by any Government Department or the NDIS about what continuity of support actually looks like in practice, or what the provider of last resort would look like and who this provider would be.

i. any other related matters.

None to raise.

Conclusion

Key issues for the community mental health sector with market readiness include market viability, the price structure of the NDIS and adopting the recovery approach of the sector within the NDIS structure. The sector has developed responsive recovery-oriented models of support and practice over many

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years, and has developed a workforce that is appropriately qualified and skilled to deliver this support. A recovery approach is aligned to the objectives of the NDIS.

The key issues to highlight from this submission include:

- The Mind the Gap project and report undertaken by University of Sydney in partnership with CMHA found that in some instances NDIS participants were unable to implement NDIS plans as the services were not available. This was particularly in the following contexts missing services particularly those able to deal with complexity; weekend services; Rural and remote services; appropriate staff not available in particular Aboriginal workers; Lack of service funding for travel. Some of stakeholders described the non-government service provision system being on the brink of collapse.
- The issue that many people, particularly people with psychosocial disability, will require support coordination over their lifetime. This may vary in the level of need, however, this need will always be there.
- The potential role for peer workers to assist people in navigating the NDIS. Peer workers should be supported to apply for leadership roles and not restricted to intermediary or support roles. They should be able to work consistent with peer work principles and practices and be supported as an integral part of the overall NDIS workforce and recognised as such, including in terms of salaries and conditions.
- A central part of delivering quality psychosocial supports is the workforce, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of reforms that are impacting mental health, including the NDIS. The Implementation Plan for the Fifth National Mental Health and Suicide Prevention Plan includes the development of a Workforce Development Program to guide strategies to address future workforce supply requirements and assist with recruitment and retention of staff, and the inclusion of the community mental health workforce in this Program will be vital, as the various reforms are having an impact on the workforce in community-managed mental health sector.
- Approaches to encourage a greater supply of disability supports over the NDIS transition period could include:
    - Co-operative enterprises developed and led by people with psychosocial disability.
    - Empowering local community driven, social enterprise based customised solutions.
    - Embracing a broad diversity of supply solutions.
    - Encouraging types of alternative business models to generate viable employment and business solutions for people with disability and to retain the concept of participants owning and driving their own solutions.
    - Providing clear market incentives for new entrants. Businesses outside the sector, especially from sectors that provide similar supports such as health and aged care can

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bring their experience and learnings into the disability marketplace in many cases for the first time.

- Provide block funding to service providers to enable them to train the very low level of disability support worker so that they can provide psychosocial supports at an acceptable level, or increase the hourly rate of supports substantially to enable providers to generate enough revenue to achieve the same.

- CMHA included establishing an independent price regulation body for the NDIS as a recommendation in the 2018-19 Federal Pre-Budget Submission and that this should occur as a matter of priority.
- In addressing thin markers, such as in remote Indigenous communities, adding, building and investing in local people to develop and deliver programs and services needs to be highlighted. This is the same approach which should be taken with the NDIS in other thin markets including in rural and remote areas in general, along with examining best practice.
- Utilising and amending planning regulations and laws to act a means of encouraging developers to diversify accommodation for people with a disability, may be one means of creating a market or changing the market. This would require the NDIA and Federal Government to work with state, territory and local governments, where the controls for planning laws exist.
- With regards to the Quality and Safeguarding Framework and how it is implemented and monitored through the processes of the Commission, it's impact on the market around achieving safety and quality will be dependent on the extent to which it will provide independent oversight and achieve national consistency. How the changes are implemented by the Commission and the support that is provided by the Commission, for example in the form of training, guidance and other support, will impact on how the services are supported through the transition and how the market develops.
- CMHA propose that clarity around the arrangements for a provider of last resort need to be determined as a matter or priority between the Federal and State and Territory Governments. This is directly linked to the continuity of support provision. The dual impacts of the loss of programs and funding with the potential withdrawal of services for people with psychosocial disability in the NDIS is an issue that must be confronted and who will be the provider of services when those services may not be there. To date, there has been no clear articulation by any Government Department or the NDIS about what continuity of support actually looks like in practice, or what the provider of last resort would look like and who this provider would be.

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