# SUBMISSION TO THE REVIEW OF THE NDIS

## 14 JULY 2023

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# Contents

# Introduction

This submission focusses on the needs of people living with a primary or secondary of psychosocial disability (PSD). CMHA notes and supports submissions prepared individually by our members and by:

- Mental Health Australia (MHA)
- The Australian Psychosocial Alliance (APA)

The sector's key desired changes resulting from the review include:

1. Evidence of measurable improvements in quality of life of people living with psychosocial disability, both those who are eligible and ineligible for the NDIS.
2. Equity of NDIS access and plans outcomes.
3. A strengths-based approach to eligibility assessment.
4. Enhanced flexibility in the use of NDIS packages and longer recovery plans to reflect the episodic nature of PSD as well as the diverse and unique experiences of people living with PSD.
5. A greater level of exercise of choice and control by NDIS participants with the NDIS pricing model adequately covering the costs of training staff or enabling service providers to build worker competency in supported decision making.
6. People with psychosocial disability who are not eligible for the NDIS are able to access the supports and services they need and prefer.
7. People living in regional, rural and remote areas are able to access supports both through the NDIS and outside of the NDIS.
8. The NDIS works for First Nations people living with PSD and First Nations communities and community-controlled organisations are empowered to provide a range of disability supports including cultural healing and cultural activities.
9. A specialised psychosocial disability workforce is developed and the PSD knowledge and skills of the overall disability support workforce are increased.
10. The NDIS pricing model is restructured to adequately recognise the complexity of and the skills and expertise required to provide, disability support for people with psychosocial disability.
11. The psychosocial disability knowledge and skills within the NDIS and NDIA are increased and there is greater utilisation of a PSD lived experience workforce.
12. The roles and responsibilities of all Australian governments in relation to providing disability support to people with PSD and their families and carers are clarified and all Australian governments opt into fulfilling their responsibilities.

# About CMHA

Community Mental Health Australia (CMHA) is the coalition of states and territory peak community mental health organisations and provides a voice for several hundred community-based non-government organisations working to improve the mental health and wellbeing of people living with mental health conditions, their families, and carers and for all Australians.

### CMHA Coalition

- Mental Health Coalition of South Australia
- Mental Health Community Coalition of the ACT
- Mental Health Coordinating Council NSW
- Mental Health Council of Tasmania
- Northern Territory Mental Health Coalition
- Queensland Alliance for Mental Health
- Western Australian Association for Mental Health

# About the Community Mental Health Sector

The Community Mental Health Sector is a network of Community Managed Organizations (CMOs) that promote and provide a wide range of mental health and psychosocial support within local communities across Australia. This sector emphasizes accessibility, prevention, early intervention, and holistic approaches to mental well-being and a range of practical supports for a wide range of social determinants. The sector is a vital part of civil society. Many CMOs were originally founded by people with lived experience and CMOs are a major channel for the growth of the peer workforce. Over the past several years, with the introduction of the NDIS and the demise of many other mental health and wellbeing services outside the NDIS, the sector has been under considerable stress and data indicate that its number have declined considerably.

# Equity of Access and Plan outcomes

Mellifont and Hancock et al (2023) provide a thorough analysis of the barriers to applying to the NDIS for people with psychosocial disability. Their thematic analysis points to the following barriers:

- "*social inequities acting as barriers to applying*
- *stigma, trauma and previous negative experiences*
- *barriers to finding supports needed to apply*
- *challenges understanding the relevance of the Scheme; and*
- *experiences and symptoms of mental illness extend and exacerbate barriers*." (p,262)

Members have emphasised the cost/affordability of out-of-pocket expenses for required assessments as a key barrier to people applying to the NDIS. In the NT for example, the problem is compounded by lack of lack of GPs, psychiatrists and allied health professionals as well as the provision of culturally safe and appropriate pathways for remote First Nations communities.

The Mental Health Coalition of SA reported in their NDIS Transition Pilot Project (2020) found that "*NDIS Planning was reported to be inconsistent and at times inequitable*". The report concluded that clients of

State psychosocial programs were more likely to engage with the NDIS when the following service principles applied:

- "*Clients received advocacy support from State psychosocial non-government organisation (NGO) support workers, public mental health service (MHS) clinicians, and carers, to negotiate the NDIS process and gain eligibility*
- *Clients were supported by State psychosocial providers (with carers if possible) at NDIS planning meetings*
- *There was open communication and cooperation between key service stakeholders, carers and NDIS Planners, working together with the client to develop NDIS Plans*
- *State psychosocial NGO support workers and NDIS support providers worked collaboratively to ensure effective handover periods involving face to face meetings with clients;*
- *State psychosocial NGO support workers continued to work side by side with NDIS Support Coordinators* to mitigate gaps in service." (pp. -7)

**Recommendation 1:** That the Scheme's application and planning processes be redesigned through a genuinely co-designed approach to ensure responsiveness to the expertise of and insights into people living with psychosocial disability.

## A strengths-based approach to eligibility assessment

Kate Anderson and Darryl Selwood (2023) argue that to become an NDIS participant, assessments of permanent disability that:

"…. *focus on a person's deficits can put them in a vulnerable and confronting position. Re-assessments may even impact mental health."*

NDIS participants once assessed as having a permanent disability, should not have to justify that they still need their packages. Participants should not have to prove upon review that they are "*disabled enough*." Nor should they have to imagine their "*worst day"* when detailing the support, they continue to need. Such practices may lead to further detrimental impacts on mental health.

Anderson and Selwood provide an example of how a strengths-based approach might be adopted within the NDIS.

"*While a "worst day" description could indicate that NDIS participant "Maggie" is unable to shower independently or maintain personal hygiene, a strengths-based assessment would highlight the following: With the aid of a shower chair and an adapted loofah, Maggie can work towards her goal of bathing safely and independently, while still acknowledging that occasional assistance may be required."*

CMHA agree with the recommendation of Anderson and Selwood that:

"*Revised assessment protocols that celebrate strengths and account for social barriers could scaffold a more collaborative and empowering approach to decision-making across the scheme.*"

**Recommendation 2**: That assessment protocols be inclusive of a person's strengths as well as social barriers to achieving personal goals.

**Recommendation 3:** That assessment protocols incorporate a trauma informed approach and to require recovery-oriented language.

## Plans and packages are tailored to individual need

CMHA members support flexible and adaptable plans and packages that are tailored to individual need and the episodic nature of psychosocial disability. Recommendations of the Queensland Alliance for

Mental Health (QAMH) and the Australia psychological Alliance (APA) to this review capture the type of changes required.

**Recommendation 4**: That a flexible plan funding approaches for people with psychosocial disability be developed involving the preapproval of funds enabling stepping down and stepping up with the reservation of funds for periods of higher need.

**Recommendation 5**: That in developing an adaptable and flexible funding approaches the NDIA partner with rural, remote and First Nations communities to ensure the approaches are suited to the unique needs and challenges of these communities.

## A greater level of choice and control exercised by NDIS participants with PSD

Our members note there are likely to be a very large number of people with primary PSD who currently have limited ability to articulate their support needs and hence limited capacity to exercise choice and control as intended by the NDIS. As the MHCSA states in its submission to this review:

"*There are significant risks identified for this cohort of not only harm but also that NDIS will fall short of the vision intended for people to recover and better enjoy their human rights*."

**Recommendation 6**: That funding approaches for plans for people with (PSD) encourage greater flexibility between Core and Capacity Building support items.

**Recommendation 7**: That supported decision-making be viewed as a key workforce competency necessary for supporting NDIS participants and that the pricing model adequately covers the necessary staff training. (See MHCC and MHCASA submissions)

**Recommendation 8:** That the NDIA provide adequate support and resources to enable providers to implement the new NDIS Supported Decision-making policy.

## A sufficient supply of accessible Disability supports and services for NDIS participants with psychosocial disability

Our members note with concern the large number of NDIS plans that can't be implemented due to a lack of supports and services for people with psychosocial disability. A variety of actions have been recommended to the review including the conduct of a market scan to identify what is and isn't available and the introduction of new and appropriately priced psychosocial disability specific support items. These and other recommendations require urgent consideration by the NDIA.

**Recommendation 9**: That the NDIA acts to ensure a sufficient supply sufficient supply of accessible disability supports and services for NDIS participants with psychosocial disability and to address the problem of thin markets.

# The gap in Psychosocial disability Support outside the NDIS is addressed

The mental health and wellbeing service ecosystem should offer a full range of available supports[1] with all the necessary components to achieve positive fully individualised outcomes[2].

Currently, such alternatives do not exist at the scale and level required. As part of the implementation of the National Agreement of Mental Health and Suicide Prevention the extent of the unmet need for psychosocial support in each jurisdiction with the result anticipated in March 2024. Based upon previous Productivity Commission estimates (2020) the number of people living with significant mental health issues who are not receiving support either from the NDIS, PHN or State/territory services is 155,000[3].

The dilemma is: Excluding people living with significant psychosocial disability from suitable supports is a violation of their human rights[4]. But inclusion of these people within the NDIS would place an unsustainable strain on its resources thus the necessity of a suitable Tier 2 option(s)

**Recommendation 10**: That the gap in Psychosocial Supports outside the NDIS be urgently addressed by all Australian Governments.

**Recommendation 11**: A national discussion should commence to consider the principles and features of a future Tier 2 Psychosocial Support Program

Appendix 1 outlines some design principles for a future psychosocial support program outside the NDIS (regardless of who or how it is commissioned) could/should include.

# Disability supports for people living with PSD are Integrated and coordinated

People are integrated biopsychosocial beings. Their health and capacity building may be inhibited because a particular need or issue (e.g., lack of appropriate psychiatric and allied health support) goes unaddressed.

Our social and health service architecture is not integrated; it is disparate and unevenly distributed[5]. Connecting people up to the right service has three key barriers:

- Availability (absence, affordability, accessibility, cultural appropriateness, etc.)
- Lack of help seeking behaviour (see Reports from the ACDC Project)
- Lack of effective referral and service coordination.

[1] This should include addressing key social determinants, such as housing, welfare, inclusive education and employment, social inclusion, connection and opportunities for meaningful contribution, etc.

[2] Such as the SCORE (Standard Client Outcomes Reporting) model developed by DSS. This Framework incorporates Outcome Domains for improved circumstances (social determinants), capacity building, and service satisfaction, with a very wide range of specific outcome measures (tools) that can be selected and for each individual.

[3] Recent estimates (Productivity Commission, 2020) are that approx. 280,000 people live with significant psychosocial disability, about 55,000 are in the NDIS and approximately 70,000 receive support though state and PHN programs.

[4] United Nations Convention on the Rights of Persons with Disabilities (CRPD), states that all people with disabilities have a right to receive the necessary supports to enable them to "*attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life".*

[5] This is because the arrangement develops over time based upon slowly evolving population needs, triage of limited resources and the need for "divisions of labour".

Fragmentation has long been reported on and several, largely unsuccessful, solutions tried[6]. NDIS Local Area Coordinators and Support Coordinators being recent attempts7. Integration and coordination is required at three levels

- Between service providers
- With the broader mental health system
- Services outside of the NDIS

**Recommendation 12**: That the NDIA codesign pilots with providers of recovery-oriented psychosocial supports to enable effective coordination between the person living with psychosocial disability and providers ensures that participants receive personalised and holistic support through a cohesive, evidence-based care plan for the person. See APA recommendations in NDIS Review submission p.19). Alternatively, the role of Recovery Coach is expanded to cover this function.

**Recommendation 13**: That a whole of Government approach be established through the aligning of bilateral agreements in the National Mental Health and Suicide Prevention Agreements with a view to better integrating and coordinating systems and supports for participants nationally. (See APA recommendation in submission to Review, p.30)

# Skilled workforce supply, recruitment and retention

There is a significant evidence regarding the qualities and skills needed by NDIS workers (e.g., Recovery-Oriented Psychosocial Disability Support Report) to better meet the needs of people with psychosocial disability. Several stakeholders have reported that the skillset is sparse in the NDIS workforce. This is reflected in the current levels of participant outcomes.

Despite the deserved criticism of some providers, the supply and distribution of quality providers able to do the above is essential. The recruitment, support, training and development, and retention of workers with the appropriate skills is key to shaping a future NDIS to better meet the needs of people with psychosocial disability and achieve greater recovery outcomes. This is largely a consequence of the both the overall business model (fees for items of service) and the pricing of those items.

Our members have also noted the need for increased specialist PSD skills and knowledge within the NDIS and NDIA.

**Recommendation 14**: That priority is given to building psychosocial expertise and skills within the NDIA and externally with partners and support provides (See APA recommendation in submission to Review, p.27; QAMH, pp. 22-23; MHCSA entry level training core supports recommendation).

**Recommendation 15**: That NDIA partner with rural, remote and First nations communities to build capacity of community-controlled organisations, families, carers and community members to provide supports to people with psychosocial disability.

**Recommendation 16**: That the NDIA explores alternative funding models and pricing to better support recovery-oriented outcomes and to enhance skilled workforce supply and sustainability.

[6] The Hon. Mark Butler said in a 2013 Media Release announcing Partners in Recovery "The last thing people with severe mental illness, their families & carers need is to battle with multiple service systems. PiR is designed to pull together services like income support, housing, employment, medical care and education which can often lack coordination."

[7] Similarly Head to Health Centres are being established with the goal of service coordination and assisting people with mental health issues in accessing of appropriate services.

# The NDIS Business model for the provision of Psychosocial disability support is viable

The current NDIS "business model" [8] makes it very difficult, if not impossible, for quality NDIS providers to fund services without making a sustained financial loss.

**Recommendation 17**: That the exploration of alternative funding models and pricing include a review of price limits for relevant support items to reflect the higher complexity involved with psychosocial disability support provision as well as to incentivise investment in the provision of psychosocial disability support (see QAMH recommendations p. 21; APA recommendations p. 27)

# Measuring outcomes

Despite the rising cost of the NDIS, data collection on outcomes or providers of is limited and inconsistent across jurisdictions. For participants with psychosocial disability, outcomes should include addressing key social determinants, such as housing, welfare, inclusive education and employment, social inclusion, connection and opportunities for meaningful contribution, etc. One relevant measure is the SCORE (Standard Client Outcomes Reporting) model developed by DSS. This Framework incorporates Outcome Domains for improved circumstances (social determinants), capacity building, and service satisfaction, with a very wide range of specific outcome measures (tools) that can be selected and for each individual.

**Recommendation 17**: That outcomes for NDIS participants with psychosocial disability be appropriately and regularly measured and reported.

# Research and Development

The example of the many reviews[9] and modifications of employment services in Australia (Job Network to Workforce Australia) shows that adjustments within the framework of the original model, look like solutions, but turn out to be not. Tinkering with the current NDIS architecture may or may not lead to real change and to the bolder changes that are required. Whilst policy and architectural changes are occurring as a result of this review, an accompanying process of research and development is required to ensure discernible and measurable change to the quality of life for people participants with psychosocial disability.

Recommendation 18: That a program of PSD research and development is set up to (a) explore new thinking for wicked NDIS problems; (b) select some ideas for concept testing; and (c) fund and evaluate a range of pilot projects designed to sustainably improve outcomes for example:

i) assertive outreach and advocacy
ii) coordination of support between services;
iii) coordination support teams for participants
iv) rethinking plan reassessments and reviews.

# Buy in from all Australian governments

Our members note how state and territory governments have increasingly reduced their "buy in" to supporting people with psychosocial disability. This situation must be remedied. CMHA repeats its recommendation that bilateral agreements in the National Mental Health and Suicide Prevention Agreements be revised to facilitate and enable people with psychosocial disability whether they are eligible or not eligible for the NDIS to receive the support and services they need and prefer.

[8] "Business Model" means the configuration of all NDIS services for participants and their associated payments.
[9] Workforce Australia Review

# Appendix 1 Draft principles and criteria for a future psychosocial support program outside the NDIS

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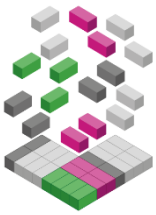
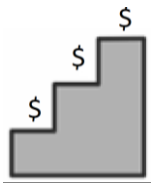
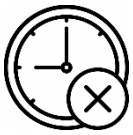
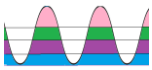
|---|---|
|  | 1. Incorporate recognised good practice criteria. Criteria recognised in international evidence-based literature includes being holistic; person-centred; empowerment and recovery-focused; trauma informed AND a workforce able to deliver on these criteria |
|  | 2. Co-design with people with lived experience, family/carers, representatives of all diversity groups, service providers and all key stakeholders |
|   | 3. Build Capacity. T2-PSP should be designed from the ground up, to support recovery and capacity building:<br>i) So that its incentives, for both provider and participant, encourage the above<br>ii) To consist of modular evidence-based components, that can be tailored to suit local conditions, communities, and stakeholders[10].<br>iii) By reviewing, borrowing and improving upon the many positive elements of previous Commonwealth programs, such as the *Personal Helpers and Mentors (PHaMs)* program and *Partners in Recover (PiR)* that were defunded to support funding the NDIS. |
|  | 4. Build the Lived Experience Workforce. An opportunity for T2-PSP is to:<br>i) Require minimum numbers (or %) for a Peer/Lived Experience Workforce<br>ii) Provide a benign spiral, enabling service recipients to transition to support workers (i.e., participant to peers, as in the *Recovery College* model). |
|   | 5. Provide an adequate level of resourcing. To achieve the above outcomes, attract and retain the necessary workforce and be a workable alternative to NDIS supports T2-PSP should not be an order of magnitude less in its offering or resourcing. If T2 is well constructed, the lifetime cost per participant may be considerably less. The step down from NDIS supports should be a stepped care continuum not a 'cliff'[11]. |

[10] These could include components like the Recovery College Model (with peers as trainers); the Clubhouse Model (ensuring it is adequately resourced to include a full and varied "work ordered day" and a "transitional employment program"); and IPS (Individual Placement and Support).

[11] T2 should not be just waterholes around the "oasis in the desert" (Bonyhady), nor a lifebuoy ring outside the "only lifeboat in the ocean" (Shorten).

| | |
|---|---|
|    | 6. Outreach. T2-PSP should incorporate outreach in **two ways**:<br>i) Proactive Outreach: To locate and connect with people who may be eligible for T2-PSP, but are isolated and not engaging in "help-seeking" behaviours, such as recently trailed in Mental Health Australia's Community Connectors program for people who were homeless; and the Proactive Outreach approach in Community Mental Health Australian's Assisting Communities through Direct Connection (ACDC) Project.<br>ii) Assertive Outreach: Maintain connection and support T2-PSP participants in the community or at home, as an alternative to requiring people to visit a centre. Interacting with people in the context of their lives greatly increases understanding of barriers and opportunities, and the ability to affect these. |
|  | 7. Outcomes: A holistic and individually adaptable Outcomes Framework be adopted that includes a range of valid & reliable tools that can be selected in consideration of each individual's unique circumstances, needs and goals[12]. An example of such a model is the Commonwealth DSS SCORE framework. |
|  | 8. Open Door for entry with delayed eligibility testing. T2-PSP should have an open entry pathway while still having eligibility criteria. For example, the previously mentioned PHaMs program had a three month "getting to know you" period, during which an eligibility screening was done rather than depending upon one off Functional Assessment Eligibility Tool at the initial encounter. |
|  | 9. No time limit. Just as the NDIS now accepts that mental health issues may be episodic but with an underlying permanent vulnerability, T2 should be available for as long as deemed necessary for a person. The knowledge that supports are available when needed may be the very reassurance that helps underwrite an individual's ongoing stability. |
|  | 10. Levels of support. It is suggested T2-PSP incorporate various levels of support, that participants can shift through as their needs require. Consideration could be given to implicit program incentives, so that participants choose to go to lower levels of support when appropriate. The lessons from the NDIS, that seems to have created the opposite incentives (for providers and participants), should be learned from. |

[12] NOTE: The lesson arising from several decades of experience with programs like DES (Disability Employment Service) is that T2-PSP should not incorporate a payment for outcomes model. Such a model damages relationships, trust and incentivises wrong practices. For example, as noted by Professor Jerry Muller in "The Perils of Metric Fixation", when the New York Health Services introduced scorecards for cardiologists, which publicised their surgery mortality rate, many doctors stopped operating on sicker, riskier patients.

Instead, careful market stewardship that incorporates a range of evaluations that for example SCORE makes possible (including monitoring progress towards improving circumstances, capacity building, service satisfaction, etc.) can cultivate over time a healthy and high-quality provider market.

# References

Mellifont, D., Hancock, N., Newton Scanlon, J & D. Hamilton 2023, Barriers to applying to the NDIS for Australians with psychosocial disability: A scoping review, *Australian Journal of Social Issues,* Vol 58, Issue 2, pp 26-278

Mental Health Coalition South Australia 2020, *National Disability Insurance Scheme Transition Pilot Project*, Final Report, Funded by the Office of the Chief Psychiatrist, Department for Health and Wellbeing (SA)

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