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Submission to the Joint Standing Committee on the NDIS: Market Readiness

Mental Illness Fellowship of Australia (MIFA) is a federation of long-standing member organisations, established in 1986. Our members deliver specialist services for individuals living with severe mental ill-health and their carers, friends and families, out of nearly 60 'front doors' in metropolitan and regional areas, to over 20,000 people each year. Our membership has a strong focus on building community, valuing peer support and lived experience, and supporting recovery. We have substantial experience delivering specialist, place-based, community-building programs to those experiencing mental illness, and over 50% of our workforce has a lived experience as a consumer or carer; as such, we feel we are well placed to assist the Joint Standing Committee on the NDIS in its inquiry into market readiness in the NDIS, and we welcome the opportunity to provide our input.

Impact on service providers and service provision

The transition to market based individualised funding under the NDIS has resulted in significant challenges for psychosocial support providers, and consequently significant impacts on services available for people with mental health issues and their carers. Pressures have been felt from delays in transition and unpredictable market uptake, the shift in models of service provision, and unrealistic NDIS pricing. These pressures have resulted in significant numbers of redundancies, service contraction from certain services; and service contraction from certain areas, particularly rural and remote regions. Some providers have or will be forced to exit the NDIS market altogether.

The financial impacts of the transition to the NDIS on psychosocial support providers must not be underestimated. MIFA member One Door Mental Health reported a $1.238m loss in 2017-18, 21% of their equity, and commenced 2018-19 with a potential projected loss of $2.6m, 58% of their remaining equity. This jeopardises service provision to extremely vulnerable people, some of whom have worked with that organisation for many years.

Funding uncertainty and transition to the market

Service providers have taken on the bulk of the risk of the transition to the NDIS, providing a high amount of unpaid or underpaid support to participants applying for the NDIS, and drawing on reserves to manage delays in transition and unpredictable market uptake. Staggered cuts to funding and overly ambitious transition targets have caused significant financial stress to service providers administering existing programs. Some reprieve has been offered where service providers have been able to re-negotiate block funding contracts, however, many organisations are loss-leading to support the short-fall in income while waiting for pre-existing participants to gain access to the NDIS. Slower transitions have been due in part to lower than predicted levels of client eligibility for the NDIS, significant barriers for people choosing to apply, extremely slow

processing of applications on the part of the NDIA, and high numbers of people choosing not to apply for the NDIS. The uncertainty has stalled incentives for co-investment and limited desire to make capital investments.

The transition pressures are further increased by the fact that the bulk of staff, administrative processes, infrastructure, and practice models from previous programs are not viable in an NDIS environment. Transitioning staff has been difficult with the unrealistic cost pressures under the NDIS. This has resulted in many redundancies and resignations, and consequently, a major loss of institutional memory and organisational stability, and an increase in human resources and recruitment costs. The shift to billing and payments in arrears has resulted in massive changes to administrative processes, and cash flow challenges for not-for-profit organisations with typically small cash reserves. Furthermore, significant investment is required from service providers up-front to enter into the market, including staff training, marketing, and new financial, IT and client management systems, and investment in financial management expertise. All of these required investments have added to the financial pressure of transition.

Pressures have been exacerbated by the recently emerging evidence of individual support packages being cut drastically at one year reviews. This has meant service provider revenue projections have been over-estimated, therefore jeopardising budgetary processes and making it difficult to predict or invest in the emerging market.

Although transition support programs exist, service providers have received very little support on an individual basis to undertake business modelling, up-skill in financial management, support the development of new administrative systems, and/or fund new technology. In addition to these pressures, sharing across the sector is decreasing due to competition and expansion of service areas, thereby reducing the ability to leverage off knowledge capital and shared resources within the sector.

More funding is needed to assist service providers to adapt to NDIS, including providing in-house business re-design and modelling services, and grants for back-end adaptations including investment in technology.

Existing program funding must not cease until all clients are transitioned to the NDIS or Continuity of Support programs. The money should "follow the participant."

Service pressure and closures

Service providers report extreme pressure on transitioning services which do not fit within the model of the NDIS, to the point of imminent or completed closure of certain services. These pressures have arisen due to a combination of issues with the kinds of services individualised

packages will fund, and the viability of offering these services. These pressures have made it particularly difficult for services to continue to provide welcoming community drop-in spaces and one-off referral, information, support and service navigation programs; group programs; carer support services; and programs for clients transitioning from hospital or forensic mental health facilities. Within programs that have service elements compatible with the NDIS transition, there has still been a loss of other service elements within those programs, including:

- Flexible, low-barrier entry criteria
- Flexibility in type, range and length of supports offered
- Timely and crisis-responsive
- Assertive outreach and assertive engagement approaches
- Cross-sector collaboration and systemic advocacy

There have also been significant issues providing services in rural and remote areas, which will be covered in a later section.

Information, support and referral

Many service providers have reported increasing difficulty providing one-off information, support and referral to people with a lived experience and their carers. This is deeply concerning as incidental, as-needed, brief support and service navigation has been a core part of service provision in the consumer, carer and peer driven movement, alongside more ongoing and long-term support programs. There are national and State-based information services which provide telephone support, but do not have the local connections needed to provide locally relevant referrals or peer-support networks. Some participants strongly benefit from centre-based drop-in style supports: people with psychosocial disability often prefer face-to-face contact with a trusted organisation, and also experience significant isolation and additional barriers to accessing information, such as lack of internet, discomfort with telephone conversations, or literacy issues.

This service gap was identified by MIFA members, who formed a consortia alongside additional community partners to provide the *MINetworks* national service guarantee. *MINetworks* provides welcoming 'front-doors,' where staff and volunteers (of whom up to 80% have a lived experience) are available to provide information, brochures, brief support, and referral and service navigation services, leveraging off local hospital, primary care and allied health relationships and knowledge. The network also provides the same services via an integrated telephone line, diverting to the most local provider.

Information and referral provision was frequently built into other block-funded programs, enabling MIFA members to provide these services on a local level, whereas NDIS service provision does not enable service providers to provide specialist entry or gateway supports. Individualised funding in hourly supports does not provide adequate corporate overheads for maintaining

accessible and welcoming locations, or adequate flexibility for people dropping in at short notice and for short amounts of time. Some information and referral services have been funded under the Information, Linkages and Capacity Building (ILC) block grants, however, these programs are not nationally consistent and the current level of ILC funding is vastly inadequate to provide nationally consistent services in this area for people with psychosocial disability, especially given ILC funding must be split between all types of disability. Additional funding from non-NDIS sources to provide these services is inconsistent and often short-term. The roll-out of the NDIS has seriously jeopardised MIFA member ability to continue to provide essential brief information, support and referral services as an integrated part of other group, peer, and one-on-one support programs.

The Local Area Coordinators (LACs) are tasked with providing information about the NDIS and pre-planning support, however, this is different to incidental support for people who are newly diagnosed or struggling with mental health issues generally, and seeking locally relevant, specialist support, information, referral and service navigation for the full range of mental health issues.

Group programs

The NDIS pressures have also impacted on the provision of group programs, due to inadequate margins in the NDIS pricing to allow for maintaining premises, and pressures caused by cancellations. Group programs are more successful where service providers have access to premises at subsidised rates, either subsidised public building leases or access to community neighbourhood premises. This essentially represents a cross-subsidisation across sectors to the NDIS market, therefore success in this sense does not imply that the current pricing is adequate. Group programs are further jeopardised by the high levels of cancellations in the psychosocial disability sector. The NDIA must consider adopting alternative funding models for individualised support with greater flexibility to ensure provision of group programs is viable. Without block-funding or increased flexibility, many centre-based group services are facing closure.

Carer support programs

Carers need a range of supports, including information, referral, peer support groups, counselling and one-on-one support. This is particularly important as often carers are the first to reach out, and can be instrumental in encouraging consumers to access services (noting that around 54% of people with mental ill-health do not seek help)[1]. There is emerging evidence that NDIS planners are failing to properly consider the needs of carers when formulating plans, and participants,

[1] Whiteford, H., Buckingham W., Harris, M. et al. (2014). 'Estimating treatment rates for mental disorders in Australia.' *Australian Health Review* 38(1): 80-5.

planners and support coordinators may not always recognise or value the needs of carers. As a result, carer support programs, including information, support and referral, peer support groups, and carer respite services (beyond indirect respite) are reducing under the NDIS.

Clients transitioning from hospital or forensic mental health facilities

Service gaps are also emerging as a result of lack of clear delineation of responsibilities between 'mainstream services' and the NDIS, in particular, health. This is particularly evident for clients who are in-patients of hospitals, including forensic consumers. For forensic consumers, the process of integration back into the community often begins with day leave and gradually overnight leave. In New South Wales, these supports were previously funded through a combination of State health funding and NDIA funding. This staged exit is essential for the treating teams to be able to approve conditional discharge, however the experience on the ground in NSW has been that the NDIA is no longer funding escorted overnight leave for forensic consumers without a conditional release date. Without NDIS funding for overnight leave, these consumers will not be able to be integrated back into the community.

Psychosocial support under the NDIS

There is a need to adapt the expectations and understandings of the type of NDIA supports provided by psychosocial services, towards a greater understanding of how recovery-oriented services function, and an understanding of the capacity building and case management role required for people with psychosocial disability. These adjustments relate not only the core price and the balance of core to capacity building elements in a person's plan, but also to the method of funding, the design and delineations of roles, and the definition of line items. Many psychosocial support providers believe alternative models of funding or alternative line items are required for psychosocial disability to allow for recovery-oriented support, proper wrap around case management, risk and incident management. Funding needs to account for variations in support provision and the integrated nature of support provision (as opposed to separation into discrete tasks by different levels of workers). Flexibility in individualised funding for psychosocial support and group supports could be provided through alternative funding arrangements such as subscriptions, memberships, bulk buying of support incidences in advance, full 'course' fees, and/or much more lenient cancellation policies.

Block-funding services outside the NDIS, and alternative individualised funding models (such as subscriptions or up-front bulk-buying of support incidences, etc.) is required to ensure essential programs and service elements are not lost in the transition.

Inadequate cost estimations in pricing

Current pricing under the NDIS is unviable for psychosocial service providers. The Reasonable Cost Model (RCM)[2] fails to acknowledge the true costs of providing psychosocial disability support to individuals with serious mental illness, many of whom are extremely vulnerable to self –harm, misuse of medication, mood instability and addiction to legal and illegal substances; and who face poverty, challenges with tenancy, offending behavior and disengagement with services.

The implications of the current pricing for psychosocial services are potentially the exclusion of participants with higher needs that require higher levels of staff support from these service, or 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.

There are a number of flawed assumptions within the RCM[3], and cost drivers that do not appear to be adequately taken into account. These include:

- An underestimation of staff costs
- An overestimation of the minimum safest ratio of staff to supervisors, and the required expertise level of supervisors, and staff time to engage in supervision
- An overestimation of percentage of client-facing time that is viable
- Unrealistic allowance for corporate overheads, and flawed assumptions that overheads will decrease.
- Inadequate loading for rural and remote areas

Underestimation of core staff costs

The modelling for staff costs under the NDIS does not account for the level of training required for psychosocial support and supervision of psychosocial support work; increases in staff costs over time; the increasing casualisation of the workforce; and the need for incentives in rural and regional areas.

The original cost modelling indicated core supports would be provided by a worker classified at

[2] NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

[3] p12, NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

SCHCADS Level 2. A higher level is required due to significant client complexity; and an increasingly mobile workforce resulting in less supervision. Classification Level 2 SCHCADS suggests staff will work under regular supervision, will have ready access to assistance, and have limited scope to exercise initiative[4],[5]. This does not reflect the expectations of an increasingly mobile, unsupervised workforce, where workers are expected to work alone and one on one with clients with complex needs and requiring high level of risk management abilities.

MIFA members report that the absolute minimum skill level and experience of employees servicing all participants with psychosocial disability is a Level 3, with minimum Cert III or IV. Most service providers require their staff to hold additional certification across several areas, including responding to suicidality, identifying trauma, responding to aggressive behaviour, and in some circumstances First Aid. MIFA members reported that pre-NDIS, most staff were Level 4s, and some were level 5s. The National Mental Health Standards also require that staff receive regular ongoing professional development for a range of issues, including consumer engagement, working with carers, cultural diversity, and responding to aggressive behaviour.

Further pressures are experienced by the impact of increases from the the Equal Remuneration Order pricing and for some Queensland providers, the Fisher pay equity order rates, which mandate hourly rates of between $2 to $5 more than providers under the modern Award. It is expected these rates will eventually reach parity, but in the meantime, affected providers are facing severe pressures operating in the NDIS market. This is particularly concerning as some such providers, such as MIFA member Selectability, provide essential and important services to some of the most vulnerable people in rural and remote Aboriginal communities. There are additional staff costs associated with service provision in rural and remote areas that will be addressed later.

Furthermore, the modelling should be based on a casual rate. Given the nature of the NDIS and the control and autonomy given to participant, there is a high risk in employing support staff on a permanent basis, even part time. A participant may change their mind and want a different support worker and or change in provider, or go on holidays at short notice, meaning the risk of these costs of paying staff during these times is too great for organisations.

The core price for support is further unviable due to mandatory Award Level increases over time. The level cost modelling was based on pay point 1, whereas the SCHCADs Award allows for mandatory increments over time and so on average, the workforce will sit at a pay point 3.

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[4] Schedule B, *Social, Community, Home Care and Disability Services (SCHCADS) Industry Award 2010*. Available at: http://awardviewer.fwo.gov.au/award/show/MA000100#P1116_93973

[5] p44, Cortis, N., Macdonald, F., Davidson, B. and Bentham, E. (2017). *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*. Available at: http://apo.org.au/system/files/98111/apo-nid98111-354151.pdf

Core staff costs should be modelled from a minimum of SCHCADS Level 3.3 - Casual rate in psychosocial support services, and should account for costs of ongoing professional development.

Underestimation of level of supervision required

The cost model further underestimates the level of supervision required in psychosocial services: the modelled Award level of supervisors is too low, and the ratio of supervisors to staff too high. Inadequately low levels of supervision fail to account for the significant risks of psychosocial service provision, including the risk of death of a client from suicide; other risks to clients from poorly supervised practice; and risk of harm to workers from aggressive behaviour, or harm through vicarious trauma from over-exposure without suitable supervision. Risks are exacerbated by staff being increasingly mobile (removing opportunities for incidental supervision); and due to cost pressures, increasingly underqualified to identify or manage risks. The skills of supervisors and the ratio of supervision intensifies where general staff are less qualified or experienced, and/or where case complexity increases. The level of supervision also does not account for peer support workers, who sometimes require higher levels of support but also bring invaluable expertise to the workforce.

Current supervision levels assumed in the RCM contradict Award conditions[6], both due to the expectation for a Level 2 staff to function too independently, and the expectation for a Level 3.3 to supervise 15 (up to 18 post-transition) staff members in a complex environment. Supervisors must have the skills to manage complexity and risk, and have enough time (and therefore fewer supervised staff) to allow for increases in supervision during critical incidents.

Pricing under the NDIS must provide for adequate supervision in a complex service provision environment, accounting for both the level of experience of supervisors and the ratio of staff to supervisors.

Overestimation of viable percentage of client-facing time

The RCM projected client facing of 75% to 85%, with post-transition "efficiencies" gained by moving (ex-leave) client-facing time to 85% to 90%. Many MIFA members have made significant changes to their service provision model to adapt to the extremely tight operating margins of the NDIS and unrealistically low amount of non-client facing time factored in, however, even with extreme efforts to increase "efficiency", this expected percentage of client-facing time is highly

[6] p44, Cortis, N., Macdonald, F., Davidson, B. and Bentham, E. (2017). *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*. Available at: http://apo.org.au/system/files/98111/apo-nid98111-354151.pdf

unrealistic and reflects a lack of understanding of the type and complexity of psychosocial disability support provision.

There are several non-client facing activities that require non-client facing time. These include activities standard to any kind of support work: administration and reporting; formal professional development time; staff meetings; and staff travel time (particularly with an increasingly mobile staff). However, the non-client facing time required is even higher levels in situations with complexity, and with the added issues of shorter lengths of support and cancellations.

Time for supervision, professional development and risk management

Psychosocial support staff require non-client facing time to engage in adequate supervision, which encompasses both formal, informal and group supervision, as well as critical incident debriefing and support. The requirements are higher for workers newly graduated or new to the organisation, and professional standards also require minimum supervision times for workers with certain qualifications which may be additional. With increased complexity of support, staff require more time to participate in professional development and risk management activities, including incident reporting.

Rostering and staff travel

MIFA members report it is often impossible to schedule all clients back-to-back. Perhaps in contrast to other disability supports, people with psychosocial support needs often only require one hour of support at a time. This creates additional staff time throughout the day in travel, corporate staff time in rostering and scheduling, and makes back-to-back scheduling more difficult. This also presents a significant issue for the casualised workforce where minimum shifts in many circumstances are 2-3 hours long under the SCHCADS Award.

MIFA members report significant issues filling early morning shifts, and significant staff time taken between appointments waiting for the next appointment or unable to fill a time slot opened up by a cancellation. These realities must be factored into the buffer available in pricing,

Cancellations

Cancellations present a massive challenge under an hourly pricing market-based pricing model. While the NDIA allows for a certain number of cancellations, these are not adequate to account for service provision to people with psychosocial disability, who often require an assertive outreach approach and additional leniency to account for the impact of their condition. People with psychosocial disability are likely to disengage completely and be un-contactable, or ask that appointments be changed or postponed to a day when the person is feeling better able to benefit from the support. One psychosocial service provider conducted a worker time use analysis and found up to 1 hour of cancellations for every 4 billable hours. For a medium-sized psychosocial

support organisation, this can amount to 50 – 90 hours a week of cancellations. Managing cancellations requires additional rostering administration support, and impacts severely on the ratio of billable to non-billable hours.

If services were to implement harsher cancellation rules, such as ending service contracts with people after the 6 billable cancellation hours have been exceeded, the main person disadvantaged will be the person with disability. This does not recognise that a major part of supporting people with psychosocial disability is continuing to support them even when they disengage, and meeting them where they are at.

Care team meetings

Care team meetings related to specific individuals with either external stakeholders, support co-ordinators and treating teams, or internal care team meetings, should always be approved as billable time and therefore not relevant for non-client facing time. However, MIFA has heard reports that payment for such meetings have been denied to some service providers. If liaison with external stakeholders, or internal care team meetings are not billable, these must be factored in as additional time for non-face to face time. The National Mental Health Standards has a requirement that that service providers regularly work with other members of the treating team and engage in case management. It is imperative that all members of the team working with a participant have the opportunity to liaise as a team, and contact other stakeholders to share information and plan supports.

Expectations around client-facing time in cost modelling must be adjusted to reflect the full range of non-client facing activities required in psychosocial support.

Unrealistic estimation of corporate overheads

The assumption that costs will reduce through gains in efficiency in the transition to the NDIS has not borne out in practice. The NDIS has introduced inefficiencies into support operations in the following areas:

- Direct support staff time taking in administration of individual contracts (Service Agreements)
- Line-item billing, which is administratively intense. For example, an organisation working with 80 people each with 5 or 6 support categories and items each day will need to account for anywhere between 200 and 500 support items. This is exacerbated by inefficiencies in the technology of the NDIA. Line item billing has required additional investment in software and financial management systems, as well as additional direct service worker time on administration and an increase in administration and claiming staff.

- Intake staffing costs, which were formerly considered part of a program, but do not form part of core service provision under the NDIS. Intake staff are needed to assess participant needs and match participants with the right worker. Intake staff also often provide information, referral, and support. While some of these supports may be offered by Local Area Coordinators, community based mental health operates on the principle of no wrong door. People must be able to approach any service that provides mental health support and receive information about supports available and referral to other services if different supports are needed (as noted above around services closing due to the NDIS).

- Rostering staffing costs, due to the need for more complex rostering processes and liaison with clients around appointment-setting, which is not factored into core service provision under the NDIS. Participants require support with bookings, changing appointments and booking reminders. Many participants do not distinguish between support staff and administration staff, so administration staff can end up providing incidental brief support to participants who may be lonely or in a crisis and therefore must have a level of training. Some organisations have created a new "rostering clerk" position which was not previously needed.

- Advertising and marketing infrastructure due to the move to competitive marketing environment, which also disadvantages small, grassroots organisations without comprehensive communications machinery

- Mobile staffing costs, including increases in costs for staff mileage, and need for new technology including staff mobile phone & tablet usage (to some extent offset by decrease in costs for office space). The Award requires staff reimbursement for vehicle use including travel between participants.

There are number of hidden cost drivers in corporate overheads which do not appear to be adequately accounted for in the NDIS prices, including the cost of quality assurance and accreditation, program monitoring and evaluation, consumer & carer engagement and good governance, all of which are prescribed by the National Mental Health Standards. Given the level of risk management and high-quality assurance standards required of service providers, and the costs of administering NDIS services, many service providers agree that 20- 30% overheads are much more realistic.

The genuine cost of administration, quality and risk management, monitoring and evaluation, governance, marketing, technology, and carer and consumer engagement must be factored into allowances for corporate overheads.

Transition to deregulated market

Service providers have mixed views about whether the lack of viability in NDIS pricing could be ameliorating by a shift to deregulated pricing. Some service providers feel fixed prices are stalling progress, as low prices do not enable service providers to reflect the true costs of service provision; others feel that providers are not ready for the NDIS, let alone market prices.

NDIS prices must be increased immediately to account for the true cost of psychosocial service provision, with regular ongoing independent reviews to ensure pricing does not cause market failure.

Thin markets, including in remote Indigenous communities

In addition to the issues with pricing referred to above, the rural and remote area remuneration needs to increase to encourage the market in rural and remote areas. Particular cost pressures experienced in rural and remote areas, and provision of support to Aboriginal and Torres Strait Islander communities in remote areas, include:

- higher staff costs due to the need to attract and retain staff, while competing with similar higher-paying roles in government agencies and in mining industries. For example, Fly In Fly Out (FIFO) rates for an administration officer in remote mining towns may start on $70,000, well above the clerks Award wage. Service providers report that entry-level wages to attract staff in some rural areas are frequently over a Level 5 SCHCADS. Furthermore, offering relocation and training packages are often required to attract staff.
- significantly increased transport costs; vastly higher travel time and staff mileage cost. Worker time-use analyses have shown travel is on average 20 – 30 minutes per billable hour; in rural and regional areas, this can often increase to an hour or more. Noting that in addition to distances required in these areas, some participants do not wish to access local workers due to confidentiality issues in small communities, and therefore request workers from further afield.
- the need for more specialised and trained staff who understand rural and remote differences, can work independently, and have cultural training where language and cultural differences exist.
- additional corporate overheads associated with remote premises.
- staff housing requirements.

The areas included in the Modified Monash Model Areas do not account for the fact that increased costs and travel distances can be experienced even in areas not considered very

remote. MIFA suggests that rural and remote area loading should be extended to include Modified Monash Model areas 4 and 5, or alternatively, a more locally responsive approach to assigning rural and remote pricing and loading should be adopted. This could include supporting providers to review business models and identify cost drivers, and then responding with tailor-made supports to maintain the market. Pricing may need to adapt to local pressures.

MIFA further suggests that training and relocation worker allowances may need to be either built into the price or offered as additional remuneration for services in rural and remote areas. A rural and remote rural workforce strategy is required to support upskilling of people already living in rural and remote areas. This is essential to market stewardship and development of the disability workforce

Where thin markets continue to exist, block-funding Providers of Last Resort may be necessary.

Addressing thin markets requires a range of strategies, including increasing prices for rural and remote areas, providing additional grants and incentives to support services and develop the workforce, and expanding the areas considered rural and remote.

Participant readiness to navigate new markets

There is significant evidence to suggest that participants are not being adequately supported to participate in the NDIS market. This includes a lack of support insofar as hearing about and understanding the Scheme; applying for access; attending planning meetings; understanding the plan they have received; and implementing their plans. The Participant Pathway review, including the development of a specialist psychosocial disability participant pathway, is a welcome innovation.

Research indicates that around 54% of people with mental ill-health do not seek help[7]. Up to 30% of participants in current programs are refusing to apply,[8] and psychosocial disability has the highest rate of rejections for access requests[9]. This presents a significant issue for service system planning and policy; with over half of the target population not presenting to services, and a significant proportion struggling to self-advocate, it follows that a reasonable percentage of

[7] Whiteford HA, Buckingham WJ, Harris MG, et al. Estimating treatment rates for mental disorders in Australia. Australian Health Review 2014; 38(1): 80-5.
[8] p4, One Door Mental Health (2017). Post- Paper Submission 266 to the PC Review of NDIS Costs Position Paper, Available at: http://www.pc.gov.au/__data/assets/pdf_file/0018/219321/subpp0266-ndis-costs.pdf
[9]p15, Joint Standing Committee on the NDIS (2017). Provision of services under the NDIS for people with psychosocial disabilities related to a mental health conditio0. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Report

resources must be dedicated to supporting help-seeking behaviour and reducing barriers for access.

MIFA member experience is that participants who are supported by mental-health specialists to understand the NDIS, gather evidence, complete their access request form, and attend planning sessions are more likely to be found eligible and receive much higher packages than those acting alone – even where the impairments and support needs are equal. This suggests a gap in the information and support currently available to applicants, such that participants are turning to existing psychosocial services and carers to understand what the NDIA needs and navigate its complex and bureaucratic processes. While it is clearly important to ensure those applying are genuinely in need of the benefits provided under the NDIS, the application process places significant pressure on those applying, and their support team. Currently specialist service providers are drawing on other resources to facilitate access for people into the NDIS. The level of NDIS "success" in granting access, which often relies on this behind-the-scenes high level support, and also requires regular use the appeals process, is not sustainable. This is a failing in the way the NDIA is supporting applicants with psychosocial disability.

There are several barriers specific to people with psychosocial disability that impact their readiness to participate in the market-based NDIS system, including:

- The problematic need to self-identify as having a disability, and one that is (or likely to be) permanent, which has been shown to deter some people from applying.[10]
- The inability to access NDIS supports without committing to the full process, which creates a barrier for those who may be a contemplative stage[11] of understanding their need for support and wanting to explore options only.
- Lack of trust in service systems due to previous poor experience with services, or functional impairments in psychosocial disability which can include confused thinking, delusions and paranoia, or lack of awareness of their own condition. This can result in significant disengagement from the services system.

[10] It is for this reason, among others, that MIFA advocates removing the requirement for permanency in the NDIS in the context of psychosocial disability.

[11] For information about the Stages of Change model of intervention, see Queensland Health (2007). *Stages of Behaviour Change,* https://www.health.qld.gov.au/__data/assets/pdf_file/0026/425960/33331.pdf

- The burden of stigma, shame and fear of disclosure in the context of mental illness and how this may impact on an individual's desire to go through the invasive assessment process.
- The impact of the disability symptoms themselves on the assessment and planning process, such that those with anxiety and trauma may require significant support to prepare and attend assessment appointments in which they are exposed to strangers and may feel threatened, judged or vulnerable. Gathering and providing evidence can be triggering, and service providers report significant resources are devoted to supporting the process of gathering documents and attending appointments.
- Difficulties with literacy, concentration and appointment-keeping, which affects ability to participate in access, planning and plan implementation.

People with psychosocial disability require significant pre-planning support and assertive outreach from services who have deep understanding of the system. The best strategies go beyond public campaigns and information provision, and into dedicated pre-planning, assertive outreach and assertive engagement processes. These services need to be integrated with other kinds of supports, so that a "no wrong door" policy exists where participants prefer to connect to a previously known provider (rather than connecting with a completely different, non-mental health specialist service).

Furthermore, MIFA has heard many stories of participants receiving plans with little to no induction or explanation from the planner, making it nearly impossible for participants to implement their plans without significant assistance from mental health specific services. This is made impossible where plans do not include support coordination. It is widely considered by the sector that support coordination should to be an essential and ongoing part of plans. To readily participate in the market, participants must be adequately informed and supported. MIFA has strong reservations about the ability of Local Area Co-ordinators (LACs) to fill the gap in pre-planning and assertive outreach needs in the future, given in many areas they are only just commencing roll out, their already large area of responsibility (both planning and networking), and their lack of specialist psychosocial expertise. Specialist mental-health participant readiness schemes in some areas have been highly successful and should continue to be funded.

MIFA welcomes the specialist NDIA psychosocial pathway, and advocates it including:

- Assertive outreach, long periods of active engagement and participant readiness programs led by or in conjunction with specialist existing services with visibility, diagnostic-specific expertise, and pre-existing connections with the community.
- The ability to develop a recovery-oriented plan over time.

- Ongoing support coordination, to support ongoing goal-setting, the implementation of the plan, and preparation for plan reviews.

There is a clear and urgent need for additional specialist services to support those who are disconnected or struggling to apply for and implement NDIS plans.

Assertive outreach and engagement practices and significant pre- and post-planning supports need to be integrated into nationally consistent LAC and NDIA processes, supported by specialist mental health service providers.

Market stewardship and quality management

Even though the NDIS is intended as an un-capped, entitlements-based service system, the NDIA also has actuarial responsibilities to manage costs and ensure sustainability of the scheme. It is MIFA's opinion that this represents a conflict of interest which creates a risk that non-evidence-based and non-rights-based decision-making might occur within the NDIA. It is the responsibility of Government to fully fund the scheme, based on accurate epidemiological predictions, in line with the intent of the NDIS Act; it is not the responsibility of the NDIA to manage costs in this regard. Internal pressure to reduce costs may manifest in restricted access decisions; lower amounts awarded in plans or unfair reductions in plans at review; price-setting that reflects economic constraints while compromising on quality and safety; and low incentives to manage thin markets due to unclear boundaries between service systems. It is for this reason that the independent Quality and Safeguarding Commission is an important development, and an independent price regulation body should be established. Mechanisms must be in place to ensure the following:

1. The prices must reflect the true cost of quality service provision and should not motivated by "efficiency" and cost-saving;
2. Access decisions and plan inclusions must be based solely and completely on participant entitlements, with no pressure or consideration for scheme cost-management;
3. Quality must be prioritised over cost, and at the same time quality monitoring mechanisms should be streamlined to reduce administrative burden to service providers. This may include cross-recognition of quality assurance accreditation under different standards, such as the National Mental Health Services Standards for psychosocial disability support providers;
4. Timely and nuanced market information, including disability-specific and sub-regional analyses, application and rejection rates, plan contents and outcomes data, should be available to the public; and

5. Management of thin markets should include collaboration across governments and between sectors, and resourcing for workforce development and training, incentives for workers and providers, and block-funding where necessary.

If the combination of roles under the NDIA cause resourcing issues, conflicts of interest or poor performance in the above regard (as has, to some extent been evidenced to date), then MIFA advocates separating out functions to independent bodies as appropriate. MIFA has concerns about the NDIA's lack of transparency, poor communication, lack of resourcing, and lack of psychosocial disability expertise, although we recognise the NDIA is working on improvements.

MIFA notes that success in terms of market stewardship should not just be measured in lowered costs or "increasing efficiency", or an increase the number of providers registered to operate under the NDIS; rather, success should be measured by how many organisations are actually providing services, and providing services that are high quality and improve outcomes for participants.

Governance of the Scheme should be guided by evidence for the effectiveness of a recovery approach in achieving the objectives of the Scheme, which by nature will result not only in a reduction of costs over time, but an increase in social and economic participation, choice and control, and strong relationships. MIFA has ongoing concerns that despite the Scheme's intent, it is continuing to operate from a deficit, functional disability approach rather than an approach based on investment in independence, recovery and community participation.

It is imperative that tensions between economic viability, and the implementation of a quality, recovery-oriented market, are adequately managed. Mechanisms to achieve this could include an independent pricing body, alongside a strong focus on evidence-based practice and quality service provision.

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Disclaimer

This submission represents the position of MIFA. The views of MIFA members may vary.