Anglicare Australia
in every Community

Submission to the Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with a psychosocial disability relating to a mental health condition

27 February 2017

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About Anglicare Australia

Anglicare Australia is a network of 36 independent local, state, national and international organisations that are linked to the Anglican Church and are joined by values of service, innovation, leadership and the Christian faith that every individual has intrinsic value. Our services are delivered to one in 26 Australians, in partnership with them, the communities in which they live, and other like-minded organisations in those areas. In all, over 13,000 staff and 9,000 volunteers work with over 940,000 vulnerable Australians every year delivering diverse services, in every region of Australia.

Anglicare Australia has as its Mission "to engage with all Australians to create communities of resilience, hope and justice". Our first strategic goal charges us with reaching this by "influencing social and economic policy across Australia…informed by research and the practical experience of the Anglicare Australia network".

Contact Person

Roland Manderson
Deputy Director
Anglicare Australia
PO Box 4093
Ainslie ACT 2602

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Introductory remarks and summary of key issues

Anglicare Australia welcomes the opportunity to contribute to this inquiry. It comes at a pivotal stage in the development and implementation of the NDIS. In our view fundamental questions relating to the provision of services for people with psychosocial disabilities are unresolved, and require urgent attention. Further, it is essential that while these issues are being resolved, funding for community mental health programs must continue.

By far the biggest issue is that of unmet need. It is expected that 90% of people with psychosocial disabilities and many thousands of carers will not be covered under the NDIS.[1] While it is essential that the eligibility criteria for the NDIS are urgently clarified, doing so will not change the lack of funding for the level of services required to support Australians with psychosocial illness and disabilities and their families and carers, regardless of where that service is located (within the NDIS, or in the community, or clinical care pathways).

This unmet need is also distracting from a focus on ensuring preventative mental health services are properly resourced.

Complexities and uncertainty also remain regarding services for people with psychosocial disabilities who are eligible for the NDIS. It is becoming increasingly clear that the NDIS is likely to be insufficiently resourced to provide the level of service people with severe and persistent psychosocial disabilities need. The scheme's orientation around physical disabilities is also undermining the viability of successful mental health recovery model approaches, including continuation of successful peer-based and group recovery services, as our evidence suggests that they are best supported by block funding.

These issues strongly reinforce the need for national and regional coordinated oversight of mental health services in Australia, foreshadowed as a critical gap in the draft Fifth National Mental Health Plan, and now manifest.

This submission incorporates comments from Anglicare South Australia, Sydney, Tasmania, Southern Queensland and The Samaritans. We have additionally attached the responses and case studies provided by Anglicare South Australia (Attachment 1) and Anglicare Sydney (Attachment 2) as they provide a richness of detail and insight into the complexities of the issues identified under the Terms of Reference. We trust they will be read in full. In addition to our responses to the Terms of Reference, we also draw the inquiry's attention to our comments in our submission to the draft Fifth National Mental Health Plan, regarding the implications and risks associated with the transition of mental health services into the NDIS (Attachment 3).

[1] Mental Health Australia , (2016) *The Implementation and operation of the psychiatric disability elements of the NDIS: a recommended set of approaches.*

The eligibility criteria for the NDIS for people with a psychosocial disability

While the NDIS ostensibly endorses the recovery model of mental health, in practice there is a fundamental disconnect between the program's eligibility criteria and best practice. In particular the requirement for a psychosocial disability to be both severe and permanent significantly narrows eligibility, contradicts the known episodic nature of many severe forms of mental illness, and directly challenges a recovery framework for treatment.

Anglicare Australia fully supports the recommendation of Mental Health Australia on the steps that need to be taken to urgently clarify eligibility for people with a psychosocial disability under the NDIS, as made in their submission to this inquiry.

In addition to these broader issues around eligibility, more clarification is also needed in regards to eligibility through the transitioning of existing services. One of these relates to people with a psychosocial disability who are eligible for NDIS, and approaching the scheme's age limit of 65. Anglicare Sydney have raised this issue, pointing out that they are finding it hard to ascertain whether people near the age of 65 in the NDIS with a psychosocial disability will be allowed to retain services once they turn 65, and what alternative services they will be able to access if they don't require residential care.

The transition of short and long-term Commonwealth and state and territory funding from existing mental health services to the NDIS

Anglicare Australia network members share strong concerns that there is no clarity regarding how services for people with a psychosocial disability who do not qualify for the NDIS will be funded and delivered. It is well-established that without a substantial overhaul of eligibility and targeting the NDIS will only provide services to around 10% of the identified need. Therefore the perceived intention of the Commonwealth and state and territory governments to transfer the bulk of existing funding for community mental health services to the NDIS can only realistically result in a critical lack of services for the vast majority of people with a psycho-social disability.

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

…PHaMs has been classified as 100% in-scope for NDIS, however, a participant audit of our PHaMs services indicate that the clinical 'psychotic' disorders anecdotally deemed 'in-scope' for NDIS such as schizophrenia, bipolar and schizo affective disorder account for approximately 30% of participant's diagnosis. Depression and anxiety, often experienced together, account for nearly 70% of client's diagnosis. Our two PHaMs services support 150 participants at any one time with

a waiting list of up to six weeks…. Defunding current community based mental health services will generate a significant gap in service delivery, resulting in increased acute presentations to emergency facilities, including emergency departments, homeless shelters and prisons (where we know people with mental illness are already over-represented).

Anglicare Sydney, who also deliver PHaMs have comparable experiences:

Under the current test of eligibility, people have to have a 'permanent and significant type of disability' but for many people with mental health issues or psycho social disability, the nature of their illness is episodic and not on-going which would disqualify them from access to NDIS supports although they are currently receiving block funded supports. This is a particular issue for those people currently receiving psycho social support in the PHaMs program who experience episodic illness but not permanent functional disability.

Similarly, the PIR Tasmania consortium which Anglicare Tasmania leads asks:

In Tasmania, it has been agreed that the vast majority of federal and state government community mental health funding is being cashed out to fund NDIS, but not all those Tasmanians living with mental health conditions are eligible for NDIS Individual Funding Packages. So, which systems, funded by who are responsible for ensuring those Tasmanians with mental health conditions who are not eligible for NDIS packages receive the clinical and community support services they need?[2]

Another cohort requiring particular attention is carers. As Anglicare Sydney states:

Mental Health Australia estimates that there are 153,600 mental health consumers whose carers require ongoing support and who may not receive future supports under the NDIS. Anglicare Sydney notes that funding is being progressively reduced to carer support programs but many of the people for whom they care will not be eligible for an NDIS package leading to significant gaps and shortfalls in service delivery to these families.

Aside from the most pressing question of providing for unmet need outside the NDIS, Anglicare Australia believes that critical holistic service delivery, effective group therapies and social capital will also be lost if community based mental health services are largely discarded. Anglicare Australia network members consistently demonstrate the value of evidence-based community-based mental health services delivered via block funding. They support a large number of people with moderate illness, provide continuity in case management, keep people connected to their communities and their support networks, work with them to manage their fluctuating health needs, and reduce the demand on acute tertiary health systems.

It is difficult to see how the NDIS will be financially viable if the services that assist the vast majority of people with low to moderate psychosocial disabilities are defunded, consequently leading to an increase in numbers of people with severe and persistent cases requiring much more expensive support. Both Anglicare Sydney and Anglicare South Australia have provided detailed evidence and case studies in their attached comments

[2] See PIR Tasmania's submission to this inquiry

(Attachments 2 and 3) that demonstrate the value of community-based mental health services.

If defunded, social capital and knowledge of effective approaches that has accumulated through community mental health services may well be lost. Anglicare South Australia, for example, is concerned about the long-term viability of their proven peer learning and group programs through the NDIS, as the individualised approach of funding services threatens such effective collective approaches.

For the transitions of PHaMs and PIR that are underway, Anglicare Sydney notes that they are proceeding slowly because the NDIA (National Disability Insurance Agency) does not appear to have sufficient resources to carry out assessments and planning in a timely fashion. This is also manifesting in the form of rushed and poor planning processes which are discussed in detail below.

The scope and level of funding for mental health services under the Information, Linkages and Capacity (ILC) building framework

Anglicare South Australia notes:

From our experience, one of the original intents of the ILC was to provide funding for services that are best suited to block funding, i.e. their viability and model of service would be compromised under an individualized funding arrangement, such as peer support programs or innovative services which have evolved from block funded programs (such as Anglicare South Australia's Mental Health Respite service) which offer dual support for both participants and carers.

Yet in practice none of our members are aware of any funding under the ILC being committed to mental health services. This reinforces our view that there cannot be a reliance on ILC funding to fill significant gaps for mental health service provision through the NDIS, and again highlights the need to continue to fund community services. Anglicare South Australia concludes:

The ability for ILC and Local Area Coordinator (LAC) funding to fill the gap in supporting individuals ineligible for NDIS is to-date unproven. If the responsibility for 'case coordination' for people ineligible for NDIS falls entirely to LAC's, the system will fail for the following reasons (i) no new capacity is being created in mainstream or community services to support this cohort; and, (ii) some of these people will have high and complex needs that require intensive, specialist support that exceeds LAC's ability for case coordination.

The planning process for people with a psychosocial disability and the role of primary health networks in that process

Anglicare Australia network members are finding that current planning processes in the NDIS are proving to be a poor fit for people with a psychosocial disability. We are also concerned that these issues reflect insufficient staffing and resource support for NDIA staff. This is resulting in compromised access including the exclusion of carers and specialist support workers from the planning process; rushed planning processes; and inadequate and inconsistent plans.

Access to the NDIS for people with a psychosocial disability is being compromised by systems that fail to recognize that the type of support and style of access they need differs significantly from those of a person with a physical disability. For example, cognitive barriers and social isolation are significant impediments for people with a psychosocial disability trying to apply; therefore their ability to access the assessment and planning process is often reliant on the presence and commitment of a carer or support worker, not least because it takes significant time and resources to apply – as much as 22 hours[3].

Strong rapport and a trust-based relationship are essential for many people with a psychosocial ability with their support worker. Anglicare South Australia state:

…Significant time is needed to support people with psychosocial disabilities to understand and engage in the necessary steps to access NDIS – combined with barriers such as transport, social isolation, anxiety etc, there is a very high probability that referrals will not be pursued to the extent required to engage many of the target cohort.

While our members understand why the principle of limiting the role of service providers in planning exists in the NDIS, this blunt approach is not helpful for people with a psychosocial disability, who often take a long time to build rapport and trust with a support worker, and wish to have their assistance in the planning process. By limiting their role, our members are concerned that it increases the risk for and vulnerability of some cohorts, particularly those who are socially isolated or have limited family/support networks.

The policy also seems to be over-riding the expressed wishes of people being assessed. Samaritan staff report:

The person receiving support ticks the box that asks 'NDIS to contact my support worker first' and the contact details are provided but the support worker is never contacted by NDIS. Staff discussed that generally what happens in this scenario is that the person requiring support does not realise that they have actually been through a planning process and end up with a plan that does not meet their needs and they don't know what to do with because they have not been adequately supported.

[3] See Anglicare Sydney's full comments in Attachment 2.

Relatedly, Anglicare Sydney reports that carers are being excluded from the planning process, resulting in inappropriate plans and carers feeling disempowered. They provide a case study of the experience of one carer for two people with disabilities in their comments in Attachment 2.

The reliance on phone calls as the primary means of communicating through the planning process, and staff who may lack specialist training and don't have the capacity to build a rapport with applicants with psychosocial disabilities is compounding these concerns. It is compounded by concerns that some Local Area Coordinator staff in addition to lacking capacity and resources, also lack experience in working with people with a psychosocial disability. For example The Samaritans Foundation relate that:

Staff overwhelmingly report that they have found that removing planning meetings and replacing them with phone calls has been detrimental for people with a psychosocial disability. It is our clients who identify difficulties in phone communication and would prefer face to face meetings yet these do not seem to happen often enough where they are needed. Staff indicate they believe that planners not being able to physically see people are missing important cues they would receive with face to face meetings, for example poor personal hygiene or other physical indicators such as tics or repetitive movements.

The systemic issues with the planning process for people with psychosocial disabilities is resulting in our members' staff regularly seeing inadequate plans, and plans that provide inappropriate services that undermine mental health recovery processes; inconsistent plans for people with similar diagnoses and needs resulting in real inequities of service provision; and a high rate of plan review. With reviews often taking months rather than the stipulated two weeks the result is people in limbo without access to services critical to their health and wellbeing. It also has the perverse outcome of imposing significant administrative burden on the NDIA because their staff seem to be inadequately resourced to develop appropriate methodological approaches and carry out proper assessment and planning for people with a psychosocial disability. Also of concern is anecdotal evidence of an increase in plans for people with psychosocial disabilities not including Coordination of Support funding, but only support connection. This is unrealistic for services expected to provide intense resourcing to ensure support connection.

With regard to Primary Health Networks, we repeat here our remarks on this issue to the Fifth Draft Mental Health Plan:

"We are concerned about the ability of PHNs to connect people to the community based services that are said to be fundamental to their care, particularly as the PHN guidelines rule out the commissioning of non-medical services. Indeed, there is no substantial discussion of partnerships with community organisations, only the acknowledgement they may be involved in shared client pathways."

Whether spending on services for people with a psychosocial disability is in line with projections

Anglicare Australia believes that there is already evidence that funding within the NDIS is likely to be insufficient for eligible people with psychosocial disabilities in the scheme, or at least the pricing methodology is inadequate. This needs to be examined with regard to projections. Anglicare Sydney commented:

For those participants who are eligible for a package there are concerns from the agency perspective that the funding model will be inadequate. The pricing scale does not represent the skill level required to provide the support for people with complex mental health issues. It requires workers with a significant level of skill and experience – usually a SCHADS level 4 not a level 2 – otherwise there are people who are not really skilled or trained appropriately dealing with complex clients.

Anglicare Tasmania, as consortium leader for Partners in Recovery has raised the same concern:

"….Consortium members are finding that NDIS line item costings are not viable for the mental health sector. Current pricing is based on SCHADS 2, which is commonly used within the general disability sector, rather than SCHADS 4, which is more commonly offered for specialist mental health support workers. Our consortium members are losing about 50% an hour on any given NDIS line item, or having to compromise on the service offer; for example, one member is either offering participants a less qualified worker, or half the hours of service specified in their plan with a specialised worker. Longer term, this may lead to market failure and severe consequences for community-based rehabilitation…"[4]

The role and extent of outreach services to identify potential NDIS participants with a psychosocial disability

Given that people with psychosocial disabilities are often isolated or face other barriers such as cognitive difficulties, outreach services are essential for recognising and reaching people in need. Anglicare network members across the country have concerns that outreach services to identify and support people with a psychosocial disability are at risk or are weakened through the NDIS. Anglicare SA commented:

[Outreach] is particularly challenging in an NDIS environment, where workers' transport is poorly funded, and providers are facing severe financial restrictions in accommodating transport without putting pressure on participants or workers to personally absorb transport costs. AnglicareSA

[4] Partners in Recovery Tasmania submission to this inquiry.

believes current pricing arrangements will reduce the viability of outreach, which further marginalizes participants who are socially or physically isolated. This could also incentivise providers to take advantage of workers, which could act to further marginalize one of Australia's lowest paid and increasingly insecure (by way of casualisation) group of workers.

Examples of how outreach works in practice from The Samaritans Foundation in Newcastle demonstrate the importance of recognising that outreach to people with psychosocial disabilities often comes about from them accessing other community services:

…Primarily how people with a psychosocial disability access our services is through mainstream services providing outreach to vulnerable communities for example through our Tenant Participation & Resource Service that works with social and community housing tenants. This service connects with tenants who have no access to support. Generally workers are coming into contact with the tenants because their tenancy is at risk as they are unable to meet their tenancy obligations; this is often related to their psychosocial disability."

Anglicare Sydney have also raised concerns that particularly vulnerable groups of people who may be lost within the new system without concerted effort, such as culturally and linguistically diverse (CALD) communities. They note:

In … Sydney we have a number of hidden carers under the old system in the CALD community for people caring for those with significant mental health issues and these are not on the radar for current NDIS transitioning since they are not in the current block funded system. Anglicare Sydney is concerned that a number of potential CALD participants are not being identified and/or supported. This is an issue of concern since CALD participants can remain largely hidden. It has been estimated by FECCA that for every 1 CALD participant using the mainstream disability services there are three in the community who have not been using any supports and these may well miss out on the NDIS transitioning process.

Any related matter

Anglicare Australia Network members contribute the following two matters for consideration.

Regulatory Compliance and price-driven behaviour

Anglicare Sydney has flagged that while block funding models have rigorous guidelines and outcomes evaluation against recovery-based practice. They state:

In working in a competitive market with clients exhibiting significant mental health issues, there is a requirement on the part of the practitioner to challenge the client to identify their issues and how to manage them. However with the consumer directed package model, clients may then change services because they find it challenging to have their issues addressed and, in the longer term, clear outcomes will not be achieved. Some organisations may resist recovery based practice relying on the maintenance of a business model where the consumer is always right and cannot be challenged. Such a business model does not necessarily work in the mental health space which requires a recovery based model.

Relatedly, Anglicare South Australia has concerns about the competitive model leading to exploitative practices affecting both workers and people with NDIS participants:

NDIS pricing assumptions assume up to 95% of income is spent on client facing time. This, together with the comparatively low standard support rate of $43.58/hour (significantly less than the majority of current social service contracts), will potentially impact organisations' ability to invest time, patience and effort in communicating with and helping individuals understand the process and opportunities available through NDIS. It may also trigger exploitative practices by agencies in the way they engage staff and support customers. This could also contribute to agency's 'cherry picking' high needs or high-value customers, thereby, overlooking individuals less likely to secure high value support.

Lack of cohesion and coordination of services between departments and the NDIS

The Samaritans Foundation note that they are continuing to see people shuffled between departments, resulting in critical service gaps. For example:

"A person with a disability who is in need of community nursing because of a health issue which is separate to their disability, yet [Department of} Health will not assist as they have a disability even though their package is not for nursing, as this is not related to their disability."

Conclusion

Anglicare Australia thanks the inquiry for this opportunity to comment. We have endeavoured to provide specific information from the evidence and experience of our network members relating to the Terms of Reference; and we would be happy to appear before the inquiry and discuss them further.

We hope that our submission has made clear that there are two fundamental issues that this inquiry can make a valuable contribution to resolving. The first is ensuring that there is sufficient funding and coordination of mental health services for the many Australians, including those with psychosocial disabilities, who need them. Critically this includes ensuring ongoing funding for community-based mental health services and that vital knowledge, cross-departmental coordination and social capital is not lost.

The second is reviewing and improving the design and implementation of the NDIS for people with psychosocial disabilities that qualify for the scheme, to ensure that it supports the recovery model of mental health and delivers appropriate assessment, planning, access and funding for services.

Neither of these issues is insurmountable. What is required is a renewal of the political will and commitment from national and state governments that gave us the NDIS.

END

Attachments

NB – uploaded separately

Attachment 1 – Response from Anglicare South Australia

Attachment 2 – Response from Anglicare Sydney

Attachment 3 – Anglicare Australia's submission to the draft Fifth Mental Health Plan