



Joint Standing Committee on the NDIS

Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

27 February 2017



mental health
community coalition ACT

Peak Body in the ACT for the Community Mental Health Sector

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About Mental Health Community Coalition ACT Inc.

The Mental Health Community Coalition of the ACT (MHCC ACT), established in 2004 as a peak agency, provides vital advocacy, representational and capacity building roles for the community-managed mental health sector in the ACT. This sector covers the range of non-government organisations that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness.

The MHCC ACT vision is to be the voice for quality mental health services shaped by lived experience. Our purpose is to foster the capacity of ACT community managed mental health services to support people to live a meaningful and dignified life.

Our strategic goals are:

- To support providers deliver quality, sustainable, recovery-oriented services
- To represent our members and provide advice that is valued and respected
- To showcase the role of community managed services in supporting peoples' recovery
- To ensure MHCC ACT is well governed, ethical and has good employment practices.

Executive summary

The National Disability Insurance Scheme (NDIS) is a worthy initiative and one with the potential to improve the lives of thousands of people living with disability, their families and carers. As such, it has the potential to contribute significantly to future economic growth and the wellbeing of all Australians.

MHCC ACT and its members and stakeholders remain committed to working towards the success of the scheme.

However, the NDIS is not, and cannot be, a replacement for the mental health system and both disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness.

‘Watch out - the baby is disappearing with the bath water!’

‘Look look – what wonderful new clothes the Emperor is wearing!’

Where the NDIS is working well it is changing the lives of participants. Concerningly, however, there are many areas where the NDIS is not working well. Even those people who ultimately experience positive life change as a result of the NDIS, often have encountered significant issues and barriers before reaching this point. People are disengaging as a result of the extent and ongoing nature of these difficulties. Services are being withdrawn. Highly skilled workers are leaving for more job security and better pay.

People are being left worse off as a result of the introduction of the NDIS; a two-tier system of service access and quality is starting to emerge; downward pressure is being placed on service and workforce quality; inconsistencies in the value and types of supports offered abound; the ground is constantly moving beneath the feet of service providers; and in many fundamental ways the NDIS does not easily accommodate psycho-social disability (PSD).

The NDIS is becoming overly bureaucratic and lacking in transparency. Risk is being unreasonably shifted onto service providers. There are no apparent systems in place to measure outcomes (as opposed to outputs). Communication with stakeholders is woefully inadequate.

The NDIS is desperately in need of a partnership approach whereby the expertise of Consumers, Carers and Providers is sought out and valued.

The issues raised in this submission need to be addressed if the NDIS is to deliver on its stated goals and in the process leave no one worse off. Psychosocial rehabilitation and recovery must be part of the NDIS.

MHCC ACT strongly endorses the Submissions made by its State and Territory counterparts, and our peak body, Community Mental Health Australia. We also endorse the submission of Mental Health Australia.

In support of our submission we have **attached** the following documents

- Letter to then Minister for Health, The Hon Sussan Ley, MP et al from Simon Viereck, EO, MHCC ACT dated 27 June 2016
- Response to this letter from Anne Skordis, GM, Scheme Transition Division, NDIS, dated 17 August 2016
- Presentation made by Leith Felton-Taylor, Manager, Policy and Sector Development, MHCC ACT to ACTCOSS Forum 'Lost in Transition', 26 February 2016

Simon Viereck
Executive Officer
MHCC ACT

27 February 2017

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1. Recommendations

Following are the key recommendations from the Mental Health Community Coalition on behalf of its membership and stakeholders:

- Adopt a partnership approach in the further development and implementation of the NDIS from this day forward; recognising and valuing the significant experience and expertise of Carers, Consumers and Providers, and the contribution they are willing and able to make.
- Ensure service gaps are filled and no one is left worse off as a result of the NDIS
- Address market failures that threaten to undermine the ability of the NDIS to facilitate the provision of quality sustainable services.
- Significantly broaden the scope and increase the capacity of the ILC/second tier of the NDIS to be an effective baseline of support for people with disability, thereby reducing demand for Individual Funding Packages (IFPs)
- Introduce changes to the NDIS to make it a better fit for people with PSD; consider adopting multiple pathways through the scheme to cater for the differences in types of disability and an effective way to allow for crises situations. Ensure psychosocial rehabilitation and recovery can be supported in IFPs.
- Improve consistency of plans for people with similar support needs; consider establishment of disability specialist planning teams, as successfully trialled in the ACT to achieve this.
- Avoid the development of a two-tiered system. Simplify requirements and processes; especially when it comes to provider registration processes; plan amendments should be enabled without impact on the rest of the plan; plan reviews should involve real evaluation; and restrictions around how funding can be used.
- Increase transparency generally across the scheme.
- Introduce an effective communications strategy including an email alert system for important messages.
- Stop the rush – slow down and do it properly. An effective transition will lead to a stronger NDIS and more of the benefits that the Productivity Commission first identified as potentially flowing from such a scheme.

2. Comments specific to the Terms of Reference

a. Eligibility Criteria

Recommendation: Review eligibility criteria with the purpose of making it a better fit for people with PSD; make the system simpler to navigate

The criteria is very generic and does not easily accommodate PSD. The language itself is deficits focussed which can make it difficult for people to engage with – they do not consider themselves disabled. The use of the word permanence also causes all sorts of problems – PSD can be very episodic even if it is a permanent condition.

Lack of transparency as to how decisions are made about eligibility makes it difficult to determine exactly how well it works. What we do know though is:

- Well informed, supported and educated people are finding the system very challenging to navigate.
- The actual wait for access decisions for people with PSD is commonly up to 180 days
- There are cases where people have been found ineligible which are difficult to understand and justify given their history – ie. the condition they live with and the type of support they need to stay out of hospital and living in the community.
- Strong anecdotal evidence that GPs do not have a solid understanding of what eligibility evidence is required; and feel overburdened being asked to provide the evidence and other information required;
- Potential participants are finding it very expensive to gather the evidence required and pay for a long appointment with their GP – which is what is usually required to complete the paperwork – and there is no Medicare item to cover it.

Case study: Experience of getting and using an IFP

Single mother to be, mid 30s, articulate, intelligent and resourceful. As a result she is well informed about the NDIS. Lives with PSD (primary diagnosis) and physical disability (as a consequence of a suicide attempt).

Enters the NDIS siting the physical disability as primary diagnosis as she understands this will make it easier to support her case. During the process her long time Doctor assesses her as not needing communication aids as she is so articulate – until she points out that her physical disability prevents her from using a keyboard and she therefore needs the aid of a voice recognition program. She ends up with a very generous package which had the potential to be life changing.

After much searching she has been able to purchase the assistance of a daily Carer which she finds incredibly helpful It took a while to find a Carer – one agency sent her someone who would not touch babies (despite knowing that she had a new born). She also resorted to paying a friend to stay with her and give her the support she needed over one period.

However, despite her best endeavours, she has experienced the following issues

- The allocation to make adjustments to her car can't be used as the car is deemed too old – it is the best she can afford.
- The allocation to make adjustments to her place of residence can't be used as her home does not meet OH&S requirements – again it is the best she can afford
- She cannot find anyone to be her Care Coordinator – despite calling every reputable provider she knows of (they are either full or don't return her calls)
- She cannot find anyone to provide the regular physiotherapy which would help her greatly with the physical disability

Source: ACT Mental Health Consumer A

b. The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs

Recommendation: That the Commonwealth Government fund, through a suitable mechanism, a flexible, low-barrier-to-entry service (similar to PIR, D2DL and PHaMs) outside of the NDIS for people who need ongoing community and coordination support.

Recommendation: That the Commonwealth Government enact a mechanism to provide continuity of supports for existing participants who are ineligible for the NDIS.

The transition of Commonwealth Government funded services into the NDIS is creating significant service gaps in the ACT and available evidence suggests this will happen across Australia.

These programs were implemented slightly differently in different States and Territories and the percentage of existing participants who are eligible for the NDIS appears to be somewhat higher in the ACT than in the other NDIS trial sites. In May 2016 approximately 25% of current PHaMs participants were estimated to be ineligible, however this was only a few months before the end of the NDIS Trial and services had increasingly aligned their intake with NDIS eligibility criteria. At the time of writing it is estimated that more than 60 current ACT PIR participants will not have transitioned to NDIS when the program is due to close on 30 June 2017.

The Commonwealth funded programs were largely successful in achieving their stated aims and these supports are now not available to people in need of them. The groups disadvantaged by this change include:

- Existing participants not eligible for NDIS – this group suffers a direct loss of service.
- Expected future participants – this group would have accessed the service in future.
- NDIS participants – the key supports delivered by these programs (psychosocial rehabilitation) are not funded by the NDIS, which funds only disability supports.

It is worth noting that the Commonwealth Government has yet to give any indication that it will provide continuity of supports even for existing participants in the ACT who have been found ineligible for NDIS.

c. The transition to the NDIS of all current long and short term mental health state and territory government funded services

Recommendation: That state and territory governments continue to fund a suite of psychosocial rehabilitation and recovery services for people living with a mental illness.

Recommendation: That the NDIS deliver a range of block-funded baseline supports (in line with the originally proposed Tier 2 concept) to ensure as small a proportion as possible of people experiencing psychosocial disability go on to develop a significant permanent disability

Different States and Territories have taken different approaches to transitioning existing community-managed mental health services to the NDIS. In the ACT roughly one-third of ACT Government funding for community-managed mental health services has been transitioned to the NDIS. The remaining funding is largely invested in sub-acute services and promotion & prevention services.

The services no longer funded were primarily focused on community-based rehabilitation and their disappearance means that people no longer have access to these supports that help reduce the disabling impacts of their mental illness and support them to recover. The likely consequence of the loss of these services is a growing level of disability over time and a higher number of people with psychosocial disability needing NDIS support packages.

In the ACT it appears that the number of service participants in ACT Government funded community managed mental health services who were ineligible for NDIS was quite low, however there is an obvious impact on two other groups:

- Expected future participants – this group would have accessed the service in future.
- NDIS participants – the key supports delivered by these programs (psychosocial rehabilitation) are not funded by the NDIS, which funds only disability supports.

One of the consequences of the transition of ACT Government funded community managed mental health services to the NDIS has been the loss of group-based programs and drop-in style social participation supports. These services were not viable within the NDIS framework. Given that a tendency towards social isolation and disability in the area of social and community participation is a very prevalent characteristic of serious mental illness, this loss is keenly felt. The September 2016 Intermediate Report of the Evaluation of the NDIS by the National Institute of Labour Studies, Flinders University also noted this unintended consequence of NDIS¹.

More broadly the consequence of the transition of services into NDIS is that there is a significant gap in the available continuum of mental health services in the ACT. People living with mental illness in the ACT no longer have access to community-based rehabilitation and recovery supports – even those who are NDIS participants. This is made worse by the guidance material for PHNs specifically prohibiting commissioning of psychosocial support services. The consequence is a loss of opportunities to support recovery, to prevent deterioration and acute illness, and to avoid development of permanent disability.

The NDIS is not, and cannot be, a replacement for the mental health system and both disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness.

¹ Mavromaras, K., Moskos, M. and Mahuteau, S. (2016) Evaluation of the NDIS, Intermediate Report, September 2016. Adelaide: National Institute of Labour Studies, Flinders University.

d. The scope and level of funding for the Information, Linkages and Capacity Building framework

Recommendation: Significantly increase the capacity of this second tier of the NDIS to provide baseline supports that prevent people going on to need the higher level of support provided through IFPs and/or the tertiary health system.

One of the original objectives of the NDIS was to provide strong baseline support services to both minimise the number of people needing IFPs and people needing tertiary hospital services. It is therefore difficult to understand why the scheme has been implemented from the top down, rather than the bottom up.

Regardless of the reason this top down 'start at the most expensive and complex end of the spectrum of needs' approach has led to many of the issues with the NDIS - both in its implementation as well as the higher than anticipated number of people accessing the scheme, and the total expenditure on IFPs.

In the ACT, for example, all ACT Government funded service providers were told they must test clients' eligibility for the NDIS regardless of whether they thought they were eligible or the clients were willing to engage with the NDIS. Only in cases where Clients' eligibility had been tested and failed would the ACT Government guarantee continuity of funding for services. This caused many issues. In particular it exacerbated the situation providers found themselves in in having to do a huge amount of largely unfunded work in terms of paperwork and time taken to engage people who for a variety of reasons did not want to be part of the NDIS.

Most importantly however, the capacity of the ILC – or baseline tier of the NDIS – to meet its original objectives is severely compromised:

- The funding allocation is woefully inadequate
- Redefining the direction of the Tier 2 part of the NDIS – or ILC – towards information provision instead of service provision (or a combination of the two) means that the ILC cannot operate as a baseline of services that minimises the number of people needing IFPs
 - This is made worse by it being very small scale funding

Case study: Inadequacy of ILC funding and scope

Before the NDIS the ACT government spent approximately \$15m annually on community managed mental health service provision. In addition, the Commonwealth funded community managed mental health services such as Day to Day Living, Partners in Recovery, Personal Helpers and Mentors and Carer Respite services.

Roughly 30% of the ACT Government funding was moved into the NDIS (approximately \$5m), and 100% of the Commonwealth funding. With the funding gone so too are the services.

Under the ILC the ACT will now receive up to \$3m for all disability – general and PSD – in 2017/18. Beyond this period there is no way of knowing what the level of funding will be.

It is still not clear how service gaps will be filled and by whom.

e. The planning process for people with PSD, and the role of PHNs in this process

Recommendation: Introduce disability specific specialist planning teams

Recommendation: Introduce more effective mechanisms to meet rapid escalation of needs for people with PSD

Recommendation: Allow for plan amendments without freezing the whole package; ensure reviews are actually person centred and not just a cost cutting exercise.

The planning process

The planning process is hugely problematic and is fundamentally undermining the efficacy of the scheme. It lacks consistency and demonstrates very poor understanding of the specifics of supporting PSD.

During the ACT Trial, the NDIA was convinced to set up specialist planning teams to allow for deeper expertise in the planning process for the different types of disability. Anecdotal evidence showed that this was improving the situation - plans became less inconsistent and more appropriate to the person with PSD's needs. However, it was abandoned at the end of the trial period and the beginning of national rollout.

Following is a summary of the key issues:

- Outcomes are almost guaranteed to be better if a participant is supported by a formal/informal advocate through the planning process
- Ongoing reports from all providers of big discrepancies in plans being received by clients with similar needs – in terms both of the total value of the plan and the allocation of supports within a plan
- Participants are being given incorrect information about what they can and can't use their plans for during the planning process
- Lack of clarity about which supports are NDIS funded and which are considered Health services. This appears to be a factor in the inconsistency in plans.
- Lack of contingency in plans for crisis situations or rapid escalation of support needs due to a mental health episode.
- Lack of supports for carers in plans
- Limited access to respite under NDIS leading to stress for participants and pressure on carers.

Review of plans

Plan amendments

The inability to amend plans without a full review, even if the issue is clearly a mistake is very problematic. If a review of one aspect of the scheme is requested, the whole plan is frozen. This means the person with PSD has no ability to purchase services during that time which can take several months.

In reality, the provider usually continues to provide the services but carries the financial burden and risk in the interim. This is not a sustainable situation.

Annual Review process

The annual reviews of plans are not actual reviews of what's working and what is not, and how the Plan might be changed to better support the person with PSD. Instead, it is consistently being reported that at annual review IFPs are being reduced in value, and important supports withdrawn.

People with PSD are often not given adequate notice of when the review will take place, and sometimes are contacted out of the blue by telephone for their review. This is clearly not acceptable for people who live with conditions such as paranoia, psychosis, severe anxiety and the like. People with PSD must be given adequate opportunity to organise to have a support person with them during plan review.

The annual review process then appears rather to be an opportunity for the NDIA to reduce the amount of funding in packages without any evidence that this is in the best interests of the person with PSD. It also flies in the face of having to prove lifelong enduring disability to be eligible for the NDIS in the first place.

Case studies: inconsistencies in IFPs

Male, early 50s, with an NDIS plan of \$58k pa.

At the first year plan review, it was cut back to \$19k. A review process was initiated which took two months, during which the service provider continued to support this person at their own expense. The outcome of the review was to restore the original \$58k pa.

Male, 50 yrs, living with another person with similar support needs.

Although their needs are very similar, there is a differential of \$20k between their plans, and the allocations to the various components of their respective plans are very different. This led to the need for a review. People talk to each other, compare their NDIS plans, and note the differences especially when their needs are similar.

Male 45 yrs - was not listened to in his need for Respite from his living experiences.

He is becoming very unwell as he has used his respite, and NDIS is unresponsive to his situation and need for more.

Source: ACT Service Provider M

Service User A as compared to Service User B

Service User A encountered a NDIA Planner with good understanding of PSD. Resulted in an excellent plan: completely appropriate to the person A's needs and worth \$30k

Service user B's needs are much higher than that of Service User A: long history with the Provider of very complex, intense needs. Huge amount of evidence demonstrating the extent of support needed. Was given a plan of \$17k. After appeal it was doubled. But this is still inadequate to properly support Service User B's needs for support.

Source: ACT Service Provider W

Role of PHNs in the planning process

It is difficult to see how PHNs could play a role in the planning process. PHNs have specifically been prevented from commissioning psychosocial services. They can promote links to broader services, recognising these services are vital, but they are not within their scope (*Primary Mental Health Care Services for People with Severe Mental Illness, PHN Primary Mental Health Care Flexible Funding Pool implementation Guidance, Department of Health Australian Government*)

To the extent that PHNs have a role, it would be in educating and supporting GPs in understanding the NDIS and how to meet the needs of patients who want to test their eligibility for, or are participants in, the scheme. It would be very beneficial for the PHNs to work with GPs to find ways to support them with the cost and time involved in working with NDIS participants.

Another useful role PHNs could play would be in facilitating better integration of and between the different types of services that support people with PSD.

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

Recommendation: establish a mechanism to (i) investigate this issue more thoroughly, including by looking at the impediments to service purchase and delivery and (ii) review projected NDIS participation rates

We only know what is reported by the NDIA in this regard. We also know there are projections that the ACT NDIS participation rate could be 35% higher than originally estimated. In September, the NDIS released a Market Position Statement that said it expected there would be 6,900 participants in the scheme in the ACT – the original projection was 5075.

While there has been discussion about significant under expenditure within NDIS packages to date, in the ACT at least this appears largely to do with an inability to find a provider of many of the services people want, rather than a lack of need for them in the first place.

There are many impediments both to the purchasing and supply of services.

Purchasing impediments include:

- Lack of availability
- Lack of Support Coordinators with capacity to take on new clients
- Inadequate transport funding to access the service
- Only part of the service is funded and the rest is too expensive for the person to self fund

Supply impediments include

- The hourly rate permitted by the NDIS is not adequate to provide the service on a financially sustainable basis and/or with adequate safeguards or quality frameworks
- For group activities, there is often not a large enough critical mass of people with packages wanting to purchase the service at this time – particularly group activities – thereby making it unviable to offer the service even if it had been popular previously

- Provider registration processes are unduly onerous, so many are choosing not to register. This is exacerbated by the often relatively low remuneration rate offered under the NDIS and that providers in some professions already experience plenty of demand.
 - If providers can show evidence of qualifications and registration with professional bodies, it is hard to understand why the additional information required by the NDIA should be so onerous.

Case study: Provider de-registers from NDIS

The NDIS sets the basic rate for support work at \$43.58 per hour.

"Ultimately that NDIS rate is a bargain basement rate for what is expected to be a platinum quality service," said Rob Woolley, general manager of Just Better Care in the ACT.

Just Better Care charges non-NDIS clients \$52.80 per hour.

Mr Woolley's company has decided to de-register from the NDIS. That means it will not be bound by the scheme's rates — but it also will not be able to do any work for the majority of NDIS participants whose plans are managed by big agencies.

The company said it had no choice because it lost \$200,000 last year providing services on NDIS rates. "We think we're a prime example. If we can't make it work, nobody can," Just Better Care Canberra owner Mr Fergus said.

Mr Fergus said other providers are also thinking of de-registering. If that happens, the number of workers available to provide services at NDIS rates could collapse. "This is a great scheme. We've seen some fantastic outcomes with the people that we work with," he said. "But this pricing issue ... is putting that at risk."

Extract from Canberra Times article by Norman Hermant, 6 January 2017

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

Recommendation: Outreach services need specific funding or they will disappear.

Outreach services aimed at identifying people with PSD are time intensive and expensive to provide. In short, these type of vital services are fast disappearing under the NDIS. With the removal of bloc funding and the relatively low hourly rates offered by the NDIS, Service Providers simply cannot afford to provide this sort of service anymore.

At the beginning of the NDIS Trial in the ACT, service providers literally spent weeks, and sometimes months, trying to engage clients with the NDIS. Most of this work was unfunded by the NDIS and only made possible by using the remains of bloc funding, cross subsidising from other areas of the organisation, or some of special funding packages provided by the ACT Government during the trial period. Change does not come easily to many people with PSD while suspicion and resistance are easily aroused. Relationships of trust take a lot of time and energy to develop. Without that trust it is difficult to achieve much.

h. The provision and continuation of services for NDIS participants in receipt of forensic disability services.

We are not in a position to offer much perspective on this issue except to say that:

- These people deserve to receive the same levels and quality of support as others in the community
- The lack of a NDIS Quality and Safeguards Framework from the beginning of the trial and rollout of the NDIS is particularly problematic for this group of people and those providing support services to them.

i. Any related matter

While the above points cover some of the more important issues, unfortunately the list could be extended significantly. The following is an attempt to summarise some of the more important of these other issues.

Two-Tier system evolving

Recommendation: measures be taken to remove unnecessary restrictions on the prices paid for services and to avoid the development a two-tier system of support.

It is becoming very apparent that a two-tier system is emerging under the NDIS.

People with PSD who are agency managed are restricted to services that are available at NDIS prices. People who have the personal or financial capacity to self-manage can use their funding like a subsidy to potentially purchase faster access to higher quality services.

This is reminiscent of the current medicare system where some people depend on bulk billed services for their primary health care needs. This can restrict their access to timely quality services, which in turn restricts their choice and control.

In the ACT we have the example of *Just Better Care* who are in the process of de registering from the NDIS for business sustainability and service quality reasons (see case study). They are committed to finding other agencies for those clients who wish to remain agency managed but it is not easy to find places with spare capacity or able to provide the same suite of services. Just Better Care are reported as knowing of other providers who are considering a similar path.

Ignoring expertise

Recommendation: a partnership approach with service providers, carers and consumers be taken henceforth by the NDIA and Governments in the further development and rollout of the NDIS

The significant body of PSD expertise amongst service providers, carers and consumers has been largely ignored in the design, implementation, and fine-tuning of the scheme. The majority of issues raised in this submission are not new. People from a range of different backgrounds have been warning of them from the beginning.

Instead, people have been put in decision making capacity who, as a generalisation, are significantly lacking in the required understanding and expertise in supporting people with PSD

A partnership approach would help avoid the extent of problems experienced, and the need for the sort of time consuming and expensive inquiries and reports that taken place around the NDIS to date.

Learnings from the Trial Sites

Recommendation: A study into the learnings from the trial sites, including a series of recommendations, be commissioned urgently and be publicly available.

What is the use of Trials if the outcomes from them are not analysed and learnt from? The NDIA claims to have recorded the learnings from the Trial Sites, but none of this is publicly available. We are not aware of people being approached to provide input into such a report. Instead it has been left to chance that each trial site might decide to produce their own evaluation report. The learnings are valuable to everyone, particularly those jurisdictions still preparing to enter the NDIS.

Change management and transition planning

Recommendation: Slow the process down: put quality, efficacy and safety ahead of artificial rollout deadlines

Recommendation: Dramatically improve the transparency of NDIA decisions and processes

Recommendation: Prioritise the development of an effective communications strategy that guarantees consistent and timely information sharing. This needs to include an email alert system.

Recommendation: Establish a mechanism whereby feedback can be heard, considered and responded to.

There has been a distinct and concerning lack of change management and transition planning in the implementation of the NDIS. This is a massive social policy change – it needs time to be done properly. At the moment, meeting rollout deadlines/targets is being put ahead of the efficacy of the scheme and compromising peoples safety – both workers and service users.

Some of the more important issues include:

- Very limited transparency in decision-making processes, including reasons.
- Confusing lack of clarity and consistency in information which is shared
- Apparent lack of an effective communications strategy
- No attention given to the substantial cultural change involved in the implementation of the NDIS

How can organisations plan for a sustainable business model

Recommendation: That providers of psychosocial disability are given the same due consideration and support as would be given the corporate sector if such radical change were required of them

Recommendation: Recognition that the professionalism and efficiency of the services delivered by NFP community service providers is uniquely valuable and there is a lot to be lost if it were to collapse.

The change from bloc funding of service providers to individual funding of service users has required a quite radical change to organisations' business models. However, Providers have not been provided the crucial information needed to establish these models with any certainty.

This is compounded by the constantly moving sands of the NDIS, inconsistency of information available, gaps in information, and a shifting of risk onto providers. It is extremely concerning that the Government could begin implementing a scheme without a quality and safety framework. We would not allow a hospital to open under such conditions – so why is it OK for the NDIS?

Some examples include

- Instructions to implement new practice based on a verbal briefing only and no written instruction available for another 2 months (ACT Disability Sector Forum - arrangements pertaining to supported independent living– February 2017);
- insufficient notice (1 week) given ahead of the closure of the Portal for end of financial year 2015/16; the subsequent collapse of the Portal and failure to put in place adequate interim measures forcing providers to either withdraw services or carry debt;

then when it was reinstated many Providers were told information was lost and could not be retrieved.

- The requirement of people with PSD to use 'my Gov' puts providers in difficult position – people with PSD who refuse to engage with government websites either get no service or the Provider has to breach website guidelines and do it for them.

The NDIS pricing framework also very importantly provides little if any capacity to build in crucial aspects of quality service sustainability – training, induction, supervision, systems upgrade, innovation, specialist services.

Individual versus Community

Recommendation: Ensure the NDIS model enables the ongoing viability of community spaces catering for people with PSD.

Increasing individual choice and control is crucial. But this does not mean that a person with PSD is best served living in a world entirely made up of one to one relationships. Most people enjoy and benefit from access to community spaces as well.

The NDIS model though is seeing the closure of community spaces. In the ACT a long established and valuable community space run by the Mental Health Foundation, 'The Rainbow' was closed in January 2017. We also know that St Vincent de Paul are finding it increasingly challenging to maintain the community space they have at Oaks Estate.

People need more than a paid friend or cleaner. Community spaces disappearing isolates people and removes an effective component of the recovery journey. Community spaces have also provided very effective mechanism for 'soft', less threatening, outreach services.

Market failure impacting quality and availability of services

Recommendation: address NDIS market failures by implementing a hybrid system of individual funding based on realistic prices, and some form of business sustainability funding.

During the ACT Trial period questions were often asked about the possibility of business sustainability under the NDIS model. Service Providers were told that they just needed to

adapt, become efficient and innovative, and get used to operating in a competitive market. The fact that prices are fixed and there were large gaps in information fell on deaf ears.

What we are experiencing is indeed a market in action – it is responding in a predictable way when there is market failure. Service providers are responding to price signals and either withdrawing NDIS services where there are ethical concerns or remodelling services to a more transactional lower quality type.

In the ACT this market response is also beginning to undermine years of investment to raise the qualifications of the workforce in the sector to a minimum Cert IV level, the adoption of national mental health standards and instil the practice of continuous quality improvement. Indeed, in the few years preceding the introduction of the NDIS, Service Providers were reporting increasingly highly qualified candidates for positions advertised, including those with tertiary level qualifications. Providers can no longer afford to employ people of this calibre and they are leaving the sector in the face of potentially lower wages and a lot of job insecurity.

3. Attachments

Sent as separate documents x3

- Letter to then Minister for Health, The Hon Sussan Ley, MP et al from Simon Viereck, EO, MHCC ACT dated 27 June 2016
- Response to this letter from Anne Skordis, GM, Scheme Transition Division, NDIS, dated 17 August 2016
- Presentation by Leith Felton-Taylor, Manager, Policy and Sector Development, MHCC ACT to ACTCOSS Forum ‘Lost in Transition’, 26 February 2016