mhcc
mental health coordinating council

PO Box 668 Rozelle NSW 2039
T 02 9555 8388
F 02 9810 8145
E info@mhcc.org.au
W www.mhcc.org.au

National Disability Insurance Agency
GPO Box 700
Canberra ACT 2601
Email: ilc@ndis.gov.au

30 October 2015

Re: Development of National Disability Insurance Scheme (NDIS) Information, Linkages and Capacity Building (ILC) Commissioning Framework (ILC Co-design Program)

To Whom It May Concern,

The Mental Health Coordinating Council (MHCC) is the peak body representing non-government community managed organisations (NGOs/CMOs) in NSW. We have been working in partnership with the NSW Mental Health Commission in the three Local Government Areas (LGAs) that constitute the Hunter NDIS trial site since June 2013.[1] This has included co-convening a Hunter NDIS and Mental Health Community of Practice (COP) Forum which has so far met on eight occasions with around 70 people attending each event. The purpose of the COP Forum is to facilitate the learning that is occurring, and maximise the opportunities presenting through NDIS implementation, for mental health consumers, carers and those that provide services and supports to them.

This submission is being provided on the basis of nearly two and a half years of direct experience of the NDIS from a community managed mental health sector perspective. Regrettably, the time frame for the ILC Commissioning Framework 'co-design' process did not allow for the strategic consultations as suggested by the National Disability Insurance Agency (NDIA).

In providing feedback on the ILC Commissioning Framework, MHCC notes that the ILC Policy draft consultation was provided with feedback to better explain how ILC will support people with mental illness and that this has not occurred for the final ILC Policy. What the ILC Policy does say is that configuration of ILC arrangements should be designed to optimise the alignment with mainstream interface areas and preventing the development of parallel systems, particularly … mental health where participants are not entitled to an IFP. MHCC acknowledges that work is underway through a range of national NDIS and mental health projects to better understand this interface and the early learning from these must inform the ILC Commissioning Framework as it is understood to be a three year operational plan (ie, the inclusion of mental health related considerations in the ILC Policy and related practice/service delivery must not wait up to four years and be pending three years of ILC operationalization and subsequent review/evaluation).

[1] Mental Health Coordinating Council (2015). *Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis*. MHCC, Sydney.

In this submission MHCC provides feedback in response to the ILC Commissioning Framework consultation papers and related questions:

- The NDIAs five proposed priority areas of ILC investment
- What ILC success might look like and how it should be measured
- Other ILC considerations
- Specific consultation questions.

Before doing this consideration is also given to the policy and NDIS environments from a community managed mental health sector perspective.

- Policy, planning and practice (ie, service delivery) environment
- ILC Policy and Commissioning Framework overview.

Environment

Policy, planning and practice (ie, service delivery) environment

MHCC has observed that the NDIS has presented many opportunities for people impaired as a result of a mental health condition and those that provide services and supports to them. Additionally, the impact on the existing human services system – both social/disability and mainstream – has been extremely high. The NSW government has a priority to outsource disability services provided by government including the closure of the Department of Ageing, Disability and Homecare (ADHC) in 2018/19. This priority means that little strategic direction appears to have been given to NSW Health 'Partnerships for Health' funding reforms in the context of NDIS implementation. The current environment for NSW Health funded mental health programs delivered by CMOs lacks clarity making it difficult for MHCC to comment on what this might mean in terms of services remaining for people not eligible for an NDIS Individually Funded Package (IFP).

MHCC acknowledges the work being undertaken by Australian governments and the NDIA to turn the ILC Policy into action through development of a three-year ILC Commissioning Framework. We also acknowledge that the NDIA needs to have the ILC Commissioning Framework finished by the end of this year in order to start the next phase of work in early 2016. It is regrettable that this ambitious timeline is not allowing thorough co-design to occur. However, we understand that there will likely be many other future opportunities to contribute to operational directions for the ILC.

A key question for ILC operations is "What can be communicated about support to be provided to people living with mental illness who are not assessed as having a permanent disability"? The Mental Health Drug and Alcohol Office in NSW is currently developing a purchasing plan for its mental health community sector programs under 'Partnerships for Health'. This is a complex undertaking which is further complicated by the potential of NDIS to support a similar cohort of consumers. One can assume some continuing State funding for mental health programs but even this is unclear in the context of the pending Commonwealth government response to the National Mental Health Commission Review of Mental Health Services and Programs (ie, the Fifth National Mental Health Plan). What is known is that NSW mental health spending in the public community sector and the community managed sector continues to be significantly below the national average.

The experience of the NDIS in the mental health space in the Hunter trial site may be quite different to elsewhere in NSW and nationally. One reason for this is that the three LGAs that constitute the trial contain the majority of non-government mental health program

infrastructure for this large Local Health District. There are very few mental health specific support services outside of the three LGAs and this is also true for many parts of NSW.[2], [3] The lack of mental health specific ILC infrastructure in many parts of NSW means that consideration will need to be given to the development of additional services and supports for people with mental health conditions that are ineligible for an NDIS IFP.

All indicators are that mental health sector reform – both in NSW and nationally - will likely transition existing block funded arrangements, where practicable, to individualised approaches. This re-orientation is supported by MHCC but only in the case of there being early intervention, prevention, promotion and disability/recovery support services outside of the NDIS. This is not the case in Victoria and early indications are that Queensland may be considering handing over state funded mental health programs to the NDIS. The 'mainstream' public mental health priority of acute and sub-acute mental health treatment make it unlikely that they will be able to be effective providers of early intervention, prevention, promotion and disability/recovery support services and access to such services within the non-government sector also remains limited. Increasing access to such services is a reform aspiration that successive governments have struggled with for more than 20 years under the National Mental Health Strategy.

The recently reviewed Commonwealth and NSW Bilateral Agreement for NDIS Implementation is silent on the subject of mental health and the NSW government NDIS website has no mental health specific content: http://ndis.nsw.gov.au/ The recent Review of Mental Health Programmes and Services undertaken by the National Mental Health Commission has called for government to conduct detailed modelling on the interaction between clinical mental health supports, community supports and the NDIS (Recommendation 3; Volume 1 p.61). This exploration of treatment, rehabilitation and supports roles and functions across a range of mental health work settings is essential to implementation of the NDIS and operationalization of the ILC (ie, this is not as simple as 'clinical' and 'non-clinical' but a much more deeper conversation about who does what and where and with which skills/qualifications). This conversation is critical not just for people with psychosocial disability but also to increase access to mental health treatment for the hundreds of thousands of Australians with physical, sensory and/or developmental disability that also struggle with poor mental health.

The social service support system is complex, wide-ranging and can at times seem difficult to negotiate. This is particularly true for people with mental health issues who have complex needs and require a multi-faceted and coordinated service system response across both health and social services. It has long been acknowledged that people with complex needs can fall through the cracks in service delivery – between national and jurisdictional service delivery, between government and non-government services, and between services delivered by different portfolio agencies. People with persistent complex needs are more likely to experience chronic health problems, particularly disability and mental illness. Support needs will often vary over time and be cyclic in nature. For these reasons, the interface between the NDIS and 'mainstream' services is critical.

[2] Mental Health Coordinating Council (2010). *The NSW Community Managed Mental Health Sector Mapping Report 2010.* NSW Australia.

[3] Mental Health Coordinating Council (2012). *NSW Community Managed Sector Benchmarking Project, Working Paper 2: Service Benchmarks for Selected Core Service Types*. Sydney, Australia (confidential document to NSW Health Mental Health and Drug and Alcohol Office).

It is important to consider changes to the human services system in a holistic way and consider the needs of people who will receive both IFPs as well as those who will only be able to access support through the ILC or the mainstream system.

ILC Policy and Commissioning Framework overview

This brief ILC overview is provided to familiarise readers with what is known about the ILC so far: http://www.ndis.gov.au/consult-info-link-capacity-building

The high level ILC Policy has five parts, called streams of activity (ie, 'activity streams'):

- Information, Linkages and Referrals - to make sure people with disability and their families have access to reliable and relevant information
- Capacity building for mainstream services - to make services more accessible for people with disability
- Community awareness and capacity building - to make it easier for people with disability to fully participate socially, economically and in their communities
- Individual capacity building - to help people with disability develop the skills and confidence to achieve their goals
- Local Area Coordination (LAC) - which will incorporate every other ILC activity stream and support ILC initiatives within local communities as well as work directly with individuals on their NDIS plans.

The LAC functions are NDIS work roles (ie, jobs/workers) whose functions are seen as the key focus of operationalising the ILC.

While the ILC Commissioning Framework has not yet been fully designed, it is assumed that in the future, services which receive ILC block funding should:

- Fit into one or more of the 5 ILC Activity streams outlined in the ILC Policy
- Fit into one or more of the ILC funding priority areas (these are still being built; see below)
- Not overlap with any other major government programs, services or funding source
- Complement the work of LACs
- Be able to demonstrate that they can make a difference and help the ILC achieve its intended outcomes
- Build and not replace existing social and community effort.

Limited ILC block funding will be available to programs and organisations that fit into one of the ILC activities and meet funding eligibility criteria.

The draft block funding priority areas are:

- Specialist or expert delivery - such as diagnosis-specific advice services (1)
- Cohort focused delivery - such as awareness raising for services for particular cultural groups (1)
- Multi-regional supports - such as a national awareness raising campaign (1)
- Remote/rural solutions - such as development of specific online support (3)
- Delivery by people with disability for people with disability - such as a peer support group for people who want to self-manage their plans (5).[4]

[4] The numbers against each of the draft block funding priority areas are explained over page.

ILC Commissioning Framework consultation questions

The NDIA's five proposed priority areas of ILC investment

The numbers against the draft block funding priority areas on the previous page reflect MHCC's relative weighting of the draft priority area (this is further explained in response to 'Specific Consultation Questions' on pp. 7 & 8).

The NDIA advise that in the future funding submissions from an organisation may fall into multiple funding areas. MHCC supports the proposal that initiatives that fit into more than one funding area be treated as a higher priority.

Neither the five ILC activity streams or proposed priority areas propose mental health specific activity but neither is it precluded. The problem is that in the absence of strategic affirmative actions and reasonable accommodations to ensure a mental health profile and related accountabilities there is a high risk that this will be seen as a 'mainstream' health issue when it is abundantly clear from the complexities of NDIS in the mental health space that it is much more complex and diverse than that. The learning arising from the trial sites that is being captured through the range of national NDIS projects at present attests to this and this learning needs to be captured in the ILC Commissioning Framework.

One way of accommodating for this that is not simply 'cohort specific' might be to add a sixth category 'health and well-being' which is inclusive of the supports required to access and benefit from mainstream health services including, but not limited to, mental health (this is further explained in response to 'Specific Consultation Questions' on p. 7). This would have benefits to all people with disability.

It is understood that the forward budget estimates for the ILC are as outlined in the table below.[5]

$M	2015/16	2016/17	2017/18	2018/19	2019/20	5 Year Total
Grants	9.875	30.630	69.740	112.085	131.518	353.858
LAC	6.052	42.365	83.693	110.332	102.896	345.338
Total	**15.927**	**72.995**	**153.433**	**222.417**	**234.414**	**699.196**

While the NDIS is disability specific it is imperative that it not be built on the back of a non-government mental health sector whose scope of work is broader than disability and that is already poorly funded by both international standards and Australian policy aspirations. This includes any titration of funding that may currently be allocated within the non-government sector for people with 'severe and persistent' mental illness including, but not limited to, the innovative Partners in Recovery initiative (ie, $549.8M over 5 years to 2015/16).

The experiences of the NDIS as this relates to the 'engagement, outreach and access' of people with mental health conditions create a strong argument for continuation of funding allocated to block funding programs – both Commonwealth and state – that provide both

[5] Adapted from Senate Select Committee on Health, Answers to Questions on Notice Social Services Portfolio, 26 August 2015 (Outcome Number: 5.2 Question No: 1 Topic: Transition of PHaMs clients to the NDIS in Tasmania).

individualised and centre-based services in this area and encourage 'warm referrals' to NDIS for consideration of IFPs.

What ILC success might look like and how it should be measured

The proposed shift from outputs to outcomes does not go far enough. MHCC advocate for the use of scientifically validated outcome measures as a preferred approach and the use of such measures is fairly common practice within the community managed mental health sector. Our experience in this area relates to the challenges of measuring change over time and the fact that not all outcome measurement tools are sensitive to change over time.

MHCC disagrees that outcomes are:

- 'more difficult (than measuring outputs), but not impossible, to measure, and are typically measured subjectively by approximation'
- 'not tangible or hard facts, such as statistics'.

There is a considerable body of mostly psychological peer reviewed literature that speaks to the reliability, validity, sufficiency and feasibility of a range of common outcome measures to monitor change over time.

Examples of outcome measures most commonly used by the community managed mental health sector have most recently been discussed in the following publication:

> Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia (2015). *Implementing Routine Outcome Measurement in Community Managed Organisations.* AMHOCN, Sydney, NSW.

The tools discussed in the above report target individual level change with the most common multi-dimensional tool in use being the Camberwell Assessment of Need – Short Appraisal Scale (CANSAS). A modified CANSAS tool is also used by Partners in Recovery initiatives nationally. There a similar compendiums of mostly validated measures used for monitoring community changes of various types.

One tool not mentioned in the above report that was recommended by the Productivity Commission is the World Health Organisation Disability Assessment Scale (WHODAS 2).This allows for complex data collections over time that are inclusive of both the persons experience and environmental/community factors. It is understood that the forthcoming NDIS (IFP?) Outcomes Framework and 'References Packages' may be linked in some way to the WHODAS 2. Until these things are seen and better understood it is difficult to say more about ILC outcome measurement approaches.

Other ILC considerations

- MHCC is concerned that the terms 'peer support', 'peer support group' etc. make several appearances across the ILC Commissioning Framework consultation materials and that the context of this appears to be unpaid and voluntary activity. MHCC has undertaken considerable work since 2009 to build and professionalise the paid mental health peer workforce in Australia. While natural supports and voluntarism are important social capital that contribute to strong communities we would not want to see notions of unpaid peer work erode directions for paid mental health peer workforce development.
- The intersection of NDIA Local Area Coordinators (LAC) with other NDIA Price Guide 'service coordination' support categories and also Partners in Recovery roles and functions appears to be a vitally important area of the ILC but lacks clarity. This is of

particular concern from a mental health perspective given current understandings that care/service coordination is a vitally important component of recovery oriented service provision.[6]

- The ILC Commissioning Framework needs to include information about the interface between Tier 1/IFP and Tier 2/ILC for people whose needs may be expected to vary in intensity at different times (ie, whose needs are episodic), including many people with psychosocial disability. While IFP access is intended to be lifelong and as needed MHCC is observing an early trend in the Hunter trial site for people with mental health conditions to be provided with time-limited (eg. one year) 'capacity-building' only IFP (ie, we assume this means no 'core' supports?). The intent of the NDIA in regard to this approach is unclear.

Specific Consultation Questions

- *Did participants identify any services (existing or future) that are worthy of funding but don't seem to fit into any funding category?*

Health and well-being support services. These services support a person in their social, emotional and physical wellbeing. This is about working with a person to assess/review their wellbeing and to support them in activities that promote physical (including mental), social, emotional and cultural/spiritual wellbeing.[7] For example, a person may need support to access a GP/specialist or religious/cultural leader.

- *Should there be a sixth/seventh/eighth funding priority? If so, what should it be? Why?*

Health and well-being support services because of the complex interactions between health and social/disability care.

- *Did participants have any concerns about these funding areas? Do they overlap? What risks do they foresee?*

Likely that development of health and well-being support services will be overlooked.

- *What advice did participants have for the NDIA in moving forward with the draft funding areas?*

Use the three years to trial diverse approaches but have a strong external evaluation framework around this so that initiatives that are identified to work well can be scaled up.

- *What were the reasons why participants prioritised/de-prioritised each funding area during voting?*

Delivery by people with disability for people with disability (5) was prioritized because it supports notions of social and economic participation that are central to the NDIS. Work – whether paid or unpaid – is well understood evidence based practice in recovery oriented mental health practice. Paid peer support work is essential to changing the culture of a range

[6] Please refer to various MHCC publications located at MHCC Service Coordination Strategy: http://www.mhcc.org.au/policy-advocacy-reform/strengthening-relationships/service-coordination.aspx

[7] This definition has been adapted from the Community Services Training Package Unit of Competence CHCMHS011 Assess and promote social, emotional and physical wellbeing (August, 2015). This unit describes the skills and knowledge required to work collaboratively with individuals to assess, promote and review all aspects of wellbeing.

of human services and also the community generally to be more accepting and understanding of people with mental health issues.

Remote/rural solutions (3) was prioritized because a 'market' solution to these communities will not likely be quickly forthcoming. Furthermore, because much of Australia can be considered rural/remote and where thin markets exist – such as is the case with non-government mental health services nationally - some type of regulatory government support to develop the market will likely be required.

Specialist or expert delivery (1), cohort focused delivery (1) and multi-regional supports (1) were de-prioritized as there will be so many competing priorities both across and within these proposed priority areas. It is more likely to be the use of meaningful application of co-design principals, and also the selection criteria and selection transparency for any available block funding, that are at issue here.

- What Individual-level outcomes and/or indicators did participants identify for the ILC?

Alignment to forthcoming NDIS Outcomes Framework but it is also difficult to justify this statement when that document is not yet public. Also, unlike the WHODAS 2, it can only be assumed that this is not a psychometrically sound measure and so its sensitivity to change over time may be questionable.

- What community-level outcomes and/or indicators did participants identify for the ILC?

Knowledge of mental health services and support (ie, where people can go to get help for a range of health and social issues that can vary in intensity over time). The Australian National Survey of Mental Health Literacy and Stigma demonstrates that our community is increasingly aware and accepting of people with mental health conditions. What people don't know, however, is where to direct them to get help when and as needed. While the acute and sub-acute 'mainstream' mental health system is somewhat understood people are generally unaware of the full range of services other than hospitalisation and pharmacological treatment to assist people with mental health conditions.

- How should the ILC measure changes and outcomes? What did your participants think?

Population increases in access to mental health services. The National Survey of Mental Health and Wellbeing tells us that only about one in three people that need mental health services are accessing them. A good outcome measure would be to see this statistic increase. Also, increased employment rates for people with disabilities.

- What risks do your participants identify? What were they worried about?

That the important, and much needed, development of the community managed mental health sector could be undermined through NDIS implementation particularly with reference to creating innovative and shared practice approaches with an evidence base.

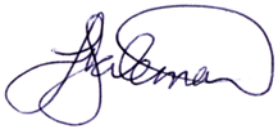
- What advice did your participants have for the NDIA relating to measuring outcomes?

As per above.

MHCC thanks the NDIA for the opportunity to comment on development of the ILC Commissioning Framework.

For additional information please don't hesitate to contact either myself or Tina Smith (MHCC Senior Policy Advisor – Sector Development: tina@mhcc.org.au).

Kind regards,



Jenna Bateman
Chief Executive Officer
Mental Health Coordinating Council
T: 02 95558388 Ext. 102
E: jenna@mhcc.org.au