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# Submission to the Joint Standing Committee on the NDIS:

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

Mental Illness Fellowship of Australia (MIFA) is a federation of long-standing member organisations, delivering specialist services for individuals living with mental illness and their friends and families. MIFA members operate out of over 180 'front doors' in metropolitan and regional areas, and support 30,000 people living with mental illness and their carers each year. Our membership has a strong focus on building community, valuing peer support and lived experience, and supporting recovery. We have substantial experience delivering specialist, place-based, community-building programs to those experiencing mental illness, and over 50% of our workforce has a lived experience as a consumer or carer; as such, we feel we are well placed to assist the Joint Standing Committee in their inquiry into psychosocial supports and we welcome the opportunity to provide our input.

MIFA contributed to the Mental Health Australia submission 1 - Attachment 2[1]: "Key actions to ensure continued access to community support for people affected by severe mental illness during NDIS transition and beyond". MIFA wishes to draw the Committee's attention to the comprehensive technical report prepared by David McGrath, forming the second attachment from Mental Health Australia[2], and to the submission from MIFA member One Door (the new name of the Schizophrenia Fellowship of NSW).

## Eligibility for those with psychosocial disability

Eligibility criteria for the NDIS needs to be urgently clarified. This issue has been outstanding for several years, and has been repeatedly raised by Mental Health Australia, Community Mental Health Australia, the National Mental Health Commission (NMHC)[3] and MIFA, among others. Clarifying access for individual NDIS packages is particularly relevant for planning how the rest of the system will provide for the gaps: as former National CEO of MIFA, Mr David Meldrum stated "Until we are clear about who is in, we cannot plan for those who will be out."

### Who is in?

The original Productivity Commission (PC) estimates indicated 12% of those with a severe mental illness should be 'in scope', or 57,000 people[4] – now updated to 65,000 people due to population growth. However, the NDIA has not provided specific guidelines to delineate this population with 'severe, persistent and complex' psychiatric needs. The PC indicates those anticipated to be included in the scheme were individuals who:

- have a severe and enduring mental illness (usually psychosis)
- have significant impairments in social, personal and occupational functioning that require intensive, ongoing support

[1] Mental Health Australia's Submission 1 - Attachment 2, *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*

[2] Mental Health Australia's Submission 1 - Attachment 1: McGrath, D. (2016). *The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches*

[3] Recommendation 3 in National Mental Health Commission (NMHC) (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

[4] Productivity Commission (PC) (2011). *Disability Care and Support: Productivity Commission Inquiry Report*, 54(2), Canberra.

- require extensive health and community supports to maintain their lives outside of institutional care.

This target group definition is in in addition to the age (under 65), residency and permanency requirements.

However, this definition provides inadequate clarity around how those with 'severe, persistent and complex needs' needs might be distinguished from the much larger cohort of people with severe and enduring mental illness, who also have significant impairments in functioning, and require extensive community support.

The target group was characterised by the Australian Government Actuary (AGA) review of NDIS Costings[5] as those having "complex needs requiring co-ordinated services from multiple agencies" (p14). The AGA suggested that the NDIS may not be restricted to those with high level needs, but rather that the definition turned more around the permanency and significance of the disability. They also noted that using the type of support required to distinguish between groups is not sufficient to provide more specificity, as the kinds of needs required by those at different levels of psychiatric disability are often similar, although the degree may vary. The estimates included 424,000 people with mental illness requiring some kind of community support, not covered by the NDIS. The report presented the stratification of the population as follows:

| **Description** | **Care Needs** | **NDIS coverage** |
|---|---|---|
| Episodic mental illness<br>**(est. 321,000 people)** | Clinical services both during episodes of illness and to maintain remission between episodes<br>Disability support services may occasionally be required, particularly during a lengthy episode of illness | Not included<br>Not included |
| Severe and persistent mental illness but can manage own access to support systems<br>**(est. 103,000 people)** | Clinical services<br>Social inclusion programs | Not included<br>Not included |
| Complex needs requiring coordinated services from multiple agencies<br>**(est. 56,000)** | One on one support from a carer (paid)<br>Supported accommodation, where appropriate<br>Social inclusion programs<br>Clinical services | Included<br>Included<br>Included<br>Not included |

AGA (2012)[6]

The NMHC Review of Services 2014[7] presented a similar population estimate for the complex needs group (taking in population growth) at 65,000. They characterised this group as "people with severe and persistent mental illness with complex multiagency needs – requiring significant clinical care and day-to-day support" (p46) and "very high level of need". Their breakdown of

[5] Australia Government Actuary (AGA) (2012). *NDIS Costings – Review by the Australian Government Actuary*.
[6] p14, AGA (2012). *NDIS Costings – Review by the Australian Government Actuary*.
[7] NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

psychiatric disability outside of the highest needs group had higher estimates than the PC (including around 625,000 people requiring support outside of the highest needs group).

| | | |
|---|---|---|
| <u>High-Very High Needs</u><br>• Personal and flexible packages of comprehensive health and social care (including housing, income and employment support)<br>• Specialist mental health and physical health treatments<br>• Co-ordinated care - One system, one care plan, one e-health records | Very high level of need | **0.15% (65,000 people)**<br>**Severe and persistent illness with complex multi-agency needs**<br>Require significant clinical care and day-to-day support |
| | High level of need for support | **1% (210,000 people)**<br>**Severe and persistent**<br>Chronic with major limitations to function (ie very disabling) and without remission over a long period |
| | | **2% (415,000 people)**<br>**Severe episodic**<br>Severely episodic with periods of remission |
| <u>Low-Moderate Needs</u><br>• Targeted and integrated clinical and social support<br>• Housing, income, psychosocial supports<br>• Self-directed low intensity therapies<br>• Early interventions<br>• Maintain connections with families, friends, culture and community | Moderate level of need for support | **5.5% (1 million people)**<br>Moderate |
| | Low level of need for support | **11% (2 million people)**<br>Mild |
| | | **45% (7.3 million people)**<br>Will experience a mental disorder sometime in their lifetime |
| <u>For the Population</u><br>• Investment in prevention and early intervention<br>• Foster healthy communities and encourage self help<br>• Foster mental resilience (families, schools) | Need for wellbeing and resilience promotion | **Majority (22.68 million people)**<br>Need for wellbeing and resilience promotion |

NHMC (2014)[8]

Further population profiling is provided in Mental Health Australia's technical report by David McGrath[9]. His analysis of the National Mental Health Service Planning Framework (NMHSPF) modelling (under development) revealed a population of 502,000 adults with severe mental illness in Australia, of whom approximately 290,000 will require some form of NDIS-like community support, defined as "non-clinical community based services designed to assist those with a mental illness to participate in their communities and have meaningful and contributing lives." This figure is more than 5 times the number of people estimated by the PC in 2011. He

[8] p46, NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

[9] Mental Health Australia's Submission 1 - Attachment 1: McGrath, D. (2016). *The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches*

also identified at least 153,600 carers – or more, depending on how many carers each mental health consumer has – who require some form of support.

Based on the above three sources, there is some agreement that a sub-set of those with mental illness exist who have high-level, complex needs and require significant, potentially daily support, and that based on today's population has a prevalence of around 64,000 – 65,000 people. There is less agreement about how many people sit outside of the scheme but require 'community' or psychosocial support, with estimates ranging from 225,000[10], 424,000[11] (AGA, 2014), and up to 625,000[12].

Departmental advice to service providers has been to encourage all those with community support needs and/or in existing psychosocial programs to apply for individual plans under the NDIS, and leave it to the NDIA to manage access demand. The Department highlights the experience of service providers who are transitioning up to 80-95% of PHaMs participants into the NDIS, as evidence of the broad eligibility of that cohort. Service providers are likely to push for maximum transitioning of clients in an effort to ensure service coverage for their existing clients, and due to the financial incentive for their own organisations in the absence of block funding for any other psychosocial support programs. Because the rest of the mental health community support system has been absorbed to fund the NDIS, there is a sense that the only choice is the NDIS or nothing.

MIFA is concerned that this approach may result in skewed use of resources, false expectations, and disappointment. As the scheme rolls out, the high transition rate of existing program participants will blow out the target for the scheme. There is a clear risk of overspend if the NDIA chooses to expand the eligibility ad hoc to include all those with psychosocial disability. However, the most concerning aspect is that the push to include all those with a psychosocial disability could perversely end up excluding those with the greatest need. There are many people requiring community support and/or in existing programs who do not have the "very high complex" needs that the NDIS individual packages were intended to address. Those with the most complex needs, who are hard to reach and excluded from any services, will not be supported because the resources are directed to those more easily transitioned, and the targets will be filled with lower needs clients. Unless every effort is made to identify every person with the most complex needs and highest level of disability, and provide them with a comprehensive, individualised package of support, we will once again fail to realise the unfinished business of institutional reform which began some 30 years ago. In addition to ensuring the scheme is targeted at those for whom it was intended, the rest of the service system needs to be adequately funded, to avoid over-burdening the NDIS. As noted later in this submission, the transition of funding needs to be

[10] Based on McGrath's analysis (ibid) of population with community support needs (290,000) minus the NDIS target group in today's estimates (65,000).
[11] p14, AGA (2012). *NDIS Costings – Review by the Australian Government Actuary*.
[12] P46, NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

carefully managed to ensure specialised community supports remain for those outside the scheme; the flow of funding should be publically tracked and regularly reviewed.

The use of broad eligibility criteria also presents a risk that access decisions will be made in an inconsistent or arbitrary way. In the absence of clearer guidelines, access decision-makers may rely on stigma-informed judgements about which psychiatric diagnoses are likely to impact on functionality or require complex care. There is already evidence of diagnoses-related decision-making both anecdotally from our member service providers, and in trial site evaluations which showed that those with PTSD, depression & mood disorders are more likely to be declined a package.[13]

MIFA and Mental Health Australia agree on the need for a more specific definition along the following lines:

> *Complex, severe, ongoing disabilities resulting from severe and persistent mental illness (with recent diagnostic evidence). Additional evidence might be several of—*
>
> - *frequent hospitalisation for mental illness*
> - *current or recent history of being on the caseload of public mental health services*
> - *minimal employment in recent years*
> - *poor physical health*
> - *insecure housing*
> - *extreme social isolation*
> - *insecure/non-existent informal carer support*

Such a definition would enable greater specificity to target the intensive individual plans to those with greatest need, and ensure the funding is aimed at the cohort for which it was originally intended.

## Who is out? Policy vacuum for psychosocial community supports

At the same time as ensuring that the NDIS scheme meets the needs of those for whom it was designed, it is imperative that the 225,000 people[14] not included in the NDIS are adequately planned for. There is significant unmet demand for psychosocial support, and significant barriers for people with psychosocial disability accessing the NDIS. Sector experience has demonstrated the programs that work best for people experiencing mental ill-health are those that are easily accessible with minimal assessment processes; highly flexible with the capacity to increase or reduce support as needed; and have elements of assertive outreach and wrap-around support. The population of people requiring psychosocial support can be divided into five groups:

1. Those eligible for NDIS, and have received an approved plan

[13] 15% of people with mood disorders had their application declined, see p10 in Hunter Primary Care and 360 Health and Community (2015). *Partners in Recovery and NDIS Interface: A Data Report from the Hunter and Perth Hills Trial Sites*, https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf

[14] McGrath, D. (2016). *The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches*

2. Those eligible for NDIS, connected to program due for transition, but are facing barriers to access or have chosen not to apply
3. Those eligible for NDIS, but not currently connected to any services
4. Those ineligible for NDIS but connected to a program that is due for transition
5. Those ineligible for NDIS, and not currently connected to any services

The sector remains deeply concerned about the particular cohort of people ineligible for the NDIS. The Department of Health has advised that Primary Health Networks (PHNs) are not to commission services for psychosocial support[15], and while there have been assurances under the principle of continuity of service, in practice there is no clear indication of who and how the system will provide for those not eligible for the NDIS but in existing programs, and more generally, those who were never Commonwealth clients to begin with. Members have reported ambiguities in responsibility resulting in program uncertainty (see for example One Door's submission around the impact on forensic psychosocial services). As noted above, maintaining loose eligibility criteria for the NDIS may result in inconsistent or arbitrary access decisions, and significant sustainability issues for the scheme. On the other hand, failing to provide alternative programs for those outside the NDIS would result in the significant worsening of functionality for the cohort as a whole and create greater dependence on high level support in the future.

## Transition of existing programs to the NDIS

MIFA, Mental Health Australia, and CMHA have advocated for the quarantining of mental health funding within the NDIS, and public tracking of program budget transition in the NDIS, to avoid repeating the loss of funding and poor transition of the 1980s deinstitutionalisation. This echoes the recommendations of the NMHC Review of Services that funding should follow the individual, and no more[16], meaning that the amount of funding moving into the NDIS from existing programs should be capped at the amount spent on that individual in the previous program. Programs rolled into the NDIS had much more accessible criteria, more assertive outreach capacity, and much greater flexibility of service than is possible under the NDIS. The experience of the roll out of NDIS has not alleviated concerns about funding shortfalls and loss of service among MIFA members and the mental health support sector as a whole.

Several of MIFA members are reporting issues transitioning participants to NDIS funding, with some programs at the point of closing. There has been some reprieve with a slowing down of transition percentages for some MIFA members (see One Door's submission), however, across the board services are reporting that the transition is running ahead of the number of people able to get plans. The effect is that block funding is being cut before NDIS packages are approved. In the meantime, employment stability and service continuity are affected. Some organisations try to continue services in this interim period, but incur a financial loss. Others have no option

[15] p6, Department of Health (2016). *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care.* http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF

[16] NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

other than to close affected services. The flow of mental health funding (estimated at around $1.8 billion to $2 billion of the $21 billion NDIS budget) should be tracked publically in a transparent manner. Furthermore, to ensure services can adequately plan for the future, and allow time for the full roll out of the NDIS and associated integration activities, the transition from block funding to NDIS packages should be stepped accordingly.

On the other hand, MIFA members have also reported significant positive outcomes for clients who have successfully gained plans. For example, MIFWA provided support to two people who formerly lived in the extremely restrictive environment of a psychiatric hostel. Through MIFWA's work, the two people were able to gain enough support to live back in their own home (a rented property), and therefore gain their independence, some financial freedom and choice. In these cases, NDIS provided transformative change in their lives, due to regular practical support.

The transition of participants from existing programs in MIFA member organisations have revealed anywhere from 90% of people accessing an individual plan, to as low as 1% transition to NDIS (with the latter at the point of forcing closure of programs). However, the cost of the "success rate" in obtaining individualised plans for existing clients is very high. Intensive preparation, documentation and coaching of the individual, their family and all the supporting personnel such as GPs and Psychiatrists is only possible because the staff providing this support are funded from existing program contracts with government. This will not be the case after this funding ceases. This level of NDIS "success", which often requires utilising the appeals process, is not sustainable. The barriers for people with a psychosocial disability in accessing the NDIS are noted below.

In Mental Health Australia's submission, former MIFA CEO David Meldrum presented the following estimates on existing Commonwealth client eligibility for an individual plan: Day to Day Living (D2DL)– 50%, Partners in Recovery (PIR) – 70%. Current MIFA CEO Tony Stevenson estimates the Personal Helpers and Mentors Programs (PHaMs) will ultimately be able to transition around 40% of clients to NDIS individual plans, but figures could be lower or higher in certain areas.

Given the much broader access criteria for PHaMs, as well as the need to retain programs for carers separate to individual planning (such as the Mental Health Respite: Care Support (MHR-CS) program), MIFA is advocating that PHaMs and MHR-CS cease transition and be maintained as a separate program designed to meet at least some of the needs of the estimated 225,000 people without psychosocial support – regardless of how many existing clients successfully transition into the NDIS. MIFA is also advocating that 50% of D2DL funding and 30% of PIR funding be quarantined outside of individual support package funding and channelled into maintaining the same or similar programs. This would represent a dollar value in the order of $365 million per year.

## Access issues and the need for pre-planning support

There is significant unmet demand on the NDIS individual support program, and significant barriers for people with a psychosocial disability attempting to apply. Psychosocial disability had the lowest eligibility rate of all disability groups for applications to the NDIS (apart from access determinations in the 'Other' or 'Missing' disability groups), with only 69.4% of access determinations resulting in an individual support plan[17].

Service providers report the following psychosocial-specific barriers to NDIS access:

- Significant issues with health professionals requiring 'coaching' to understand psychosocial disability and move beyond assessments based on physical functional impairment alone.
- The particular burden of stigma, shame and fear of disclosure in the context of mental illness and how this may impact on an individual's desire to go through the invasive assessment process.
- The impact of the disability symptoms themselves on the assessment process, such that those with anxiety and trauma may require significant support to prepare and attend assessment appointments in which they are exposed to strangers and may feel threatened, judged or vulnerable. Gathering and providing evidence can be triggering, and service providers report significant resources are devoted to supporting the process of gathering documents and attending appointments.
- The problematic need to self-identify as having a disability, and one that is (or likely to be) permanent, which in itself can be counter-productive labelling that hinders the focus on recovery.
- The inability to access NDIS supports without committing to the full process, which creates a barrier for those who may be a contemplative stage[18] of understanding their need for support and wanting to explore options only. Current programs such as PHaMs have no lag-time for support, and much less restrictive eligibility criteria, meaning someone can immediately start working with a peer support worker or other professional, rather than needing to be assessed and then be allocated support resources.
- The lack of programs for carers in the absence of being attached to a person with a disability, where in the context of mental health carers may sometimes be the first person to reach out for support before the person they are caring for is ready to seek support.
- As previously mentioned, particular difficulties accessing individual plans for people with mood disorders or PTSD[19]. This is particularly concerning for clients transitioning from previous programs, given that people with mood disorders often make up the largest percentage of those in programs set for transition.[20]

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[17] National Disability Insurance Agency (NDIA) (2016). *COAG Disability Reform Council Quarterly Report Q1 2016-17*

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

[19] 15% of people with mood disorders had their application declined, see p10 in Hunter Primary Care and 360 Health and Community (2015). *Partners in Recovery and NDIS Interface: A Data Report from the Hunter and Perth Hills Trial Sites*, https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf

[20] 27.8% of NSW PIR clients had mood disorders: p20, Amos, P. (2015). *Persistent Mental Illness And Complex Needs A Project Of New South Wales Partners In Recovery Organisations*

Currently services are drawing on other resources (whether loss-leading or as part of support under current programs due for transition such as PIR or PHaMs) to facilitate access for people into the NDIS. All of the above issues indicate a strong need for 'pre-planning' resources, that sit outside of planning or access determination services. These pre-planning services would preferably sit with organisations that have visibility, diagnostic-specific expertise, and pre-existing connections with the community they serve.

MIFA has strong reservations about the ability of Local Area Co-ordinators (LACs) to fill the gap in pre-planning needs in the future, given their already large area of responsibility (both planning and networking), and their lack of specialist psychosocial expertise. One Door has provided more detail around their mental health service experience of LACs. Best practice also supports the concept of continuity of care[21], such that an individual should be able to receive support from the same service and if possible the same person throughout their recovery journey; in the case of MIFA member organisations, some have 20 year histories of support with certain people and would like to be able to support these persons (if the person so chooses) from pre-planning, through to support co-ordination, plan management and/or service provision. It is understandable that actual planning and access decisions must remain separate from service providers as this poses a potential conflict of interest, however, the evidence from MIFA consumers to date suggests consumers are needing and expecting a higher level of support throughout the access process than LAC planners can provide – the weight of which is being borne by existing programs set for transition.

## Potential PHN role in planning

The proposition that PHNs may play a role in planning for psychosocial services referred to in the terms of reference is completely novel and unexpected. The Department of Health PHN commissioning guidelines have clearly delineated PHN work from any kind of psychosocial support[22]. It is possible that in the future PHNs may choose to direct their resources in such a way that will challenge the highly clinical focus of the Department of Health guidelines, given the significant unmet need for psychosocial support in the community, and the recognition that psychosocial support and in particular peer support can relieve the burden on clinical care and indeed function as a treatment intervention itself in certain contexts. MIFA has the same reservations about the ability for PHNs to take on the role of NDIS planning themselves, for the same reasons that LACs may not be best placed to support those with psychosocial disability: a

[21] For more on continuity of care, see 'Priority area 3: Service access, coordination and continuity of care.' in Australian Government (2009) *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014*, http://www.health.gov.au/internet/main/publishing.nsf/+content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/pla3.pdf

[22] p6, Department of Health (2016). *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care.* http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF

lack of mental health psychosocial support knowledge, stretched resources (given they are expected to manage primary health needs across the full range of health issues), and the lack of current client connections.

## The need for assertive outreach

A further significant component of existing programs due for transition that individual NDIS programs cannot replace is assertive outreach. Research indicates that around 54% of people with mental ill-health do not seek help[23]. This presents a significant issue for service system planning and policy; with over half of the target population not presenting to services, it follows that a reasonable percentage of resources must be dedicated to supporting help-seeking behaviour and reducing barriers for access. The best strategies go beyond public campaigns and information provision, and into dedicated outreach resources. The 2015 review of NSW PIR services indicated assertive outreach strategies were successfully able to connect with excluded cohorts, including people experiencing homelessness and Aboriginal and Torres Strait Islander people[24].

Assertive outreach involved devoting time and resources to actively seeking out people in the community (e.g. rough sleepers), and building trust and engagement with people prior to their entering formal service. It also involves having resources available for consumers to connect with services in an unplanned way, for example through connecting to support workers via telephone, having face to face drop-in centres available, and after hours supports. These services need to be integrated with other kinds of supports, so that participants feel safe connecting to a known provider (rather than connecting with a completely different service).

## Can ILC fill the gaps?

There is strong potential for the Information, Linkages and Capacity Building (ILC) component of the NDIS to address some of the gaps for those with psychosocial disability who are ineligible for an individual plan. Indeed, with the variability and inadequacy of other federal portfolio or State/Territory government taking responsibility for the psychosocial needs of the 225,000 people who will not be eligible the NDIS, ILC must step in to fill the vacuum. This is consistent with NHMC recommendations in the 2014 Review of Services report:

> "The logic of Tier 2[25] should be that it is of sufficient capacity to support people whose psychosocial disabilities are not sufficiently "permanent" or profound[,] to live productive lives in the community and reduce their risk of entering Tier 3 due to worsening disability."[26]

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[23] Whiteford HA, Buckingham WJ, Harris MG, et al. Estimating treatment rates for mental disorders in Australia. Australian Health Review 2014; 38(1): 80-5.

[24] Amos, P. (2015). *Creating Better System Responses For People With Severe And Persistent Mental Illness And Complex Needs A Project Of New South Wales Partners In Recovery Organisations*

[25] Former term for ILC

[26] p62, NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

The ILC is designed to support all people with psychosocial disability, whether or not they are eligible for the NDIS. Many of the outcomes for mental health recovery and the ILC are aligned, and in particular the Individual Capacity Building Activity in the ILC suggests individual psychosocial supports for those without a package may be in scope. Without permanency or high, complex needs eligibility criteria for the wider ILC program, there is potential for it to support a wide range of people. However, MIFA has strong reservations about the ability the ILC program to adequately fund such programs in its current formulation. Immediate action is required to quarantine funding for psychosocial services specifically, increase funding, clarify the funding criteria, and plan for integration between ILC programs, individual plans and other mental health supports, including PHNs, public and community health.

The total funding package for ILC at full roll out in 2019/20 is $132 million, which when split across all types of disability is not adequate. Mental Health Australia's submission[27] proposes quarantining $365 million from the NDIS to support the continuation of key service elements of the PHaMs, PIR, MHR-CS and D2DL programs; this amount could be directly shifted and administered under ILC, assuming the Individual Capacity Building activity area of the ILC Outcomes Framework encompasses the kind of supports provided in these programs. Our strong recommendation is that the $365 million is directed at PHaMs-like services that can respond quickly and flexibly without onerous assessment processes, PIR-like services that can assertively reach out to those with the most complex needs, and dedicated support for carers.

The ILC must provide greater clarity around the funding criteria. There are many ambiguities in ILC Policy that make it difficult for organisations providing psychosocial support to know how resources will be allocated. These include:

- Crossovers between outcomes for individual plans and the Individual Capacity Building activity of the ILC;
- Ambiguity between LAC functions and the potential work of other ILC programs, particularly as LACs are not yet widely operating;
- Contradictions between the ILC Commissioning Framework, which indicates commissioning will focus on diagnostic specific expertise and/or cohort-focused delivery[28] (among other focus areas), while ILC documents elsewhere indicate that programs must benefit a wide range of people[29]
- General ambiguity about the intent and focus of the funding, in particular the kinds of projects that are in scope

This lack of clarity has made it difficult for service providers to prepare funding bids or plan for future service delivery to clients. The focus in the ILC around mainstream service and broader community inclusion suggests a shift away from diagnostic specific expertise; MIFA has strong reservations about the ability of mainstream services to support those with psychosocial

[27] Mental Health Australia's Submission 1, *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*

[28] ILC Commissioning Framework, p. 18

[29] "We expect the activities we fund in ILC to benefit a wide range of people." From https://www.ndis.gov.au/ILC-FAQ-Organisations

disability without strong partnerships or guidance from organisations with the experience, and consumer/carer connections to understand the needs of those with mental ill-health.

The roles and responsibilities of the PHNs, public and community health should also be clearly delineated from psychosocial programs, with resources to ensure integration across services is possible.

## Conclusion

MIFA thanks the Joint Parliamentary Committee for the opportunity to provide input into the inquiry. In times of great change, the commitment to focusing on the particular needs of people with psychosocial disability in the form of this inquiry is appreciated.

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## Disclaimer

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