

Psychosocial Supports Design Project – Final Report

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Glossary

CMHA	Community Mental Health Australia
DoH	Australian Government Department of Health
DSS	Australian Government Department of Social Services
IAC	Independent Advisory Council
IFP	Individually Funded Package
ILC	Information, Linkages and Capacity Building
LAC	Local Area Coordinator
NDIA	National Disability Insurance Agency/The Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NMHSRG	National Mental Health Sector Reference Group
NQSF	National Quality and Safeguard Framework
PHaMS	Personal Helpers and Mentors Program
PIR	Partners in Recovery Program
Support Catalogue	Now called Price Guide

Executive Summary

In early 2015 the NDIA and Mental Health Australia embarked on a joint project to identify optimal packages of support for NDIS participants with a psychosocial disability, known as the *Psychosocial Supports Design Project* (the Project). The Project began in response to concerns expressed by mental health providers operating in NDIS trial sites about the applicability of the NDIS Support Catalogue (now called the NDIA Price Guide) to the types of support services likely to be chosen by participants with psychosocial disability.

The broad aims of the Project were:

1. To describe in detail the range of disability supports for people who have a primary condition of psychosocial disability that may be sourced by individuals with NDIS funding.
2. To make evidence based recommendations, where new support items may be needed to adequately assist people with psychosocial disability who are participants in the NDIS

The Project did not seek to examine issues of pricing for psychosocial support services funded by the NDIS. However, it was intended the Project's findings would provide information to support future work by the NDIA and others on pricing matters

Project activities included a literature review, consultations, national consultations, consolidation of feedback, and mapping of feedback against the NDIA Price Guide. This report reviews feedback from the consultations and identifies new developments within the NDIA during the life of the Project.

Overall, the feedback from the national consultations identified a range of concerns from the mental health sector with suggestions for improvement. Where these issues related to the Project's objectives, some appear to have been addressed by new developments in the NDIA's approach to implementation.

This report makes 12 recommendations for the Agency to consider, including further investigation, changes to NDIA practices and processes, sector development and communication activities.

Background

In late 2013, the Independent Advisory Council (IAC) for the National Disability Insurance Scheme (NDIS) identified the need to improve the Scheme's responsiveness to people with psychiatric conditions as a priority for its work in 2014. The IAC had undertaken considerable work in listening to the views of consumers and family/ carer advocates and the mental health sector and building an understanding of how the trial sites are responding to applicants and participants with disability arising from mental health issues. Conclusions and directions outlined in this Report were also informed by the findings of a concurrent Literature Review "Mental Health and the NDIS" (August 2014). The IAC recommended the development of a five-year 'NDIS Mental Health Implementation Plan' as a statement of its directions and priorities to improve the Scheme's responsiveness to people with disabilities related to mental illness.

The NDIA implemented the IAC recommendation by establishing the National Mental Health Sector Reference Group (NMHSRG) to be an effective conduit for information and communication between the NDIA, the mental health sector and the broader community. The NMHSRG provides expert advice from a cross section of the mental health sector to the NDIA about the progressive integration of psychosocial disability into the Scheme. The NMHSRG meets four times per year and a detailed communique is available publically after each meeting.

In early 2015 the NDIA and Mental Health Australia embarked on a joint project to identify optimal packages of support for NDIS participants with a psychosocial disability, known as the *Psychosocial Supports Design Project* (the Project). The report also provides information on the Project's purpose, the methodology used to gather feedback, detailed responses to stakeholder feedback, and a range of supporting information produced throughout the course of the Project. This is a report on the outcomes of the Project and includes detailed findings and recommendations.

1.1 Project inception and governance

The Project arose in response to concerns expressed by mental health providers operating in NDIS launch sites about the applicability of the NDIS Price Guide to the types of support services likely to be chosen by participants with psychosocial disability. Providers were worried that the NDIA Price Guide (at that time) did not sufficiently accommodate recovery-oriented best practice in community-based mental health supports.

Providers in trial sites raised related concerns about the pricing levels being applied to NDIS funded services for participants with psychosocial disability. Providers were keen to see pricing levels that reflected the specialist mental health workforce, which considered that they had skills and approaches that can differ markedly from other service types likely to be funded through the NDIS. These discussions led to the establishment of a Steering Group with representation from the NDIA, Mental Health Australia and providers.

The Steering Group subsequently identified the need for further collaborative work to examine the pricing of mental health supports, and agreed that the outcomes of the Project would be presented to the National Mental Health Sector Reference Group (NMHSRG) once complete. A Joint Working Group was established with representation from the NDIA, Mental Health Australia and Community Mental Health Australia (CMHA), and a Project Scope finalised (see Appendix 1).

1.2 Aims and objectives

The broad aims of the Project were:

1. To describe in detail the range of disability supports that NDIS participants with psychosocial disability may choose; and
2. To make evidence based recommendations, where new support items may be needed to adequately assist NDIS participants with psychosocial disability.

The Project did not seek to examine detailed or technical issues affecting the pricing of psychosocial support services funded by the NDIS. However, it was intended the Project's findings would provide information to support future work by the NDIA and others on pricing matters. The work carried out through the Project was therefore quite different in substance to the joint NDIA and National Disability Services (NDS) project on the reasonable cost methodology for high-volume NDIS support types, completed in mid-2014.¹

With these broad aims in mind, the Project's objectives were to:

- Investigate and document optimal packages of individual supports for people who have psychosocial disability associated with a mental illness (i.e. where a mental illness is the 'primary diagnosis' leading to the disability).
- Outline some typical support needs for this target population and detail how NDIS funding could be applied to meet these needs.
- Map examples of optimal psychosocial support against the range of support type definitions used by the NDIA.

Where evidence emerged that particular approaches to delivery of supports led to good outcomes, the NDIA would examine these for possible inclusion in NDIS individually funded supports where appropriate.

At the recommendation of sector representatives and consistent with the objectives above, the Project also sought to, where possible:

- Explore the role of peer workers in delivering NDIS funded supports.
- Gather evidence on the range of qualifications/skills required to support participants whose psychosocial disability needs range in complexity.

¹ The NDIA report on the methodology of the efficient price can be found here:
http://www.ndis.gov.au/sites/default/files/documents/methodology_for_reasonable_cost_model.pdf

- Consider appropriate types of support with regard to the agreed boundaries between the clinical system and the NDIS, including where participants require step-up and step-down support.
- Consider what support items might assist with coordinating access to different services, including clinical care.
- In consultation with mental health consumers and carers, service providers and other experts, describe 'optimal' supports that reflect different kinds of psychosocial support needs.

1.3 Methodology

The Project was carried out in staged fashion, with each stage informing the next:

- **A review of literature** and other material directly relevant to the Project's objectives, commissioned by the NDIA and undertaken by Synergia. The key findings of the literature review are summarised in Section 2, with further details available in Appendices 4 & 5 (Synergia report on *Issues and Opportunities*) and a *Background Paper* distributed to participants in stakeholder consultation sessions). Drawing from this work, Synergia advised the Project Working Group as it developed materials to inform stakeholder consultations. This work took place between February and May 2015.
- **Trial consultations** with stakeholders in a small number of locations (Melbourne, Adelaide and Canberra) in May 2015. The trial consultations were based around fictitious case studies developed to prompt feedback on what supports would be appropriate for people with psychosocial disability in a range of circumstances. Consultation materials were substantially revised following this feedback.
- **National consultations** with mental health stakeholders in each state and territory, conducted by CMHA on behalf of Mental Health Australia between September and November 2015. A total of 173 people attended consultation sessions, including existing participants and carers of participants from trial sites, consumers and carers from outside trial sites, service providers (from both within and outside trial sites), representative/advocacy services (such as state community mental health peak bodies), and a small number of officials from the NDIA and from line agencies. Consultation materials included:
 - > A Background paper, reproduced at Appendix 5.
 - > Case studies of consumers with psychosocial disability with a range of backgrounds and support needs.
 - > Preliminary mapping of items from the NDIS Price Guide against support types described in Synergia's literature review.
 - > Templates to help participants and facilitators identify and record feedback on the range of support types discussed.

- **Consolidation and synthesis of feedback** from consultation sessions, summarised in Section 2, based on a detailed report on consultation outcomes by CMHA to the Joint Project Group.
- **Mapping of feedback against the NDIS Price Guide** to identify areas where the Guide can already accommodate support needs and where further work is needed to apply, refine and/or supplement the Guide. The detailed outcomes of this mapping can be found in Appendix 3.

1.4 Adapting to new developments

A range of announcements were made during 2015 which changed the broader context in which the Project was taking place, with the NDIA making progress on many fronts in preparation for the national rollout. In response to new developments, the Project was adapted to maximise the relevance and usefulness of its findings for the NDIA and for mental health stakeholders. This did not substantially change the aims and objectives outlined above, but it did influence the nature of discussions with stakeholders and the manner in which stakeholder feedback has been interpreted in this report.

Chief among these developments was the NDIA's adoption of a revised Price Guide in August 2015, just prior to most consultation sessions for the Project. Compared with earlier iterations of the Support Catalogue, the revised Price Guide places more emphasis on the outcomes that funded providers seek to achieve for the participant. The revised Price Guide also allows participants greater flexibility in how package funds are expended in pursuit of the objectives stated in a participant's plan, rather than constraining choice with reference to a prescriptive catalogue of service types. Importantly, the revised Price Guide introduced three new types of support coordination, priced at different levels which can be included in plans for participants. Further discussion of these changes can be found in Section 3.

The revised Price Guide means there may now be less need to fully articulate the broad range of support types that someone with psychosocial disability (or indeed any other disability) might choose, given the diversity of individual circumstances and increased flexibility for providers. This report therefore describes key themes from stakeholder discussions regarding the types of psychosocial support that can be beneficial for people in different circumstances, rather than providing a comprehensive list of service types and the systems through which they might be funded and delivered. The report also identifies a range of gaps where there is the potential to improve practice, bearing in mind current knowledge about the Scheme's operation.

Key Findings

This section represents the work of the consultants engaged for this project with the view of assisting the mental health sector to better understand the NDIA (using concepts and language understood by the mental health sector) and has faithfully represented their work in this context.

2.1 Themes from literature review

In early 2015, the NDIA commissioned Synergia to undertake a review of existing literature to explore key concepts relevant to the Project's aims and to inform the consultation process. This section provides a summary of Synergia's work, with further details available in Appendices 4 & 5 (Synergia report on *Issues and Opportunities*) and (a *Background Paper* distributed to participants in stakeholder consultation sessions).

While many of the supports required by people with a psychosocial disability are common to those with other types of disability, the language, underlying assumptions and service paradigms can be quite distinctive across the two domains. A central task for the literature review was therefore to identify the intersections between different prevailing concepts in mental health and disability support. The review sought to describe:

- The extent to which there are unique aspects of support that may be required by people with a psychosocial disability
- How the boundaries between NDIS support and other support entitlements may work to provide an 'optimal mix'.

Key themes emerging from the review are presented and discussed below.

2.1.1 *Opportunities and challenges*

The NDIS represents a game-changing opportunity for mental health in Australia – an opportunity to finally secure some ongoing, recovery-oriented community support for people with severe and persistent mental illness. The NDIS provides a structure for psychosocial support that is largely unavailable to Australians currently. Its central ethos of self-directed support fits well with concepts of self-agency, independence and recovery. The NDIS also has the flexibility to operate at both individual and systemic levels. The NDIS design incorporates both individual and systemic capacity building, both of which are necessary and well suited to mental health support.

The NDIS also provides a new and important long term focus on the merit of investment in good community mental health support. This kind of lens has been missing in the clinical mental health system, which too often directs people to expensive and often traumatic hospitals as practically the only place to go for care. The longitudinal lens generated by the NDIS, in considering the lifetime costs of care, provides incentives and opportunities to

create new pathways for care and support. These new options will assist in diminishing the requirement for hospitalisation, save money and increase the quality of life enjoyed by the people concerned and their families.

The concept of packages of mental health support highlighted some of the boundary issues separating the mental health and disability paradigms. These issues could be summarised in five broad areas:

- **Reconciling the enduring nature of disability versus the paradigm of recovery.** While clearly not insurmountable, there is a mismatch between common concepts of permanent disability and the recovery ethos. There is a desire to establish a strengths-based philosophy of positivity embodied in the notion of recovery that sits awkwardly with consignment to a definition of life-long disability.
- **Reconciling the NDIS concepts of permanency and stability with the fluctuating/episodic nature of mental illness.** By its nature mental illness is rarely a stable state, particularly for people with more severe illnesses. Catering for these fluctuations lies at the heart of the NDIS's capacity to deliver good care.
- **The paradigm of self-directed choice and control versus perceived variability in capacity for self-determination and risks.** While the disability sector may have come to terms with concepts such as the dignity of risk, letting people make mistakes of their own and so on, the clinical mental health sector has become increasingly risk averse. This is perhaps one reason why the location for mental health care has become increasingly centralised to hospitals, where these risks can be best 'managed'. Clearly there is work to be done to reconcile these two approaches so as to establish a balance that meets the needs of individuals and their families.
- **An assumption of a clear differentiation between clinical and social supports.** Particularly as Australia's mental health system starts to reorient towards hospital avoidance and community support, neat categorisations such as these are coming under pressure. More and more organisations are striving to provide blended care, offering both clinical and psychosocial support services, often extending to include housing, employment, vocational training and so on. It would be a pity if these nascent services were sacrificed because of the need to be clear about who pays.
- **A Reality Check – Implementing the NDIS within the context of an under-developed system for mental health.** Particularly in relation to non-hospital services, Australia's system of mental health care is variable and not consistent nationally. Even hospital-based services are generally under enormous strain. As the NDIS further develops its approach, there is a need to be realistic about how to create new partnerships with mental health services.

2.1.2 Requirements for effective support

Workforce skills and capacity

Stresses and strains around the Australian mental health workforce are well known. The response to this challenge has been to suggest that Australia's mental health service system should be reoriented around a stepped care framework that provides a range of help options of varying intensity matching people's level of need. In particular:

- Self-help and peer-based services, especially those delivered online, that are capable of providing help and support at massive scale should be prioritised by policy makers, funding bodies and researchers, with greater and more sustainable investment
- Self-help, peer-based, and online services should be fully integrated with more 'traditional' existing services through clear treatment pathways, and a mental health workforce trained to optimise their access
- Mental health workforce capacity should be maximised through greater utilisation of mental health peer workers where appropriate, freeing up clinicians to assist those in greatest need

The role of peer workers

An important element of possible NDIS supports is the role of peer workers. Peer workers are people who identify as having lived experience of mental illness and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated roles in services who use their common experience to support and inspire hope and recovery in others².

A recent review of the evidence base by Health Workforce Australia³ noted that while evaluation of peer work has lagged behind implementation, the evidence suggests that peer work can be as effective as other service approaches and delivers significant benefit to consumers, peer workers, families, carers and services. An acknowledgement of the difference between medical or clinical focussed services and disability support services is a likely reason that peer workers are becoming an essential element of mental health service provision and a skill set of choice for community managed mental health services.

Peer workers are likely to be more familiar with the disability support needs of people with mental health conditions and are able to identify ways to meet these needs outside the mental health sector and in dealing with everyday life in the community. In providing these services they use their unique skills and experience to provide a conduit between mental health services and disability supports. They are also uniquely placed to provide pathways between generic disability services and people with a psychosocial disability⁴.

² Peer Work Strategic Framework, Western Australian Association for Mental Health, October 2014

³ Health Workforce Australia (2014a), Mental Health Peer Workforce Literature Scan

http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Literature%20Scan_LR.pdf, accessed April 2015

⁴ Unravelling Psychosocial Disability, Position Statement, National Mental Health Consumer and Carer Forum,

http://www.nmhccf.org.au/documents/NMHCCF_Psychosocial%20Disability_Booklet_Web%20version_27Oct11.pdf, accessed April 2015

A goal for the NDIS could be to ensure that all peer workers are appropriately skilled and experienced professionals who possess a comprehensive knowledge and understanding of the local service system (including health and welfare sectors) and both clinical and non-clinical support services.

Organisation of providers and networks

The focus of the literature review was on the issues and opportunities for NDIS individual packages of support rather than how that support is organised across networks of families, carers, support providers or other agency services. However the NDIS has a strong role in this area through the Information, Linkages and Capacity Building (ILC) and Local Area Coordinator (LAC) functions.

From a mental health perspective, the Partners in Recovery (PIR) program has shown the value of drawing together networks of government, health and community partners at a system level in order to facilitate access and integration of support within person centred individual plans.

As the NDIS evolves more targeted approaches to psychosocial disability through the network infrastructure developing under PIR will become highly relevant. These approaches include:

- Workforce skills development
- The capability and experience in developing recovery-oriented individualised plans, with measurement of function and outcomes
- Coordination capability in the form of information, linkages and relationship brokerage
- Information and intelligence sharing across networks of communities, providers and agencies
- Practice governance and quality assurance

Implications for NDIA staff and processes

While the NDIS clearly sets some challenges for the mental health sector workforce, the fluctuating nature of mental illness and the complexity of the 'system' of care also pose new challenges to NDIA staff. Effective planning to meet the needs of psychosocial disability requires frequent review, as well as a good understanding of the nature of the person and their unique experience of mental illness. Fluctuations in the symptoms of illness necessitate swift response to avert negative, longer term impacts and costs. This may require a different, more frequent and intimate level of interaction between NDIA planners and the people using the Scheme and their families. NDIA staff may therefore benefit from deeper insight and training in relation to psychosocial disability.

There is also excellent evidence pointing to the effectiveness of multi-disciplinary teams in the effective care and management of mental illness. There need to be opportunities for NDIA staff to build and become part of such teams, working with health, housing, community services and other staff to drive holistic care. A key part of bridging the gap between health and disability paradigms is cross-fertilisation of this type.

2.1.3 Identifying and describing good psychosocial support

People with psychosocial disability who are eligible for the NDIS will have enduring mental health issues, but their individual journeys are generally characterised as having:

- Combinations of ongoing and episodic or cyclical functional impairments manifest in a variety of forms that are only loosely related to the individual diagnosis.
- Relatively unpredictable recurrence of urgent/acute exacerbations of symptoms which fluctuate in type, severity, duration and impact. The onset process can be amenable to early proactive responses to reduce impact. By the same token, poor access to 'step-up' support can lead to crisis situations, loss of self-agency and in-voluntary treatment or admission.
- Opportunities for recovery, where the ability to live well in the presence or absence of symptoms, can be enhanced by recovery focussed support. Conversely, it is important to avoid the risk of inadvertent dependency, where people can become 'stuck' inside support services.

On this basis, NDIS supports need to be able to flexibly respond to the different and often fluctuating needs of people with psychosocial disability, both in their initial encounters with the NDIA and in how services respond to needs over time. For people with severe mental illness, experiences of the 'system' will in many cases be associated with feelings of stigmatisation and constrained access to the combinations of the clinical and support services they have needed at one point or another.

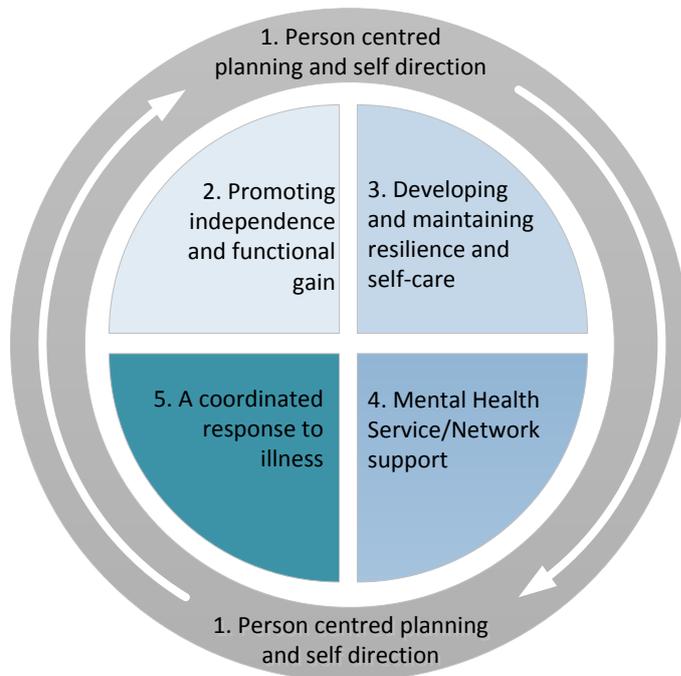
While individual journeys are unique, it is possible to describe at least three common or 'typical' journeys, each with associated needs that could be met through the provision of appropriate individual support packages under the NDIS:

1. **Substantially reduced functioning resulting in disability** described as 'prominent disablement experienced at all times'
2. **Fluctuating, unpredictable patterns of relative impairment.** This corresponds to what NDIA describes as a 'deteriorating course' or 'late improvement after a period of disablement'.
3. **Cyclical pattern of functioning,** as typified by affective disorders where periods of substantial disability are followed by periods of relative capability, although some underlying functional impairment is likely to remain that may not be consistent with the NDIS access criteria.

2.1.4 A conceptual framework for consultation

Based on the issues and themes emerging from the literature review, Synergia developed a conceptual framework to prompt discussion and feedback from stakeholders. This framework identified five 'building blocks' that could be used to describe good practice in psychosocial support from an NDIS perspective. The five building blocks are illustrated below.

Figure 1: Five building blocks for psychosocial support



Underlying the building block framework are certain principles and assumptions about the nature of psychosocial support. For example, it is generally accepted as good practice for these supports to be:

- Operating in accordance with Australia's framework for recovery-oriented mental health services
- Person-centred, ensuring that individual preferences are respected and people are supported to make their own decisions
- Designed to provide information, advice and skills to facilitate opportunities for self-help, taking control and making choices
- Aimed at providing opportunities for people to manage personal budgets for disability support and other resources that are available to them
- Working with carers to identify and provide what they need to carry out their support roles effectively and maintain their health and live their own life
- Accessible, equitable and providing opportunities without stigma or discrimination

- Responsive to the episodic nature of mental illness, the changing nature of psychosocial disability and personal consumer and carer needs and provide quality and innovation
- Working closely with clinical and other disability and community services to ensure supports are streamlined and comprehensive
- Drawing on the skills of the mental health consumer and carer peer support workers in service design and delivery

The building block framework was not intended as a definitive outcome of the Project, but rather as a device to help mental health stakeholders discuss these issues using language and concepts they could relate to. While feedback was received on the framework itself, such feedback was not central to the aims of the Project and is not reported here. Instead, the following section reports stakeholder views on the broader questions posed by the Project about optimal support for people with psychosocial disability.

2.2 Themes from stakeholder consultations

The feedback summarised in this section is based on discussions with consumers, carers, providers and other non-government stakeholders at consultation workshops in held in each state and territory in October and November 2015.

The views described below are not necessarily representative of the mental health sector as a whole or of the experiences of all participants and carers directly involved with the NDIS to date. There were approximately 110 attendees who approached the consultation questions in a spirit of genuine engagement and constructive dialogue. Any criticisms expressed were clearly based on a desire to improve the NDIA's understanding of and response to the issues at stake.

Those attending the workshops had a range of experiences with the NDIS, from direct and active participation (eg providers, participants and carers from the Hunter and Barwon regions, the most active sites to date from a mental health perspective) to no direct experience of the NDIS at all (eg in South Australia and Queensland). Feedback therefore ranged from in-depth commentary on detailed matters of implementation to much broader perspectives on long term issues to resolve through transition and beyond.

Stakeholders in trial sites readily acknowledged certain problems may already have been addressed through recent changes, but had little or no experience of these changes so soon after the introduction of the revised Pricing Guide in August 2015. They also recognised many participants with psychosocial disability have seen improvements in their lives as a result of accessing the NDIS.

Mental Health Australia thanks everyone involved in the consultation sessions, including representatives of CMHA and state/territory community mental health peak bodies who organised and hosted the workshops.

2.2.1 Engagement, readiness and pre-planning

An overriding finding of consultations with mental health stakeholders was the importance of engaging consumers and carers on their terms and in a manner appropriate to their distinctive circumstances. Stakeholders strongly cautioned against connecting with people with serious mental health issues under an assumption of ‘readiness’ or ‘preparedness’ for planning. Stakeholders in the consultations considered that many, and perhaps most, people with psychosocial disability won’t be ready to engage in a constructive conversation with a NDIA planner the first, second or third time that they meet. Instead, investment is required to support the person to work through a range of issues before. Only once this investment is made is it then possible to take best advantage of the NDIS by choosing the supports they need in the long term.

When presented with a range of case studies to prompt discussion⁵ about optimal supports matched to particular needs, there was strong consensus that identifying someone’s support needs would largely be ‘guesswork’ unless the right process is established to develop rapport and trust with that person in advance of the planning conversation. The majority of NDIS participants with psychosocial disability will have had little or no experience of choice and control, and even where someone’s goals are clear, the support options on offer are by no means straightforward.

For participants to be able to reach the point where they can make long term plans about what supports would best help them reach their goals, there would often need to be an ongoing, trusting relationship with a skilled worker or another support person who can respond to need at the participant’s own pace, commonly over several months or longer. Stakeholders argued that the NDIA’s processes would need to accommodate this reality – rather than participants always needing to adapt to NDIA processes without being ready for the planning conversation.

Trusting relationships can play a major role in helping people with psychosocial disability identify and articulate their goals, and should be encouraged wherever possible. Such relationships can be informal, such as with a carer, family member or a peer, or with people working in any service that the person might access (whether a NDIS provider organisation or not). In the latter case, or where someone has little or no informal support arrangements, a provider could be funded to work with that person in anticipation of a planning conversation taking place once they are ready to talk about how the NDIS might support them.

At a practical level, this might mean that a consumer and their worker(s) would meet often, over a period of time, in a manner which is flexible, may involve proactive outreach, and which is based on a solid understanding of mental health and demonstrated skill in engaging with mental health consumers. Under this approach, relationships would remain stable and transition with the consumer along their journey into the NDIS, with workers advocating strongly on their behalf wherever necessary and investing time in a stable and supportive relationship based on mutual trust and respect.

Depending on the nature of someone’s disability, the notion of individual capacity building was said to be problematic in some cases. For example, for some people the focus for the

⁵ See Appendix 5

foreseeable future should be in supporting them in daily life to achieve stability, guarantee safety and improve health. Stakeholders observed that some individuals may require specific approaches over considerable time to build their capacity as the challenges they experience in daily life to maintain stability, and their health and safety are significant

Similarly, planning conversations may be problematic for people with profound levels of disability. In these cases, someone's preferences are most likely to emerge over time through an ongoing relationship with the right person, rather than in a time-limited interaction with an NDIA planner. These challenges were said to be most pressing, and the role of psychosocial providers in facilitating choice most important, where there are little or no support networks and/or no carer to help someone make decisions.

The feedback described above made the Project's overall goal – to gather stakeholder views on the optimal range of supports for people with psychosocial disability – particularly challenging. Positively, the message that an ideal process for identifying support needs is a highly individualised process without a predictable formula is highly consistent with the Scheme's focus on maximising choice and control.

Notwithstanding these observations, the consultation process did identify a range of specific support types that might be considered by the NDIA for potential inclusion in plans. Further details are provided below.

2.2.2 Service principles and skillsets

A common thread in consultations was that certain principles must underpin and inform best-practice psychosocial support services. For support to be described as 'optimal', mental health stakeholders said they must be recovery-oriented, person-centred, family-inclusive, culturally secure and trauma-informed.

These service principles involve specialist ways of working, with a focus on strengths and abilities. While stakeholders were optimistic that, in time, the NDIS will enable this to happen, they also felt that much work is required to make this a reality via the NDIA's processes. In particular, stakeholders were keen that the NDIA recognise the high level of skill and sophistication required in the delivery of high-quality psychosocial support services which reflect these principles. Stakeholders hoped that, in time and as experience working with mental health providers grows, NDIA planners will better understand how community mental health providers work with their clients and appreciate the value of the specialist skills required for such work.

A primary skillset in this regard is the ability to engage someone appropriately so that a consumer believes in and drives their own recovery journey to the maximum extent possible. Engagement is particularly challenging, but also most critical, at times when someone may have lost hope for their prospects of recovery, perhaps because of negative experiences with services they have accessed in the past, because they were acutely unwell recently, or because other life circumstances have deteriorated. Regardless of the activities undertaken on any given day or the setting in which the interaction might occur, workers must make a judgement, in consultation with a consumer, about what is possible or helpful at that time.

For engagement to be trauma-informed, a worker will be able to recognise and anticipate someone's particular needs and sensitivities and minimise the actual or perceived risk of further trauma. For engagement to be family-inclusive, a worker will work with carers to learn as much as possible about someone's distinctive needs and any informal supports they might draw on.

A related skill identified by stakeholders is outreach. Many people identified the Support Facilitator role in the Partners in Recovery (PIR) program as being a great example of what is required to provide outreach to people with severe mental illness and complex needs. They regarded PIR as the best existing model providing specialist outreach for this population group. While many were unsure of the future of PIR, they saw the PIR service model as being very well matched to the task of identifying likely participants with psychosocial disability who may not currently be accessing a program in scope for the NDIS. It was noted that the value of PIR in part comes from the active role that Support Facilitators play 'behind the scenes', ensuring that clients can access the full range of services required, and known under the PIR model as 'systems change.'

Stakeholders discussed the role dedicated peer workers can and should play in engagement and outreach. Peer workers are very well placed, and sometimes uniquely suited, to working with people with mental health issues. Having a shared lived experience of mental illness provides a common language and fosters the trust needed to work with someone over time, develop rapport, support recovery and respond to changing circumstances. Within a provider organisation, a peer worker might be the primary contact for a participant, with other workers and services brought in around them as appropriate. Continuity of the relationship with a peer worker can also assist in identifying early warning signs of someone becoming unwell, so that services can respond as quickly as possible before things reach crisis point. From an insurance standpoint, peer worker roles were said to be a highly worthwhile investment by the NDIS.

2.2.3 NDIA practices and processes

Stakeholders with direct experience of the NDIS compared their understanding of the NDIA's approach to date in trial sites to what they believed to be good practice in recovery-oriented psychosocial support.

This feedback was based largely on experiences prior to the introduction of the new Pricing Guide. Stakeholders of course recognised the NDIS will continue to evolve over the coming years, and current approaches may not be replicated at Full Scheme. Some feedback was less directly relevant to the objectives of the Project, and is reported in case it assists other aspects of the NDIA's work.

The current NDIA approach is to separate various functions into distinct processes: access, being plan ready, planning, plan implementation and review. Recovery-oriented service provision, by contrast, often blurs these boundaries, with each process being undertaken on a consumer's own terms. For example, the kinds of assessment undertaken by a community mental health provider may be with a view to developing a recovery plan, in which case 'assessment' and 'planning' are seen as one and the same process, though with different definitions from the NDIA model. Alternatively, initial 'assessment' may be undertaken to identify someone's immediate needs (such as stable housing) and to intervene immediately

to help bring stability to their daily life. Different providers may take different approaches, but, according to feedback from those stakeholders consulted, good practice support will always be recovery-oriented, person-centred, family-inclusive, culturally secure and trauma-informed.

Given the integrated approach commonly employed in the sector, providers hoped the NDIA's processes will in future allow for increased flexibility so that provider responses could adapt without unnecessary delay or red tape. Compared to the plans they had seen so far, these providers expressed a desire for planning to support a greater level of integration and coordination across services, matched with funding to ensure the right degree of coordination is available. This in turn would help providers and mainstream services respond in timely fashion to episodic and fluctuating need.

Stakeholders strongly believed more needs to be done to address the needs of carers of people with psychosocial disability, given that optimal psychosocial support ought to emphasise the contribution and needs of families wherever possible. As well as maximising the involvement of carers in the planning process (an area which was said to have improved greatly since the Scheme's early days), it was felt that funded plans needed to include more provision for carer respite (regardless of what terminology is used). There are ongoing and widespread concerns that the focus on participant needs may unintentionally reduce the level of services available for carers, whether through participant plans, ILC funded services or programs delivered beyond the NDIA's areas of responsibility.

Another concern for providers operating in launch sites stemmed from provisions regarding participant privacy. While they supported the rights of participants to control their personal information, providers were worried about not receiving the full picture about a participant's situation in the information they receive from the NDIA. This was said to make it difficult to understand how their service would contribute to the participant's needs, particularly when multiple providers are involved. More seriously, providers reported receiving referrals from people with behaviour management issues, including behaviour that can put workers at risk without the right strategies in place, without being informed by the NDIA. These providers argued that current approaches to privacy protection do not always uphold the best interests of participants or providers.

2.2.4 Options for additional support items with a plan

As explained above, the task of identifying the full range of psychosocial support types proved problematic in practice. That said, feedback was gathered on various support types stakeholders believed should be available through the NDIS, whether documented explicitly in plans or, with sufficient flexibility in how plans are applied, as options for participants and providers where necessary.

The support types listed below were nominated in response to stimulus material regarding what is currently available to planners. Some items were seen as gaps in the Price Guide, while other items were nominated by people familiar with plans written in launch sites as being an area for improvement. The list below is in no particular order of priority or emphasis, and is presented as a set of options for the NDIA's consideration.

Further details on these suggestions, including guidance from the NDIA regarding where each might map to the Price Guide, is provided in Appendix 3.

- Advanced care planning
- Crisis planning
- Hoarding and squalor
- Individual advocacy
- Assistance to access and navigate the legal system
- Emergency step-down services upon hospital discharge
- Support items triggered at points of transition
- Support coordination
- Peer worker support
- Supports integration
- Supportive escorting
- Planning for next plan
- 'Hospital in the home' support
- Life skills training and coaching
- Access to psychological therapies
- Building relationships
- Support to gain work readiness skills
- Capitalising on periods of wellness
- Carer support
- Loading for special needs (eg Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities, involuntary treatment order, post-discharge, comorbidity)

Recent developments in NDIA policy, planning and implementation

During the life of this project, the NDIA has continued to 'listen, learn, build and deliver' to put the best possible foundations in place, based on a culture of including participants, providers, the wider community and disability experts in the planning and delivery of the Scheme.

Since the Project was first initiated in late 2014, the NDIA has introduced several important changes that may impact on how the findings in this report will be received. Some of these changes were in response to the Independent Advisory Council's (IAC's) report on *Planning to facilitate opportunities enabled under the NDIS*, published in early 2015.⁶ Much of the stakeholder feedback reported in Section 2 reflect the observations made in the IAC's report.

Significant evolutions in the NDIA's approach to planning and pricing for NDIS services make the task of identifying and 'mapping' various support types onto the Price Guide less straightforward. These changes are described below, with the implications for the aims of the Project discussed in Section 4. The NDIA has also launched an outcomes framework and continues the development of a national approach to quality and safeguards as part of the NDIS.

Although the phasing of people with psychosocial disability has often been late in the phasings of the trial sites, the NDIA is gaining experience in developing plans for people with psychosocial disability. As of 31 December 2015, there were 1,681 participants with a primary psychosocial disability and 751 NDIS participants with a secondary condition of a psychosocial nature. A further 55,000 people with a primary psychosocial disability are projected to be included at full Scheme. The NDIA has engagement and planning processes have been adapted to individual needs or specific populations as identified. There are a number of projects in trial sites such as the Morriset Hospital Project and WA Psychiatric Hostels project, alongside the development of Mental Health team in NDIA National Office and the NMHSRG which demonstrate that the NDIA recognises the unique needs of some people with psychosocial disability and continues to explore ways address these issues

3.1 Refining the Price Guide

The NDIA has introduced a new, more flexible and more outcome-based plan format, and redesigned and simplified the price guide to address feedback that it was overly lengthy and

⁶ <http://www.ndis.gov.au/about-us/governance/IAC/iac-advice-opportunities#sustain>

complex to interpret. As part of the refinement, support items that are similarly priced and have the same intent, have been collapsed into a single item and support items have been grouped to align with the NDIA outcomes framework and the Price Guide. As a result, individual participants will now have a maximum of just 14 separate support categories listed on their plan, each of which has a separate budget. This refining of the plan format and the price guide will encourage providers to offer innovative supports and participants to include broader, more flexible supports in their plans to achieve their goals. Providers will claim for the specified support that most closely aligns to the service they have delivered using a best-fit approach.

3.2 Flexibility of supports in plans

In August 2015, the NDIA also introduced changes to further increase flexibility for participants when choosing how their supports are delivered.

In response to requests from participants, the NDIA has enabled the 'bundling' of some supports so the participant is not constrained from interchanging items and planners do not have to modify plans in response to changed circumstances. This change removed the need for the inclusion of 'contingency' items and their associated cost in a participant's plan and will increase flexibility.

The 'bundles' consist of groups of support items comprising NDIA determined items that can be used interchangeably to achieve the same or similar outcomes for the participant. The bundles will give participants more choice, control and flexibility in implementing plans and making them work to deliver the outcomes they are seeking.

Participants can choose the right support from the bundle for their circumstances, without having to ask the NDIA to amend their plan. This will increase choice and control for participants and reduce workload for staff through fewer plan amendments.

Participants have flexibility to select support items from the bundle and use the total funding on any of the support items in that bundle, even if no funding was allocated for that particular item by the planner.

There is no change to the overall range of supports funded through the NDIS. There are bundles for:

- Personal Care
- Community Access
- Transport
- Employment

So what has changed?

When the NDIS first started, there was little flexibility for participants regarding the way they used their supports, particularly if their needs changed. This frequently resulted in the need for plan amendments. Now, the NDIA can build more flexibility into the participant's plan if the planner identifies the need for flexibility with the way the participant's funded supports are used during the life of their plan.

There has been no change to the way providers claim. However, providers can now see all possible items for which they are registered (even if they have no value) when they are part of a bundle in the participant's plan. Providers can deliver supports against the items that have no value in the plan if the participant requests provision of that support. Additionally, support coordinators and providers are able to source and provide support in a flexible way to meet the participant's needs.

Given the concerns raised by stakeholders about the capacity of NDIA plans to respond to fluctuating and episodic needs, the NDIA believes the changes described above address these concerns adequately and provides opportunity of further refinement.

3.3 Support coordination

In August 2015, the NDIA also introduced changes to the way Support Coordination is described and priced. The NDIA defines Support Coordination as primarily being:

“Assistance to strengthen participants’ abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.”

In relation to the NDIA's definition of Support Coordination, the primary role of a Support Coordinator is to:

- Support implementation of all supports in the plan, including informal, mainstream and community, as well as funded supports
- Strengthen and enhance the participant's abilities to coordinate supports and participate in the community
- Ensure mainstream services meet their obligations (i.e. housing, education, justice, health)
- Build the capacity of the participant to achieve greater independence to self-direct services and supports in the longer term
- Provide the NDIA with reports on outcomes and success indicators within the agreed reporting frequency.

There are three levels of support coordination that may be funded:

- a. Support Connection
- b. Coordination of Supports
- c. Specialist Support Coordination

Please see Appendix 7 for the NDIA's document on Coordination of supports – Information for Service Providers.

This change also appears to address a number of the concerns raised within the mental health stakeholder consultations, including the need for specialised Support Coordination.

3.4 NDIS Price Reviews (personal care and community participation)

3.4.1 Overview

The NDIA sets price caps for some supports and services. These prices are designed to deliver positive outcomes for NDIS participants while taking into account market risks, such as the risk of service gaps in local areas as providers adjust to market-driven business models.

At the time of writing, the NDIA was reviewing a number of supports and services across personal care and community participation. This was a targeted set of reviews, rather than a complete review of NDIS prices for personal care and community participation. The reviews have involved stakeholder consultation and include opportunities for feedback from interested parties.

3.4.2 Why has the NDIA undertaken this review?

The NDIA is committed to continuous development of pricing arrangements, to deliver positive outcomes for NDIS participants. Supports and services need to be defined in a way that allows participants to achieve the outcomes they seek, and should make room for innovation in service delivery. Price caps and implementation rules should help participants receive value for money from their support packages. They should also be sustainable, which means that efficient providers should be able to recover their costs of service delivery.

3.4.3 What did the review cover?

The review was prioritised in areas where trial experience has indicated that NDIA pricing arrangements, including the rules around how these prices apply, could be clarified or improved. It will address two service areas in particular:

- Supported Independent Living
- Community-based and centre-based support group activities

The reviews will cover:

- Service and market definitions
- Measures that recognise intensity and complexity
- Pricing for services delivered in remote and very remote towns and communities.
- Existing price setting framework structure, levels and operating rules.

3.4.4 How to be involved?

The NDIA has engaged with a range of stakeholders throughout the review process, including provider and participant peak bodies in the mental health and disability support sector. Further information is available on the NDIA website - <http://www.ndis.gov.au>

3.4.5 When will implementation take place?

The NDIA plans to implement any changes from these reviews in time for the 2016/17 financial year, along with any other adjustments to existing prices (e.g. indexation). These will be published on the NDIA website prior to implementation.

3.5 Quality and safeguards

The NDIA is working to ensure all participants are able to access high-quality services that will enable them to achieve their goals.

Governments have agreed to the development of a national approach to quality and safeguards as part of the NDIS.

There is agreement the national framework should maximise the opportunities for people with disability to make decisions about their supports while also enabling them to live free from abuse, neglect and exploitation. The framework should also promote innovation, continuous improvement and best practice in the provision of supports.

A nationally consistent quality and safeguards framework should mean that people interacting with the NDIS can expect consistent standards and safeguards wherever they live in Australia.

The Commonwealth Government, in collaboration with the NDIA and state and territory governments, is leading the work to develop a system of quality assurance and safeguards, which will include complaints and critical incidents management.

Public consultations on options for a national framework have been completed and an analysis of the findings is currently underway. A report of findings is under development for consideration by Ministers in early 2016.

Until the NDIS is fully implemented, the NDIA is using existing state, territory and Commonwealth quality and safeguarding systems in making decisions about the registration of support providers. Participants continue to have access to the same avenues for raising concerns and making complaints.

Specific arrangements for Quality Assurance and Safeguards Working Arrangements can be found at <http://www.ndis.gov.au/providers/quality-and-safeguards>.

3.6 Outcomes Framework

Fundamentally, the NDIS was established to allow people with disability to live 'an ordinary life': to fully realise their potential, to participate in and contribute to society, and to have a say in their own future – just as other members of Australian society do.

The NDIA has developed an outcomes Framework to measure the medium and long-term benefits of the NDIS for participants and their families. The NDIA will collect information from participants and families and carers on how they are progressing in different areas of their lives.

The Framework will allow tracking of participant and Scheme progress over time, and demonstrate how participants are faring relative to other Australians and other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Development of the Framework was guided by some basic principles, including that the indicators should be meaningful, informative, and feasible to collect and report. A comprehensive review of other national and international frameworks was undertaken, together with an extensive consultation and co-design process that involved people with disability, members of the Independent Advisory Council (IAC) and CEO forum (CEOs of major providers, peak bodies and advocacy groups), disability researchers, experts working with specific cohorts (such as Aboriginal and Torres Strait Islanders and Culturally and Linguistically Diverse communities), and intellectual disability experts.

Following this review and consultation, questionnaires were developed and piloted with a sample of NDIS participants, families and carers.

Almost 400 interviews were conducted during the pilot study, and the information collected was used to refine the questionnaires and inform implementation strategies.

Building on research commissioned by the IAC, the Outcomes Framework adopts a lifespan approach to measuring outcomes, recognising that different outcomes will be important at different stages of life. The questionnaires for adult participants collect information about eight domains or areas of life: choice and control, daily living activities, relationships, home, health and wellbeing, lifelong learning, work, and social, community and civic participation.

Further information on the pilot project can be found at:

<http://www.ndis.gov.au/document/outcomes-framework-pilot>

Discussion and conclusions

This Section addresses the various issues raised in discussions with stakeholders for this Project. As noted in Section 3, there have been some important changes in NDIA processes since the Project's initiation. Feedback has therefore been interpreted with these developments in mind, along with reference to the original aims of the Project.

4.1 Continuous improvement in planning and service delivery

With a revised Price Guide which is more streamlined and outcomes-focussed, and greater autonomy for providers in negotiating service requirements with consumers, mental health providers may not in future experience the same gaps in service offerings that raised concerns in the Scheme's early days.

Mental Health Australia and the NDIA hope the new flexibility and the addition of a three-tiered support coordination function will facilitate more alignment between participant goals and the outcomes achieved. However, the NDIS will continue to evolve over the transition period, and it is important that ongoing monitoring occurs, informed by the experiences of participants and providers and in collaboration with the mental health sector.

As a result of the mental health stakeholder consultations, a range of specific support items to be considered by the NDIA for inclusion in the Price Guide were suggested. Of those items proposed, the NDIA can demonstrate that these activities can already be funded with NDIA plans while some are not the responsibility of the NDIA. The NDIA's response to stakeholder suggestions for new support items can be found in Appendix 3.

In response to the stakeholder concerns, it is noted that within an NDIA plan, a participant can have access to a peer worker in any funded activity they choose. This is a negotiation between the participant and the service provider, not the NDIA. There is also support for life transition planning which specifically includes peer support.

It is further noted the NDIA has safeguards in place which an NDIA planner will utilise as needed to manage risk to the participant or others. This includes the risk assessment tool which is completed with every plan, flags/alerts on the participant file to highlight risk issues, appointing a nominee if the participant does not appear to be able to act in their own best interest, appointing a support co-ordinator where there are risk issues identified to be managed and/or asking for a specialist assessment to review behaviour management and risk issues. It would also be reasonably expected that a provider would conduct their own risk assessment before working with a participant as standard practice. Current quality and safeguarding arrangements within states remain in place while the National Quality and Safeguards Framework is developed.

4.2 Engagement, outreach and local area coordination

There was overwhelming feedback from mental health stakeholders about the importance of outreach and engagement as a necessary precursor to effective planning for participants with psychosocial disability. In retrospect, the current lack of clarity regarding the LAC model made it difficult to differentiate good practice in participant planning from good practice in local area coordination for the purposes of this Project.

While certain models for LAC have been tested at launch site level, it is not yet fully understood by the sector what lessons have been learned and how these will be applied to national LAC arrangements. Governments have signed off on some aspects of LAC in bilateral agreements, and the NDIA is working hard to further clarify these issues. At the time of writing, however, there was no broad statement of intent regarding the future of LAC, making it difficult to comment on the interaction and overlap between LAC and activities in Individually Funded Packages (IFP).

This reinforces the importance and urgency of communicating to stakeholders the respective responsibilities of IFP providers, LAC providers, ILC providers and the NDIA. Only once this information is available can providers plan for their future service offerings, matched to the appropriate function and funding stream.

Stakeholders provided consistent feedback about the effectiveness of the PIR program in working with people with mental health conditions and mental health needs, but it is not yet clear how the activities of the PIR program and the outcomes of the program align with NDIA functions. Further investigation may be required to identify specific and specialist approaches to continue meeting the needs of the PIR target population under a new model and assist consumer, carers and service providers to understand these approaches.

On a separate but related note, stakeholders provided consistent feedback about the importance of trusting and ongoing relationships with people with psychosocial disability to enable them to identify and communicate their goals and make choices about funded support to meet those goals. They identified the need to maximise continuity of relationships between participants and providers from the initial engagement stage to an NDIS access request, planning, service delivery and beyond. This may require additional or targeted support prior to the planning conversation, and indeed prior to accessing the Scheme.

4.3 Addressing pricing concerns

While consultations did not seek to gather information specifically about pricing issues, concerns from mental health providers regarding the pricing of psychosocial support services were a major impetus for the Project. At the scoping stage it was agreed that describing good practice in psychosocial support was a necessary step towards pricing such services at an hourly rate.

Stakeholders identified a range of specific activities that do not appear in the NDIA Price Guide (e.g. assisting in the preparation of advanced directives) as well as activities that could be offered through the NDIA Price Guide using different terminology (e.g. life skills training and coaching) or through other NDIA functions (e.g. 'individual advocacy' undertaken by Local Area Coordinators to ensure someone can access mainstream

services). It is hoped this feedback will enable the NDIA to review its processes and guidance for planners where appropriate.

Many activities currently undertaken by mental health providers on a flexible, client-directed basis could now be carried out through the support coordination role. This would in turn mean that, where support coordination requires higher levels of skill, higher hourly rates would be available to maintain a skilled workforce. It would also help support the significant amount of time spent by mental health providers that is not directly client-facing – that is, ‘behind the scenes’ work of various kinds that would be consistent with how support coordination often takes place for people with psychosocial disability.

Alternatively, some of these activities may be carried out by LACs, under different funding arrangements, particularly at the earlier stages of client engagement. However at the time of writing there is limited information available on the delineation between IFP and LAC functions from this perspective.

4.4 Workforce Issues

There was consensus among stakeholders that the delivery of high quality recovery-oriented psychosocial support requires a specialist workforce with the right values, skills and qualifications. Beyond core assistance with daily living, psychosocial support with a capacity building focus must be highly responsive to individual needs and is therefore not necessarily predictable from day to day. As noted above, stakeholders nominated a range of psychosocial support activities, emphasising they would ideally take place in a flexible and person-directed manner.

Examining the skills and qualifications required to deliver psychosocial support services was not within the scope of the Project and therefore not explicitly addressed in stakeholder discussions. However, stakeholder feedback highlighted the need for further work in this area, given the obvious link between good practice in psychosocial support and the need for an appropriately skilled workforce to deliver those services.

Detailed guidance on these issues can be found in a report commissioned by Mental Health Australia through its Sector Development Fund project and prepared by CMHA. The recently finalised report, *Developing the workforce: Community managed mental health National Disability Insurance Scheme workforce development scoping paper project*, includes a range of insights and recommendations regarding future work to better define psychosocial support services in an NDIS context. This work could include mapping of roles, mapping of skills and qualification requirements, and (subsequently) identification of appropriate pricing. It could also help to address the current shortfall in formally qualified mental health peer workers by supporting the greater uptake of the Certificate IV in Mental Health and Peer Support Work.

4.5 Communication issues

The consultation process confirmed the very wide range in levels of knowledge awareness across the mental health sector of how the NDIS works in practice. This highlights challenges for the NDIA in communicating ongoing changes to its processes in a fast moving, evolving environment to cope with the transition to Full Scheme while ensuring the

communication is meaningful for stakeholders. Without effective communication, there is a risk consumers, carers and providers may rely on outdated information or opinions drawn from early trial site experience.

4.5.1 Tailoring communication to need

Consumers, carers and providers in trial sites spoke in great detail about the NDIA's work to date and had many ideas about how improvements might be made. By contrast, stakeholders without direct experience were often (but not always) unaware of key aspects of Scheme design or implementation. Knowledge levels were lowest in Queensland, South Australia and the Northern Territory, where the perceived relevance of the NDIS is not immediate, compared with jurisdictions where state-wide transition is imminent.

Given the variability in knowledge levels (not just between stakeholders in different jurisdictions, but also between those in different regions, across organisations and even within organisations) any approach to communication in future must be tailored to different audiences. The fact that many people were not aware of the significance of the revised Pricing Guide reinforces the need for a strategic approach in communicating with mental health stakeholders. Segmenting the target audience would assist in providing information of most relevance and at the most appropriate level of complexity.

By way of example, providers in launch sites have had to adapt to ongoing changes in implementation approach. They would benefit from ongoing updates on detailed matters relevant to their daily work, in addition to any other communication of a broader nature. This would assist in developing efficient working relationships between local NDIA staff and provider organisations and ensure information is not out of date as the NDIA's processes evolve.

In comparison, providers who are relatively new to the NDIS could benefit from a 'stepped' approach, where simpler information is provided in the first instance to help providers understand the significance of the Scheme for their business and (in some cases) the need to undertake internal planning as a matter of urgency. More detailed information would then be available once a provider needs to understand particular issues as preparations are made and participants are referred. This may be the case for smaller community-managed organisations in particular, whereas larger state-wide or national non-government organisations may already be sharing knowledge gleaned from trial site experience.

A tailored communication approach is also required for consumers and carers who have not yet engaged directly with the NDIA, and may be unsure about eligibility. Some consumers and carers may have heard views from other consumers and carers on aspects of the Scheme that are controversial or as yet unresolved. Communication should therefore try to dispel myths and reassure consumers and carers of the potential benefits the NDIS could provide. It should also directly address some of the key issues that commonly arise in discussions with consumers and carers, such as how the requirement that someone has a (likely to be) permanent disability to become a participant does not obviate recovery-oriented support.

4.5.2 Specific terminology

A key challenge in communicating effectively with the mental health sector is the language used by the NDIA and in the 'mainstream' disability sector. The meaning of some terminology can be unclear and further clarification would ensure mental health stakeholders understand what the NDIA is referring to.

For example, the concept of *pre-planning support* can have a variety of meanings. For mental health stakeholders, it could refer to:

1. The kinds of outreach and engagement typically carried out by PIR Support Facilitators – that is, before someone makes an access request and even before someone's immediate needs are properly addressed
2. The work of LACs to identify people likely to be eligible or in transitioning programs, providing basic information and encouraging them to make an access request
3. Assistance provided after someone's eligibility is confirmed, with a specific focus on an upcoming planning conversation (such as the pre-planning workshops the NDIA currently provides)
4. Any combination of the above

While discussions for this Project emphasised the need for pre-planning support, mental health stakeholders appeared to rely on the first definition above and less on the second or third definitions.

The term *support coordination* might also require clarification. While support coordination funded in participant plans can (and is intended to) respond flexibly to individual need, the NDIA's definition is specific and may not precisely match how mental health providers understand the term. For example, the work of PIR Support Facilitators, translated into the NDIS model, may include some activities that would be funded in plans, but could also include activities that may in future be delivered through LACs, along with certain activities that would remain the responsibilities of other systems (eg case coordination across different parts of the health and mental health systems). The NDIA's definition certainly appears to accommodate different kinds of skills, including allied health practitioners, which is consistent with the integrated funding model currently operating in parts of the non-government mental health sector.

These complexities warrant further consideration so that participants and providers can better understand the NDIA's expectations of support coordination versus other functions.

4.5.3 Responsibilities of the NDIS and other systems

The interactions of the NDIS with other service systems will reinforce the obligations of other service delivery systems to improve the lives of people with disability, in line with the National Disability Strategy.

Governments have agreed that the principles outlined in the *Principles to determine the responsibilities of the NDIS and other Service Systems* will be used to determine the funding and delivery responsibilities of the NDIS in achieving this vision. The NDIS launch sites provide governments with an opportunity to review interactions between the NDIS and other

service systems and consider any lessons arising out of launch. The principles which have been in place since 2013 have been reviewed and on 27 November 2015 were published on the COAG website - <https://www.coag.gov.au/node/497>. Updated descriptions of the respective responsibilities of the NDIS and the health and mental health systems are reproduced at Appendix 6.

Feedback from mental health stakeholders suggests low awareness of the earlier version of the Principles or how they are applied in practice in planning decisions. Given the small number of people with psychosocial disability entering the Scheme due to phasing arrangements, this is to be expected. Consumers and carers are generally relatively less interested in how services are funded and more interested in the availability of services and coordination between services. Providers are generally aware the NDIS will fund 'non-clinical' services in the community with a disability focus, but there appears to be much confusion about where the boundary lies between the mental health and disability systems from a funding point of view. The new Principles bring much greater clarity to these issues, so there is now an opportunity to improve the sector's understanding of these issues.

4.6 Conclusion

The findings in this report take us a step closer in the collective effort to ensure the NDIS meets the needs of people with psychosocial disability. The pace and scale of change is enormous, and much remains to be done. Reassuringly, discussions with stakeholders for this Project revealed great willingness across the mental health sector to assist the NDIA with the task of implementation to ensure the implementation of the NDIS is consistent with recovery principles.

The NDIA and Mental Health Australia are grateful to everyone who participated in the Project for their time and expertise, and to CMHA for organising and convening consultation sessions.

Recommendations

Further investigations

1. The NDIA to consider with the NMHSRG a mechanism to gather feedback from consumers, carers and providers with recent direct experience of implementation on whether new plans for people with psychosocial disability are maximising choice and control for people with psychosocial disability. As a starting point, this work could refer to the observations regarding various features of 'good practice' psychosocial support described in Section 2, drawn from a review of relevant literature and national consultations.
2. The NDIA to consider providing reports to the NMHSRG over the transition period on the breakdown of funded supports written into plans for people with psychosocial disability.
3. The NDIA to consider providing reports to the NMHSRG to monitor the use of support coordination in plans including the relative amounts of support coordination funded at different pricing levels for people with psychosocial disability and consider the impact on the workforce.
4. The NDIA to consider liaison with the Department of Social Services (DSS) and Department of Health (DoH) to determine if further work should be undertaken by the relevant agencies to clarify the roles and functions of the Personal Helpers and Mentors Program (PHaMs) and PIR program, including:
 - The role of the Support Facilitators/personal mentors and how this maps to NDIA funded supports including overlaps between assertive outreach through PIR and any pre-eligibility and pre-planning support for potential NDIS participants
 - The capacity building functions within the PIR model and how this maps to NDIS funding and other NDIA functions.
5. The NDIA to engage the mental health sector in the current pricing review (personal care and community participation) and future pricing reviews which will provide opportunities to investigate further issues raised during the stakeholder consultations.

Changes to NDIA practices and processes

6. The NDIA (in consultation with governments) to consider how to respond to concerns raised by stakeholders about the importance of trusting and ongoing relationships between people with psychosocial disability and (where relevant) any existing providers. In addressing these concerns, there should be a focus on maximising continuity of relationships the participant values (including carer and other informal relationships and provider relationships) in the training of NDIA staff and operational guidance as relevant. Continuity of valued relationships should be promoted where

possible across, engagement, access, being plan ready, planning, and plan implementation stages in a participant's NDIS journey.

7. The NDIA to consider developing specific staff training for staff about recovery and trauma based approaches to working with people with psychosocial disability.

Sector development

8. The NDIA, DSS and the NMHSRG to consider the findings and recommendations of the Mental Health Australia/CMHA report on mental health workforce issues to inform future directions.

Communication needs

9. The NDIA to consider approaches which respond to the variability in knowledge of the NDIS among mental health consumers, carers and providers. Mental health Australia offers the NDIA any assistance in its endeavours to communicate with the mental health sector in the lead up to and during transition..
10. The NDIA consider clarifying certain terminology to assist mental health stakeholders better understand key aspects of the NDIS, in recognition of variability in how language is used across different sectors. This includes, but is not limited to, the terms pre-planning support and support coordination.
11. The NDIA consider undertaking targeted communication to help existing and new mental health providers better understand:
 - The NDIA Price Guide, how supports are built into plans, and how the increased level of flexibility works in practice.
 - Support Coordination, including the roles, expectations and funding of various level of support coordination.
 - NDIA operational processes including:
 - > Information and assistance about NDIA pre-access processes
 - > NDIA access requirements and National Access team protocols
 - > NDIA pre-planning activities
 - > Plan implementation support (including the role of Support Coordination)
 - > The role of ILC and LAC for people with psychosocial disability
 - > Review processes for both eligibility and planning
 - > Support for decision making
 - > Allocation of planners and planning for people with complex needs.
 - Mainstream interface principles including:
 - > Activities the NDIA can and cannot provide and/or fund
 - > Activities that remain ongoing responsibilities of Health and Mental Health services

- > Examples of collaboration and protocols for working together.

12. The NDIA to consider providing the mental health sector with tailored information referring to:

- The range of support types proposed by stakeholders consulted for this Project and how these supports can be funded by the NDIA
- How flexibility in plans can and should work in practice for providers, the NDIA, participants and carers in applying or activating this flexibility
- Where supports are not funded or cannot be funded by the NDIA, who has responsibility for the provision of this support
- How the NDIS will enable appropriate engagement and outreach for people with psychosocial disability and their carers and families, explaining the respective contributions that IFP providers, LAC providers, ILC providers and the NDIA to engagement and outreach.
- Any changes made to NDIA language and processes as a result of the Operational Access Review for people with psychosocial disability and other initiatives.

Appendices

- 1. Project scope**
- 2. Detailed consultation outcomes**
- 3. Detailed NDIA response to stakeholder suggestions for funded supports**
- 4. Synergia paper 1**
- 5. Principles for determining responsibilities of the NDIS and other service systems**
- 6. Coordination of Supports – Information for Service Providers**

Appendix 1

Project scope

Design of individual supports for people with psychosocial disability

January 2015

Background

The NDIS Catalogue of Supports provides a structure to assist NDIA planners in building packages of supports that reflect participants' disability-related needs. NDIA currently sets an hourly price for supports funded through NDIS participant packages. Participants can then choose how they will use their supports within the parameters set by NDIA. As the market matures and develops, NDIA will seek to further increase flexibility for participants when choosing how their supports are delivered.

When the NDIA uses a funded support item in a participant plan it is labeled as "core", "capacity building" or "capital". The supports are used for:

- Core Support Items are a support that enables a participant to complete activities of daily living and enables them to work towards their goals and aspirations.
- Capacity Building Support Items are investment supports that enable a participant to build their independence and skills so as to progress towards their goals.
- Capital Support Item are investments, such as assistive technologies, equipment and home or vehicle modifications.

In the first half of 2014 a joint working group from NDIA and National Disability Services, the peak association for not-for profit disability providers, undertook a project to examine the NDIA's set pricing for two of the highest volume supports: assistance with self-care and with community participation. The joint working group agreed on a methodology for a 'reasonable cost model' that incorporates salary and on-costs, overheads and margin. Other costs of business in delivering a support, such as provider travel to deliver a support, cancellation and establishment of new support arrangements, are not loaded into the price and are the subject of separate pricing policy. Further information on the outcomes of the NDIA/NDS working group project are available on the NDIS website.

The reasonable cost model is used for two support items: self-care and community participation. These prices are now set as a transitional price that will step down to a more efficient price by 2016.

The NDIA will continue to develop pricing assumptions that can be demonstrated through the reasonable cost model.

Project purpose

Appropriate support design and pricing is consistent with the vision of having a responsive market for disability supports. The Sector Development Fund aims to increase the capacity of people with disability and their families to exercise choice and control, both in engaging with the NDIS and in purchasing supports in an open market to realise their aspirations. It will also

assist a well-developed market, informed by the NDIS market strategy, capable of providing the necessary supports required for full scheme introduction. Mental Health Australia is supported through the Sector Development Fund to build the capacity of the mental health sector to engage with the NDIS.

The joint working group identified the need for further work to examine the pricing of mental health supports. NDIA has now agreed to undertake further work with input from the mental health sector, including Mental Health Australia, Community Mental Health Australia and consumer and carer representatives.

This project will investigate and document optimal packages of individual supports for people who have psychosocial disability associated with a mental illness (i.e. where a mental illness is the 'primary diagnosis' leading to the disability). It will seek to outline some typical support needs for this target population and detail how NDIS funding could be applied to meet these needs. These examples will then be mapped against the range of supports used by the National Disability Insurance Agency in the support cluster definition and pricing document used to cost participant packages of support. If any gaps are identified, appropriate support items can then be recommended. The NDIA can then consider the recommendations and develop associated pricing that can be demonstrated through a reasonable cost model.

This work will not re-examine the hourly rates for assistance with self-care or assistance with community participation.

The project will focus on opportunities to describe a range of optimal supports, rather than reverse engineering any existing block funded psychosocial disability programs or community mental health services into an hourly unit cost. However, where there is evidence that particular approaches to delivery of supports lead to good outcomes, these will be examined for possible inclusion in NDIS individually funded supports where appropriate.

At the recommendation of sector representatives, the project will:

- Explore the place for peer workers in delivering NDIS funded supports
- Gather evidence on the range of qualification/skills required to support for participants whose psychosocial disability support needs range in complexity
- Consider appropriate types of support with regard to the agreed boundaries between the clinical system and the NDIS, including where participants require step-up and step-down support.
- Consider what support items might assist with coordinating access to different services, including clinical care.
- In consultation with mental health consumers and carers, service providers and other experts, describe a 'optimal' supports that reflect different kinds of psychosocial support needs.
- Inform the ongoing development of the NDIS Support Cluster Definition and Pricing document.

This project is an important component in a broader body of work being undertaken by NDIA throughout 2015. The project will not seek to replicate other areas of work, including:

- Development of the purpose and scope of Information, Linkages and Capacity Building supports (previously called Tier 2)

- An Operational Access Review for Psychosocial Disability, which consider existing administration arrangements for access to the NDIS in relation to psychosocial disability;
- Clarification of the interaction between the NDIS and in-scope programs and services over the trial period; and
- There may be a range of operational process issues, support responses and policy issues that will be identified but are out of scope for this project. These will be documented in the project report for separate consideration.

This project will not be a mechanism to raise questions about eligibility for the Scheme and the expect population of people with psychosocial disability that will be participants.

Project aims

1. To describe in detail the range of disability supports for people who have a primary condition of psycho-social disability that may be sourced by individuals with NDIS funding.
2. To make evidence based recommendations, where new support items may be needed to adequately assist people with psychosocial disability who are participants in the NDIS.

Project outcomes

The joint project will seek to:

- Communicate the project's purpose and expected outcomes to people with a personal lived experience of psychosocial disability, their carers and families, and the broader mental health sector;
- Review currently available background information to identify and describe in detail typical and/or ideal individualised supports for people with psychosocial disability;
- Map the current NDIA support cluster definition and pricing list to existing definitions and descriptions of psychosocial disability supports;
- In consultation with mental health consumers, carers and service providers, seek to identify the optimal features of a range of typical individual support packages;
- Identify the skills required to provide psychosocial supports of various kinds, as identified through the project;
- Produce a report summarising the project outcomes to inform the development of the NDIS Catalogue of Supports and associated pricing. This report may be made publically available.

Resources and Reporting

The project will be overseen by a project group with representation from the NDIA and MHA, and in consultation with Community Mental Health Australia and expert consultants. This project group would in turn inform, and seek input from, the NDIA Mental Health Sector Reference Group. The Reference Group which involves a range of sector representatives, including representatives from the National Mental Health Consumer and Carer Forum. The project will be reported to the relevant Executive at both Mental Health Australia and the National Disability Insurance Agency.

Project requirements

Within this agreed scope of work, the project group will:

- Produce a work plan agreed by NDIA and MHA;
- Produce a communication and engagement plan for the project's scope, progress and outcomes ;
- Work with consumer and representatives, as well as other experts within the mental health sector, to seek feedback on optimal models of individual support and how these might link with other services out of scope for the NDIS; and
- Produce a joint report on the project outcomes with the intention of making it publically available.

Timeframe

The project will commence by the end of January 2015, with a report produced by the end of May 2015.

The intention of providing a report in this timeframe is to describe a range of supports and make timely, evidence based recommendations to NDIA where support items may need to be defined using a reasonable cost methodology and priced.

Appendix 2



COMMUNITY MENTAL HEALTH AUSTRALIA

Design of Individual Supports for People with Psychosocial Disability Project

Stakeholder Feedback

December 2015

Executive Summary

The Individual Supports Design Project (the Project) is a collaboration involving the National Disability Insurance Agency, Mental Health Australia and Community Mental Health Australia. The Project has been established to document optimal packages of individual supports for people who have a psychosocial disability associated with a mental illness. In order to best equip the Project to produce a report summarising the project outcomes, the following pieces of investigative work were commissioned, namely:

- Development of a report investigating typical support packages (prepared by Synergia Consulting)
- Stakeholder feedback (prepared by Jane Forward Consulting)

Stakeholder feedback provides valuable insight into current performance, as well as future needs and opportunities. This report presents the key findings of feedback from mental health consumers, carers, service providers and other informed stakeholders across Australia.

In September 2015 in Queensland, New South Wales, Australian Capital Territory, Victoria, Tasmania, South Australia and Western Australia, and in November 2015 in the Northern Territory, 173 individuals participated in consultation workshops organised and hosted by the peak bodies in each jurisdiction. Consultation materials were developed using a building block framework for individual psychosocial disability supports contained in the Synergia report (Appendix A), individual case stories (Appendix B), example NDIS individual supports mapped by the NDIA to the building block framework (Appendix C) and learnings from the trialling of preliminary materials conducted in Victoria, the ACT and South Australia in June. The correlated results of these workshops are at Appendix D.

Workshop engagement processes in each location varied dependent on local needs and preferences, but all addressed the following research questions:-

Identify the optimal individual supports.

- Identify the types of optimal supports currently listed under each building block.
- Do they cover the full range, if not identify the additional supports required.

Mapping examples - NDIA supports for people with psychosocial disability

- Identify gaps in the NDIA example supports.
- Suggest clarification of language and definition to the NDIA example supports.

Building Block descriptions

- What, if any opportunities exist to further strengthen the description of the Building Block functions of support?

A strong correlation of response was found throughout the data, with overwhelming feedback that the development of an optimum list of supports can only be achieved once three overarching themes have been addressed, namely:

Theme One: Engagement, preplanning and readiness

It was perceived that the NDIS structure connects with participants under an assumption of 'readiness' or 'preparedness' for planning. Participants expressed that many, if not most, people with psychosocial disability won't be ready to engage in an adequate conversation with a NDIA planner the first, second or third time that they meet. Instead, investment is required to support the person work through a range of

issues before they can identify how they might best take advantage of the NDIS and what supports they will need in the long term to help them realise their goals and aspirations. The current ‘preplanning workshops’ delivered by the NDIA or other initiatives currently offered to educate and support people understand the NDIS, do not target the development of capacity to a point of the participant being recovery-ready. Through ‘engagement/preplanning and readiness’ investment more efficient and effective plans will be developed, yielding better outcomes.

These supports go beyond information exchange and could include, but are not limited to

[Table1: Short term, entry plan support items](#)

Support	Explanation
Access and Engagement	Building rapport and the development of a trusting relationship. Assertive outreach and culturally appropriate engagement mechanisms. Trauma informed engagement process.
Recovery Planning	Development of participant narrative as to what recovery means to them.
Preplanning	Being ready to have a plan conversation <i>‘Supporting someone to work out their ‘wants’ and ‘needs’ is an experiential process, not an interview process. It takes time, skilled workers and advocates to ensure the participant’s voice is truly being heard.’(Victoria)</i>
Capacity Building	Supported decision making, self-advocacy and advocacy.
Support Facilitation	Identifying support needs. Assisting with coordinated care and community based recovery. Collaborating with support and service providers. (Partners In Recovery was provided as a good example of how this can occur)
Peer	Strengthening of connection and recovery planning.

Theme Two: Recovery framework

Participants felt that the current workings of the NDIS have yet to be fully governed by principles of wellness, person centred, recovery, family inclusivity, culturally secure and trauma-informed. Application of these principles focuses on the development of strengths and wellness, shifting away from models of impairment and deficit. Participant feedback was that while the Building Block Framework provided a conceptual framework that assisted understanding some specific characteristics for mental health in the NDIS neither it nor the supports identified by the NDIS appear to be fully congruent with these principles. Evolution of the foundational ideology to a recovery framework would see increased flexibility (supporting better planning and responses to the episodic and fluctuating nature of mental illness), increased capacity for review with increased capacity to respond to the episodic presentation of acuity and periods of relative wellness and illness. Once the scheme is delivered through this different lens it becomes apparent that a high level of skill and sophistication is required in the delivery of recovery-oriented psychosocial services, which should be supported by the pricing structure.

Theme Three: Co-design, co-evaluation and co-delivery

Participants stated that for true 'choice and control', things need to be done, with people not for them. This can only be achieved through the development of a relationship which takes time and investment; as such the consumer and the staff member must meet often, over a period of time, in a manner which is flexible, may include outreach and is based on a solid understanding of mental health and demonstrated skill in engaging with mental health consumers. Under this methodology relationships are stable and transition with the consumer along their journey and can be evidenced by a strong occurrence of consumer advocacy and investment in the development of stable and supportive relationships based on mutual trust and respect.

Language

In addition to the identification of additional support items, participants reviewed current use of language within the scheme and opportunities for improvement. Stakeholders were unanimous in a belief that there is significant opportunity to improve language, in the use of definitions and descriptions that are familiar to the lived experience of psychosocial disability and that promote recovery and growth.

A consistent theme was that language needed to honour the strengths that individuals, carers and families have and to support models of aspiration, recovery and wellness. Stakeholders identified the following additional supports to the suggested list provided in the Synergia report and to the current NDIS example of draft supports, incorporating descriptions and definitions in language reflective of recovery and growth:

Table 2: List of additional supports and descriptions for inclusion in NDIS example supports

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
				Extra layer of supports to be included - <i>Short term, entry plan support items</i> (Refer Table 1, above for detail)
Building Block 1.	Individual engagement and capability development support: A confidence and	Support to improve daily living skills support items	Coordination of supports (including higher intensity rates)	Recovery support coordination (similar to Partners in Recovery (PIR) support worker role). Supported Decision

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
Person-centred planning and self-direction	<p>skills development support that can work in people centred advocacy and support roles in developing the planning partnership with services</p> <p>Family/carer education and skills development support</p> <p>Aligned/shared psychosocial support planning</p> <p>Self-directed plan initial implementation and execution support</p> <p>Support coordination: that provides continuity and review components and escalation support processes</p>	<p>Support to improve my home arrangements</p> <p>Support to improve health and wellbeing</p> <p>Support to plan and choose preferred options</p>	<p>Training in planning and plan management</p> <p>Development of skills for community, social and recreational participation</p> <p>Mentoring and peer support, focussing on individual skill development to improve personal skills</p> <p>Training for carers</p> <p>Training for carers and others in behaviour management strategies</p> <p>Individual social skills development</p> <p>Assistance with decision making, daily planning, budgeting</p>	<p>Making and advocacy would be key supports in this area</p> <p>Support to plan for next NDIS plan period</p> <p>Education in planning and plan management</p> <p>Crisis response coordination and support (risk assessment and mitigation strategies)</p> <p>Facilitation of integration, coordination and inclusion; the inclusion of carers, family, and other natural supports</p> <p>Bridging the gap between clinical referral and uptake – transportation, transitional support, system navigation, development of trusting relationship</p>
Building Block 2.	Support to find, get and keep a job - Individualised	Support to find, get and keep a job	Employment preparation and support in a group	Independent living and planning support e.g. paying rent, bills and food – initial and ongoing as needed to

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
Promoting independence and functional gain	<p>Placement and Support and beyond</p> <p>Support in life-long learning: vocational or other training supports</p> <p>Housing options support, including investigation of suitable independent housing arrangements desired by the individual and assistance to maintain a tenancy or living arrangement</p> <p>Opportunities for community engagement and social inclusion</p> <p>Peer support (more about this later in this report)</p>	<p>Support to improve my home arrangements</p> <p>Supported independent living arrangements</p> <p>Support to improve access to social and community activities</p> <p>Support to improve daily living skills</p>	<p>Individual employment support</p> <p>Assistance with accommodation and tenancy obligations</p> <p>Transition to school and other education programs – program design, planning and implementation</p> <p>Assistance in a shared living arrangement</p> <p>Short term accommodation and assistance in centre or group residence</p> <p>Development of skills for community, social and recreational participation</p> <p>Assistance to access community, social and recreational activities</p> <p>Assistance with decision making, daily planning and budgeting</p> <p>Skills development in a group</p>	<p>ensure things aren't overlooked during periods of crisis– maintaining a household</p> <p>Pet therapy</p> <p>Interpersonal skills development</p> <p>Respite and accommodation</p> <p>Recovery-oriented practice</p> <p>Facilitation of integrated response</p> <p>Support to employers</p> <p>Peer worker/support to assist recovery, hope and positivity</p> <p>Psycho-education and recovery for individuals, carers and supports</p> <p>CBT and other therapies to manage disabling effects of mental illness</p>

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
			<p>Mentoring and peer support, focussing on individual skills development to improve personal skills</p> <p>Individual assessment and/or therapy</p>	
<p>Building Block 3.</p> <p>Developing and maintaining resilience and self-care</p>	<p>Supports to improve health and wellbeing: promoting good physical as well as mental health</p> <p>Supports to improve relationships, including carer training and family intervention services</p> <p>Support for peer support services</p> <p>Support to plan and choose preferred options (particularly where this care is provided by agencies other than the NDIS)</p>	<p>Support to improve health and wellbeing</p> <p>Support to plan and choose preferred options</p> <p>Support to improve daily living skills</p>	<p>Exercise physiology in a group</p> <p>Personal training</p> <p>Exercise physiology</p> <p>Training for carers</p> <p>Individual life and personal skills development</p> <p>Mentoring and peer support, focussing on individual skills development to improve personal skills</p> <p>Coordination of supports (including higher intensity)</p> <p>Individual assessment and/or therapy</p>	<p>Support for diversity of individual life experience and identity</p> <p>Support to address self- stigma</p> <p>One-on-one support for rural and remote services</p> <p>Cultural responses</p> <p>Resiliency support/training</p> <p>Use of technology – e.g. Apps for training or remote alert Support to carers e.g.: self-care, respite, counselling</p> <p>Capacity building – self care</p>

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
	<p>Assistive technology such as e-mental health supports, designed to provide private and easy to use self-care support</p> <p>Support to improve daily living skills - tailored to meet fluctuating participant requirements</p> <p>Support to improve access to social and community activities: focused on community engagement and social inclusion</p>		<p>Development of skills for community, social and recreational participation</p> <p>Assistance to access community, social and recreational activities</p> <p>Assistance with accommodation and tenancy obligations</p> <p>Assistance with decision making, daily planning and budgeting</p> <p>Skills development in a group</p>	<p>Peer support with self-care, strategies to manage disabling effects of mental illness</p> <p>Psycho-education and support with strategies to manage anxiety and other disabling psychosocial issues including peer-led</p> <p>Recovery training</p> <p>CBT and other therapies to manage disabling effects of mental illness</p> <p>Strengthen and develop support networks</p> <p>Building strengths to solve own problems</p> <p>Alcohol, tobacco and other drug support and treatment</p> <p>Sexual and physical health advice and prevention</p> <p>Work readiness skills</p>

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
Building Block 4. Mental health services/network support	<p>Regular or 'relapse' planning including family, peer support and clinical input as appropriate</p> <p>Flexible step up 'call in' support e.g. through peer workers to help stabilise and utilise individual and social strengths, recognition of increased time demands on this providing daily living support</p> <p>Include additional volume of support in an NDIS plan if respite is needed</p> <p>Support to plan and choose preferred options: focused on helping to stabilise housing and employment and prevent additional stressors and coordination and navigation support to</p>	<p>Support to plan and choose preferred options</p> <p>Support to improve daily living skills</p>	<p>Support coordination (including higher intensity)</p> <p>Assistance with decision making, daily planning and budgeting</p> <p>Mentoring and peer support, focussing on individual skills development to improve personal skills</p> <p>Development of skills for community, social and recreational participation</p> <p>Short term accommodation and assistance in centre or group residence</p>	<p>Proactive and collaborative planning – what to do when participants feel out of control</p> <p>Training to recognise early warnings/trigger signs</p> <p>Extra supports – maintain and sustain critical relationships</p> <p>Continual wellness and recovery plan</p> <p>Regular review planning as scheduled with the NDIA plan</p> <p>Increase supports as needs arise</p> <p>To cope with additional stressors</p> <p>Coordination of supports to access clinical or other services supports</p> <p>Case coordination</p> <p>Planning support for holiday periods</p> <p>Facilitation of integrated care</p>

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
	help access clinical or other service supports			Maintenance of relationships with supports during periods of hospital or residential care Including the role traditional healers Preserving the aboriginal connection to country and elders
Building Block 5. A coordinated response to mental illness	Inclusion of proactive planning for response to an acute phase of distress (e.g. maybe initiated once building block four has been triggered). A support coordination response package that can be triggered by an Emergency Department attendance or admission to help cover time in liaison with health services and organise or coordinate changes in individual support	Support to plan and choose preferred options	Support coordination (including higher intensity) Assistance with decision making, daily planning and budgeting Mentoring and peer support, focussing on individual skills development to improve personal skills Development of skills for community, social and recreational participation Short term accommodation and assistance in centre or group residence	Support for integration facilitation/coordination, inclusive of natural supports, service providers, primary and allied health Action planning – how to capitalise on periods of wellness as well as agreed identification of triggers–planning and supports Engagement (‘buy in’) with remote communities to assist with identifying and understanding the type of support available in communities Engagement, planning, selection and scheduling supports

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
	<p>services. Similar arrangements may be necessary with Crisis Assessment and Treatment Teams operating as part of the existing mental health system.</p> <p>In-reach support response package that can cover the maintenance of contact, e.g. with social service provided peer support.</p> <p>A flexible ‘stand-down’ support package that can be used help to maintain and stabilise essential social support structures that would otherwise jeopardise or delay return to home and prior level of functioning achieved.</p>			<p>Concept of “hospital in the home” – medications / support</p> <p>Preplanning and trusting relationships</p> <p>Advocacy for individuals/carers/families</p> <p>Carer/family/significant other support</p> <p>Advanced care directives</p> <p>Involvement of supports in clinical decisions/conferences (carer/family/friends)</p> <p>Legal assistance</p> <p>Home maintenance/pet care/home safety during periods of sickness</p> <p>Triggers for increasing support coordination need to be articulated in plans</p> <p>Plan must cover acute phases of distress and support to stay at home i.e.</p>

Suggestions for individual psychosocial disability supports contained within the Synergia Report		DRAFT Examples of the outcomes and supports used in NDIS plans		Additional support items identified by consultation participants (stakeholders)
Building blocks	Suggested supports for people with psychosocial disability	Some examples of outcome domains (linked to reporting) that will be in an NDIS plan	Some examples existing NDIS support items that a participant could choose to use	
				<ul style="list-style-type: none"> • Anticipatory planning – 24/7 • Medication support – 24/7 • Advocacy for appropriate housing allocation • Emergency responses/training – educational emotional CPR for emergency staff, paramedics and nurses • How to connect • How to facilitate a person’s needs (empowerment) • Vitality to re-engage with community • Coordinated response to mental illness not a useful descriptor – coordinated response to service system - as in coordinated between various clinicians, service provider, client and support system (family, partner etc.) • Use of technology to coordinate supports/responses

Conclusion

In conclusion, a shared belief was held that while there are specific support items and important language requirements for psychosocial disability in relation to the NDIS, outcome improvements of the NDIS will ultimately be achieved through the development of an insurance scheme system which is flexible, develops meaningful relationships with participants, allows them to return at multiple review points, focuses on strengths not illness and is founded on concepts of person centred, family inclusive, culturally secure and trauma informed support.

Appendix 3

INDIVIDUAL SUPPORT DESIGN FOR PSYCHOSOCIAL DISABILITY PROJECT

NDIA FEEDBACK ON SUPPORTS SUGGESTED FOR INCLUSION IN THE NDIA PRICE GUIDE BY STAKEHOLDERS IN THE CMHA CONSULTATION PROCESS: FEBRUARY 2016

Current catalogue structure – support clusters	Proposed new support for inclusion in the NDIA Price Guide from the CMHA Stakeholder Consultations	Feedback from NDIA
<p><u>Cluster 1- Assistance with daily life at home, in the community, education and at work</u></p> <ul style="list-style-type: none"> • Establishment Fee for Personal Care/Community Access • Assistance with self-care activities: day • Assistance with self-care activities overnight • Assistance to access community, social and recreational activities • Group based community, social and recreational activities – e.g house and/or yard maintenance, 	<p>Hoarding and squalor: An item to specifically target this issue as it is a complex problem that needs not only practical help but skilled support and change management overtime</p>	<p>The NDIA funds supports to build the capacity of a participant i.e. skills development, getting a job, and/or making social connections. All these activities can contribute to the ‘recovery’ of an individual. The NDIA provides disability support funding which supports recovery.</p> <p>Specifically to address hoarding/ squalor, the NDIA planner would work with the individual to identify their goal i.e. clear some items from my home so it is safe for me to move around. This goal might be addressed in a variety of ways including connecting to local government clean up services or volunteer organisations, providing some peer support in home to develop strategies to clear items, house</p>

<p>house cleaning and other household activities, community and social activities, assistance with personal domestic activities</p>		<p>cleaning services and possibly behaviour management support/ individual counselling.</p> <p>Behaviour management support/ individual counselling is time limited (usually 10 sessions) and must be a strategy to directly support the individual’s goal rather than ongoing therapeutic support. For example, the individual counselling could be funded to address anxiety management associated with using public transport but could not be funded as a treatment for anxiety support to address the underlying mental health issue i.e. paranoid beliefs. This remains the responsibility of the mental health service. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>
	<p>‘Hospital in the home’ support: supports to assist with medication supervision etc.</p>	<p>This is a mainstream health responsibility. The NDIA is not responsible for funding supports related to the treatment of a health or mental health condition. As per the COAG Agreed Principles and Tables of Support, the NDIA would not be responsible for the funding of hospital in the home services. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>

<p><u>Cluster 4 – Improved daily living skills</u></p> <ul style="list-style-type: none"> • training for carers/parents • assistance with decision making, daily planning, budgeting • specialist driver training • individual assessment, therapy and/or training (includes assistive technology) • group therapy • therapy assistant • multidisciplinary team intervention • individual counselling • counselling group • selection and/or manufacture of customised or wearable technology • individual assessment and support by a Nurse • specialised group early childhood interventions • transdisciplinary early childhood intervention • specialised individual therapy for early childhood 	<p>Individual advocacy: to help participants identify and access the services they need, including mainstream services. Best carried out by chosen provider – as LACs may not have the establishing trusting relationships required.</p>	<p>The described activity matches support co-ordination in the NDIA support catalogue and could be funded as either support connection or support coordination depending on the participant’s needs.</p> <p>The relationship between ILC and advocacy is shaped by the agreement reached by the Commonwealth, state and territory governments in April 2015, that the NDIS will fund decision support, safeguard supports and capacity building for participants, including support to approach and interact with disability supports and access mainstream services. Governments also agreed that systemic advocacy and legal review and representation will be funded outside of the NDIS.</p> <p>The National Disability Advocacy Framework (NDAF) and the National Disability Advocacy Program (NDAP) are now being reviewed to take into account the implementation of the NDIS. The Agency will continue working closely with DSS to ensure that the role of ILC complements the role of the NDAP in the future.</p>
	<p>Access to psychological therapies: such as cognitive behavioral</p>	<p>Access to psychological therapies is the responsibility of the mainstream health service,</p>

	<p>therapy (CBT) to manage disabling effects of mental illness.</p>	<p>not the NDIA. In some circumstances, the NDIA will fund individual counselling/ behaviour management support where it is directly related to an individual’s goal to increase skills and functional capacity. For example, anxiety management related to accessing the community.</p>
	<p>Training for carers and others in recognition of stressors and de-escalation techniques.</p>	<p>As per the COAG Agreed Principles and Tables of Support, training for carers in the recognition of stressors and de-escalation techniques in relation to the mental health condition remains the responsibility of the mainstream mental health service. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>
<ul style="list-style-type: none"> . 	<p>Supportive escorting: bridging the engagement gap between referral and uptake of clinical/treatment supports – i.e system navigation, development of trust in service systems – escorting to and from appointments to build confidence and stable engagement.</p>	<p>The NDIA may fund this type of activity within an individual’s plan as part of support co-ordination and/or improved daily living skills depending on the focus of the activity. However, as per the COAG Agreed Principles and Tables of Support, it is not the responsibility of the NDIA to fund support to navigate between health systems i.e. between the GP and in patient services – this remains the responsibility of the health service. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>

	<p>Carer support: Respite provision. Funded support for carer’s maintenance of mental health aid for their needs - who will support the support team? critical to the wellbeing of the participant)</p>	<p>The NDIA does not use the term respite but does include in plans, ways to build, support and maintain informal supports including family member and carers. This can be a range of funded activities for the participant depending on their goal i.e. a support worker to assist the participant to attend and develop relationships and networks at a local football club for 5 hours on a Saturday which then means the carer is not required to provide this support. Within the legislation, support cannot be funded within a plan directly for the carer, rather than the participant.</p> <p>As outlined in the ILC Commissioning Framework, the kinds of carer activities that may be funded under ILC include:</p> <ul style="list-style-type: none"> • linking carers and families to existing social and recreational activities that give carers a break from their caring role and connect them with the community • activities that promote carer wellbeing such as personal development, peer support and mentoring • linking carers into direct carer support services. <p>The activities ILC will fund to assist carers will be determined by two things:</p>

		<ol style="list-style-type: none"> 1. The intent of the NDIS Act 2. Other Australian Government reforms currently underway.
<p><u>Cluster 9 - Increased social and community participation</u></p> <ul style="list-style-type: none"> • individual skills development and training • skills development in a group • community participation activities • innovative community participation • Life transition planning including mentoring and peer support, focussing on individual skill development 	<p>Peer support workers: Specific item to purchase support from a peer worker to strengthen connection and recovery planning. To help educate carers, families, service providers and other natural supports. To assist in mentoring, recovery, hope and positivity. To support in relapse planning, crisis support and assistance in transition process. To provide -flexible step up 'call in' support.</p>	<p>A participant can have access to a peer worker in any funded activity they chose. This is a negotiation between the participant and the service provider, not the NDIA. There is also support for life transition planning which specifically includes peer support.</p> <p>As per the COAG Agreed Principles and Tables of Support, it is the responsibility of the mainstream health service to support and build the capacity of the participant around recovery planning, relapse planning and crisis support in relation to the mental health condition. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p> <p>The NDIA funds supports to support and build capacity of a participant's functional impairments such as skills development, getting a job, making social connections. All these activities can contribute to the 'recovery' of an individual. This may include the funding of support in a flexible way that can be increased and decreased as needed by the participant (step up/ call in support).</p>

	<p>Capitalising on periods of wellness: Support for planning, long and short term for the participant – regarding their carer e.g. ability to maintain care etc. Development of participant narrative as to what recovery means to them. Recovery planning. Planning around insights/awareness of self and symptoms. Educating the person and their family/network support group to recognise the early warning signs.</p>	<p>Both the NDIA and Health have responsibilities to assist participants with planning depending on the focus i.e. symptom management and treatment or goals for an ordinary life. However, the NDIA can fund planning for individuals at transition life stages to assist them to determine their future goals and aspirations in relation to an ‘ordinary’ life. The funding of support in a flexible way that can be increased and decreased as needed by the participant is built into NDIA plans.</p> <p>As per the COAG Agreed Principles and Tables of Support, the education of the participant and their family/ network about their mental health condition is the responsibility of the mainstream mental health service.</p>
<p><u>Cluster 10 - Finding and keeping a job</u></p> <ul style="list-style-type: none"> • employment preparation and support in a group • individual employment support • employment related assessments and counselling • assistance in specialised supported employment level 1 DMI • assistance in specialised supported employment level 2 DMI 	<p>Support to gain work readiness skills: literacy, TAFE, work placement etc.</p>	<p>The NDIA can fund a range of activities to assist participants to return to education and/or obtain employment.</p>

<ul style="list-style-type: none"> • assistance in specialised supported employment level 3 DMI • assistance in specialised supported employment level 4 DMI • support in employment (ADE) • supported employment start-up fee (ADE) 		
<p><u>Cluster 11 – Improved relationships</u></p> <ul style="list-style-type: none"> • intensive behavioural intervention- development and monitoring of management plan • behaviour management plan, training in behaviour management strategies • individual social skills development 	<p>Building relationships: Inclusion of supports to improve and build relationships</p>	<p>In line with the participant’s goals, the NDIA can fund a range of supports to assist with improved relationships.</p>
<p><u>Cluster 12 - Improved life choices</u></p> <ul style="list-style-type: none"> • support connection • coordination of supports • specialist support coordination • financial intermediary - set up costs • financial intermediary monthly processing • financial and service intermediary set up costs 	<p>Support coordination – navigator/ support facilitator:</p>	<p>The NDIA funds support co-ordination including highly specialised support coordination. Additionally, the NDIA has planners in Intensive teams who work with those individuals have complex and multiple needs including issues with mainstream service interfaces and may require additional assistance with planning.</p> <p>The funding of support in a flexible way that can be increased and decreased as needed by the participant is built into NDIA plans.</p>

<ul style="list-style-type: none"> • financial and service intermediary activities • training in planning and plan management 		
	<p>Crisis response coordination and support: Specific item to plan for crisis event – development of a process to assess risk assessment and design mitigation strategies</p>	<p>The funding of support in a flexible way that can be increased and decreased as needed by the participant is built into NDIA plans. The participant can also specify in their service agreement with their service provider what support should continue when in crisis. As per the COAG Agreed Principles and Tables of Support, it is the responsibility of the mainstream health service to support and build the capacity of the participant and their family/ network around recovery planning, relapse planning and crisis support in relation to the mental health condition. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>
	<p>Advanced care planning: Capacity for increased integration between support provider organisations to provide a ‘connected’ set of services – case conferencing and involvement of family, other supports to facilitate care coordination. A better connected</p>	<p>The NDIA funds support co-ordination including highly specialised support coordination.</p> <p>The funding of support in a flexible way that can be increased and decreased as needed by the participant is built into NDIA plans. The participant can also in their service agreement</p>

	<p>set of providers under a consumers plan would also be beneficial in times of crisis. Case conferencing - a funded item to bring together all providers under plan + family and any other supports and carers to assess the participants gains – if the plan is working.</p>	<p>with their service provider specify what support should continue when in crisis.</p> <p>As per the COAG Agreed Principles and Tables of Support, it is the responsibility of the mainstream health service to support and build the capacity of the participant and their family/ network around recovery planning, relapse planning and crisis support in relation to the mental health condition. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>
	<p>Points of transition</p>	<p>The NDIA funds planning for individuals at transition life stages to assist them to determine their future goals and aspirations in relation to an ‘ordinary’ life.</p> <p>However, it is noted that both the NDIA and Health have responsibilities to assist participants with planning depending on the focus i.e. symptom management and treatment or goals for an ordinary life.</p>
	<p>Assistance to access and navigate the legal system: i.e. when interacting with the criminal justice system</p>	<p>The NDIA has planners in Intensive teams who work with those individuals who are complex and have multiple needs including issues with mainstream service interfaces such as accessing the justice system.</p>

		The NDIA also funds support co-ordination including highly specialised support coordination.
	Crisis planning: Emergency step-down services upon hospital discharge to make sure someone has food, is safe etc. Support for hospital to home, helping participant go home to prevent release and loss of job, assistance with employment change in circumstances transition	The funding of support in a flexible way that can be increased and decreased as needed by the participant is built into NDIA plans. The participant can also specify in their service agreement with their service provider what support should continue when in crisis to assist the individual to remain in the community. The NDIA can fund supports to assist the individual to transition from hospital to their home and can fund support coordination to assist with comprehensive discharge planning. As per the COAG Agreed Principles and Tables of Support, it is the responsibility of the mainstream health service to support and build the capacity of the participant and their family/ network around recovery planning, relapse planning and crisis support in relation to the mental health condition. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.
	Supports integration/ case conferencing	The NDIA funds support co-ordination including highly specialised support coordination.

Other Potential Service Provision to be funded by the NDIA

Options for items – outside of plan

Name	Explanatory notes	NDIA Response
<p>Pre-eligibility support –</p> <ul style="list-style-type: none"> • increased funding to CMOs to be able to find hard to reach potential participants and help them become eligible • Funding for new participants post full scheme transition – will LACs preform this role? 	<ul style="list-style-type: none"> • Information gathering e.g. assessment, review of prior service/system interactions) • Recognising the cognitive, social and practical difficulties many people with psychosocial disabilities will have in being active partners in processes of planning: • Address the understanding and knowledge needs of families and carers for them to participate in planning processes 	<p>It is expected during the transition to the NDIA that programs that are currently funded by the State and Commonwealth Governments along with other mainstream services to assist potential participants to access the NDIA along with the National Access team and LACs where available. In Full scheme, the National Access team would be able to assist potential participants to access the NDIA.</p> <p>Within the NDIA ILC Commissioning Framework, people who are hard to reach and hard to engage are proposed as a priority area for funding.</p> <p>Local Area Coordination services are an important part of the NDIS, as they will work with participants on the ground to help enter, and make the most of the NDIS - while supporting individuals to build strong, inclusive relationships in their communities.</p> <p>Local Area Coordination (LAC) is an important part of the supports and activities that will be available to people with disability and their communities as they transition to the</p>

		<p>NDIS. It is designed to support people with disability to explore and build an ordinary life within their communities. LACs will work with participants to</p> <ul style="list-style-type: none"> • Provide assistance to connect to and build informal and natural supports • Provide assistance with the planning process and effective implementation • Work with non-participants as part of Information, Linkages and Capacity Building • Work with community, providers and mainstream to build inclusion and awareness of the needs of people with disability.
<p>Post-eligibility: increased funding to CMOs to provide that is;</p> <ol style="list-style-type: none"> 1. recovery focused 2. peer lead 3. consumer and carer orientated – co designed 4. trauma informed 	<ul style="list-style-type: none"> • Post- eligibility pre-planning • some eligible participants may require significant time and resources to understand the NDIS system and be able to feel confident in making choices • Recognising the cognitive, social and practical difficulties many people with psychosocial disabilities will have in being active partners in processes of planning: 	<p>All sites have pre planning activities (post access) run by a range of NDIA staff which can be adapted for specific cohorts and/or specific circumstances. These activities are often held off site and in partnership with other organisations. Individual assistance with pre planning can also be provided in some circumstances. NDIA has also funded peer support initiatives across Australia (including for people with psychosocial disability) to assist in pre planning and innovation in planning.</p> <p>The NDIA also has planners in Intensive teams who work with those individuals who have complex and multiple needs including issues with mainstream service interfaces and may require additional support with planning.</p>

		<p>The NDIA funds support for individuals at transition life stages to assist them to determine their future goals and aspirations in relation to an 'ordinary' life within a plan. The NDIA also funds support co-ordination including highly specialised support coordination which may also assist an individual with ongoing planning.</p> <p>However, it is the responsibility of the mainstream health service to support and build the capacity of the participant and their family/ network around recovery planning, relapse planning and crisis support related to the mental health condition. Please see the COAG website - https://www.coag.gov.au/node/497 for further details.</p>
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Appendix 4

National Disability Insurance Agency
Individual Supports for People with Psychosocial Disability

Synergia Project Report

Report 1

Psychosocial Support Packages

Issues and Opportunities

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Definition of Terms

Term	Definition
Support options	The range of psychosocial services accessible under the NDIS contributing to quality of life and participation for people with a mental illness
Psychosocial disability	According to the National Mental Health Consumer and Carer Forum, this is the term used to describe the disabilities that are associated with mental health conditions. While not everyone with a mental illness will experience psychosocial disability, those that do, can experience severe effects and social disadvantage.
Clinical services	These are mental health services provided by health professionals as part of the medical system, in hospital or other designated settings. These services are not accessible under the NDIS but remain the responsibility of existing state, territory or federal health services.
Severe and Persistent/Enduring Mental Illness	The episodic nature of mental illness, even severe illness, is clear. The extent of a person's disability is dynamic, relative to the course of active symptoms. However, the focus of the NDIA will be to assist people whose mental illness is the cause of long-term or life-long disability. This disability is the regular or frequent cause of substantially reduced function, capacity and quality of life.
Recovery	The definition is elusive because recovery is different for everyone. However, recurring themes include self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.
Functional ability	This refers to a person's capacity to perform the activities of daily living - the tasks and activities that are necessary or desirable in their lives.
Activity of daily living	These are the everyday tasks of life: eating, bathing, walking, preparing meal, shopping, assisting with medication etc.
Capacity building supports	Supports designed to help people understand the choices available to them and the consequences of these choices (for both themselves and others) and to assist people to communicate their decisions to others

Capital supports	Capital support items are investments, such as assistive technologies, equipment and home or vehicle modifications.
Clinical mental health services	Services provided health professionals in clinical settings. These are typically in the professional's private consulting rooms or in hospital settings.
Community mental health	These refers to mental health services provided in settings other than hospitals. Community mental health services can be provided by government, non-government and private service providers.
Step up – step down services	These refer to a blend of clinical and psychosocial services designed to act as an alternative to hospitalisation at times when living at home is no longer appropriate or to smooth the transition to home following discharge from an acute mental health service.
Peer support	Peer support is provided by people who identify as having lived experience of mental illness and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated service roles who use their common experience to support and inspire hope and recovery in others.

Introduction

The National Disability Insurance Agency (NDIA) is aiming to assist people with psychosocial disability and their families to better understand and describe the types of supports they require to live well in the community. The NDIA's ambition is that National Disability Insurance Scheme (NDIS), will support every opportunity to help people with severe and enduring psychosocial disability to recover, to live well in the presence or absence of symptoms of mental illness. In doing so the NDIS support complements that provided informally by family, friends and carers as well as the formal support from health, housing and welfare. Central to the NDIS are the principles of supporting people to achieve independence through processes of self-directed planning and choice and control over the support that is accessed.

Australia has now had several decades of experience in the application of these principles in relation to organising and funding care for people with physical and intellectual disabilities. Individual packages of care have been part of how jurisdictions, particularly states and territories, have funded disability support over this time. There is a level of understanding about how this can best be made to work for people and fit family circumstances.

The advent of the NDIS takes this to a new level by including people with a mental illness as part of the scheme. We need to understand psychosocial disability and the distinct patterns of need arising from these clinical conditions. It is important to also appreciate the life context of people with psychosocial disability, including their access or engagement with other service systems such as mental health.

The goal of this project is to explore those unique aspects of psychosocial disability and provide a conceptual structure for adapting the NDIS processes to better meet those needs. In doing so the aim is to inform the NDIA in the design of support options, help people and their carers use these supports effectively and build the understanding of support providers on delivery of assistance.

Synergia was commissioned to support a joint project of the NDIA and the Mental Health Australia and Community Mental Health Australia to develop both concepts and suggested structure of support packages to be used in consultation with people with psychosocial disability, carers and providers.

This paper provides background information that sets out the context and rationale for an approach to self-directed psychosocial packages of support. It provides a review of the available evidence and experience regarding existing mental health services and provides guidance to NDIA about some effective supports that are relevant to the NDIS and may be included in participant packages.

A second paper provides more detail on the concepts, structure and suggested packages themselves.

NDIS and Mental Health

Consistent with successive national mental health plans and strategies, the NDIS is intended to provide a range of support options for people with an enduring psychosocial disability that are designed to maximise their capacity to live well in the community, facilitate social and economic participation and minimise their need for acute hospital care.

If someone wishes to participate in the NDIS, they are assessed against the [access requirements](#). If someone meets these requirements they become a participant in the scheme and may receive individually funded supports.

The NDIS funds reasonable and necessary supports that help a participant to reach their goals, objectives and aspirations, and to enable the participant's social and economic participation. A participant's reasonable and necessary supports take into account any informal supports already available to the individual—those informal arrangements that are part and parcel of family life or natural connections with friends and community services—as well as other formal supports, such as health, mental health and education.

These reasonable and necessary supports are funded by the NDIS to help a participant to reach their goals, objectives and aspirations in a range of areas, which may include education, employment, social participation, independence, living arrangements and health and wellbeing.

While many of the supports needed by people with a psychosocial disability will be common to those with other types of disability, the challenge in this report is to describe:

- The extent to which there are unique aspects of support that may be required by psychosocial disability
- How the boundaries between NDIS support and other support entitlements may work to provide an 'optimal mix'

To address this challenge this paper asserts that there needs to be a dialogue formed and sustained between paradigms of disability support and mental health. There is a propensity in Australia for the driving factor in arranging health and social care to be less about what is required and more about who pays. The NDIS represents an opportunity to address this unhelpful reflex, particularly by focusing on some key areas:

- Reconciling the enduring nature of disability versus the paradigm of recovery;
- Reconciling the NDIS concepts of permanency and stability with the fluctuating/episodic nature of mental illness; and
- The paradigm of self-directed choice and control versus perceived variability in capacity for self-determination and risks

These areas will now be discussed.

Reconciling the enduring nature of disability versus the paradigm of recovery

The NDIS is founded on a paradigm of providing support to manage ongoing, enduring, life-long disability where a relatively predictable structure of support can be defined. This is clearly the case for many physical and intellectual disabilities. Mental health however is increasingly founded on the paradigm of recovery; doctrines and practices of hope and support that maximise the possibility for people to live well in the presence or absence of symptoms of mental illness.

From this perspective admitting to 'permanency' of a mental illness is a negative, deficit concept that limits hope and has a deep and tragic history of being used to justify asylums and long term removal of personal rights.

However, the NDIS also brings an aspect that could be hugely beneficial to mental health, arising from its long term perspective as an insurance-based system of support, one that is vitally concerned about positively influencing future costs and benefits. By embracing the ongoing nature of people's disability, the insurance based paradigm of the NDIS seeks to both support today's needs and identify where investments in capability building or modifications to the daily infrastructure of people's lives could make a positive difference. This contrasts with the short time horizon of most mental health systems of support, mostly driven by funding mechanisms that often struggle to provide more than reactive acute clinical support.

In this paper (and the associated support package concepts paper) we believe there is a useful and productive bridge between the NDIS disability and the mental health recovery paradigms. It lies in the potential to fuse a recovery oriented approach to support with the long term perspective of NDIS that values functional capability development and strengthening of natural social supports. This is covered in more detail in the sections following.

Reconciling the NDIS concepts of permanency and stability with the fluctuating/episodic nature of mental illness

Just like anybody else, people with a disability have good days and bad days. However the implications of a bad day for a person with severe mental illness can be quite different to many other disabilities, even to the point where that person could suffer deprivation of liberty and be subject to involuntary treatment. These consequences are uncommon in other disabilities. This situation represents the complete opposite of the core goals of choice and autonomy the NDIS aims to foster.

There are clear limitations to the paradigm of enduring, relatively stable disability that prevails in physical or intellectual disability. However, it does appear to be at odds with the fluctuating and episodic nature of mental illness as experienced by people, family, carers and service providers. In these cases, what may seem to be an appropriate level of support one day may be either much less than needed in an escalating episode of illness or an unnecessary, overbearing, dependency creating level of support when things are going well.

The NDIS statutory access requirements require that a person's eligibility is assessed against criteria of permanent impairment that results in functional limitations that are likely to result in life time requirements for support. The intensity of impairment may vary but the expectation of life-long support remains, (a more full explanation of the access criteria is described later).

From a practical perspective a fluctuating/episodic impairment means the needs of an individual may not be particularly evident at a certain point in time when eligibility or support planning is being undertaken. A longer baseline of history and experience may be needed in the initial eligibility assessment and the assessment itself may need a greater understanding of the pathway of mental illness than just an assessment of today's impairment.

One key positive impact made possible by the advent of the NDIS is to reconsider the role of planning in the lives of people with severe mental illness. This cohort are likely to already be subject to multiple levels of planning – plans written for or about them by general practitioners,

psychiatrists, case managers, PIR workers, PHAMS workers and others. The NDIS offers an opportunity to recast this planning task.

More akin to the maternity 'blue books', planning at this level is an ongoing story of management of mental illness and development of mental health. Shared care records is another example of this kind of planning. It is not a one-off job or just one part of a process, quickly done so as to move the 'real' treatment. Planning instead is a long term, ongoing undertaking aimed at delivering a new level of autonomy and control to individuals and their families.

Psychosocial disability may require more continuity and connection of the planning process to track and respond to fluctuations and episodes in comparison to other, more stable types of disability. It may require more coordination across types of support, including clinical support.

However, in our view, these point to the necessary attributes of good psychosocial disability support design, rather than fundamental limitations of approach. The challenge will be to adapt the NDIS processes and develop the skills to address this complexity.

The paradigm of self-directed choice and control versus perceived variability in capacity for self-determination and risks

A major driver of disability reform, of which the NDIS is part, is the political and practical agenda of placing choice and control of supports into the hands of people with disability, who can best know their own situation, needs and what will work for them. In practical terms, NDIS planning is used to determine the type and level of support, but people are free to choose alternatives that work for them as long as they fit within broad constraints.

Self-determination and self-agency also lie at the heart of the mental health recovery paradigm. However there is a tension with the awareness that people with mental illness may not engage, or experience periods of impaired judgment where their choices may create risk to themselves or others and exacerbate episodes of ill-health.

Within existing mental health systems of support the tendency has been to prescribe support types and levels, and manage risks to minimise impact on both people and the services deemed to be 'responsible' for them - at the extreme through involuntary treatment. Choice and control implies a freedom of people to take risk that many providers have learned to actively avoid.

The tensions between these paradigms will require ongoing dialogue between people in disability and mental health supports that actively includes people and their families/carers.

However from a design perspective the NDIS does have the ability to specify that some supports (e.g. plan monitoring) are obligatory and to be undertaken by providers with adequate skills. Likewise mental health has developed approaches and methods that enable self-agency and support from others to be used in times of diminishing capacity (e.g. 'relapse prevention'). The challenge will be to create a blend that is deeply respectful of self-agency, acknowledges the impact of psychosocial disability on capacity for choice and supports a more balanced approach to risk.

An assumption of a clear differentiation between clinical and social supports

In the design of the NDIS there is intended to be a clear differentiation between NDIS funded supports and the range of clinical services available for people with a mental illness. These services will continue to be an important element of care for many, however responsibility for providing these services does not lie with the NDIA.

The challenges of drawing this boundary are substantial since effective care for people with mental illness always requires a blend of clinical, psychosocial and home living supports. Effective linkages and partnerships between clinical, community based health services and psychosocial supports will be critical to better outcomes for people. The nature of future support is being informed by evidence focusing on the complementary roles to be played by the clinical and psychosocial aspects of rehabilitation and recovery from mental illness [7]. This challenge is further highlighted by increasing focus on hospital avoidance and effective community mental health care.

It will also be critical to ensure effective ongoing relationships between participants and their general practitioners, given the common co-occurrence of physical health problems among people with severe and persistent mental illness (this is described in more detail later). The new Primary Health Care Networks will also lead a new level of regional planning for primary mental health that needs to reflect the advent of the NDIS and its participants.

One of the most important things the NDIA could offer is to enable consumers and their families with information and self-care capacity that improves their access to the range of support options available, including clinically oriented services. For many people with substantially reduced functioning psychosocial disability and their families finding effective supports that build individual capacity over time can be very difficult. The experience of Partners in Recovery, (described later), is highlighting the valuable role of navigation and coordination as a bridge between individual's personal goals and aspirations and the supports available from formal and informal services.

A Reality Check – Implementing the NDIS within the context of an under-developed system for mental health

A final challenge in this area is the context of the existing mental health service and support system, which is widely acknowledged as being under-developed to meet the needs of people with complex psychosocial disability.

By and large current systems of mental health are set up to provide reasonably good access for relatively straight forward mental health issues via primary care, and, at the other extreme, provide acute crisis care in hospital settings. Successive reports show that this acute system is often under extreme pressure to cope with demand. Clinical services in these settings struggle to provide the quality of care they desire and we must be realistic when we consider what is possible in terms of change now. Further, beyond this acute sphere, there is a 'missing middle' where those with complex, non-acute mental health needs are poorly served.

⁷ A National Framework for Recovery-oriented Mental Health Services, Australian Health Ministers' Advisory Council, 2013

Government and non-government organisations have been providing community-based mental health care in Australia for more than one hundred years. These services were designed to deliver good outcomes to people linked to reducing the costs on the clinical mental health system. There are hundreds of organisations across Australia, many now looking to combine delivery NDIS funded psychosocial disability supports with (non-NDIS funded) clinical services in emerging service models.

However, these community-based mental health services have traditionally accounted for only a small fraction of overall spending in mental health, the significant majority of spending being directed towards hospital-based services. As a result, in most places in Australia community mental health services (both clinical and psychosocial) have until recently struggled to grow. There has also been only very limited investment in research and evaluation in relation to the outcomes achieved by the existing supports offered. The research is generally orientation to reduction of cost to clinical mental health services which is a different outcome than what is expected from the NDIS.

This has meant that for people with psychosocial disability and their families:

- Reliable access to community mental health services has often been very difficult to find; and
- It has been very difficult for people to tell which services are effective and provide quality mental health care and psychosocial disability support

The advent of the NDIS can contribute to improving people's quality of life including access to reasonable and necessary funded psychosocial supports. The NDIS and the mental health system both have the opportunity to invest in supports that increase the overall independence of someone who lives with mental illness. However, this will require that the NDIA and mental health services can collaborate on system level development, rather than stand at arm's length to each other.

A further reality check must be to acknowledge the potential consequences of establishment of the NDIS in this environment. With the mental health system typically struggling, right across Australia, decisions about which clients and which services will be included under the NDIS are naturally of strong interest to the mental health sector. Establishing a set of reasonable, judicious rules and procedures for the NDIS to apply in relation to psychosocial disability will be a significant task. There is concern about the impact these rules will have on people with psychosocial illnesses, however sensitively constructed. Particularly for those people who might just miss out on eligibility for NDIS-funded support, there is concern to ensure the advent of the NDIS does not unintentionally trigger any diminution of non-NDIS support services.

Characteristics and Patterns of Psychosocial Disability

Around 20% of the Australian population are estimated to have a mental illness each year – 4.6 million people. Of this, around 600,000 people are estimated to have severe mental illness [8] causing psychosocial disability. Some people are so severely affected by mental illness that it affects their ability to participate fully in society. Schizophrenia can be a particularly disabling condition for some: this is a persistent form of mental illness that affects approximately 1% of Australians (approximately 200,000 people) at some stage in their lives [9].

⁸ DoHA 2013. National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 - 2011. Canberra: Commonwealth of Australia.

⁹ SANE Australia Mental Health Factsheet

Not everyone with schizophrenia may need NDIS support but there may be others with other illnesses; bipolar, depression etc; causing similarly severe psychosocial disability.

At the same time rates of access to mental health care and treatment are poor. Of people who reported they had a mental illness in the preceding year only 35% received any care for that illness [10]. There is some recent suggestion this figure has now risen, primarily due to the impact of the Federal Government's Better Access Program [11]. For people with severe mental illness, this rate is much higher with almost all (95%) accessing mental health services and most (81%) accessing services for their physical health care. Some other key attributes of this more severely affected population include [12]:

- Most people (88.2%) had visited a general practitioner in the past year
- Most (86.3%) had used outpatient or community clinics and ambulatory health care services in the past year.
- Two-fifths (41.0%) presented to an emergency department and one quarter (26.4%) had done so for a psychiatric problem.
- 17.2% had telephone contact and 16.3% had face-to-face contact with a psychiatric emergency service.
- One in five people (20.7%) had at least one involuntary inpatient admission and one-fifth (19.2%) were under a community treatment order in the past year.
- One third (34.8%) of people with psychotic illness had one or more psychiatric inpatient admissions in the past year, with an average of 40 days in hospital.
- Two-fifths (43.0%) spent from four to thirteen weeks in psychiatric inpatient treatment.
- 11.5% of this group are likely to have serious current thoughts about taking their own life while two thirds (67.0%) of people will think about suicide at some time in their lifetime. Over their lifetimes, half the participants (49.5%) had attempted suicide.

Critically, a new study shows that the average life expectancy of men and women with schizophrenia is 15 years and 12 years shorter respectively than for those who do not suffer from the disease [13]. In relation to the social and economic characteristics of this severely affected cohort, nearly 22.4% feel socially isolated and lonely while 69.3% indicate their illness makes it hard to a close relationship. 13.3% indicated they have no friends at all, 14.1% no-one to rely on. Over two thirds do not attend any social or recreational programs. 51.5% have indicated they are satisfied with their current living situation, 27.8% somewhat satisfied and 12.5% were somewhat or very dissatisfied. 8% of this cohort are likely to be homeless, institutionalised or living in poor shelter (such as a caravan).

One third had been in paid employment over the past year. This is in comparison to 72.4% of the general working age population (15-64 years) who were employed (as at July 2010).

¹⁰ Australian Bureau of Statistics National Survey of Mental Health and Wellbeing, 2007

¹¹ Whiteford H, Buckingham W, Harris M, Burgess P, Pirkis J et al, Estimating treatment rates for mental disorders in Australia, Australian Health Review, 2014, 38, 80-85

¹² Survey of High Impact Psychosis, 2010

¹³ Casey Crump, Marilyn A. Winkleby, Kristina Sundquist, Jan Sundquist. Comorbidities and Mortality in Persons With Schizophrenia: A Swedish National Cohort Study. American Journal of Psychiatry, 2013; DOI: 10.1176/appi.ajp.2012.12050599

These characteristics and figures, while only providing part of the picture, help set out some of the key challenges facing the NDIA in attempting to devise sensible supports for people with a mental illness, particularly in relation to social disability.

Pathways and Journeys within Psychosocial Disability

People’s experience of mental illness is unique. However, based on the overall population characteristics above, it is possible to assert some patterns or common journeys among people living with lifelong mental illness. Wiersma et al [14] studied level of disability over a 15-year period and were able to create five categories to explain the variable course of social disability in participants over time: early improvement in functioning (in the initial years following onset of psychosis); deteriorating course; prominent all the time; late improvement (in the later years of the 15-year study); and never a prominent disability. The table below summarises this evidence, which suggests that between 50-60% of people who experience a psychotic disorder will have extended impairment in relation to their psychosocial functioning.

Course of disablement	Likelihood
Early improvement in functioning following onset of psychosis	36%
Deteriorating course	29%
Prominent disablement experienced all the time	19%
Late improvement, after a period of disablement	10%
No disablement	7%

(nb. The percentage totals sum to 101% - this is as per Wiersma et al’s study)

The same study confirmed that psychosocial disability resulting from a psychotic disorder can persist for long periods of time. After a 15 year study, the following levels of disability were found in relation to people with schizophrenia *(figures below sum to 99% as per Wiersma et al’s study)*:

- 14% no disability
- 26% ‘some’ disability
- 34% ‘obvious’ disability
- 25% ‘severe’ disability.

Across the sample, they identified 14% of participants who needed to be ‘continuously cared for’ over the 15-year study, regardless of the country or mental health care system in which the participant lived. For the vast majority, however, the level of disability showed a substantially fluctuating course, with level of disability in the period following onset of psychosis found to be the strongest predictor of later disability. In sum, for one in seven participants, there was no improvement over the 15-year course; however, for one in three participants, there was considerable improvement over time, such that about 40% of all participants showed little or no disability after 15 years. For the remaining participants, there was still an obvious or severe disability at the end of the 15-year study, suggesting a persistent and severe level of disability for more than half of people with schizophrenia for at least 15 years following onset of the disorder.

¹⁴ Wiersma, D., et al., Social disability in schizophrenia: its development and prediction over 15 years in incidence cohorts in six European centres. *Psychol Med*, 2000. 30(5): p. 1155-67.

The contention of this paper is that it is possible to plan and organise support options for people with lifelong mental illness in response to epidemiological evidence regarding patterns of illness. These patterns will not fit everyone. People's journeys from mental illness to recovery are unique. But the identification of these patterns can assist in determining which supports might be most valuable and at what point in these journeys.

Useful here is the National Mental Health Commission's conception of "a contributing life"; meaning a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty. The NDIS aims to help participants in the Scheme enjoy this contributing life.

NDIS access criteria and types of support

There are specific access requirements for accessing assistance from NDIS during the launch period of the scheme (July 2013 to 30 June 2016). It is set out in the legislation that: A person **meets the access criteria** if:

- (a) the CEO is satisfied that the person meets the age requirements (see section 22); and
- (b) the CEO is satisfied that, at the time of considering the request, the person meets the residence requirements (see section 23); and
- (c) the CEO is satisfied that, at the time of considering the request:
 - (i) the person meets the disability requirements (see section 24); or
 - (ii) the person meets the early intervention requirements (see section 25).

Section 21 NDIS Act 2015

Of most interest to this project are the disability requirements. A person meeting the disability requirements if:

- (a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and
- (b) the impairment or impairments are, or are likely to be, permanent; and
- (c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:
 - (i) communication;
 - (ii) social interaction;
 - (iii) learning;
 - (iv) mobility;
 - (v) self-care;
 - (vi) self-management; and
- (d) the impairment or impairments affect the person's capacity for social or economic participation; and
- (e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.

(2) For the purposes of subsection (1), an impairment or impairments that vary in intensity may be permanent, and the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime, despite the variation.

Section 24 NDIS Act 2013

NDIA staff make decisions based on the National Disability Insurance Scheme Act 2013 (NDIS Act) and the rules made under the NDIS Act. The operational guidelines also provide practical guidance for decision makers.

In order to meet the access criteria, there needs to be enough information that there is no known evidence-based treatment that would remedy the condition and it does not required further medical treatment or review in order for its likely permanency to be demonstrated.

NDIA then needs to confirm if the impairment results in a substantially reduced functional capacity and is likely to need life-time support from the NDIS.

When NDIA staff members make decisions about which supports would be reasonable and necessary for a particular participant, they refer to the particular operational guideline that relates to each specific support. The operational guidelines are publically available on the NDIS website. In order to be considered reasonable and necessary, a support must:

- be related to the participant's disability
- not include day-to-day living costs that are not related to a participant's disability support needs
- represent value for money
- be likely to be effective and beneficial to the participant, and
- take into account informal supports given to participants by families, carers, networks, and the community.

A broad range of supports can support good outcomes for people with psychosocial disability. The types of supports that the NDIS might use to determine an individual package of supports include:

- transport to enable participation in community, social, economic and daily life activities
- workplace help to allow a participant to successfully get or keep employment in the open or supported labour market
- therapeutic supports that relating specifically to improving person functions in daily living - including behavior support planning and,
- help with household tasks to allow the participant to maintain their home environment
- daily personal activities

The NDIS Act and the rules made under the NDIS Act also tell us which supports will not be funded by the NDIS. A support will not be funded if it:

- is not related to the participant's disability
- duplicates other supports already funded by a different mechanism through the NDIS
- relates to day-to-day living costs that are not related to a participant's support needs, or
- is likely to cause harm to the participant or pose a risk to others.

When NDIS uses a funded support item in a participant plan it is defined as being "core", "capacity building" or "capital":

- Core support items are a support that enables a participant to complete activities of daily living and enables them to work towards their goals and aspirations.
- Capacity Building Support Items are investment supports that enable a participant to build their independence and skills so as to progress towards their goals.
- Capital support items are investments, such as assistive technologies, equipment and home or vehicle modifications.

NDIS participants have choice and the control over how they use funded supports in their NDIS plan. That includes choice of how the supports are given and which service providers are used. In some cases the NDIA or others will manage the funding for supports. For example, where there is an unreasonable risk to a participant.

Recovery, Dependency and the Role of Other Agencies

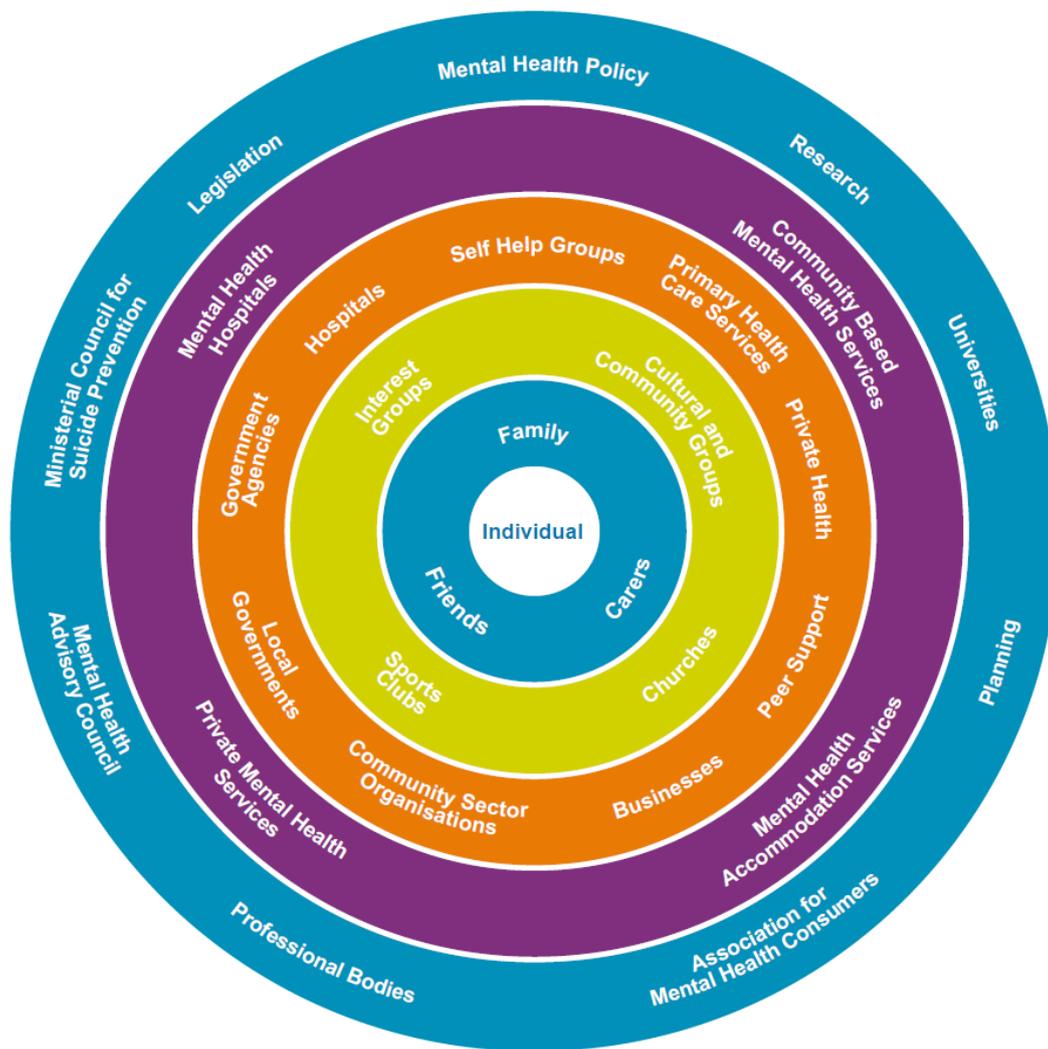
The episodic nature of mental illness means that there will be times when support is needed and important, and other times less so. Some people manage well for long periods. The support they may need is less to do with managing the effects of their illness and more to do with maintaining aspects of a good life such as finding and keeping a job. Others may need more ongoing access to psychosocial supports to maintain good functioning in the community. It may also be critical to provide additional layers of support just when it becomes apparent a person is at risk of deteriorating mental health. Appropriate psychosocial disability support at this point may curtail both the severity and duration of an episode of ill-health and may also provide support to refer people to the mental health system.

In all these circumstances, and in accordance with the principles of recovery, the NDIS support goal is to promote resilience and independence.

The opportunity afforded by the NDIS is to consider this goal in new ways. This opportunity will have palpably been lost if one set of service dependencies merely replaces another.

On this basis, it is important to consider how NDIS supports fit with the range of other service and support systems that people with a mental illness may be accessing. Consistent with the approach taken by the NDIS, the illustration below represents an 'eco-map' which not only demonstrates this breadth but also the centrality of the person with mental illness in determining their own relationships and directing their own supports and services wherever possible [15].

¹⁵ Mental Health 2020: Making it personal and everybody's business, WA Mental Health Commission Strategic Plan



The ‘eco-map’ presents the complex web of relationships on which good mental health can depend. The circles nearest to the individual represent their natural supports, family, carers and others. There are also layers of community support, in organisations like clubs, churches, self-help groups and others. Strong relationships of NDIS participants with their primary health care services are vital – principally general practitioners, but also community mental health centres in some locations. Access to psychology and psychiatry can be critical to maintaining and improving mental health. The significantly reduced life expectancy of people with schizophrenia has been noted earlier. Generally speaking this population die, not because of their mental illness but due to cardio-vascular and other physical illnesses. Focusing on good primary care can address these as well as provide a layer of mental health support.

This eco-map could be expanded further to include employment services - having a job is critical to the health, welfare and dignity of people with a mental illness [16].

¹⁶ Paul K and Moser K, Unemployment impairs mental health: Meta-analyses Journal of Vocational Behaviour Volume 74, Issue 3, June 2009, Pages 264–282

There is no shortage of evidence that mental health service users want and are able to work or that employment can benefit mental health. Surveys have found that aspirations to work are widespread, even amongst those who have lost touch with the labour market over an extended period [17].

The Federal government currently funds employment support agencies to assist people into work, via a range of Employment Services Programs (Job Services Australia, Disability Employment Services, Australian Disability Enterprises etc). There is increasing evidence and understanding about what works in relation to helping people with a mental illness (including severe illness) find and keep a job [18]. The challenge will be to arrange supports to capitalise on those times when a person is well and ready to work. These are precious opportunities to build skills, confidence, increase social engagement and, of course, create an economic benefit both for the individual in terms of wage earning and to the government in terms of reduced welfare spending.

Cost of rent, board and lodging or other day to day usual living expenses such as food and activities are not funded by NDIS. Secure housing is clearly a critical matter for many people with severe mental illness. There are tested models of housing support [19], including the Housing and Supported Accommodation Initiative in NSW which, by combining secure accommodation, clinical and psychosocial supports has demonstrated massive positive benefits for its clients, including reduced hospitalisations, better mental health and social outcomes [20].

One of the most critical service areas for people with severe mental illness is obviously the acute and ambulatory mental health services, mostly run by state and territory governments from hospital campuses. Access to these services is around 1.5% of the population and has not changed over the past decade [21] and pressure on this system seems ever-rising.

On this basis the hurdle for entry to this system continues to lift and the quality and quantity of care able to be provided to people in these settings can be compromised. There is an urgent need to build mental health service alternatives to hospitalisation. For example, step-up step down services are relatively new in Australia but some early evidence indicates their effectiveness [22,23].

While there are currently only a handful of step up/step down services across Australia, mostly in Victoria, these services are successfully blending clinical and psychosocial services for people either at imminent risk of hospitalisation or immediately on discharge from acute care. Good clinical care in these settings is critical. However, they psychosocial aspects of care are also vital. The types of psychosocial activities undertaken in these settings includes developing goals and life skills (e.g. consumer skills, daily living skills, financial counselling, relaxation, sleep hygiene and grief workshops).

¹⁷ Secker, J. & Membrey, H. 2003. Promoting mental health through employment and developing health workplaces: the potential of natural supports at work. Health Education Research, 18 (2): 207-215

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<http://jobaccess.gov.au/sites/default/files/MentalHealthEmploymentAssistanceLiteraturereviewweb.pdf>

¹⁹ <http://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Final%20Report%20-%20AHURI%20-%20Mental%20Health%20and%20Homelessness.pdf>

²⁰ https://www.sprc.unsw.edu.au/media/SPRCFile/2011_5_1_SPRC_Report_511.pdf

²¹ National Mental Health Report 2013

²² https://mhaustralia.org/sites/default/files/imported/component/rsfiles/mental-health-services/Smart_Services.pdf

²³ <http://www.health.vic.gov.au/mentalhealth/publications/parc-evaluation.pdf>

Daytime activities include re-motivating (walking and other physical exercise), education (self-identify, understanding their mental illness, interpersonal skills, education on dealing with stigma). An important part of the psychosocial staff's role is linking clients with other support services, for example drug and alcohol services, activities that link back into the community and accommodation services.

These interventions have a rehabilitation and recovery focus that underpins the range of activities offered by community mental health services and the way the staff approach service delivery. This important aspect of the step up/step down model is distinctly different from the clinician focus on treating an illness.

A range of community sector organisations provide mental health interventions for people with severe mental illness. Various forms of psychosocial intervention have been found efficacious as adjunctive treatments for severe mental illnesses, including family-focused therapy, interpersonal and social rhythm therapy, cognitive-behavioural therapy, and individual or group psycho-education. When used in conjunction with pharmacotherapy, these interventions may prolong time to relapse, reduce symptom severity, and increase medication adherence [24, 25]. However, to the extent that these therapies are delivered in a clinical setting it is unlikely that they would be funded by the NDIS. However blended models of support are emerging that will make this boundary determination more challenging, for example blends of peer delivered motivational techniques, physical activity and e-therapies maybe equally delivered under social supports as well as health services.

As the NDIS emerges as a vital new player for people with disability in Australia and a potential source of funding for the mental health sector, there is a need for sound relationships to be established between the NDIA and other mental health service providers, to create holistic and contiguous care.

While all these inter-agency type relationships will be critical, of primary concern to the NDIS is to establish its funding relationship to the participants in the Scheme. This means equipping them with tools and resources for better self-care and self-management, to give participants every opportunity to exercise independence, choice and control.

It should also be remembered that above all else, the NDIS is in fact an insurance scheme. The Scheme is designed to provide reasonable and necessary supports to people with a mental illness. Its aim in doing so is to consider the future likely liability of each participant in the Scheme and devise intelligent ways of supporting that person better so as to reduce these future liabilities. The lifelong aspect of some mental illnesses can have huge costs, to the individual, their family, the community and the taxpayer. The spectre of this liability is becoming clearer to governments [26], as is the merit of better planning and support to reduce these costs.

An example of this approach can be seen in the development of an insurance, actuarial based approach to youth beneficiaries in New Zealand. A young person receiving an unemployment benefit

²⁴ Miklowitz DJ J, A review of evidence-based psychosocial interventions for bipolar disorder Clin Psychiatry. 2006;67 Suppl 11:28-33.

²⁵ <http://www.psychology.org.au/assets/files/evidence-based-psychological-interventions.pdf>

²⁶ <http://igps.victoria.ac.nz/WelfareWorkingGroup/Downloads/Options%20Paper/Welfare-Working-Group-Reducing-Long-Term-Benefit-Dependency-The-Options-Executive-Summary.pdf>

was found to have a more than 40% chance of being on a benefit in 15 years’ time and around 25% of being on a benefit 40 years after the first entry date. The approximately 3,000 young people on a benefit under 18 years were estimated to have a total future liability of almost \$0.6 billion.

This future liability information is used to tailor interventions towards longer-term sustainable outcomes that mean people are less likely to need help in the future.

This analysis helps inform what support each beneficiary group would most benefit from and help us target services to the individual. More effective and efficient delivery of the right services to the people who will benefit from them most will improve outcomes - both for clients and for the taxpayer.

Environmental Scan – Approaches to the Arrangement of Psychosocial Supports

While Australia’s circumstances may be unique in the world, it is worth noting that several other nations have grappled with questions similar to those posed in this report – how to describe useful packages of mental health supports so as to assist consumers and their families find and choose good care? This section of this report provides a rapid scan of some of the most compelling lessons.

Organisation of mental health support packages

UK Care Clusters and Payment by Results

“Care clusters” provide the framework for the UK’s Mental Health Payment by Results model. These clusters have been established over a number of years in several stages [27]. The development path for the mental health care clusters commenced in 2001. Starting as a local initiative to improve care provision, the process has involved a number of iterations leading to the 21 care clusters that have been mandated for use as part of a National Mental Health Payment by Results system.

21 UK Mental Health Clusters

1 Common Mental Health Problems (Low Severity)	12 Ongoing or Recurrent Psychosis (High Disability)
2 Common Mental Health problems (Low Severity with Greater Need)	13 Ongoing or Recurrent Psychosis (High Symptom and Disability)
3 Non-Psychotic (Moderate Severity)	14 Psychotic Crisis
4 Non-Psychotic (Severe)	15 Severe Psychotic Depression
5 Non-Psychotic (Very Severe)	16 Psychosis and Affective Disorder (high substance misuse and engagement)
6 Non-Psychotic Disorders of Overvalued Ideas	17 Psychosis and Affective Disorder Difficult to Engage

²⁷ Rigby A, Cluster Development Story, Care Pathways & Packages Project 2013

7 Enduring Non-Psychotic Disorders (High Disability)	18 Cognitive Impairment (Low need)
8 Non-Psychotic Chaotic and Challenging Disorders	19 Cognitive Impairment or dementia Complicated (Moderate Need)
9 Blank	20 Cognitive Impairment or dementia Complicated (High need)
10 First Episode in Psychosis	21 Cognitive Impairment or dementia Complicated (High physical or engagement needs)
11 Ongoing Recurrent Psychosis (Low Symptoms)	

Payment by results aims to more transparently link the allocation of funds more closely to the needs and service requirements of individual service users [28]. Broadly, service users with similar types of characteristics are clustered and a price is determined for each cluster. Funding based on this model should enable providers to deliver the care which corresponds with the service needs of people in each cluster. It provides a mechanism for moving from block funding to a system based more closely to the needs of individuals. The challenge is to ensure that ‘cluster based funding’ will not hinder the level of flexibility and responsiveness to individuals. Work is continuing in the UK to refine this approach and to determine how it fits with more individualised approaches such as personal budgets.

It should be noted that even after some years of development, a recent UK analysis found issues within cluster costing data (and the activity data that underpins it) that means the cluster approach may not yet be robust enough to be used as a payment or pricing system [29].

The National Mental Health Services Planning Framework

Action Area 16 under the 4th National Mental Health Plan was a commitment to develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services. Work on this framework commenced in 2011 and was completed in 2013. The framework has evolved a six level structure, describing mental health services by groups, streams, categories, elements, activities and quantities. The framework reflects population-based modelling with epidemiological data, to improve strategic and coordinated approaches to mental health planning and service delivery. The NMHSPF establishes service elements common to all jurisdictions and considered necessary components to a comprehensive mental health care system. It is understood the framework describes a set of Mental Health Specialised Community Support Services – largely the kind of psychosocial supports of particular concern to the NDIS.

The framework is yet to be made publicly available. Jurisdictions have not yet agreed to use the framework for planning purposes.

²⁸ Williams T, Churchill Fellowship Report 2011, To investigate the policy and practice of self-directed support for people with a mental illness.

²⁹ The quality of Mental Health care cluster costing and activity data in the NHS Payment by Results data assurance framework, UK Government, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/364480/The_quality_of_Mental_Health_care_cluster_costing_and_activity_data_in_the_NHS.pdf, accessed April 2015

Mental Health Establishments (MHE) National Minimum Data Set

The MHE NMDS establishes a taxonomy of ten categories to describe the types of psychosocial support services commonly provided by non-government organisations across Australia. This taxonomy is based on the work of the Non-Government Mental Health Services Information Project undertaken in 2004. The ten general categories of service identified are:

1. Advocacy services (Individual, Systemic)	2. Respite services
3. Psychosocial support services	4. Independent living skills support services
5. Pre-vocational training services	6. Self-help support groups
7. Recreation services	8. Other and unspecified services
9. Counselling services	10. Accommodation services (Crisis/interim accommodation, Transitional supported accommodation, Headleasing, Residential rehabilitation, Long-term supported accommodation)

Community Managed Mental Health Sector Service Benchmarks

Australia's community managed mental health sector has already identified seven core service types [30]. The sector acknowledges that service planning across the community managed mental health sector is still in its infancy. Most of the published material is related to supported accommodation; there is little information on the non-accommodation service types.

Despite this, the sector has attempted to set some benchmark service quantities for adults aged 18–64 with a severe mental illness. These packages are the sector's best estimation of the number of residential days and contact hours a person would need each year.

Service type	Benchmark
Supported accommodation	No. residential days per person per year
Crisis accommodation and residential respite	78
Residential rehabilitation (24 h)	365
Residential rehabilitation (< 24 h)	365
Supported public housing	365
Supervised supported hostels	365
Other CMO service types	No. contact hours per person per year
Personalised support	280

³⁰ Mental Health Coordinating Council. 2012. NSW Community Managed Sector Benchmarking Project, Working Paper 2: Service Benchmarks for Selected Core Service Types., Sydney, Australia

Group support	208
Mutual support & self-help	260
Employment, education & training	234
Counselling	104
Family & carer support	260

Organisation of Self Directed Support for Psychosocial Disability

Several countries have experimented with schemes designed to promote greater autonomy and choice for people with disabilities. Some of these approaches have focused on the provision of personalised budgets or self-directed funding. There is good evidence from many studies that self-directed funding has significant overall positive benefits for people with disability and their families [31].

UK Personal Budgets

Personal (also called individual) budgets are a particular form of self-directed funding implemented in England a decade ago. They allow people to bundle and direct funds from a wide range of disability services, but with a variety of options for people about how they wish to manage the funds (including 'contracting out' the management of funding and services). People know how much they will get and what services cost before they plan how they would allocate their funds. It is noteworthy that while this approach has been evaluated as having positive outcomes for clients, take-up of these new arrangements in England was lowest among people with a mental illness. This may have implications for how any such new arrangements are communicated.

Self-direction identifies four core elements: 1) participant control, 2) participant responsibility, 3) participant choice and 4) avoidance of conflict of interest. In essence it is about handing more control and responsibility over to individual service users [32]. The most sophisticated international assessments of the effects of self-directed funding have been undertaken in the United States. Many of these assessments were part of large demonstration programs that allowed people to take the funding from traditional agency care and to spend it on what they needed [33]. The Productivity Commission examined 27 US studies into self-directed funding, spanning the last 25 years. The evaluations consistently found that self-directed funding provides significant benefits to people with disability and their families compared with traditional agency-based services. Positive results were found for those with physical, intellectual and mental health disabilities, and for the non-elderly and elderly.

The National Mental Health Consumer and Carer Forum has strongly supported self-directed funding options with the caveat that many people also need help to ensure they can effectively control decision making about their lives [34].

³¹ Productivity Commission Report into Personalised Budgets

³² Crozier, M., Muenchberger, H., Ehrlich, C. & Coley, J H. (2012). Self-directed Support: A state, national, international understanding. Griffith University.

³³ Productivity Commission Report into Personalised Budgets

³⁴ Unravelling Psychosocial Disability, Position Statement, National Mental Health Consumer and Carer Forum,

http://www.nmhccf.org.au/documents/NMHCCF_Psychosocial%20Disability_Booklet_Web%20version_27Oct11.pdf, accessed April 2015

NZ Enabling Good Lives

In September 2012, New Zealand agreed to trial a new scheme called Enabling Good Lives, operating to a set of principles similar to the NDIS [35]:

- Self-determination: disabled people are in control of their lives.
- Person-centred: disabled people have supports that are tailored to their individual needs and goals, and that take a whole life approach.
- Ordinary life outcomes: disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation - like others at similar stages of life.
- Mainstream first: disabled people are supported to access mainstream services before specialist disability services.
- Easy to use: disabled people have supports that are simple to use and flexible.

Enabling Good Lives put the disabled person at the centre, joining funding from three Ministries (Health, Education and Social Development) to create one single funding pool (or allocation) which a disabled person can utilise to meet their needs. Once the funding is in the 'pool' the eligibility or rules guiding its usage are not carried forward from each respective Ministry, i.e. Education funding doesn't have to be spent on Education – although it is likely that it will be as it was provided in the first place to meet an identified need by that Ministry.

An important component of the Enabling Good Lives is that significant levels of planning support are provided to disabled before, before they seek government funding. This support is provided within a flexible 'planning framework'. The intention is to support people to maximise their own goals and outcomes by utilising the resources of self, carers, friends/family, community, broader networks and mainstream services and support – exhausting these options before seeking government funding. Essentially, government funding is seen as a later option, not the first. The planning support is provided by a group of navigators and whilst being 'person directed' is based on the development of a 'life plan', which goes broader than formal services and looks at all aspects of a person's life, their goals, outcomes, networks and own resources.

Funding is allocated to an individual via a supported self-assessment (SSA) process. The SSA process is moderated by the funder, in NZ this comes in the form of a number of regional Needs Assessment and Service Co-ordination organisations. This process of allocation, sits within the broader planning framework – meaning that each technical or formal step is the process of continuously building on the understanding of the disabled person and their context – the planning framework is the 'glue' that brings it all together. Once funding is allocated, choices that people make about how to use the funding allocated by government are guided by the Purchasing Guidelines. These guidelines are principles based and non-prescriptive, giving disabled people the greatest flexibility possible to choose services and supports that meet their needs.

Disabled people receive ongoing support from the navigators to ensure their 'life plan' is on track and that the various funding sources, included those from government are being used to maximise

³⁵ Ministry of Health. 2013. Purchasing Guidelines for the New Model for Supporting Disabled People. Wellington: Ministry of Health. Available here: <http://www.health.govt.nz/publication/purchasing-guidelines-new-model-supporting-disabled-people>.

the persons 'value for outcomes'. Value for outcomes asks the question, is the disabled person getting the most out of the funding for them and their goals/outcomes – if not adjust the plan.

Funding and its usage are monitored and review by the Needs Assessment and Service Co-ordination organisation. The initial focus on the Enabling Good Lives rollout is youth in transition from formal education. This scope has been broadened recently (2015) to include other groups at the discretion of the governance group overseeing the pilot.

Partners in Recovery

Partners in Recovery (PIR) is a Commonwealth initiative aiming to better support people with severe and persistent mental illness and complex needs, and their carers and families, by connecting them more effectively with the services and supports they need in a collaborative, coordinated and integrated way. There are currently 48 PIR initiatives operating nationally with a target of reaching 24,000 PIR consumers nationally by the end of the initiative.

From an NDIS perspective PIR provides an opportunity to learn from the experience of individualised, personal goal directed planning, coordination as well as a system level influence, similar to the Tier 2 'Information and Linkages' component of the NDIS.

While little has yet emerged from the evaluations of PIR the Hunter region has produced a report of their experience of PIR and its linkage to the NDIS pilot in their region [36].

This report notes some of the practical issues and paradigm challenges described at the beginning of this paper:

- The report noted the contradiction between the NDIS eligibility question "Is your disability likely to continue for the rest of your life?" and the recovery focus of PIR and the national mental health standards. The view was that the demand to substantiate permanence could have a material negative impact on people's wellbeing and hope.
- People with a mental illness may not be able to recognise the impact of their mental illness or describe the level of help they require to manage a range of issues; mobility, self-care, domestic duties, communication, interpersonal relations and behaviour or learning and applying knowledge.
- The impact of stigma that means people with mental illness may internalise their feelings/symptoms, make efforts to minimise the impact of their illness, find it difficult to trust people and being willing to share personal information. Pre-engagement may be an extensive process.
- People with psychosocial disability may require one-on-one guidance, support and coaching throughout the process of application and planning. This can be an intensive process with requirements to compile information from multiple sources, including clinical input.
- The report recommends that a specialised assessment process be used for psychosocial disability in order to tailor support, improve functioning and enable individuals to live in the community with a reduced reliance on acute mental health services.
- Finally the report noted the essential role for active participation of family and carers in contributing to psychosocial support planning and delivery. This is a complex area where the

³⁶ Hunter Medicare Local 2015 *Hunter PIR and the NDIS: Building a Stronger Partnership*

NDIS is required to abide by the decision of eligible individuals as to whether families are involved and the manner of their involvement.

Evidence for Psychosocial Supports

This section summarises the work undertaken in a literature review prepared by the University of Melbourne for the NDIA [37]. This information can inform not only the NDIS as it considers the shape of potential packages but also consumers and carers who often face difficulties assessing what constitutes quality services. This review found that in assessing the overall effectiveness of psychosocial support interventions for people with severe mental illness and/or a substance abuse disorder, supported employment and skill building have the strongest level of evidence in their favour. Supportive housing has ‘moderate’ strength evidence to support its effectiveness, while personalised support has ‘weak’ evidence in support of its effectiveness. Skill building has also been deemed as an evidence-based practice, specifically social skills training, social cognitive training and cognitive remediation.

There is lesser support, however, for the effectiveness of life skills training alone and cognitive behavioural approaches to illness management, which can also be grouped under the ‘skills building’ intervention type.

There is some evidence that supportive housing can reduce homelessness and hospital contacts. Evidence for the positive effects of peer support are mixed, although positive findings relate peer support to improved service engagement, hope and motivation among people with mental illness and/or a substance use disorder. There is also a moderate level of evidence that personalised support services can promote satisfaction with services and reduce illness acuity. In relation to peer support and peer services it is possible to identify more evidence for effectiveness of intervention and for consumer satisfaction.

Overall, while there has been some considerable interest worldwide in better arranging psychosocial supports, there is no clear method or direction as to how this should occur. The approach to be taken by the NDIS should be seen as a contribution to this development. It is likely that further refinements will be required to better reflect practical experiences and evolving evidence, both in terms of the type and quantity of services necessary. Even then, the nature of personalised support means the final decision rests with the participant.

Requirements for effective support

Workforce skills and capacity

Stresses and strains around the Australian mental health workforce are well known [38]. Estimates which reflect a relatively modest increase in the proportion of people seeking help for mental health difficulties, combined with projected Australian population growth, produce a cumulative increase in the use of mental health services ranging from 135% to 160% for select mental health professions, over 15 years. If services continue to be delivered unchanged, the increase in utilisation will drive demand for front line professions with an additional 4,500 general practitioners (GPs), 2,150

³⁷ Nicholas A, Reifels L Mental health and the NDIS: A literature review, August 2014

³⁸ <http://about.au.reachout.com/wp-content/uploads/2015/01/ReachOut.com-Crossroads-Report-2014.pdf>

psychiatrists and 2,150 clinical psychologists projected as required. It is highly likely that existing services will not meet this demand. The AIHW indicate the mental health workforce is growing but at less than 1.5% each year [39] and the nursing workforce in particular is ageing.

The response to this challenge has been to suggest that Australia's mental health service system should be reoriented around a stepped care framework that provides a range of help options of varying intensity matching people's level of need. In particular:

- Self-help and peer-based services, especially those delivered online, that are capable of providing help and support at massive scale should be prioritised by policy makers, funding bodies and researchers, with greater and more sustainable investment.
 - Self-help, peer-based, and online services should be fully integrated with more 'traditional' existing services through clear treatment pathways, and a mental health workforce trained to optimise their access.
 - Mental health workforce capacity should be maximised through greater utilisation of mental health peer workers where appropriate, freeing up clinicians to assist those in greatest need.
- This is consistent with the approach outlined both in this paper and the companion paper regarding package concepts and structures.

The Role of Peer Workers

An important element of the possible NDIS supports is the role of peer workers. Peer workers are people who identify as having lived experience of mental illness and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated roles in services who use their common experience to support and inspire hope and recovery in others [40].

A recent review of the evidence base by Health Workforce Australia [41] noted that while evaluation of peer work has lagged behind implementation, the evidence suggests that peer work can be as effective as other service approaches and delivers significant benefit to consumers, peer workers, families, carers and services.

An acknowledgement of the difference between medical or clinical focussed services and disability support services is a likely reason that peer support workers are becoming an essential element of mental health service provision and a skill set of choice for community managed mental health services.

Peer support workers are likely to be more familiar with the disability support needs of people with mental health conditions and are able to identify ways to meet these needs outside the mental health sector and in dealing with everyday life in the community.

In providing these services they use their unique skills and experience to provide a conduit between mental health services and disability supports. They are also uniquely placed to provide pathways between generic disability services and people with a psychosocial disability [42].

³⁹ <http://www.aihw.gov.au/media-release-detail/?id=10737421552>

⁴⁰ Peer Work Strategic Framework, Western Australian Association for Mental Health, October 2014

⁴¹ Health Workforce Australia (2014a), Mental Health Peer Workforce Literature Scan

http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Literature%20Scan_LR.pdf, accessed April 2015

⁴² Unravelling Psychosocial Disability, Position Statement, National Mental Health Consumer and Carer Forum,

http://www.nmhccf.org.au/documents/NMHCCF_Psychosocial%20Disability_Booklet_Web%20version_27Oct11.pdf, accessed April 2015

A goal for the NDIS could be to ensure that all peer Support Facilitators are appropriately skilled and experienced professionals who possess a comprehensive knowledge and understanding of the local service system (including health and welfare sectors) and both clinical and non-clinical support services.

Organisation of providers and networks

The focus of this paper has been on the issues and opportunities for NDIS individual packages of support rather than how that support is organised across networks of families, carers, support providers or other agency services. However the NDIS has a strong role in this area through the 'Tier 2 Information and Linkages' funding and the function of NDIA Local Area Coordinators.

From a mental health perspective PIR has shown the value of drawing together the networks of government, health and community partners at a system level in order to facilitate access and integration of support within person centred individual plans.

As NDIS evolves more targeted approaches to psychosocial disability the network support infrastructure developing under PIR will become highly relevant. These include:

- Workforce skills development
- The capability and experience in developing recovery oriented individualised plans, including measurement of function and outcomes
- Coordination capability in the form of information, linkages and relationship
- Information and intelligence sharing across networks of communities, providers and agencies
- Practice governance and quality assurance

NDIA Workforce Implications

While the NDIS clearly sets out some challenges for the mental health sector workforce, the fluctuating nature of mental illness and the complexity of the 'system' of care also pose new challenges to NDIA staff. Effective planning to meet the needs of psychosocial disability requires frequent checking, as well as a good understanding of the nature of the person and their unique experience of mental illness. Fluctuations in illness necessitate swift response to avert negative, longer term impacts and costs. This may necessitate a different, more frequent and intimate level of interaction between NDIA planners and the people using the scheme and their families. NDIA staff may benefit from deeper insight and training in relation to psychosocial disability.

There is also excellent evidence pointing to the effectiveness of multi-disciplinary teams in the effective care and management of mental illness. There need to be opportunities for NDIA staff to build and become part of such teams, working with health, housing, community services and other staff to drive holistic care. A key part of bridging the gap between health and disability paradigms is surely some cross-fertilisation of this type.

Conclusion

The NDIS represents a game-changing opportunity for mental health in Australia – an opportunity to finally secure some ongoing, recovery-oriented community support for people with severe and persistent mental illness. The NDIS provides a structure for psychosocial support that is largely unavailable to Australians currently. Its central ethos of self-directed support fits well with concepts of self-agency, independence and recovery. The NDIS also has the flexibility to operate at both individual and systemic levels, through existing Tier 2 information and linkages. The NDIS design incorporates both individual and systemic capacity building – both are necessary and well suited to mental health support.

The NDIS also provides a new and important long term focus on the merit of investment in good community mental health support. This kind of lens has been missing in mental health which too often directs people to expensive and often traumatic hospitals as practically the only place to go for care. The longitudinal lens generated by the NDIS, in considering the lifetime costs of care, provides new incentive and opportunity to create new pathways for care and support. These new options will assist in diminishing the requirement for hospitalisation, save money and increase the quality of life enjoyed by the people concerned and their families.

The concept of packages of mental health support has highlighted some of the boundary issues separating the mental health and disability paradigms. This paper suggests these issues could be summarised in five broad areas:

- a) Reconciling the enduring nature of disability versus the paradigm of recovery - while clearly not insurmountable, there is a mismatch between common concepts of permanent disability and the recovery ethos. There is a desire to establish a strengths-based philosophy of positivity embodied in the notion of recovery that sits awkwardly with consignment to a definition of life-long disability.
- b) Reconciling the NDIS concepts of permanency and stability with the fluctuating/episodic nature of mental illness – by its nature mental illness is rarely a stable state, particularly for people with more severe illnesses. Catering for these fluctuations lies at the heart of the NDIS capacity to deliver good care;
- c) The paradigm of self-directed choice and control versus perceived variability in capacity for self-determination and risks – while the disability sector may have come to terms with concepts such as the dignity of risk, letting people make mistakes of their own and so on, the mental health sector has become increasingly risk averse. This is perhaps one reason why the location for mental health care has become increasingly centralised to hospitals, where these risks can be best ‘managed’. Clearly there is work to be done to reconcile these two approaches so as to establish a balance that meets the needs of individuals and their families.
- d) An assumption of a clear differentiation between clinical and social supports – particularly as Australia’s mental health system starts to reorient towards hospital avoidance and community support, neat categorisations such as these are coming under pressure. More and more organisations are striving to provide blended care, offering both clinical and psychosocial support services, often extending to include housing, employment, vocational training and so

on. It would be a pity if these nascent services were sacrificed because of the need to be clear about who pays.

- e) A Reality Check – Implementing the NDIS within the context of an under-developed system for mental health. Particularly in relation to non-hospital services, Australia’s system of mental health care is weak. Even hospital-based services are generally under enormous strain. As the NDIS further develops its approach, there is a need to be realistic about how to create new partnerships with mental health services.

Some practical ideas about how to deal with these challenges are suggested in Paper 2 but clearly opportunities for joint planning and training are critical, placing NDIS staff as part of new multi-disciplinary teams driving responsive planning and service delivery for people in the Scheme. It is also important to start collecting and publicising good practice examples of where this kind of holistic planning is occurring and how it is being fostered.

The recurring challenge set out in this paper is how best to fit the fluctuating nature of mental illness into the NDIS. In doing so, it must be alert to the episodic nature of the illness and its common trajectories. These trajectories can help in identifying key points of intervention and arranging support designed to minimise the impact and severity of illness.

It is about finding this right level and mix. And while it is possible to plan and anticipate these common trajectories, nothing detracts from the essentially individual experience of mental illness.

All this makes it critical for the NDIA to effectively manage its boundaries with other services, particularly the health sector. Critical here are considerations of new approaches to assessment and planning the aim of which is to create continuity of contact and care. In turn, this continuity and frequency of care permits responsiveness to change. This type of care needs staff with the right skills and mindset.

The advent of the NDIS offers a chance to re-frame mental health towards a more calibrated approach, offering step up and step down levels of support. It offers the chance to end the over-dependence on acute hospitals as the front door to care. For this to occur, the NDIS has a broader role in encouraging optimal system-level investments. Are governments (and others) doing enough to build the types of services and settings the NDIS needs in order to promote good community mental health care for people?

This is clearly the start of a process not the end. There is a critical role for continuous learning and evaluation to help build the evidence base of how to effectively manage mental illness as part of the NDIS. There is a need for ongoing dialogue between the NDIS and its partners, particularly in the health sector.

Appendix 5

PRINCIPLES TO DETERMINE THE RESPONSIBILITIES OF THE NDIS AND OTHER SERVICE SYSTEMS

All governments have agreed that our vision is for an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens. To achieve this vision, all Australian governments, non-government organisations, business and the wider community have a role to play. The interactions of the NDIS with other service systems will reinforce the obligations of other service delivery systems to improve the lives of people with disability, in line with the National Disability Strategy.

Governments agree that the principles outlined in this document will be used to determine the funding and delivery responsibilities of the NDIS in achieving this vision. The NDIS launch sites provide governments with an opportunity to review interactions between the NDIS and other service systems and consider any lessons arising out of launch.

These applied principles, and arrangements needed to operationalise them, have been reviewed through the process set out in Part 8 of the Intergovernmental Agreement for the NDIS Launch. Based on this review and on the lessons from trial, the Disability Reform Council may provide advice to COAG on amendments to the Applied Principles and ‘tables of supports’. The Agency Board may also report to the Disability Reform Council and COAG on the operation and effectiveness of the interface with other service systems.

1. People with disability have the same right of access to services as all Australians, consistent with the goals of the National Disability Strategy which aims to maximise the potential and participation of people with disability.
2. The NDIS will fund personalised supports related to people’s disability support needs, unless those supports are part of another service system’s universal service obligation (for example, meeting the health, education, housing, or safety needs of all Australians) or covered by reasonable adjustment (as required under the Commonwealth Disability Discrimination Act or similar legislation in jurisdictions).
3. Clear funding and delivery responsibilities should provide for the transparency and integrity of government appropriations consistent with their agreed policy goals.

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| 4. There should be a nationally consistent approach to the supports funded by the NDIS and the basis on which the NDIS engages with other systems, noting that because there will be variation in non-NDIS supports funded within jurisdictions there will need to be flexibility and innovation in the way the NDIS funds and/or delivers these activities. |
| 5. In determining the approach to the supports funded by the NDIS and other service systems governments will have regard to efficiency, the existing statutory responsibilities and policy objectives of other service systems and operational implications. |
| 6. The interactions of people with disability with the NDIS and other service systems should be as seamless as possible, where integrated planning and coordinated supports, referrals and transitions are promoted, supported by a no wrong door approach. |

Applied principles and tables of services

In addition to the six general principles, applied principles have been developed in a range of other service systems to assist governments to further define the funding responsibilities during the launch of the NDIS. There is also a table of specific activities funded by the NDIS and by other systems for each of these other service systems. The purpose of this document is to define the activities funded by the NDIS and other systems and it does not intend to place additional obligations on other systems. Responsibility for the identified activities will be reviewed based on the NDIS launch experience.

Applied principles and more detailed tables of funding responsibilities have been developed for:

1. Health
2. Mental health
3. Early childhood development
4. Child protection and family support
5. School education
6. Higher education and Vocational Education and Training (VET)

7. Employment
8. Housing and community infrastructure
9. Transport
10. Justice
11. Aged care

1. HEALTH

APPLIED PRINCIPLES — HEALTH

1. Commonwealth and State and Territory health systems have a commitment to improve health outcomes for all Australians by providing access to quality health services based on their needs consistent with the requirements of the National Healthcare Agreement and other national agreements and in line with reasonable adjustment requirements (as required under the Commonwealth Disability Discrimination Act or similar legislation in jurisdictions).
2. The above health system will remain responsible for the diagnosis, early intervention and treatment of health conditions, including ongoing or chronic health conditions. This may involve general practitioner services, medical specialist services, dental care, nursing, allied health services, preventive health care, care in public and private hospitals, and pharmaceuticals (available through the PBS).
3. Health systems are responsible for funding time limited, recovery-oriented services and therapies (rehabilitation) aimed primarily at restoring the person's health and improving the person's functioning after a recent medical or surgical treatment intervention. This includes where treatment and rehabilitation is required episodically.
4. The NDIS will be responsible for supports required due to the impact of a person's impairment/s on their functional capacity and their ability to undertake activities of daily living. This includes "maintenance" supports delivered or supervised by clinically trained or qualified health professionals (where the person has reached a point of stability in regard to functional capacity, prior to hospital discharge (or equivalent for other healthcare settings) and integrally linked to the care and support a person requires to live in the community and participate in education and employment.
5. The NDIS and the health system will work together at the local level to plan and coordinate streamlined care for individuals requiring both health and disability services recognising that both inputs may be required at the same time or that there is a need to ensure a smooth transition from one to the other.

Note: In applying these principles, consideration will be given to alignment with services funded under the National Health Reform Agreement, with a view to avoiding overlap or gaps.

<i>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — HEALTH</i>	
<i>REASONABLE AND NECESSARY NDIS SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Elements of community re-integration which enable the person to live in the community such as assistance with activities of daily living and home modifications. – Active involvement in planning and transition support, on the basis of the person having reached a point of stability in regard to functional capacity, prior to hospital discharge (or equivalent for other healthcare settings) wherever there is a need for ongoing maintenance support. – Prosthetics, orthoses and specialist hearing and vision supports (excluding surgical services) where these supports directly relate to a person’s permanent impairment. – Allied health and other therapy directly related to maintaining or managing a person’s functional capacity including occupational therapy, speech pathology, physiotherapy, podiatry, and specialist behaviour interventions. This includes long term therapy/support directly related to the impact of a person’s impairment/s on their functional capacity required to achieve incremental gains or to prevent functional decline. Also includes allied health therapies through early intervention for children aimed at enhancing functioning. – The delivery of nursing or delegated care by clinically trained staff (directly or through supervision), where the care is required due to the impact of a person’s impairment/s on their functional capacity and integral to a person’s ongoing care and support to live in the community and participate in education and employment (including, but not limited 	<ul style="list-style-type: none"> – [Jointly with NDIS] Provision of specialist allied health, rehabilitation and other therapy, to facilitate enhanced functioning and community re-integration of people with recently acquired severe conditions such as newly acquired spinal cord and severe acquired brain injury. – Acute and emergency services delivered through Local Hospital Networks including, but not limited to, medical and pharmaceutical products (available through PBS), medical transport, allied health and nursing services (where related to treatment of a health event), dental services and medical services covered under the Medicare Benefits Schedule, or otherwise government funded (including surgical procedures related to aids and equipment). – Sub-acute services (palliative care, geriatric evaluation and management and psychogeriatric care) including in-patient and out-patient services delivered in the person’s home or clinical settings. – Rehabilitative health services where the purpose is to restore or increase functioning through time limited, recovery oriented episodes of care, evidence based supports and interim prosthetics, following either medical treatment or the acquisition of a disability (excluding early interventions). When a participant is receiving time limited rehabilitation services through the health system, the NDIS will continue to fund any ongoing ‘maintenance’ allied health or

<p>to, PEG feeding, catheter care, skin integrity checks or tracheostomy care (including suctioning).</p> <ul style="list-style-type: none"> – The delivery of routine personal care required due to the impact of a person’s impairment/s on their functional capacity to enable activities of daily living (e.g. routine bowel care and oral suctioning) including development of skills to support self-care, where possible. – Any funding in a person’s package would continue for supports for people with complex communication needs or challenging behaviours while accessing health services, including hospitals and in-patient facilities. – Training of NDIS funded workers by nurses, allied health or other relevant health professionals to address the impact of a person’s impairment/s on their functional capacity and retraining as the participant’s needs change. – Aids and equipment to enhance increased or independent functioning in the home and community. – In relation to palliative care, functional supports as part of an NDIS participant’s plan may continue to be provided at the same time as palliative care services, recognising that supports may need to be adjusted in scope or frequency as a result of the need to align with the core palliative care being delivered through sub-acute health services. – Funding further assessment by health professionals for support planning and review as required. – The coordination of NDIS supports with supports offered by the health system and other relevant service systems. 	<p>other therapies the person requires and that are unrelated to the health system’s program of rehabilitation.</p> <ul style="list-style-type: none"> – Preliminary assessment and disability diagnosis as required for the determination of an individual’s eligibility for the NDIS (e.g. developmental delay). – General hearing and vision services unrelated to the impact of a person’s impairment on their functional capacity as determined in the NDIS eligibility criteria (e.g. prescription glasses). – Inclusion of people with disability in preventative health and primary health care delivered through General Practice and community health services, including dental and medical services covered under the Medicare Benefits Schedule. – Intensive case coordination operated by the health system where a significant component of case coordination is related to the health support.
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2. MENTAL HEALTH

The designation of mental health system responsibility here refers chiefly to public funding through the state and territory public mental health system and/or private mental health services receiving Commonwealth funding through the Medicare Benefits Schedule, together with non-government organisations in receipt of state, territory or Commonwealth funding where these continue to undertake roles outside the NDIS.

APPLIED PRINCIPLES — MENTAL HEALTH

1. The health system will be responsible for:
 - a. Treatment of mental illness, including acute inpatient, ambulatory, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs;
 - b. residential care where the primary purpose is for time limited follow-up linked to treatment or diversion from acute hospital treatment; and
 - c. the operation of mental health facilities.
2. Where a person has a co-morbidity with a psychiatric condition:
 - a. The health or mental health system will be responsible for supports relating to a co-morbidity with a psychiatric condition where such supports, in their own right, are the responsibility of that system (e.g. treatment for a drug or alcohol issue).
 - b. The NDIS will be responsible for additional ongoing functional supports associated with the co-morbidity to the extent that the co-morbidity impacts on the participant's overall functional capacity. This applies equally where the impairment is attributable to a psychiatric condition and/or is the co-morbidity to another impairment.
3. The NDIS will be responsible for ongoing psychosocial recovery supports that focus on a person's functional ability, including those that enable people with mental illness or a psychiatric condition to undertake activities of daily living and participate in the community and in social and economic life. This may also include provision of family and carer supports to support them in their carer role, and family therapy, as they may facilitate the person's ability to participate in the community and in social and economic life.

4. The NDIS and the mental health system will work closely together at the local level to plan and coordinate streamlined care for individuals requiring both mental health and disability services recognising that both inputs may be required at the same time or that there is a need to ensure a smooth transition from one to the other.

Note: In applying these principles, consideration will be given to alignment with services funded under the National Health Reform Agreement, with a view to avoiding overlap or gaps. Investments in psychosocial early intervention supports for people with early onset psychosis may improve whole-of-life outcomes for individuals, consistent with the insurance principles of the NDIS. Governments will continue to focus on and consider this issue in the implementation of the NDIS and other government programs.

<u>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — MENTAL HEALTH</u>	
<i>NDIS REASONABLE AND NECESSARY SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Support for community reintegration and day to day living including development of skills, assistance with planning, decision-making, personal hygiene, household tasks, social relationships, financial management, transport, support for accommodation access**, and community connections provided other than where provided as an integral part of an established treatment program. – Allied health and other therapy directly related to managing and/or reducing the impact on a person’s functional capacity of impairment/s attributable to a psychiatric condition, including social and communication skills development, routine symptom and medication management, and behavioural and cognitive interventions. – Capacity building support to help the person access and maintain participation in mainstream community, including recreation, education, training and employment, housing, and primary health care. 	<ul style="list-style-type: none"> – Services and therapies in which the primary function is to provide treatment* of mental illness targeted towards people affected by mental illness or a psychiatric condition, including acute and non- acute residential services, mental health crisis assessment services, hospital avoidance services and post-acute care services. – Early intervention designed to impact on the progression of a mental illness or psychiatric condition, especially where delivered by health services (notwithstanding the note above). – Intensive case coordination operated by the mental health system where a significant component of case coordination is related to the mental illness.

<ul style="list-style-type: none">– Community supports aimed at increasing a person’s ability to live independently in the community or to participate in social and economic activities, including in-home and centre-based care, recreational activities, day centre services and holiday care, community access (including life skills and social skills day programs).– The coordination of NDIS supports with the supports offered by the mental health system and other relevant service systems.	
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[Treatment is defined here as activities associated with stabilisation and management of mental illness (including crisis, symptom and medication management) and establishment of pathways for longer term recovery.*

*** Supports to assist a person to obtain and maintain accommodation and/or tenancies where these support needs are required due to the impact of the person’s impairment on their functional capacity.]*

3. CHILD PROTECTION AND FAMILY SUPPORT

APPLIED PRINCIPLES — CHILD PROTECTION AND FAMILY SUPPORT

1. In recognising the statutory role of the child protection system and in line with the National Framework for Protecting Australia's Children 2009-2020:
 - a. other parties will be responsible for promoting the safety of children from abuse and neglect, including public education on child safety, and management of the statutory child protection system including reports of child protection.
 - b. the NDIS will ensure its rules and processes are consistent with jurisdictional child protection legislation, including reporting requirements.
2. The child protection, community services, family support, education and/or health sectors will continue to be responsible for universal parenting programs, counselling and other supports for families that are provided both to the broad community and families at risk of child protection involvement, or families experiencing or at risk of experiencing family violence, including making these services accessible and appropriate for families with disability.
3. Relevant state and territory authorities will be responsible for meeting the needs of children with disability in out-of-home care and support to carers of children in out-of-home care, including making reasonable adjustments to meet the needs of children with disabilities.
4. The NDIS will fund supports required due to the impact of the child's impairment/s on their functional capacity where a child with disability is in out-of-home care and has support needs that are above the needs of children of a similar age. The diversity of out-of-home care arrangements is recognised and the level of 'reasonable and necessary' supports will reflect the circumstances of the individual child. The standard supports provided by the child protection system to carers relevant to their out-of-home care arrangement will continue.
5. The NDIS will be responsible for support for children, families and carers required as a direct result of the child's or parent's disability, including supports that enable families and carers to sustainably maintain their caring role, including community participation, therapeutic and behavioural supports, additional respite, aids and equipment and supports to help build capacity to navigate mainstream services.

6. The NDIS and the systems providing child protection and family support will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both child protection and/or family support and disability services recognising that both inputs may be required at the same time or that there is a need to ensure a smooth transition from one to the other.

<u>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — CHILD PROTECTION AND FAMILY SUPPORT</u>	
<i>REASONABLE AND NECESSARY NDIS SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Funding disability-specific family supports, which are required due to the impact of the person’s impairment/s on their functional capacity, including for parents with disability. – Disability-specific and carer parenting training programs both for when the child has a disability or the parent has a disability. – Funding the reasonable and necessary disability support needs of children with disability in out-of-home care where these supports are required due to the impact of the child’s impairments on their functional capacity, and are additional to the needs of children of similar ages, including: <ul style="list-style-type: none"> • skills and capacity building for children with disability; • supports to enable sustainable caring arrangements (such as additional respite and outside school hours care); • home modifications (consistent with other applied principles); 	<ul style="list-style-type: none"> – Accepting, assessing and responding to reports on child protection issues. – Community awareness of children’s safety and wellbeing. – Responsibility to place children in out-of-home care arrangements* as well as arranging and providing the standard supports to sustain those out-of-home care arrangements. – Child protection statutory requirements. – Family support, including general supports for families where a parent has a disability. – Accommodation needs of children in out-of-home care, including the purchase and maintenance of any capital assets such as housing, care allowances and payments. – Universal parenting programs. – Intensive case coordination operated by the systems providing child protection and family supports where a significant component of the

<ul style="list-style-type: none"> • therapeutic and behaviour support; and • equipment and transport needs (consistent with other applied principles). <p>– The coordination of NDIS supports with the systems providing child protection and family supports and other relevant service systems. This includes services which aim to support people experiencing or exiting family violence.</p>	<p>case coordination is related to child protection and family support. This includes coordination of services where a significant component of the case coordination is related to issues associated with family violence.</p>
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*[*NOTE: Out-of-home care includes statutory and voluntary care as defined by legislation or policy within the jurisdiction including from child protection involvement or other state or territory authorities.]*

4. EARLY CHILDHOOD DEVELOPMENT

APPLIED PRINCIPLES — EARLY CHILDHOOD DEVELOPMENT

1. The early childhood education and care sector will continue to be responsible for meeting the education and care needs of children with a development delay or disability, including through:
 - a. reasonable adjustment;
 - b. inclusion supports that enable children to participate in early childhood education and care settings; and
 - c. building the capacity of early childhood education and care services to provide inclusive education and care to all children, including those with high needs subject to reasonable adjustment.
2. The health system, including child and maternal health services, will be responsible for supports which are treatment related including acute, ambulatory, continuing care and new-born follow-up.
3. The NDIS will be responsible for:
 - a. personalised individualised supports required due to the impact of the child's impairment/s on their functional capacity and additional to the needs of children of a similar age and beyond the reasonable adjustment requirements of early childhood development service providers.
 - b. Working with and through a child's family, carers and educators to implement supports/early interventions that promote and support their functional capacity.
4. The NDIS will be responsible for early interventions for children with disability (or development delay) which are:
 - a. specifically targeted at enhancing a child's functioning to undertake activities of daily living or specialised supports to transition a child with a disability into school (not supports, such as school readiness programs, which are for the purpose of accessing universal education);
 - b. likely to reduce the child's future support needs (recognising the degenerative and evolving nature of many functional impairments), which would otherwise require support from the NDIS in later years, including through a combination and sequence of supports (not including medical and health treatments outlined in the health interface); and
 - c. supporting connections and access to community and mainstream services.
5. The implementation of the NDIS' responsibilities for early childhood development services will be coordinated with other early childhood services being provided, and will take account of relevant workplace relations arrangements, duty of care, quality standards and state-based schemes such as 'working with children checks'.
6. The NDIS and the systems providing early childhood supports will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both disability services and early childhood supports recognising that both inputs may be required at the same time or that there is a need to ensure a smooth transition from one to the other.

[NOTE: LINKAGES WITH THE ‘CHILD PROTECTION AND FAMILY SUPPORT APPLIED PRINCIPLES’ AND ‘EDUCATION APPLIED PRINCIPLES’.]

<i>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — EARLY CHILDHOOD DEVELOPMENT</i>	
<i>REASONABLE AND NECESSARY NDIS SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Post-diagnosis information, linkages, referrals and coordination with community and early childhood mainstream and specialist services. – Additional supports required due to the impact of the child’s impairment/s on their functional capacity including portable aids and equipment (e.g. hearing aids, wheelchairs or personal communication devices), where the support needs are above the needs of children of a similar age and the supports are additional to what is required under reasonable adjustment, and those legislative requirements applicable to early childhood education and care service providers in that jurisdiction. – Early interventions that are likely to increase a child’s level of functioning towards that of other children of a similar age without which the child is likely to require NDIS funded supports in the future (except where these are treatment related and/or aimed at treating a medical condition). – Additional supports to address behaviours which are a result of the impact of the child’s impairment/s on their functional capacity and which are integrally linked to the support the child needs to live in the community and participate in education. – Capacity building and general disability supports through Information, Linkages and Capacity Building focusing on children with disability (or 	<ul style="list-style-type: none"> – Diagnostic assessment and specific screening for development delay and other mental or physical conditions that are likely to lead to a disability. – Support for families and carers to understand and manage the process and outcomes of assessment/diagnosis, including counselling and other family supports. – Learning assistance (this may include teachers’ assistants) and inclusion supports (for example Auslan interpreters) to enable the participation of children with disability in early childhood education and care services in line with reasonable adjustments and any other legislative requirements. – General children’s services, including play groups. – Maternal child health programs where interventions are primarily treatment related or medical in nature, including new-born follow-up. – Intensive case coordination operated by the systems providing early childhood supports, where a significant component of case coordination is related to early childhood supports.

<p>development delay) where this improves awareness, builds community capacity, creates networks or 'circles of support' for children and parents.</p> <ul style="list-style-type: none">– The coordination of NDIS supports with the systems providing early childhood support and other relevant service systems.	
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5. SCHOOL EDUCATION

APPLIED PRINCIPLES — SCHOOL EDUCATION

1. The allocation of responsibilities between the NDIS and schools will be consistent with the legal obligations of schools and governments' policy objectives for education, including:
 - a. the compulsory nature of schooling;
 - b. the current responsibilities schools have for reasonable adjustment, under the Commonwealth Disability Standards for Education; and
 - c. curriculum planning, assessment and reporting requirements and requirements for students to receive the legislated number of hours instruction or meet class attendance requirements.
2. In recognising the universal and statutory role of the schooling system:
 - a. schools will be responsible for making reasonable adjustments to personalise learning and support for students that primarily relate to their educational attainment (including teaching, learning assistance and aids, school building modifications and transport between school activities); and
 - b. the NDIS will fund supports that the student requires due to the impact of the student's impairment on their functional capacity and additional to reasonable adjustment (i.e. those not primarily relating to education attainment), including personal care and support and transport to and from school and specialist transition supports to and from school to further education, training or employment. Any funding arrangements for individual students will recognise the operational requirements and educational objectives of schools.
3. The allocation of funding responsibilities will avoid placing inappropriate legal, financial or administrative obligations on schools or on the NDIS.
4. The NDIS and the school education system will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both school education and disability services recognising that both inputs may be required at the same time or through a smooth transition from one to the other or across service systems.

[NOTE: Further work will be undertaken on how students' personal care needs will be assessed, the calculation of the level of funded supports for personal care and how these funds will be managed/administered.]

<i>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — SCHOOL EDUCATION</i>	
<i>NDIS REASONABLE AND NECESSARY SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Personal supports at school/education facility that are required by an individual regardless of the activity they are undertaking (e.g. feeding, managing airways/ventilation). – Aids and equipment at school/education facility that are required by an individual due to the impact of the person's impairment on their functional capacity and are additional to reasonable adjustment obligations of schools regardless of the activity they are undertaking (e.g. hearing aids, wheelchairs, personal communications devices). – Specialist transport to and from school/education facility required as a result of a person's disability (where no other transport option is available and not substituting for parental responsibility). – Specialised support and training for school staff related to the specific personal support needs of a student with disability, including specialised behaviour intervention and support. – Responsibility for funding and coordinating allied health and other therapies to support a student's functional capacity including those which may be delivered during school times, as negotiated with the school, for non-educational purposes. 	<ul style="list-style-type: none"> – Skills, capability and other forms of training and transition support, including reasonable adjustment for students with disability, delivered in schools through the Australian curriculum. – Learning assistance (this may include teachers' assistants), and inclusion support (for example Auslan interpreters) to enable the participation of students with disability in education services, in line with reasonable adjustment. – Reasonable adjustment to campuses, including capital works (e.g. ramps, lifts, hearing loops). – Aids and equipment which are fixed or non-transportable in schools that enable a student access to education (e.g. hoists). – Aids and equipment for educational purposes (e.g. modified computer hardware, education software, braille textbooks). – Transport for school activities e.g. excursions, sporting carnivals. – General support, resources, training and awareness building for teachers and other school staff to support and engage students with disability at school and in the classroom.

<ul style="list-style-type: none"> – Specialist transition supports required due to the impact of the student’s impairment on their functional capacity and additional to the reasonable adjustment obligations of schools. – The coordination of NDIS supports with the supports offered by the school education system and other relevant service systems. 	<ul style="list-style-type: none"> – Therapy delivered in schools for education purposes (e.g. allied health practitioners assisting classroom teachers to make adjustments to the curriculum). – Intensive case coordination operated by the school education system where a significant component of case coordination is related to educational supports.
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6. HIGHER EDUCATION AND VOCATIONAL EDUCATION AND TRAINING (VET)

APPLIED PRINCIPLES — HIGHER EDUCATION AND VOCATIONAL EDUCATION AND TRAINING (VET)

1. The allocation of funding responsibilities between the NDIS and both the Higher Education and Vocational Education and Training (VET) providers will be consistent with the legal obligations and governments’ policy objectives for education, including the current responsibilities education providers have for ‘reasonable adjustment’, under the Commonwealth Disability Standards for Education.
2. Higher Education and VET providers will be responsible for the learning and support needs of students that directly relate to their educational and training attainment (including teaching, learning assistance and aids, building modifications and transport between education or training activities where this transport is being arranged for all students), as well as general transition supports from education or training to employment consistent with reasonable adjustment.
3. The NDIS will fund supports that the student would require due to the impact of the student’s impairment/s on their functional capacity and which are additional to reasonable adjustment (i.e. those not primarily relating to education or training attainment), including personal care and support, transport from home to and from the education or training facility and specialist transition supports required as a result of the person’s disability, consistent with the NDIS individualised approach to funding.

4. The NDIS and the higher education and VET system will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both further education/vocational education and disability services recognising that both inputs may be required at the same time or through a smooth transition from one to the other or across service systems.

INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — HIGHER EDUCATION AND VOCATIONAL EDUCATION AND TRAINING (VET)

<i>NDIS REASONABLE AND NECESSARY SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Personal supports at the education or training facility that are required by an individual regardless of the activity they are undertaking (e.g. feeding, managing airways/ventilation). – Aids and equipment that are required by an individual regardless of the activity they are undertaking (e.g. hearing aids, wheelchairs, personal communications devices). – Transport to and from an education or training facility for those unable to use public transport, as part of broader transport assistance a person would receive to address their mobility needs. – Specialised support and training for education or training staff related to the specific personal support needs of a student with disability, including development of specific behaviour management plans. – Specialist transition supports which are required due to the impact of the student’s impairment/s on their functional capacity and are additional to the needs of all Australians and reasonable adjustment. – The coordination of NDIS supports with the supports offered by the higher education and VET system and other relevant service systems. 	<ul style="list-style-type: none"> – Learning assistance (this may include teachers’ assistants), and inclusion support (for example Auslan interpreters) to enable the participation of students with disability in Higher Education and Vocational Education and Training programs and services, in line with reasonable adjustment and any other relevant legislation. – Reasonable adjustment to education and training facilities, including capital works (e.g. ramps, lifts, hearing loops). – Aids and equipment which are fixed or non-transportable which enable a student access to education or training (e.g. hoists). – Aids and equipment for education or training purposes (e.g. modified computer hardware, education software, braille textbooks). – Reasonable adjustments to transport for education or training activities (e.g. excursions, site visits) where this transport is being arranged for other students. – General support, resources, training and awareness building for education/training staff and other staff to support and engage students with disability.

	<ul style="list-style-type: none"> – Skills, capability and other forms of training and transition support, including reasonable adjustments for students with disability, delivered in higher education and VET institutions through their education curriculum (e.g. programs assisting transition between education or training and employment). – Intensive case coordination operated by the higher education and VET system where a significant component of case coordination is related to education and training supports.
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[Note: There are different funding arrangements for universities and vocational education and training institutions. The Commonwealth currently provides funding to eligible higher education providers to assist them to meet the costs of providing support to students with a disability with high cost needs. Vocational education and training organisations may not have access to similar funding sources to assist the organisation meet the needs of students with disability]

7. EMPLOYMENT

<u>APPLIED PRINCIPLES — EMPLOYMENT</u>
<ol style="list-style-type: none"> 1. Employment services and programs, including both disability-targeted and open employment services, will continue to be responsible for providing advice and support to: <ol style="list-style-type: none"> a. people with disability to assist with preparing for, finding and maintaining jobs; and b. employers to encourage and assist them to hire and be inclusive of people with disability in the workplace (e.g. support, training and resources, funding assistance to help employers make reasonable adjustments, and incentives for hiring people with disability, such as wage subsidies). 2. Employers will continue to provide work-specific support to people with disability related to recruitment processes, work arrangements and the working environment in line with the <i>Disability Discrimination Act 1992</i>, including workplace modifications, work-specific aids and equipment, and transport within work activities.*

3. The NDIS will be responsible for supports related to daily living that a person would require irrespective of the activity they are undertaking (including personal care and support and transport to and from work) consistent with the NDIS individualised approach to funding.
4. The NDIS will be responsible for reasonable and necessary supports additional to those required by reasonable adjustment, that assist people with disability to take part in work where the person’s impairment has an impact on their functional capacity and/or productivity and the person is unlikely to be able to find or retain work in the open market, including with the assistance of employment services.
5. The NDIS will be responsible for funding individualised assistance to support a person with disability to take part in work where the person’s impairment has an impact on their functional capacity and/or productivity and where these supports are additional to the needs of all Australians and additional to what is required by reasonable adjustment, such as training on dress, workplace relationships, communication skills, punctuality and attendance, and travelling to and from work. **
6. The NDIS and the employment system will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both employment services and disability services recognising that both inputs may be required at the same time or through a smooth transition from one to the other or across service systems.

*[*Where a person’s employment includes a program of training, such as apprenticeships the, training organisations will also be responsible for providing reasonable adjustment, in line with the Disability Discrimination Act 1992 and the Disability Standard for Education.]*

*[** Commonwealth officials will continue to work through arrangements with the Departments of Human Services and relevant agencies where supports offered by the NDIS are similar to those offered by Centrelink and/or employment services.]*

<u>INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — EMPLOYMENT</u>	
<i>NDIS REASONABLE AND NECESSARY SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>

<ul style="list-style-type: none"> – Personal attendant care for people who require support within the workplace due to the impact of the person’s impairment/s on their functional capacity in the workplace (e.g. assistance with personal hygiene, feeding). – Aids and equipment related to the person’s functional needs (e.g. wheelchair). – Transport to and from work for those unable to use public transport, as part of broader transport assistance a person would receive to address their mobility needs. – Specialised or targeted employment supports that respond to the nature of a person’s disability. – Transition support into employment where a person’s support needs are additional to what is required by reasonable adjustment for employers and additional to the needs of all Australians and specifically related to the impact of the person’s impairment/s on their functional capacity (e.g. training on travelling to and from work, dress and hygiene, relationships with colleagues, communication skills, and punctuality and attendance). – The coordination of NDIS supports with the supports offered by the employment system and other relevant service systems. 	<ul style="list-style-type: none"> – Employment services and programs that provide advice and assistance to people with disability to prepare for, find and maintain jobs, including the development of industry-specific or workplace specific knowledge and skills (e.g. job applications, on-the-job training, and career development). – Employer support services and programs that encourage and assist employment of people with disability (e.g. support, training and resources for employers, funding to make reasonable adjustments, and wage subsidies). – Workplace specific supports (including modifications, employment-specific aids and equipment). – Transport for work activities (e.g. meetings). – General employment-related planning and support (e.g. retirement planning, careers counselling). – Intensive case coordination operated by the employment system where a significant component of case coordination is related to employment supports.
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8. HOUSING AND COMMUNITY INFRASTRUCTURE

APPLIED PRINCIPLES — HOUSING AND COMMUNITY INFRASTRUCTURE

1. Social housing providers will be responsible for providing accessible accommodation for people in need of housing assistance in line with existing allocation and prioritisation processes, and consistent with universal design principles and livable housing design standards as outlined in the National Disability Strategy 2011-2020, including appropriate and accessible housing for people with disability, routine tenancy support, and ensuring that new publicly-funded housing stock, where the site allows, incorporates Liveable Design features.
2. Housing and homelessness services will continue to be responsible for homelessness-specific services, including through homelessness prevention, outreach and access to temporary and long term housing for people who are homeless, or at risk of homelessness.
3. Parties responsible for community infrastructure will continue to improve the accessibility of the built and natural environment (including roads and footpaths) through planning and regulatory systems and through building modifications and reasonable adjustment where required.
4. The NDIS will be responsible for support to assist individuals with disability to live independently in the community, including by building individual capacity to maintain tenancy and support for appropriate behaviour management where this support need is related to the impact of their impairment/s on their functional capacity.
5. The NDIS will be responsible for home modifications required due to the impact of a participant's impairment/s on their functional capacity in private dwellings, in social housing dwellings on a case-by-case basis and not to the extent that it would compromise the responsibility of housing authorities to make reasonable adjustments.
6. The NDIS is also responsible for user costs of capital in some situations where a person requires an integrated housing and support model and the cost of the accommodation component exceeds a reasonable contribution from individuals.
7. The NDIS and the housing system will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both housing and disability services recognising that both inputs may be required at the same time or through a smooth transition from one to the other.

[NOTE: Social housing is inclusive of public and community housing.]

INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — HOUSING AND COMMUNITY INFRASTRUCTURE

<i>REASONABLE AND NECESSARY NDIS SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
<ul style="list-style-type: none"> – Supports that build people’s capacity to live independently in the community, including living skills training, money and household management, social and communication skills and behaviour management, where these are required due to the impact of the person’s impairment/s on their functional capacity. – Supports to assist a person to obtain and maintain accommodation and/or tenancies where these support needs are required due to the impact of the person’s impairment/s on their functional capacity. – Reasonable and necessary home modifications to private dwellings and on a case by case basis in social housing where the modifications are additional to reasonable adjustment and specific to the impact of a participant’s impairment/s on their functional capacity. – User costs of capital in some circumstances, including for disability-specific housing options. – Working with other parties to facilitate appropriate housing options and improve accommodation choices for people with disability, including through developing partnerships with housing providers and influencing the development of housing options and housing design (not regulation or setting standards in housing design). – Supports for participants at risk of or experiencing homelessness to support the participant, their families and carers to access and maintain secure and stable accommodation including by accessing housing and homelessness services, where the need for support is due 	<ul style="list-style-type: none"> – Provision of accessible and affordable accommodation options that meet the needs of people with disability, through social housing within available resources. – Provision of routine tenancy support by social housing authorities. – Homelessness-specific services, including homelessness outreach and emergency accommodation. – Provision of accessible community infrastructure, including modifications to general community amenities. – Encourage innovative models of affordable and accessible housing investment by private or corporate investors. – Social housing providers have a duty to make reasonable adjustment in providing accessible housing stock for people with a disability. – Intensive case coordination operated by the housing or homelessness system where a significant component of the case coordination is related to housing supports.

<p>to the impact of the participant's impairment/s on their functional capacity.</p> <ul style="list-style-type: none">- The coordination of NDIS supports with the housing system and other relevant service systems.	
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[Further work required in 2013 to define responsibilities for 'Development of options/innovative models of housing/accommodation solutions']

9. TRANSPORT

APPLIED PRINCIPLES — TRANSPORT

1. The public transport system will be responsible for ensuring that transport options are accessible to people with disability, including through concessions to people with disability to use public transport (including parties choosing to provide concessions for the total cost of transport) and compliance with relevant non-discrimination legislation including the Disability Standards for Accessible Public Transport.
2. Others parties will continue to be responsible for transport infrastructure, including road and footpath infrastructure, where this is part of a universal service obligation or reasonable adjustment, including managing disability parking and related initiatives.
3. The NDIS will be responsible for funding supports for individuals that enable independent travel, including through personal transport-related aids and equipment, training to use public transport and modifications to private vehicles (i.e. not modifications to public transport or taxis).
4. The NDIS will be responsible for reasonable and necessary costs associated with the use of taxis or other private transport options for those not able to travel independently.

[Note: links with the ‘Education Applied Principles’ and ‘Employment Applied Principles’ regarding transport to and from work/school.]

INDICATIVE ROLE OF THE NDIS AND OTHER PARTIES — TRANSPORT

<i>REASONABLE AND NECESSARY NDIS SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
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<ul style="list-style-type: none"> – Training and support to use public transport where public transport is a viable option for the participant and the person’s mobility device(s) can be used. – Modifications to private vehicles and driver assessment and training. – Costs associated with innovative transport options for people who cannot travel independently or use public transport due to the impact of their impairment/s on their functional capacity. – Costs associated with the use of taxis/private transport for people who cannot travel independently or use public transport due to the impact of their impairment/s on their functional capacity. 	<ul style="list-style-type: none"> – Accessible public transport. – Concessions to facilitate use of public transport, including where a full concession is offered. – Community transport services. – Modifications to public transport and taxis.
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10. JUSTICE

<p><u>APPLIED PRINCIPLES — JUSTICE</u></p>	
<p>1.</p>	<p>The criminal justice system (and relevant elements of the civil justice system) will continue to be responsible for meeting the needs of people with disability in line with the National Disability Strategy and existing legal obligations, including making reasonable adjustments in accordance with the <i>Disability Discrimination Act 1992</i> (CTH), through:</p> <ul style="list-style-type: none"> a. ensuring its systems, supports and buildings are accessible for people with disability including appropriate communication and engagement mechanisms, adjustments to the physical environment, accessible legal assistance services and appropriate fee waivers; b. general programs for the wider population, including programs to prevent offending and minimise risks of offending and reoffending and the diversion of young people and adults from the criminal justice system; and c. the management of community corrections, including corrections-related supervision for offenders on community based orders.

2. Other parties and systems will be responsible for supports for people subject to a custodial sentence or other custodial order imposed by a court or remanded in custody. This includes where a court has ordered a person reside in a prison, or other facility accommodating people on custodial orders such as youth detention and training facilities, secure mental health facilities or secure facilities for people with disability. These parties are responsible for meeting the day-to-day care and support needs of people with disability in these custodial settings, including supervision, personal care and general supports which are also required by the general custodial population, and also general supports to enable skill development and living skills and promote the effective transition of people with disability out of custodial settings, in line with supports offered to other people in custodial settings.
3. The health system, mental health system and other parties will be responsible for operating secure mental health facilities which are primarily treatment focused.
4. The NDIS will continue to fund reasonable and necessary supports required due to the impact of the person's impairment/s on their functional capacity in a person's support package where the person is not serving a custodial sentence or other custodial order imposed by a court or remanded in custody. As such the NDIS would fund supports where the person is on bail or a community based order which places controls on the person to manage risks to the individual or the community (except in the case of secure mental health facilities).
5. The NDIS will fund specialised supports to assist people with disability to live independently in the community, including supports delivered in custodial settings (including remand) aimed at improving transitions from custodial settings to the community, where these supports are required due to the impact of the person's impairment/s on their functional capacity and are additional to reasonable adjustment.
6. Where a person is remanded in custody NDIS funding for reasonable and necessary supports in the participant's plan will continue to be available to the person when they are released.
7. The NDIS and the justice system will work closely together at the local level to plan and coordinate streamlined services for individuals requiring both justice and disability services recognising that both inputs may be required at the same time or through a smooth transition from one to the other.

[Note: Governments acknowledge that the NDIS interface with justice is complex. Consistent with the approach to all interface areas, the lessons learned from NDIS trial will assist governments in refining the supports most appropriately provided by the NDIS and those most appropriately provided by other service systems.]

<i><u>ROLE OF THE NDIS AND OTHER PARTIES — JUSTICE</u></i>	
<i>NDIS REASONABLE AND NECESSARY SUPPORTS FOR ELIGIBLE PEOPLE</i>	<i>OTHER PARTIES</i>
SUPPORTS FOR PEOPLE IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM CURRENTLY LIVING IN THE COMMUNITY (INCLUDING PEOPLE ON BAIL, PAROLE AND NON-CUSTODIAL ORDERS)	

<ul style="list-style-type: none"> – Coordination of NDIS supports in collaboration with the supports offered by the justice system, including for victims, witnesses and alleged offenders with disability. – Supports to address behaviours of concern (offence related causes) and reduce the risk of offending and reoffending such as social, communication and self-regulation skills, where these are additional to the needs of the general population and are required due to the impact of the person’s impairment/s on their functional capacity and are additional to reasonable adjustment. – The NDIS will continue to fund the reasonable and necessary supports including the funded supports outlined in the participant’s plan, including assistance with planning, decision making, scheduling, communication, self-regulation and community living. 	<ul style="list-style-type: none"> – Pre-sentence psychological and psychiatric reports regarding cognitive ability, psychiatric conditions or other matters required to assess a person’s ability to plead in court or considerations prior to sentencing or diversion. – Support for people with disability including victims and witnesses of crime to access and navigate the justice system including guardianship, advocacy, community visitors and legal support. – Reasonable adjustment to mainstream services provided to individuals, organisations and systems that have contact with the justice system that provide services to people with disabilities. – Court-based support programs and specialist lists, including bail support. – Management of offenders to ensure compliance with supervised orders or conditions. – Early identification and intervention programs and post-custody services to prevent (re)offending, including in accessible formats for people with disability. – Offence specific interventions which aim to reduce specific criminal behaviours, reasonably adjusted to the needs of people with a disability and which are not clearly a direct consequence of the person’s disability. – Intensive case coordination operated by the justice or other service systems where a significant component of the case coordination is related to the justice system.
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SUPPORTS FOR PEOPLE SUBJECT TO CUSTODIAL SENTENCES OR OTHER CUSTODIAL ORDERS (INCLUDING PEOPLE ON REMAND)

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| <ul style="list-style-type: none"> – Coordination of NDIS supports with the supports offered by the justice and other service systems. – For people in a custodial setting (including remand) the only supports funded by the NDIS are those required due to the impact of the person’s impairment/s on their functional capacity and additional to reasonable adjustment, and are limited to: <ul style="list-style-type: none"> • aids and equipment; • allied health and other therapy directly related to a person’s disability, including for people with disability who have complex challenging behaviours; • disability specific capacity and skills building supports which relate to a person’s ability to live in the community post-release; • supports to enable people to successfully re-enter the community; and • training for staff in custodial settings where this relates to an individual participant’s needs. – Where a person is remanded in custody, NDIS funding for reasonable and necessary supports in the participant’s plan will continue to be available to the person when they are released. | <ul style="list-style-type: none"> – Pre-sentence psychological and psychiatric reports regarding cognitive ability, psychiatric conditions or other matters required to assess a person’s ability to plead in court or considerations prior to sentencing or diversion. – Offence specific interventions which aim to reduce specific criminal behaviours, reasonably adjusted to the needs of people with a disability and which are not clearly a direct consequence of the person’s disability. – Early identification and primary intervention programs, post-custody services to prevent (re)offending, including in accessible formats for people with disability. – Meeting the day-to-day support needs of people while in custodial settings (as well as forensic services in custodial settings) including personal care, fixed aids and equipment (e.g. hoists and specialised beds) and supports required by reasonable adjustment. – Secure accommodation facilities (including the accommodation, general operations and supports available to all people in the facility) where a person is residing in this facility due to a custodial order, including supervision, personal care and fixed aids and equipment. – Support for people to access and navigate the justice system including guardianship, advocacy, community visitors and legal support. – Intensive case coordination operated by the justice or community services systems where a significant component of case coordination is with justice or enforcement agencies. – Advising, consulting and assisting prison systems to improve supports for eligible prisoners including the development and implementation of behaviour management, risk and case management plans. |
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	<ul style="list-style-type: none"> – Implementing practical disability training available to Corrections Officers and other criminal justice staff and additional specific disability training to staff having high contact with people with disability within the prison. – Assisting prison staff to understand individual client’s needs and human rights, especially in relation to triggers for challenging behaviours, de-escalation strategies, issues associated with vulnerability and interaction with other prisoners, as specified in any behavioural plan the person may have. – Cultural, linguistic and religious support for people in custody (including Aboriginal Liaison Officers, Cultural Liaison Officers, Chaplaincy). – Training and skills to increase people’s capacity to live in the community post-release, in line with the supports offered by these systems to other people in custodial settings, as part of the reintegration process and to reduce recidivism, including general education services and self-regulation.
<p>SUPPORTS FOR PARTICIPANTS RESIDING AT YOUTH TRAINING CENTRES (ALSO KNOWN AS YOUTH JUSTICE CENTRES OR YOUTH DETENTION CENTRES)</p>	
<ul style="list-style-type: none"> – Coordination of NDIS supports with the supports offered by the justice, disability, education, health, community services and other systems. – For young people in youth training centres (or youth justice centres) the only supports funded by the NDIS are those which are required due to the impact of the person’s impairment/s on their functional capacity and additional to reasonable adjustment, and are limited to: <ul style="list-style-type: none"> • aids and equipment; 	<ul style="list-style-type: none"> – Intensive case coordination operated by the justice or community services systems where a significant component of case coordination is with justice or enforcement agencies. – Support for people to access and navigate the justice system including guardianship, advocacy, community visitors and legal support. – Meeting the day-to-day support needs of young people while in residential centres including supervision, personal care, fixed aids and equipment (e.g. hoists and specialised beds) and supports required by reasonable adjustment. – Implementing practical disability training available to Corrections Officers and other criminal justice staff and additional specific disability

<ul style="list-style-type: none"> • allied health and other therapy directly related to a child or young person’s disability, including for children and young people with disability who have complex challenging behaviours; • disability specific capacity and skills building supports which relate to a person’s ability to live in the community post-release; • supports to enable people to successfully re-enter the community; and • training for staff in custodial settings where this relates to an individual participant’s needs. 	<p>training to staff having high contact with people with disability within the prison.</p> <ul style="list-style-type: none"> – Offence specific interventions which aim to reduce specific criminal behaviours, reasonably adjusted to the needs of young people with a disability (for example, therapeutic services to address problematic sexual or violent behaviour or difficulties with self-regulation). – Early identification and intervention programs and post-custody services to prevent (re)offending, including in accessible formats for young people with disability. – Secure accommodation facilities (including the accommodation, general operations and supports available to all young people in the facility) where the purpose of this accommodation is to safeguard the community or prevent (re)offending. – Mental health services (as described in the Mental Health interface). – Drug and alcohol services (as described in the Health interface). – Education services (as described in the Education interface).
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11. AGED CARE

APPLIED PRINCIPLES — AGED CARE

1. The aged care system will continue to be responsible for access to quality and affordable aged care and carer support services, including through subsidies and grants, industry assistance, training and regulation of the aged care sector, information assessment and referral mechanisms, needs-based planning arrangements and support for specific needs groups and carers.
2. Consistent with Principle 6 of the *Principles to Determine Responsibilities of the NDIS and Other Service Systems*:
 - a. where a participant chooses to move from the NDIS to the aged care system there will be a seamless approach to the person's transition between these systems, with the person supported at all points during the transition to ensure people receive appropriate supports as they age;
 - b. the NDIS and the aged care system will recognise their relative areas of expertise and seek to leverage this expertise as appropriate.
3. A participant can choose to continue to receive supports from the NDIS after age 65, or can choose to take up an aged care place.
 - a. A person ceases to be a participant in the NDIS when the person enters a residential care service on a permanent basis, or starts being provided with community care on a permanent basis, and this first occurs only after the person turns 65 years of age (residential care service and community care have the same meanings as in the *Aged Care Act 1997*).
 - b. All parties will fulfill the responsibilities set out under Schedule F of the National Health Reform Agreement in relation to aged care and disability services, to the extent relevant to Parties of the Agreement (Clause 17 National Disability Insurance Scheme, Intergovernmental Agreement).
4. An NDIS participant under the age of 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' support costs.

Appendix 6

***COORDINATION OF SUPPORTS
INFORMATION FOR PROVIDERS***

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Introduction

Plan implementation involves a series of activities to connect with, and maintain, the supports outlined within the participant plan's Statement of Supports. These activities may include linking to supports and ensuring service delivery is of satisfactory quality and is helping the participant meet their goals. Plan implementation may be performed independently by the participant, or with assistance.

Support to implement the plan (known as support coordination) is the provision of assistance in one or more of the components of plan implementation. The National Disability Insurance Agency (NDIA) defines Support Coordination as primarily being;

'Assistance to strengthen participants abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.'

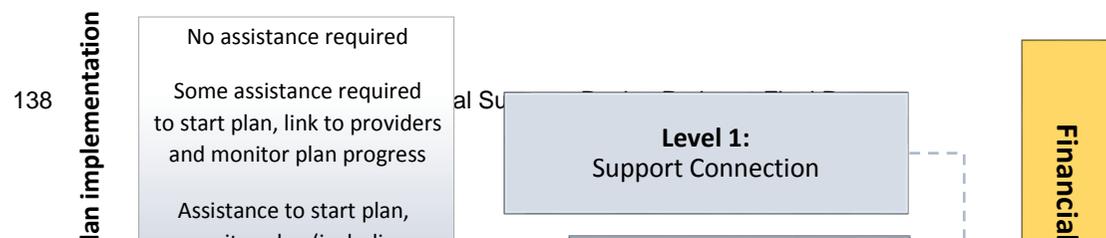
Role of a funded coordinator of supports

In relation to the NDIA's definition of Support Coordination, the primary role of a Support Coordinator is to:

- Support implementation of all supports in the plan, including informal, mainstream and community, as well as funded supports
- Strengthen and enhance the participant's abilities to coordinate supports and participate in the community
- Ensure mainstream services meet their obligations (i.e. housing, education, justice, health)
- Build the capacity of the participant to achieve greater independence to self-direct services and supports in the longer term
- Provide the NDIA with reports on outcomes and success indicators within the agreed reporting frequency

Three levels of coordination

A broad outline of a tiered approach for funded coordination of supports is illustrated in the following diagram:



Level 1: Support Connection

Time limited assistance to strengthen participant's ability to connect with informal, mainstream and funded supports, and to increase capacity to maintain support relationships, resolve service delivery issues, and participate independently in NDIA processes.

Support Connection is a non-ongoing service focussed on enabling the participant to connect to supports in the plan. The word “connection” is appropriate for a support that assists participants to establish arrangements with funded providers, and to build a network of informal and mainstream supports.

Support Connection's primary focus is helping the participant to start their plan implementation by assisting them to:

- Identify options (funded, mainstream and in informal networks)
- Investigate options
- Understand funding flexibility
- Reach decisions regarding services
- Reach agreement with providers
- Commence service and ensure new support arrangements thrive

Through the provision of this support it is expected that participants will gain skills to participate in NDIA processes, and gain independence in creating and maintaining supports.

In the first participant plan, Support Connection may be made available for the full duration of the plan (up to 12 months) to support the participant to learn how to:

- Activate their plan (i.e. link to service providers)
- Monitor quality and spend of services
- Manage flexibility within the plan
- Prepare for review

There may also be some need to address barriers to participation, and resolve service delivery issues.

During subsequent (review) plans, Support Linkages should only be provided for a specific purpose, such as to support the participant to change service provider, or build capacity to achieve specific community participation goals, as opposed to the first year where it may be provided to orient the participant to implement their plan more generically.

Level 2: Support Coordination

Assistance to strengthen participant's abilities to connect to and coordinate informal, mainstream and funded supports in a complex service delivery environment. This includes resolving points of crisis, developing capacity and resilience in a participant's network and coordinating supports from a range of sources.

Support Coordination has the features of Support Connection, with an increased focus on:

- Addressing barriers to participation, and
- Resolving service delivery issues.

The word “coordination” indicates a more intensive engagement than “connection”. It avoids using either “Complex” or “Higher Intensity”, both of which may be viewed by participants as not being strengths based.

In addition to the features of Support Connection, Support Coordination would focus on:

- Regular active management and ongoing adjustment of supports due to participant's

changing needs.

- Management of multiple/complex supports from a range of providers which intersect with mainstream services.
- Crisis resolution and developing resilience.
- Regular monitoring and outcome reporting for the participant/NDIA

In the first participant plan, Support Coordination may be made available to enable the participant to activate their plan and learn about other aspects of the plan cycle, including preparing for review.

There is an expectation that, where possible, Support Coordination will be replaced in subsequent (review) plans by Support Connection.

If Support Coordination is required in a review plan, it should be provided for a specific purpose, such as to support the participant to change service provider, or to resolve specific points of crisis or barriers affecting support, as opposed to the first year where it may be provided to orient the participant to implement their plan more generically.

Level 3: Specialist Support Coordination

The provision of Support Coordination within a specialist framework necessitated by specific high level risks in the participant's situation. This support is time limited and focuses on addressing barriers and reducing complexity in the support environment, while assisting the participant to connect with supports and build capacity and resilience.

Specialist Support Coordination includes all the activities outlined in “Support Coordination”, but addresses situations where it is appropriate to have a specialist deliver Support Coordination-style activities, necessitated by specific high level risks in the participant’s situation.

Specialist Support Coordination is time limited and focuses on addressing barriers and reducing complexity in the support environment, while assisting the participant to connect with supports and build capacity and resilience.

For Specialist Support Coordination to be included within a plan there must be clear benefits to the participant that result from this model of supports coordination. It is anticipated that this support will be very rarely required and only under exceptional circumstances. Specialist Support Coordination must include clear goals for the duration of the first plan that aim to decrease the need for this high intensity support to continue. It is expected that if coordination is required beyond the first plan, the NDIA will recommend Support Coordination, rather than Specialist Support Coordination.

Financial Intermediary

A Financial Intermediary assists participants to manage their plan by paying for and monitoring the funded supports on their behalf. A participant can decide to use a registered plan management provider to manage some or all of the funding of supports in their plan.

The activities of a Financial Intermediary include:

- Paying service providers and processing expense claims for participants
- Developing monthly statements for participants

Claiming from the NDIA

The core goal for a Financial Intermediary is to manage the administrative elements of the funded supports in the participant plan, which in turn helps the participant to achieve their goals and live their life without the concern of claiming.

A financial intermediary is not responsible for negotiating or organising service providers to deliver supports, monitoring delivery or the quality of the supports received.

Additional information

- It is a policy of the NDIA that coordination of supports is delivered by an NDIA registered provider.
- The Support Coordinator should not be the provider of any other funded supports in the plan. This is necessary to ensure that there is no conflict of interest. In certain circumstances, this condition may be waived. Please contact the NDIA for further information.

Definitions

Carer	A person who provides unpaid care and support to a family member or friend who has a disability.
Capacity	In this context, refers to the participant's current ability to understand and follow the NDIA's processes, and to engage with other organisations. It is based on existing knowledge and skills, and the ability to develop new knowledge and skills as required.
Disability	An umbrella term used in relation to the disability requirements for access to NDIS. (NDIS Act 2013 s.24)
Financial Intermediary	A service provider engaged by the NDIA that holds funds, makes payments at the direction of the person with a disability or nominated person in accordance with their plan, keeps records of each person's funding and reports expenditure to the person and to the NDIA.
Informal Support	Naturally occurring support or assistance available within families, among friends, neighbours and members of a community.
Mainstream Support	Goods, services supports and assistance available for the general community which lie outside funding in the NDIS. These are the first option for service provision for all NDIS participants. Support required to access such services will be included where required in a statement of support for an NDIS participant. Example mainstream services are: <ul style="list-style-type: none">• health• education• employment• mental health• palliative care• aged care• housing• veterans affairs• transport• early childhood services• income support• justice• child care
Participant Plan	The plan approved by the Agency CEO which contains the participant's statement of goals and aspirations and statement of participant supports. (NDIS Act 2013 s33)

Plan Implementation	A series of activities to connect with, and maintain, the supports outlined within the participant plan's Statement of Supports.
Plan monitoring	Monitoring the implementation, progress and continued appropriateness of the participant plan.
Service Provider	A person or body (for example a community service organisation) who provides funded disability services under the NDIS Act and is registered with the NDIA.
Support coordination	Assistance to strengthen a participants abilities to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training and developing participant resilience in their own network and community.
Supports	Services and products required by a participant to address the impact of a disability. Can include mainstream services, assistance from family and carers (informal) and NDIS funded items.