Queensland Alliance for Mental Health

Submission: *NDIS Review – Building a Strong, Effective NDIS*

June 2023

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The Queensland Alliance for Mental Health (QAMH) is pleased to provide this submission to the NDIS Review: Building a Strong, Effective NDIS.

QAMH represents more than 100 organisations and individual members delivering community mental health and wellbeing services across Queensland. Many of our members provide services and supports within the NDIS. QAMH's vision for the future is where the mental health system and the NDIS move from the current deficit model to a social model of disability. This is particularly relevant for people with a psychosocial disability resulting from mental health challenges.

The following submission addresses the Terms of Reference for the NDIS Review and outlines the experiences, challenges and recommendations of our members with respect to building a strong and effective NDIS for the psychosocial cohort.

We would be happy to provide further information to support the challenges raised in this submission. Please contact QAMH via email jblack@qamh.org.au or 07 3252 9411.

Yours sincerely

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QAMH acknowledges the assistance from DSC in the development of this submission.

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Disability Services Consulting

Introduction

The National Disability Insurance Scheme (NDIS) is a government-funded insurance scheme aimed at providing support and services to people with a permanent disability. The NDIS aims to provide a person-centred approach to disability support and services, where individuals have control and choice over their support needs, including psychosocial disability support. Psychosocial disability is a term used to describe disabilities that arise from mental health challenges[1]. Psychosocial disabilities are often episodic in nature and are long-term disabilities that can affect an individual's ability to function in daily life. The NDIS is designed to provide people with disabilities with access to reasonable and necessary services and support, regardless of their type of disability. However, the provision of psychosocial disability support within the NDIS model presents significant challenges that require careful and specific consideration.

Significant progress has been made in attempting to improve the Scheme's response to people with psychosocial disability via the development of the NDIS Psychosocial Disability Recovery-Orientated Framework[2] and the introduction of the Psychosocial Recovery Coach support items. However, the practical implementation of these initiatives has been hampered by the Scheme's failure to recognise and accommodate the unique nature of providing support for people with psychosocial disability.

This submission discusses the challenges of accessing and providing psychosocial disability support within the NDIS model. These challenges include recognising the episodic nature of psychosocial disability, the need for greater flexibility in support and funding, and the development and retention of specialist skills within the sector. It also examines the NDIS model and the challenges it presents in delivering psychosocial disability support and considers the policy and practice implications of these challenges. Finally, the submission offers recommendations for improving psychosocial disability support within the NDIS.

[1] NDIS. (2021). *Mental Health and the NDIS*. Mental health and the NDIS | NDIS
[2] NDIS. (2021). *Psychosocial Disability Recovery-Oriented Framework* PB NDIS Psychosocial Disability Recovery Oriented Framework PDF (2).pdf

Summary of Issues and Key Recommendations

ISSUE 1: NDIS plan access, structure, and administration

Recommendations:

1. Improve and make widely available information and training for intermediaries, medical professionals, family members, and anyone else supporting people with psychosocial disability during access and review processes, to increase community-wide understanding of NDIS access criteria, access evidence requirements, Reasonable and Necessary criteria, and supporting information for reviews. This information and training should be tailored to the specific needs of people with psychosocial disability;
2. Review assessment tools and procedures for people with psychosocial disability as part of the planned review of procedures for access;
3. Consider an alternative plan funding construction for psychosocial disability that reinforces the recovery orientated and capacity building nature whilst enabling reservation of funds for periods of higher need;
4. Ensure that appropriate plans are developed for participants with psychosocial disability by increasing the psychosocial disability specific skills and knowledge of planners, planning via specialised teams and improving the ability to tailor plans to the needs of the individual (as per recommendation 5.2 below);
5. Encourage a greater focus on recovery orientated support and services by enabling greater flexibility between Core and Capacity Building support items, introducing a Mental Health Support Worker line item in the Core support category and/or increasing the proportion of Capacity Building funding compared to Core funding in plans for psychosocial disability;
6. Ensure that plans are appropriately funded up-front (i.e. in participant's first plan) to allow for higher intensity support by providers to build rapport and trust with participant, build an effective support team and resolve any crisis situations facing participant. Sufficient funding for case management and collaboration between providers and other support systems for example justice or health should be included;
7. Recognise that progress is not always linear for people with psychosocial disability and remove the time-limited nature of funding for psychosocial disability plans, including the expectation that funding should be fully consumed by plan review or it will be reduced.

ISSUE 2: Challenges implementing the NDIS Psychosocial Recovery Coach model

Recommendations:

1. Clarify the roles of Psychosocial Recovery Coach and Support Coordinators by clearly separating the role of Psychosocial Recovery Coach and Support Coordinator ***or*** widely communicating that Psychosocial Recovery Coach role *includes* support coordination as a key element of the role;

2. Ensure that the Psychosocial Recovery Coach roles and responsibilities are consistently reflected across all relevant NDIS guiding materials;
3. Adjust price limits for Psychosocial Recovery Coach to reflect complexity of support and the specialised support coordination required within the role;
4. Provide education for NDIS providers of psychosocial disability supports within the Community Mental Health and Wellbeing sector to assist them to transition to the NDIS fee for service model.

ISSUE 3: Pricing and cost structure

Recommendations:

1. Review the assumptions underpinning the Disability Support Worker Cost Model to ensure that they are sufficient to sustain an appropriately supported, skilled and experienced workforce;
2. Create a discrete group of support items, prices and requirements for workers within the psychosocial sector. This should include the introduction of a Mental Health Support Worker line item;
3. Review price limits (upwards) for support items in Issue 5.2 to reflect the higher complexity within psychosocial support provision.

ISSUE 4: Development and maintenance of appropriate workforce

Recommendations:

1. Consider expanding qualification requirements to mental health support workers either as a requirement to work towards or to have prior to commencing;
2. Coordinate ongoing professional development opportunities for registered providers and ensure they are accessible, high quality and updated regularly;
3. Consider limiting psychosocial workforce to registered entities, or including a specific psychosocial disability module for registration with the NDIS Quality and Safeguards Commission.

ISSUE 5: Lack of psychosocial specific skills, knowledge and lived experience

Recommendations:

1. Increase number of lived experience staff within the NDIA and improve psychosocial disability training for NDIA and NDIS Partner in the Community staff, especially Local Area Coordinators;
2. Develop specialist NDIS planning teams and resources, similar to NDIS Home and Living, who are trained to provide specialised planning for psychosocial disability, and who are responsible for the development and review of all NDIS plans for participants with psychosocial disability.

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ISSUE 6: Multi-agency and cross system responsibility and navigation

Recommendations:

1. Deliver the six key reforms to the NDIS particularly ensuring the community and mainstream services are providing their required service level;
2. Review the Information Linkages and Community (ILC) program to ensure it effectively supports the ongoing delivery of viable Tier 2 services.
3. Clarify roles and responsibilities of intermediaries as per recommendation 2.1 above.
4. Consider the introduction of a codesigned ILC funded service that provides community based link workers who offer psychosocial supports such as Mental Health Recovery Support Workers and/or Psychosocial Recovery Coaches who can support non-NDIS participants experiencing mental health challenges to access community and mainstream supports and provide assistance with NDIS access requests for those likely to meet NDIS psychosocial disability criteria, via assertive outreach and support. This program should consider utilising a social prescribing model in which general practitioners and other professionals are able to refer people to the service to develop a recovery plan and link in with social and community activities that foster mental health and wellbeing.
5. Consider expanding the current LAC Information Linkages and Communities Program to include specialised psychosocial supports such as Recovery Support Workers and/or Psychosocial Recovery Coaches who can assist non-NDIS participants as per recommendation 6.4 above.

Research, Consultation and Engagement

This submission is the latest in a series of QAMH consultation and engagement activities regarding the intersection of the Community Mental Health and Wellbeing sector and the NDIS, and relevant reviews of psychosocial disability supports within the NDIS.

Key QAMH papers completed in this area since 2020 include:

- NDIS Quality and Safeguarding Framework Submission
- 2023 Federal Budget Pre-Budget Submission
- Community Mental Health Workforce Project
- Inquiry into the Capability and Culture of the NDIA
- Pre-Budget Submission to the Federal Government
- Annual Pricing Review 2021-22
- Current Scheme Implementation and Forecasting for the NDIS
- Proposed NDIS Legislative Improvements and the Participant Service Guarantee
- Response Paper NDIA Support Coordination Discussion Paper

This submission builds on the findings of this previous work representing the concerns of the sector. In addition, QAMH has conducted extensive consultation with member organisations and individuals to collate key challenges, specific examples and recommendations for this submission response. Engagement activities completed to inform this submission included:

- an online survey of QAMH members;
- three facilitated workshops exploring the issues facing NDIS participants with psychosocial disability, Community Mental Health and Wellbeing providers of NDIS psychosocial supports and cross-agency collaboration; and
- direct engagement with various member groups and individuals.

Over 27 organisations and six individuals, representing approximately a third of the QAMH membership base, took part in the consultation process.

We are pleased to present our findings below.

Psychosocial Disability and the NDIS

ISSUE 1: NDIS plan access, structure and administration

Access

It is widely acknowledged within the literature that people living with psychosocial disability face significant barriers to accessing the NDIS[3]. Many providers and individuals confirmed to us during consultation that the process to access the NDIS is distressing for people with psychosocial disability. In addition, the burden of having to collect functional capacity, and other information, often from many different specialists and services, can be overwhelming for many people. There are often excessive out-of-pocket expenses for health and specialist reports and assessments that are prohibitive for people who may be on disability support pension or income support. All these potential barriers are magnified if a person is located in a regional or remote location where there may be very limited, if any, services to assist with the access requirements.

Many participants have to relive previous trauma which is counter to the recovery orientated framework. 'Deficit model' language focusing on impairment is distressing to many people and reinforces the stigma attached to psychosocial disability. Assessments are often undertaken by people who do not know the person, rather than gathering information from treating professionals who have known the person for a considerable time. Some participants won't access the Scheme because they have to meet someone new.

If a person is able to navigate the gathering, collation and submission of the necessary information, they often face inconsistent access and plan outcomes from the NDIS despite people having similar functional capacity. The NDIS has acknowledged this challenge stating *"Inconsistency and bias, whether real or perceived, can contribute to frustration and reduced trust in the Scheme from the perspective of participants, prospective participants, support teams and the wider community"*[4] and *"An explicit definition of functional capacity is required for NDIS purposes that allows for evidence based assessment"*[5].

The 2019 Review of the NDIS Act identified that "health professionals who assist prospective participants to make an access application have found the assessment processes inconsistent, with people with similar clinical and psychosocial disability needs and circumstances receiving different outcomes. It appears that in some cases, this inconsistency is a result of insufficient guidance being provided to health professionals about the form of evidence needed to support a decision[6]. Health professionals have also reported a lack of respect from NDIA staff about their professional expertise,

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[3] See for example, Mellifont, D., Hancock, N., Scanlan, J.W. & Hamilton, D. (2022). *Barriers to applying to the NDIS for Australians with psychosocial disability: A scoping review*. Australian Journal of Social Issues, 00, 1– 15. https://doi.org/10.1002/ajs4.245

[4] NDIS. (2020). *NDIS Independent Assessment Framework*

[5] NDIS. (2020). *NDIS Independent Assessment Framework*

[6] Tune, D. (2019). *Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee*, NDIS Act Review - final - with accessibility and prepared for publishing1 (dss.gov.au) p.73

when submitting evidence to support a NDIS application[7].

The recent COAG report from the NDIS highlights that as of 31 December 2022 there was a total of 56,213 participants identified as having a psychosocial disability within the NDIS[8] which equates to 10 per cent of the total participants. This number is less than the original Productivity Commission estimates in 2011[9] and less than the NDIA estimates of 13.9 per cent in 2021[10]. The shortfall in the cohort is likely to be due to people either not accessing the Scheme or not continuing as a participant after their initial experience. These statistics are unique to the psychosocial cohort as most other disability groups have exceeded the NDIS estimated participant numbers and reflects access (and sustainability) challenges.

Plan Construction and Reviews

NDIS plans for people with psychosocial disability are too focussed on the provision of core supports and not focussed enough on capacity building. The focus on core supports as opposed to capacity building acts to maintain dependency rather than capacity building towards meaningful personal recovery. The "one size fits all" approach to plan structure creates difficulty for people with psychosocial disability in terms of day-to-day application of the plan as well as ensuring there are sufficient funds available in periods of increased need.

The episodic nature of psychosocial disability means it is unlikely over a typical 12-month plan duration that there will be a consistent pattern of support that would be expected from most other types of disability. Psychosocial disability is characterised by periods of stability that can vary from days to months followed by periods of higher support needs when a person may experience an acute episode[11]. This presents difficulties for funding management and often people run out of funding prior to the annual plan renewal due to a higher than anticipated frequency and/or duration of higher support needs during a period of crisis. Conversely, a person with psychosocial disability may not need such a high frequency of support, however is then faced with the prospect of having their funding reduced at plan review which then creates issues during their next plan or next crisis episode when support utilisation quickly escalates.

The current approach to plan construction typically provides a higher level of Core funding than Capacity Building supports. While this creates stability in the funding cycle for participants, it also emphasises the "maintaining support" focus of NDIS plans rather than a recovery focus for people with psychosocial disability. Appropriate Capacity Building supports may include Individual Skills Development which can be provided by a Mental Health Support Worker, psychologist, occupational therapist, or group therapy for example. Psychosocial Recovery Coaches can also provide an element of direct support as well as providing support coordination and are funded through Capacity Building

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[7] Mental Health Australia. (2019). *Health professionals, psychosocial disability and NDIS access: Final Report.* health_professionals_psychosocial_disability_and_ndis_access_w_attachments_0.pdf (mhaustralia.org)

[8] NDIS. *NDIS Quarterly Report to COAG, Year 10, Quarter 2, (2023/24)* p162

[9] Productivity Commission. (2011). *Productivity Commission: Inquiry Report – Disability Care and Support.* Inquiry report - Disability Care and Support - Productivity Commission (pc.gov.au)

[10] NDIS. (2021). *Annual Financial Sustainability Report.* Annual Financial Sustainability Report 2020-21 | NDIS p31

[11] DSS. (2018). *Accessing the NDIS – A Guide for Commonwealth Funded Community Mental Health Service Providers.* Accessing the NDIS - Assisting people with psychosocial disability to access the NDIS: a guide for Commonwealth-funded community mental health providers | Department of Social Services, Australian Government (dss.gov.au)

Support Coordination budget. However, with the majority of funding clustered in Core, this focus on capacity building and recovery is potentially lost. It also compounds the challenges of attracting, training and retaining appropriately skilled and experienced Mental Health Support Workers who – due to their higher skills and qualifications, as well as the complexity inherent to the role – should be paid at a higher rate than general disability support workers currently available through Core support line items.

QAMH believe better planning outcomes could be achieved by having specialised psychosocial planning teams who are responsible for developing and reviewing NDIS plans to align with recovery plans as recommended in Issue 5 of this submission. This could allow the development of a planning and review approach that is better able to flexibly tailor supports to the unique nature and needs of psychosocial disability rather than being restricted to the current “Typical Support Package” model which has been developed with the more stable needs of physical disability in mind. Introducing a new line item for a Mental Health Support Worker in Core which incorporates a recovery-oriented approach, and therefore helps develop capacity, or ensuring that funding for plans for psychosocial disability is clustered predominantly in Capacity Building, are both options that would help to introduce a greater recovery oriented and capacity building approach to NDIS plans for psychosocial disability.

Recent changes to plan durations, extending to three years in some cases, may not be appropriate for all people within the psychosocial cohort. Plan durations for this cohort should be considered on a case-by-case basis, considering the stability of support needs, to determine what is the most appropriate duration. For some people a one year plan may be appropriate whereas for others the three year duration may provide the best outcome. For flexibility in plan durations to be considered there would need to be a corresponding certainty of the process for unscheduled plan reviews. Unscheduled plan reviews would need to be consistent in terms of a short time frame from request with a predictable and reliable process for implementation.

Administration

Participants with psychosocial disability are highly likely to have frequent changes in their circumstances, experience homelessness or involvement with the justice system, and require periods of time in hospital or in the care of family. A person’s situation can escalate to hospitalisation and/or homelessness quickly, which in turn results in an increase to support and assistance to meet the change in circumstances. In these circumstances, if a person’s current plan is not meeting their needs, the ability to easily access a quick and simple change of circumstances is essential to avoid serious risk to participant well-being if supports are not maintained due to a lack of funds in their plan.

Frequent changes in circumstances create issues for providers of psychosocial supports too. The need for manual payment requests often come about when there is a plan review or change of circumstances that has not been finalised, whilst providers continue to deliver the necessary support. As a safeguard, providers will often deliver supports unfunded to participants with psychosocial disability. These costs may not be able to be recouped and present a significant risk to provider viability, as well as to the participant if the service is stopped suddenly due to lack of funds.

Providers may also spend a considerable amount of unbillable time in processing manual payment requests when issues arise in claiming for supports that are rejected, even when the funds are available in the client’s service bookings. Providers have experienced plans being ended by the NDIA without notification while providers continue to provide services until advised or a claim is rejected. While

timeframes for processing manual payments have improved, it still takes considerable time for providers to prepare the information to make a claim, all of which is unfunded. Finally, another administrative burden that providers face is the preparation of supporting material and interactions with the NDIS Quality and Safeguards Commission when an incident or critical incident occurs, which entail significant reporting responsibilities.

There is also a large turnover of providers in the current market, particularly when inexperienced providers and/or workers are attempting to support a participant with more complexity. In many circumstances this results in the person being admitted to hospital because the complexity of support needs exceed the provider's capability and experience.

Member Examples:

- *NDIA delays and incorrect plan reviews, requiring investment of time to correct, compounded with lack of knowledge of NDIA assessors of recovery, trauma, and mental health.*
- *By the time we got a plan review the person condition had deteriorated so far that all capacity gained over the period was lost.*
- *We have seen people that are effectively very similar in functional capacity and recovery support needs receive completely different levels of funding.*

Recommendations

1. Improve and make widely available information and training for intermediaries, medical professionals, family members, and anyone else supporting people with psychosocial disability during access and review processes, to increase community-wide understanding of NDIS access criteria, access evidence requirements, Reasonable and Necessary criteria, and supporting information for reviews. This information and training should be tailored to the specific needs of people with psychosocial disability;
2. Review assessment tools and procedures for people with psychosocial disability as part of the planned review of procedures for access;
3. Consider an alternative plan funding construction for psychosocial disability that reinforces the recovery orientated and capacity building nature whilst enabling reservation of funds for periods of higher need;
4. Ensure that appropriate plans are developed for participants with psychosocial disability by increasing the psychosocial disability specific skills and knowledge of planners, planning via specialised teams and improving the ability to tailor plans to the needs of the individual;
5. Encourage a greater focus on recovery orientated support and services by enabling greater flexibility between Core and Capacity Building support items, introducing a Mental Health Support Worker line item in the Core support category and/or increasing the proportion of Capacity Building funding compared to Core funding in plans for psychosocial disability;
6. Ensure that plans are appropriately funded up-front (i.e. in participant's first plan) to allow for higher intensity support by providers to build rapport and trust with participant, build an effective support team and resolve any crisis situations facing participant. Sufficient funding for case management and collaboration between providers and other support systems for example justice or health should be included;

7. Recognise that progress is not always linear for people with psychosocial disability and remove the time-limited nature of funding for psychosocial disability plans, including the expectation that funding should be fully consumed by plan review or it will be reduced.

ISSUE 2: Challenges implementing the NDIS recovery coach model

Qualifications, training and supervision support

Whilst QAMH welcomes the Recovery Orientated Framework and the roles of Psychosocial Recovery Coaches, there remain significant challenges in the implementation of the framework and clear definition of the role of the Psychosocial Recovery Coach. A key challenge relates to ongoing confusion as to the role of the Psychosocial Recovery Coach verses the role of Support Coordinators and the disparity in the NDIS price limits for each role. The disparity does not recognise the unique skills required for Psychosocial Recovery Coaches and does not recognise the increased levels of training, reflection and supervision support that are typically necessary for a Psychosocial Recovery Coach role. Currently, a Psychosocial Recovery Coach is required to be more qualified than a Support Coordinator, and perform a more complex role, that incorporates all of the functions of a Support Coordinator however at lower pay. The requirement for dual skill sets in mental health/peer work and navigating the NDIS creates challenges in recruiting, training and developing an appropriately skilled workforce.

The current pricing structure also makes it difficult to accommodate the significantly higher mentoring, support and supervision requirements that Psychosocial Recovery Coaches require due to the complexity of the support that they provide and the higher likelihood of psychosocial hazards in the workplace. There is a risk that the unfunded cost of meeting the support and supervision obligations under the workplace health and safety laws could lead to unsustainability of service provision.

Disparity in Psychosocial Recovery Coach and Support Coordination Funding

Support Coordination and Psychosocial Recovery Coaching are funded under the same Capacity Building budget in NDIS participant plans and sit together under the same NDIS Commission registration group. There is also some clear crossover in what each role can perform for participants, however there is confusion as to the role and responsibilities of each and there is disparity in the hourly rates for each line item. Below are the current rates for each.

Support Coordinator Price Limits

Item Number	Item Name and Notes	Unit	National	Remote	Very Remote
07_001_0106_8_3	Support Coordination Level 1: Support Connection	Hour	$70.87	$99.22	$106.31
07_002_0106_8_3	Support Coordination Level 2: Coordination of Supports	Hour	$100.14	$140.19	$150.21
07_004_0132_8_3	Support Coordination Level 3: Specialist Support Coordination	Hour	$190.54	$266.75	$285.80

Psychosocial Recovery Coach Price Limits

Item Number	Item Name and Notes	Unit	National	Remote	Very Remote
07_101_0106_6_3	Psychosocial Recovery Coaching - Weekday Daytime	Hour	$93.34	$130.68	$140.01
07_102_0106_6_3	Psychosocial Recovery Coaching - Weekday Evening	Hour	$102.86	$144.00	$154.29
07_103_0106_6_3	Psychosocial Recovery Coaching - Weekday Night	Hour	$104.76	$146.66	$157.14
07_104_0106_6_3	Psychosocial Recovery Coaching - Saturday	Hour	$131.40	$183.96	$197.10
07_105_0106_6_3	Psychosocial Recovery Coaching - Sunday	Hour	$169.45	$237.23	$254.18
07_106_0106_6_3	Psychosocial Recovery Coaching - Public Holiday	Hour	$207.50	$290.50	$311.25

The rate for Psychosocial Recovery Coach is seven per cent lower than for a Support Coordinator during typical weekday hours. However, as discussed at length throughout this submission, the role of the Psychosocial Recovery Coach, and the experience required, suggests that the role should be at least at parity or higher than the rate for Support Coordination (Level 2).

Confusion Regarding Psychosocial Recovery Coach and Support Coordinator Roles

Psychosocial Recovery Coaches are a newly introduced NDIS support which hold overlapping functions with Support Coordinators as well as specialist functions, yet significant confusion remains regarding the role in the general community as well as amongst providers, including those in the Community Mental Health and Wellbeing sector. This confusion is magnified by planning inconsistencies, including where some plans for psychosocial disability are funded with both Support Coordination and Psychosocial Recovery Coaching, and others just with Psychosocial Recovery Coaching or unstated funding in the support coordination category. Within the NDIS guiding materials for people with psychosocial disability there also remains a lack of delineation between the role of the Psychosocial Recovery Coach and role of the Support Coordinator. In many guiding documents only the role of the Support Coordinator is mentioned, for example in the NDIS Code of Conduct[12], although technically Psychosocial Recovery Coaches carry the same responsibilities and perform the same functions.

This lack of clarity in the roles, combined with the challenging cost model for Psychosocial Recovery Coaching has led to a considerable sense among many in the Community Mental Health and Wellbeing Sector that Psychosocial Recovery Coaching should be a separate role to Support Coordination, with some providers delivering discrete services in this manner. Greater clarity is clearly required, as is clear

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[12] NDIS. (2022). *Mental Health and the NDIS.* Mental health and the NDIS | NDIS

communication across all relevant NDIS information, guidelines and standards (e.g. the support coordination page on the NDIS website, NDIS Practice Standards and the NDIS Code of Conduct) as to what these roles and responsibilities are.

Ultimately, greater clarity will also assist providers to work collaboratively for best participant outcomes. For some participants, it is unclear who is coordinating or accountable for the management of the NDIS plan and/or what can be funded by their NDIS plan. All of these factors can present a significant risk to the participant and their recovery journey as they may become overwhelmed by the complexity of the environment without adequate support.

Member Examples:

- *The NDIS Psychosocial Recovery Coach Model is primarily focused on supporting individuals, rather than addressing systemic issues related to disability support. While individual support is important, it may not be enough to address the broader issues faced by people with disabilities, such as discrimination and a lack of access to services.*
- *The NDIS Psychosocial Recovery Coach Model has the potential to be an effective approach to supporting people with disabilities, however issues such as availability and training of coaches, the scope and structure of the program, and the need to address broader systemic issues need to be addressed.*
- *Working as a Psychosocial Recovery Coach can be a challenging and emotionally demanding role, and there is a risk of burnout among coaches who are providing intensive support to individuals.*
- *Establishing rapport and case management are extensive with Psychosocial cohorts however are largely not funded.*
- *In usual service there is an expectation that Psychosocial Recovery Coaches deliver most of the same reports and requirements as Support Coordinators and doing that for even less money when the staff require more specialised Mental Health skills is not reasonable.*
- *Support Coordination and Psychosocial Recovery Coaching do overlap and attempting to bill some of the interaction with a participant to a support coordination line, with another part of the interaction to the Psychosocial Recovery Coaching line can lead to confusion.*

Recommendations:

1. Clarify the roles of Psychosocial Recovery Coach and Support Coordinators by clearly separating the role of Psychosocial Recovery Coach and Support Coordinator ***or*** widely communicating that Psychosocial Recovery Coach role includes support coordination as a key element of the role;

2. Ensure that the Psychosocial Recovery Coach roles and responsibilities are consistently reflected across all relevant NDIS guiding materials;

3. Adjust price limits for Psychosocial Recovery Coach to reflect complexity of support and the specialised support coordination required within the role;

4. Provide education for NDIS providers of psychosocial disability supports within the Community Mental Health and Wellbeing sector to assist them to transition to the NDIS fee for service model.

ISSUE 3: Disability support worker cost model

The NDIS model operates on a funding-based system, which means that the amount of funding provided to people with psychosocial disabilities may not be sufficient to cover the full cost of providing comprehensive psychosocial disability support and recovery. This limited funding can result in inadequate support, particularly for those with complex mental health issues that require specialised intervention.

Pricing for NDIS supports designed to assist people with psychosocial disability fail to acknowledge the cost drivers of psychosocial service delivery. It is unclear how an organisation could maintain a sustainable, skilled, and supported workforce within NDIS pricing structures. It would be difficult for any organisation to meet essential requirements such as one-on-one professional supervision and development, investment in quality and improvement and an adequate hourly rate to attract and retain people with required skills, experience and qualifications. It is also unclear how funding and supervision of lived experience workers, who may have their own recovery journey, is feasible within the current funding structure.

The inadequacy of the NDIS pricing structure has seen at least one major national provider discontinue providing psychosocial services through the NDIS altogether and several others scale down and reduce their service offering.

> *"Current price caps aim to encourage providers to operate 'efficiently'. However, some stakeholders suggest current price caps do not support the supply of services to participants with more complex needs. Some providers also suggest they are unable to invest in the capability of their workforce under current pricing arrangements and where workers can leave and set up as independent contractors or join online platforms. This exacerbates workforce retention challenges"[13].*

Other providers have reported needing to casualise workforces and reduce workforce supports to enable a viable business model under the current pricing structure. Providers have reported that this casualisation and reduction in workforce supports has led to higher staff turnover and reduced availability of experienced and appropriately qualified staff. There is also the potential for an increase in risks and vulnerabilities for the participant due to staff with limited skills and experience and an organization that has limited ability to provide suitable training and ongoing supervision.

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[13] NDIS Review. (2023). *The Role of Pricing and Payments Approaches in Improving Participant Outcomes and Scheme Sustainability*. The role of pricing and payment approaches in improving participant outcomes and scheme sustainability (ndisreview.gov.au)

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Specific issues with the DSWCM Elements

QAMH and/or other examples relevant to psychosocial disability are included in the following subsections.

Staff Rates and Shift Loadings

Disability support staff are typically remunerated under the SCHADS award. Most organisations consulted for this submission reported that the majority of their support workers are engaged at Level 2.4 of the award with small number on Level 3 which typically work in supported independent living (SIL). In some cases, QAMH is aware that providers employ people at Level 1 due to financial pressures which may increase the risks regarding the support provided.

Many support workers work weekends, afternoons, night shifts and on public holidays. Typical makeup of total support worker hours include 85 per cent of hours delivered on weekdays, one per cent on public holidays and 14 per cent on weekends. Penalty rates are also applicable to some frontline supervisors who can be 'on call' and may perform 'remote work' over weekends or into evenings. Staff rosters frequently include broken shifts which attract allowances under the recent Award changes or breaks between supports that have to be paid as they cannot be considered a meal break. As the examples below show, these issues have been identified for all support workers, and are not just relevant to psychosocial disability.

> *"Broken shifts – (a) An employee required to work a broken shift with 1 unpaid break will be paid an allowance of 1.7 per cent of the standard rate, per broken shift. (b) An employee who agrees to work a broken shift with 2 unpaid breaks will be paid an allowance of 2.5 per cent of the standard rate, per broken shift"*[14].

The DSW cost model is used to come up with the base rate and does not consider the time of day or day of week that services may be delivered.

Employee Allowances

Employee Allowance in the cost model are assumed to be one per cent. It is not clear what the NDIA includes in this figure but it may include allowances paid for mileage, broken shifts, on call, remote work, laundry, etc.

The most significant costs for organisations is mileage which is not always recoverable/claimable. Mileage is the largest allowance in terms of cost with the cost equating to approximately eight per cent of total direct wages costs (Support worker and front-line supervision). Mileage costs can be claimed as provider travel (non labour costs) or as activity-based transport (non-labour costs). Providers

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[14] National Disability Services. (2021). ***NDS submission 2021/22 Price Review.*** Submission_202122_Annual_Pricing_Review.pdf (nds.org.au)

experience issues in claiming travel related costs for Support Coordination when clients do not have the travel as part of their core support plan. This includes both staff time and non-labour related costs. Note this will also impact utilisation.

> *"Providers are struggling to recruit and retain enough employees to service demand on an average of SCHADS 2.3 base salary"*[15].

Recovery of travel costs is an important consideration for the psychosocial cohort as there is a high percentage of participants who will only engage with face-to-face supports as many people have concerns and or limitations using phones, emails and virtual platforms. Face-to-face support is also a means to "check-in" on a person's welfare, offer motivation and encourage activities that work towards recovery goals.

Leave Entitlements

Large percentages of staff work weekends or shift work which means they are entitled to five weeks annual leave and leave loading. The DSW model allows for only four weeks annual leave. Given the majority of support worker staffing being casual this does not impact significantly at this time but may going forward as staff transition to permanent contracts with casual conversion and the change in industrial relations legislation with respect to fixed term contracts becoming effective from December 2023.

Staff Training

There are higher staff training requirements for the psychosocial cohort. This occurs both at the initial employment stage but also ongoing as support needs change. Differences and additional training requirements within the psychosocial cohort include considerations for critical incidents, behaviour support approaches and restrictive practices, risk management and additional reporting requirements. Reflection is also an important aspect of practice and significantly supports better outcomes and approaches for people. Often, adequate time for reflection is not possible within the DSW Cost Model assumptions.

> *"Mandatory training and professional development costs increased by 11.77 per cent and 27.60 per cent for each year (to 2021/22)"*[16].

Staff utilisation

A recent benchmarking analysis completed by a QAMH member provider indicated that Support Workers (SW) spent on average 82 per cent of their time on claimable supports either face to face or non-face to face, 12 per cent on travel equating to approximately 94 per cent utilisation. The balance

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[15] National Disability Services. (2021). *NDS submission 2021/22 Price Review.* Submission_202122_Annual_Pricing_Review.pdf (nds.org.au)
[16] Thirdsector. (2021). *Opinion: The new NDIS National Workforce Plan misses the mark.* Opinion: The new NDIS National Workforce Plan misses the mark (thirdsector.com.au)

of SW time is on training, breaks, admin and team meetings. Whilst the utilisation is higher than the DSW cost model Mean of 84 per cent, it aligns with the 75th percentile of 92 per cent. This utilisation has only been possible by employing a largely casual support worker workforce to allow for workforce flexibility, albeit at a higher hourly rate. This differs to the cost model which historically assumed 80 per cent permanent staff. A highly casual workforce can also make the delivery of mental health supports more difficult due to the limited ability for workers to form meaningful and trusting relationships with people.

There are a few factors that impact utilisation. The requirement to pay staff a minimum of two hours when the support engagement is less than two hours. The administration time and cost are the same as it would be for a longer support session, but providers are often out of pocket as in reality it is difficult to achieve back-to-back appointments and providers are out of pocket for gaps in service. This is a particular problem on weekends and public holidays. It is often not viable for our organisation to provide services for such short engagements.

> *"Costs to the provider can be impacted by EBAs and award conditions for example a participant may only need a one hour shift but the worker must be paid for two hours. Some workers must be paid a minimum of four hours on a public holiday"*[17].

Staff often also have breaks which cannot be classified as meal breaks and are not long enough to split a shift and have to be paid. This also impacts utilisation.

The number of days available for billing in the cost model is 220, NDIA have not provided their assumptions around what they have included for staff meetings, breaks, mandatory training, etc. which are paid hours not available for performing billable activities. This non billable activities have a more relevant for our more senior staff. These appear to be all allowed for in the operational overheads percentage but assumptions are not evident.

For this service, utilisation is considerably lower as staff have a much higher administrative burden that is not billable that in core supports is typically performed by the front-line team.

Span of control

The DSW cost model historically assumes a supervision to DSW ratio of 1:15, whereas the average ratio is typically 1:6 on an FTE basis when delivering supports to a psychosocial cohort. With the current marketplace, the type of work involved, and flexibility required, it is very difficult to employ people on a full-time basis.

The psychosocial cohort of clients, who typically require greater support to engage, leads to greater time spent on client liaison, generally higher cancellations, many rostering changes, and generally greater need for change requests and plan reviews. All this additional administration required leads

[17] Ability First Australia. (2020) *Submission: Review of (SIL) Price Controls, AFA.*

to the need for a higher front-line supervisory ratio and the need for greater flexibility in the support workforce.

> *"The expected supervisory span of control is rarely met. While the model calls for a span of 15 FTE for each supervisor, the reality varies between 1:7.5 and 1:24 FTE"*[18].

The functions performed by front-line supervision include the following broad range of activities: rostering and rescheduling, client liaison, taking enquiries, engaging with Support Coordinators and NDIA, creating new and administration of service agreements, data management, approval of work to be billed and budgets, approval of timesheets, quality audits, staff supervision and meetings, recruitment, staff training and induction, attending client review meeting, induction of new staff, internal client reviews, plan change requests, manual payment claims etc. Whilst some of these tasks may be billable, in part, via the non-face-to-face line items, this ultimately may reduce the funding available for face-to-face supports and/or responses to a person becoming unwell.

The composition of what is included in front-line supervision may differ from organisation to organisation depending on size and structure. For example, large organisations may centralise some of these functions and may not include them in the ratio. Whereas most providers have administration split at a local level and corporate level with processes to ensure quality of service delivery and to ensure that claiming is accurate for services that are delivered.

Staff turnover is reported as being as high as 25 per cent in the broad NDIS workforce[19]. Within the Psychosocial cohort, QAMH members have reported this rate can be as high as 28 per cent. Staff have a period of time before they are fully productive and must undertake a period of training and induction as well as shadowing as part of client engagement and to build rapport. The time and investment vary depending on the level of experience of new staff. It is not clear whether the impact of staff turnover and lead time to become productive is considered in the cost model. The 6-hour annual allowance for shadowing is insufficient particularly for those clients with larger support needs and/or with larger support teams.

Front-line Supervision

Typical front-line supervision positions range from Level 3 through to Level 7 with team composition depending on the size of the NDIS business and staffing structures of the region. The DSW cost model notes these roles as Level 3, however, providers find that these classifications do not align with the level of responsibility and complexity of the roles they perform along with the added complexities of working with psychosocial client cohort.

Roles within the psychosocial cohort require a higher level of skill, experience and expertise to support both staff and clients and to effectively engage with and advocate for cross sector supports. Level 3

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[18] Thirdsector. (2021). *Opinion: The new NDIS National Workforce Plan misses the mark.* [Opinion: The new NDIS National Workforce Plan misses the mark (thirdsector.com.au)]

[19] Department of Prime Minister and Cabinet. (2022). *NDIS Workforce Retention, Results from Workforce Survey, December 2022*

supervisors typically do not have the relevant supervisory work experience to navigate staff, systems, and complex client issues.

Critical incidents are more likely and more frequent with the psychosocial participants due to their high intensity supports needs. Experience of many providers is that this occupies at least 3-4 hours of senior management time for each incident with an average of one incident every two weeks.

Other operational costs

In the past year providers have experienced a significant uplift in costs associated with property including increases in rents and electricity as well as other operational costs.

> *"Most providers are paying significantly more than the DSWCM allowance of 1.7 per cent in workers compensation premiums. The risk of lost time injuries appears to be more significant and prevalent in NDIS supports than the model assumes"*[20].

Personnel costs equate to 71 per cent of total organisation costs with the balance relates to other operational costs and corporate costs. At present, the provider comes close to breakeven on core supports after including direct costs (support worker and front-line supervision) and local operational costs. The core support services marginally contribute to what we consider corporate overheads.

Corporate overheads

According to the DSW Cost Model, corporate overheads cover the admin side of the business such as accounting, HR, legal, marketing, technology. There are other costs such as governance of the organisation, quality assurance, insurance, marketing, learning and development to name a few.

> *"Non-labour costs are understated in the DSW model by at least $4.27 per hour. Recent changes to the NDIS compliance framework will add to these costs over the next 6 months"*[21]

> *"We would like to start by acknowledging the reality that a 12 per cent corporate overhead is unattainable for all NDIS service providers. The average overheads percentage (as a loading on direct care costs) among*

[20] Thirdsector. (2021). *Opinion: The new NDIS National Workforce Plan misses the mark.* Opinion: The new NDIS National Workforce Plan misses the mark (thirdsector.com.au)

[21] Thirdsector. (2021). *Opinion: The new NDIS National Workforce Plan misses the mark.* Opinion: The new NDIS National Workforce Plan misses the mark (thirdsector.com.au)

> *survey respondents (27.7 per cent) is higher than the current Model assumptions (12 per cent)"*[22].

The DSW model limits corporate overheads to 12 per cent as a percentage of direct costs and front-line supervisor costs. QAMH member providers reported that by calculating corporate overheads on the same basis as the NDIA approach, i.e. assume corporate overheads include what we term other local operational costs, the comparable percentage is 29 per cent to 40 per cent of total costs.

Member Examples:

- *The sector welcomed the nine per cent increase to NDIS core supports that was put into place on July 1, 2022. For many, this bridged the gap between the price cap and what organisations had been funding, at their own cost, to maintain participant safety, quality of life, staff working conditions, and training for quality service provision.*
- *Increasing costs to attract and retain talent and specialised staff, expected to become more challenging with changes to Aged Care in FY24*
- *Workforce costs, increase in super guarantee, SCHADS Award changes, employer is required to pay part-time and casual social and community services employees, who are undertaking home care or disability services work, for a minimum of 2-hours, at the appropriate award rate, for each shift, or period of work in a broken shift.*
- *The Temporary Transformation Payment (TTP) also reduces a further 1.5 per cent in the next pricing review so given this unit price reduction, if the two per cent is not renewed then some services will reduce in price by 3.5 per cent in an environment of high inflationary pressures, this may impact providers ability to run services into the future.*
- *The current price is not sustainable as over time it has become insufficient to cover cost of service delivery. We have experienced staffing cost increases since July 2020 close to 16 per cent due to a combination of increases in Award base rates, Superannuation and LSL, staff annual increments and increases in workers compensation, with no corresponding increase in price for services.*

Recommendations:

1. Review the assumptions underpinning the Disability Support Worker Cost Model (that inform the price of the Psychosocial Recovery Coach support item and other support items designed to support people with psychosocial disability) to ensure that they are sufficient to sustain an appropriately supported, skilled and experienced workforce.
2. Create a discrete group of support items, prices and requirements for workers within the psychosocial sector. This should include the introduction of a Mental Health Support Worker line item.
3. Review price limits (upwards) for support items in Issue 5.2 to reflect the higher complexity within psychosocial support provision.

[22] National Disability Services. (2021). *NDS submission 2021/22 Price Review.* Submission_202122_Annual_Pricing_Review.pdf (nds.org.au)

ISSUE 4: Development and maintenance of appropriate workforce

The NDIS model requires a skilled mental health workforce to provide psychosocial disability support. However, there is a shortage of mental health professionals in Australia, particularly in rural and remote areas. The lack of mental health professionals can result in inadequate care for people with psychosocial disabilities, particularly those with complex mental health issues that require specialised support. This is present in not only the NDIS, but across multi-agency services where access to, and maintenance of, a skilled and experienced workforce is increasingly difficult. It is also possible that recent increases in remuneration for people working in aged care[23] will create increased difficulty to attract workers to mental health and disability and to retain them within this service area.

Workers providing psychosocial supports require a higher-level of communication and negotiation skills and knowledge to manage the psychosocial disabilities associated with severe mental illness. These include excellent relationship building skills as well as higher levels of personal awareness, a 'growth mindset', flexibility and resilience. Staff also need an understanding of the roles and responsibilities of other stakeholders and how to work effectively across a range of diagnosis. Ideally people working in this sector would be at least a Level 3 or 4 however with the growing disparity in remuneration combined with the complexity of providing support within the psychosocial sector, there is an increasing risk that attracting new workers and retaining the existing workforce will become more difficult.

The complexity of providing disability supports is higher in psychosocial markets than in the majority of other disability supports. This is a result of the complex nature of people and their recovery requirements but within the NDIS, it is magnified by the complexity of the price guide structure, the price limits and the confusion between the roles of Psychosocial Recovery Coach and coordinator of support. There exists an opportunity for psychosocial supports to separate these into a discrete group of supports and associated price guide items that may encapsulate supports workers, Psychosocial Recovery Coach, Support Coordinator and other key roles that should be differentiated for the psychosocial sector. This would significantly increase the ability to develop and maintain a skilled and experienced workforce and could also simplify the price guide structure for these supports.

There has been an increase in unregistered providers and/or sole traders operating in the psychosocial support markets over recent years. This is being driven primarily by workers attempting to recover more funding per hour by working directly with people or by groups operating with thin margins due to limited compliance and in some cases, quality focus. In some cases unregistered providers are also carefully screening clients to ensure they have relatively low support needs which leaves the more complex clients to the registered providers. This is having a significant impact upon the work force and provider viability for those providers who are registered. Consideration of limiting psychosocial supports to registered providers should be undertaken.

[23] Ministers Department of Health and Aged Care. (2023). *Press Release - Budget 2023/24: Delivering the largest ever pay rise to aged care workers* Budget 2023–24: Delivering the largest ever pay rise to aged care workers | Health Portfolio Ministers and Aged Care

Member Examples:
• *Providers are relying on Level 2 workers to provide complex supports which require a higher level of skill and associated pay.* • *Our workforce turnover for psychosocial cohort is twice the turnover for other disability supports.* • *We cannot attract people to a role in mental health when other sectors are providing higher pay with a less stressful workplace.* • *Consideration of limiting psychosocial supports to registered providers should be undertaken.*

Recommendations

1. Consider expanding qualification requirements to Mental Health Support Workers either as a requirement to work towards or to have prior to commencing;
2. Coordinate ongoing professional development opportunities for registered providers and ensure they are accessible, high quality and updated regularly;
3. Consider limiting psychosocial workforce to registered entities, or including a specific psychosocial disability module for registration with the NDIS Quality and Safeguards Commission.

ISSUE 5: Lack of psychosocial specific skills, knowledge and lived experience

A particular area of concern highlighted during QAMH consultation is that the National Disability Insurance Agency (NDIA), Local Area Coordinators (LACs) and other Scheme partners lack adequate psychosocial disability specific skills, knowledge and lived experience. This hampers their ability to effectively support people with psychosocial disability to access the NDIS or complete NDIS planning and review processes in ways that recognise the unique requirements of plans for psychosocial disability. It can also contribute to further re-traumatisation of people with psychosocial disability who are engaging with the scheme.

For example, although NDIS access decisions should be based on evidence regarding a person's functional impairment, we consistently hear of examples where access requests for people with psychosocial disability are refused due to inability to produce a specific diagnosis. Likewise, once access is successful, the lack of psychosocial specific skills, knowledge, and lived experience, as well as lack of knowledge among planners and LACs of how to apply this to NDIS planning and review processes often results in plans that are not recovery oriented in nature nor flexible enough to able to accommodate the specific needs and episodic nature of psychosocial disability. As a result, our members report that often a person's personal recovery plan is not well recognised within, or able to be aligned with, participants' NDIS plan goals.

The NDIA has committed to "develop and implement learning and development strategies to deliver psychosocial disability competencies and skills required for NDIA and partner staff"[24] and to "embed lived experience positions in both policy and operational areas of the NDIA"[25]. To date, there is little evidence of the implementation of these commitments within the NDIA and QAMH strongly recommends they be expedited.

We believe improving the Scheme's capacity in this area is crucial to the wellbeing of people with psychosocial disability engaging with the NDIS. In 2020, the NDIA funded Mental Health Australia to manage a NDIS Community Connectors program to deliver support to people with psychosocial disability who were homeless or at risk of homelessness. The evaluation of this program identified common barriers for people with psychosocial disability in accessing the NDIS including the appropriateness of NDIS policies and processes for people with mental illness, previous trauma and negative experiences of services or NDIS leading to mistrust and disengagement. In some circumstance this can lead to homelessness which further amplifies barriers to engagement with the NDIS and the NDIS appears to have little flexibility to adapt their processes to avoid this outcome[26]. Interactions between people and the Scheme often result in people reliving traumatic experiences and/or having critical services removed which can lead to a deterioration in the person's functional capacity.

The lack of relevant skills and lived experience adds to confusion within stakeholder groups as to the most appropriate response when supporting a person on their recovery journey. This may lead to a person "falling through the cracks" between various NDIS and non-NDIS sector services and supports, resulting in deterioration and a divergence from their recovery journey.

QAMH believe that implementing specialised access and planning teams with supporting resources for psychosocial disability is one key way that the NDIS can improve its performance in this area. These teams should incorporate lived experience staff and leadership where possible. The NDIS has recently implemented specialised resources for planning within Home and Living supports and it is this specialised support approach, in recognition of the specialised skills required, that we suggest should be implemented for psychosocial disability access decisions, planning and review processes.

Member Examples:

- *How personal recovery plans interact with NDIS plans is unclear and inconsistently applied. NDIS participant plans do not appear to include or reference the personal recovery plan when one exists.*
- *NDIS plan assumes regular support during the plan period, rather than the need for flexibility to support the episodic nature of psychosocial disability.*
- *Apart from Specialist Support Coordination, plans do not account for participants changing needs including responding in crisis situations.*

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[24] NDIS. (2021). *Psychosocial Disability Recovery-Oriented Framework* PB NDIS Psychosocial Disability Recovery Oriented Framework PDF (4).pdf p.13
[25] NDIS. (2021). *Psychosocial Disability Recovery-Oriented Framework* PB NDIS Psychosocial Disability Recovery Oriented Framework PDF (4).pdf p.13
[26] Mental Health Australia. (2021). *Outreach and connection: NDIS National Community Connectors Program for people with psychosocial disability: Final Report* https://mhaustralia.org/ndis-psychosocial-community-connectors-program

- *Not all plans include Psychosocial Recovery Coaching to support participants develop and manage their personal recovery journey.*
- *Plans are often not reflective of a person's recovery planning needs*

Recommendations:

1. Increase number of lived experience staff within the NDIA and improve psychosocial disability training for NDIA and NDIS Partner in the Community staff, especially Local Area Coordinators;
2. Develop specialist NDIS planning teams and resources, similar to NDIS Home and Living, who are trained to provide specialised planning for psychosocial disability, and who are responsible for the development and review of all NDIS plans for participants with psychosocial disability.

ISSUE 6: Multi-agency and cross system responsibility and navigation

Viability of the ILC program / Tier 2 Services

Both NDIS participants and non-NDIS eligible people with psychosocial disability need to access various supports and services from Tier 2 services. NDIS participants may access the majority of their services and supports from within the NDIS market, however, they still rely upon many other services along their recovery journey. People that are not eligible for the NDIS have a greater reliance on these services and may need to access them more frequently.

When a person is found to not be eligible for the NDIS there remains a need for the provision of multi-agency services within all jurisdictions in Australia via functional and viable Tier 2 services. Since the inception of the NDIS there is evidence that state and territory Tier 2 services have been reduced in response to an expectation of people accessing the NDIS[27].

The Productivity Commission Inquiry into Mental Health recommended that Governments ensure all people who have psychosocial needs receive adequate psychosocial support, however under current policy settings an estimated 154,000 people would not be able to access the psychosocial support services they require[28]. It recommended that “the shortfall in the provision of psychosocial supports outside of the NDIS should be estimated and published at both State and Territory and regional levels”[29].

The NDIS are acutely aware of the current issues surrounding viable Tier 2 services. This was reinforced on 18 April 2023 when the Minister for the NDIS addressed the National Press Club and outlined six key

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[27] Melbourne Disability Institute. (2022). *The Tier 2 tipping point: access to support for working aged Australians with Disability without NDIS Funding.* FINAL-TIER-2-REPORT-SUMMARY-ISBN.pdf (unimelb.edu.au)
[28] Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Vol. 1* Inquiry report - Mental Health (pc.gov.au) p.827
[29] Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Vol. 1* Inquiry report - Mental Health (pc.gov.au) p.866

focuses for systemic reform of the NDIS. The sixth focus is "Increasing Community and Mainstream Supports"[30]. The focus is upon ensuring that mainstream services are actually delivering on inclusion and universal service provision as they have always been meant to do and to ensure that states and territories honour their commitment to their citizens with disability, providing them with high quality, inclusive healthcare, education, transport, housing and justice, as is their responsibility.

In addition to ensuring that comprehensive, inclusive community and mainstream services for psychosocial disability exist, QAMH believe there is an opportunity to improve Tier 2 supports and outcomes for people with psychosocial disability who are not NDIS participants via the ILC program. It is widely acknowledged that the ILC program is not delivering on its intended objectives[31]. It is also clear that people with psychosocial disability who are not NDIS participants need more than a list of phone numbers or referrals to online resources. Instead, support that can help to build capacity to navigate mental health supports and work towards personal recovery is needed, which can ultimately help to reduce the likelihood of developing severe and persistent mental health challenges. For example:

"I can't find what I need because I don't know what support would be useful to me… Every website ends with the phone numbers to Lifeline and Beyond Blue. But I'm not in crisis. I just want a list of instructions, things to work on so I can function in a society that was designed without me (and many others) in mind." - Survey participant[32].

As the Melbourne Disability Institute have identified, codesigning ILC services together with those who the service is intended to serve – including people with lived experience of mental health challenges - is an important element of successful program design, as is utilising "natural supports" available in the community to provide information and support to people when and where they need it:

"People with disability, and representative organisations, should co-design how ILC resources intended to serve their interests are prioritised, applied and structured, with a focus on sustainable inclusion in society and the economy"[33].

"Universal platforms routinely accessed by people with disability and their families - such as schools, GPs, allied health services, Neighbourhood Houses, local government, pharmacies, Medicare, and Centrelink – could be better used both to flag service gaps and to provide information to people with disability about

[30] Ministers for the Department of Social Services. (2023). *Address to the National Press Club*. https://ministers.dss.gov.au/speeches/10911

[31] See for example, Melbourne Disability Institute. (2022). *The Tier 2 tipping point: access to support for working aged Australians with Disability without NDIS Funding.* FINAL-TIER-2-REPORT-ISBN.pdf (unimelb.edu.au)

[32] Melbourne Disability Institute. (2022). *The Tier 2 tipping point: access to support for working aged Australians with Disability without NDIS Funding.* FINAL-TIER-2-REPORT-ISBN.pdf (unimelb.edu.au) p.13

[33] Melbourne Disability Institute. (2022). *The Tier 2 tipping point: access to support for working aged Australians with Disability without NDIS Funding – Executive Summary.* FINAL-TIER-2-REPORT-SUMMARY-ISBN.pdf p.12

mainstream services and support aligned to their needs and circumstances. Providing intuitive and user-friendly access points for information would significantly reduce the administrative burden for people with disability and their families of sifting through information about services and support online"[34].

We encourage the government to consider improving psychosocial supports available via the ILC program as per our recommendations below.

Cross System Responsibilities

Personal recovery relies on support and input from a diverse range of stakeholders and support services working collaboratively, communicating effectively, and understanding their responsibilities in the person's recovery journey. Unfortunately, there is a lack of understanding of responsibilities and contributions of different sectors to a participant's personal recovery journey. For example, the roles of plan manager, Support Coordinator, Psychosocial Recovery Coach, LAC, community mental health services, primary health services and others are unclear and inconsistent.

There exists confusion and a lack of clear delineation between the roles and responsibilities of the various stakeholders that are involved in delivery of services and supports to the psychosocial cohort. Despite the development of the Applied Principles and Tables of Support (APTOS)[35] that outlines the funding responsibilities across the NDIS and other funding systems, there is clearly ongoing confusion and even ignorance of the various cross system responsibilities. This could be due to a lack of knowledge of the APTOS and/or lack of translation of the APTOS principles into on-the-ground practice.

This leads to a lack of collaboration between supports and services involved in a person's recovery journey. It also heightens the risk of a person not receiving adequate supports and/or being referred to another service based upon a lack of understanding of their universal service obligations and/or a lack of budget.

Member Examples:

- *Personal recovery relies on support and input from a diverse range of stakeholders and support services.*
- *The responsibilities and contributions of different sectors to a participant's personal recovery journey are unclear. E.g., the roles of plan manager, Support Coordinator, Psychosocial Recovery Coach, LAC*
- *Identified lack of collaboration between stakeholders/supports. Service providers can be more transactional and business oriented, rather than working collaboratively for participant outcomes.*

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[34] Melbourne Disability Institute. (2022). *The Tier 2 tipping point: access to support for working aged Australians with Disability without NDIS Funding – Executive Summary.* FINAL-TIER-2-REPORT-SUMMARY-ISBN.pdf p.12

[35] DSS. (2015). *The Applied Principles and Tables of Support to Determine Responsibilities NDIS and other service*. The Applied Principles and Tables of Support to Determine Responsibilities NDIS and other service | Department of Social Services, Australian Government (dss.gov.au)

- *For some participants, it is unclear who is coordinating or accountable for the management of the NDIS plan.*
- *"We cannot assist you until you have applied for the NDIS"*

Recommendations

1. Deliver the six key reforms to the NDIS particularly ensuring the community and mainstream services are providing their required service level;
2. Review the ILC program to ensure it effectively supports the ongoing delivery of viable Tier 2 services.
3. Clarify roles and responsibilities of intermediaries as per recommendation 2.1 above.
4. Consider the introduction of a codesigned ILC funded service that provides community based link workers who offer psychosocial supports such as Mental Health Recovery Support Workers and/or Psychosocial Recovery Coaches who can support non-NDIS participants experiencing mental health challenges to access community and mainstream supports and provide assistance with NDIS access requests for those likely to meet NDIS psychosocial disability criteria, via assertive outreach and support. This program should consider utilising a social prescribing model in which general practitioners and other professionals are able to refer people to the service to develop a recovery plan and link in with social and community activities that foster mental health and wellbeing.
5. Consider expanding the current LAC Information Linkages and Communities Program to include specialised psychosocial supports such as Recovery Support Workers and/or Psychosocial Recovery Coaches who can assist non-NDIS participants as per recommendation 6.4 above.

Thank you for the opportunity to contribute to this consultation process. We look forward to continuing to work with the Australian Government to better the lives of people living with psychosocial disability. Please do not hesitate to contact QAMH should you require any further information.

Who is QAMH?

The Queensland Alliance for Mental Health (QAMH) is the peak body for the Community Mental Health and Wellbeing Sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental health and wellbeing services across the state. Our role is to reform, promote and drive community mental health and wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners. At a national level, we have a formal collaboration with Community Mental Health Australia and provide input and advice to the work of Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

QAMH contact details

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Acknowledgement of Country

QAMH acknowledges the Traditional Custodians of the land on which we live, learn, and work and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders past, present and emerging.

Recognition of Lived Experience

QAMH recognises that the Community Mental Health and Wellbeing Sector exists because of people with Lived Experience of mental distress, their families, carers and support people. We acknowledge the expertise and the courage of people with Lived Experience, and we commit to work with and alongside people with Lived Experience in all we do.