Chapter 3
Access and planning

Introduction

3.1 This chapter discusses access to NDIS services and explores the establishment and review of plans for NDIS participants with a psychosocial disability.

3.2 It deals with terms of reference e) the planning process for people with a psychosocial disability; and g) the role and extent of outreach services to identify potential NDIS participants with a psychosocial disability.

Access

3.3 Entry to the Scheme begins with an access request lodged through a form or being completed by telephone. The NDIA has 21 days to respond. If the applicant meets the eligibility criteria, the planning process begins. Supports are allocated through a plan, which is prepared through conversations between a planner and the participant.

3.4 The committee heard there were a number of key barriers to access NDIS services. Inquiry participants reported lack of information, unclear referral pathways, emerging service gaps and means of communications used by the NDIA as contributing factors to jeopardising access as well as developments of adequate plans.

Online engagement and phone

3.5 The committee heard that key communication tools (website, *myplace* portal and phone) used by the NDIA can lead to adverse outcomes and contribute to a number of individuals with psychosocial disability missing out on services.[1]

3.6 Access to the internet and some degree of digital literacy are required to engage in the NDIS. Accessing information about the Scheme, engaging with the access and planning process as well as managing plans are mostly done online. According to the Commonwealth Ombudsman, this is a source of concern because many people with psychosocial disability do not access the internet for a variety of reasons including lack of access to a computer, cost of services and mistrust of the technology.[2]

3.7 Ballarat Community Health explained how the need to use online tools is a barrier to accessing the NDIS:

> That the eligibility process does rely on participants accessing MyGov, the Portal and using IT skills that they do not have (or lack confidence with) is

1 See for example: Royal Australian and New Zealand College of Psychiatrists, *Submission 18*, p. 9; Commonwealth Ombudsman, *Submission 4*, p. 5; VCOSS, *Submission 50*, p. 21.

2 Commonwealth Ombudsman, *Submission 4*, p. 5.

> further isolating and will ensure many do not commence or proceed with NDIS.[3]

3.8 One Door Mental Health reported that 'there does not appear to be an alternative to or supports for the participants to use the online portal, *myplace*, for those that do not have access to, or are unable to use computers'.[4]

3.9 Central Adelaide Hills Partners in Recovery (CAH PIR) reported that participants found 'there was limited or no promotion or information from the NDIA and that the website is not user friendly'.[5]

3.10 Queensland Program of Assistance to Survivors of Torture and Trauma also commented on the difficulty to navigate the NDIS website and to access information for non-English speakers:

> It is not sufficient to have translated material in 10 languages (we work with more than 70 languages each year) tucked away under a sub-heading on the website. People would not be able to access this site if they cannot speak English let alone find the right links.[6]

3.11 As stated on the NDIS website, due to the large number of people entering the Scheme over the next few years, the NDIA offers to undertake most access requests over the telephone.[7]

3.12 Communicating by phone can be extremely problematic for people with a mental health condition. Inquiry participants have reported experiences of people with psychosocial disability not answering or not returning calls for a variety of reasons. Due to the nature of their mental health condition, this includes feeling not comfortable speaking over the phone and not wanting to answer calls from numbers they do not know.[8] In addition, it can put the participant under undue pressure and excludes the family and carer from the initial and subsequent planning discussions.[9]

Accessibility of information and role of primary health care professionals

3.13 The first professional encounter for many people seeking help for a mental illness is their GP.[10] GPs are often the 'frontline' access point to treatment and can play

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3 Ballarat Community Health, *Submission 58,* p. 2.

4 One Door Mental Health, *Submission 74,* p. 9.

5 Central Adelaide Hills Partners in Recovery (CAH PIR), *Submission 30,* p. 6.

6 Queensland Program of Assistance to Survivors of Torture and Trauma, *Submission 79,* p. 7.

7 NDIS, *Access requirements*, https://www.ndis.gov.au/people-with-disability/access-requirements/completing-your-access-request-form.html (accessed 27 June 2017).

8 See for example: VCOSS, *Submission 50,* p. 21; VICSERV, *Submission 65,* p. 5; Office of the Public Advocate, *Submission 7,* p. 14.

9 Tandem, *Submission 69,* p. 10.

10 BEING, *Submission 48,* p. 12.

a critical role in identifying potential NDIS participants and providing them with essential information.[11]

3.14 However, to date, many health professionals and organisations find it difficult to obtain information about how to access the NDIS and navigate the planning process. This leads to health professionals being unable to adequately assist individuals to access or prepare for NDIS assessment. Mental Health Australia said:

> The most obvious sources of referral to the NDIS, i.e. assertive outreach services, general practitioners, mental health nurses and allied mental health professionals, are yet to receive the information and resources they need to assist people to access the NDIS.[12]

3.15 Dr Meyer, Director, Operations Support, Aftercare, reported:

> We are seeing a very particular gap around accessibility, and that is in the information and support provided to GPs and other health professionals in assisting people to do the assessments.[13]

3.16 The Queensland Alliance for Mental Health reported that a lack of knowledge of the NDIS amongst GPs and other clinical service providers has resulted in major barriers to access an NDIS package in some areas of Queensland.[14]

3.17 The Royal Australasian College of Physicians (RACP) recommended that the NDIS provides information about how physicians and specialists can appropriately refer people with psychosocial disability, especially children to the NDIS.[15]

3.18 Similarly, at a public hearing in Penrith, Ms Jaime Comber, Policy Officer with BEING, recommended:

> …I think they [NDIS] need to work with health professionals to make sure that that information is getting out there. What we propose in our submission is doing more education with GPs and people who are having the frontline interactions with people.[16]

Engagement and assertive outreach

3.19 Outreach services are essential to identifying and supporting people with psychosocial disability. They are often isolated and face other barriers such as a lack of knowledge of services available and negative prior experience with service providers. It is likely that a group of people who are eligible will not access services through NDIS, or will not make full use of allocated plans, without active outreach.

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11 Office of the Public Advocate (QLD), *Submission 93,* p. 12.

12 Mental Health Australia, *Submission 1,* p. 3.

13 Dr Isabelle Meyer, Director, Operations Support, Aftercare, *Committee Hansard*, 28 April 2017, p. 16.

14 Queensland Alliance for Mental Health, *Submission 23*, p. 2.

15 RACP, *Submission 17*, p. 4. VCOSS, *Submission 50*, p. 21.

16 Ms Jaime Comber, Policy Officer, BEING, *Committee Hansard* , 17 May 2017, p. 5.

3.20 BEING recommended that the NDIA develops an assertive outreach plan for people with psychosocial disability, particularly regarding how to reach those without regular contact with current Commonwealth funded programs such as PIR and PHaMs.[17]

3.21 Many inquiry participants[18] stressed the need for appropriate services to engage with hard-to-reach populations, including CALD, LGBTI and Aboriginal and Torres Strait Islander communities:

> Data from the NDIA indicates that people who identify with Aboriginal and Torres Strait Islander heritage or from Culturally and Linguistically Diverse communities are not accessing the Scheme at a rate that is reflective of the needs in these communities. Special attention needs to be paid to ensure that culturally appropriate and safe outreach strategies, processes and other elements of the Scheme are developed in consultation with relevant communities.[19]

3.22 The Queensland Alliance for Mental Health gave the example of the NDIS rollout on Palm Island where utilising an outreach model to support the transition was crucial:

> Experiences of the NDIS rollout on Palm Island and in some other Aboriginal and Torres Strait Islander communities have uncovered the importance of working with a community to identify tailored ways in which to support the transition utilising an outreach model. Identifying activities appropriate to the community, ensuring appropriate methods for measuring outcomes are employed, appropriately resourcing and acknowledging the importance of family supports are all important aspects of outreach that should be considered for many communities. This includes CALD communities as well as Aboriginal and Torres Strait Islander communities.[20]

3.23 The issue of funding to deliver assertive outreach was brought to the attention of the committee on several occasions.[21] Mental Health Australia noted:

> In the long term, without specific policy and funding arrangements, there is a risk assertive outreach for people with severe mental illness and complex needs will no longer be delivered, either through the NDIS or elsewhere. Assertive outreach takes place before someone accesses the NDIS, so NDIS registered service providers are not able to charge the NDIA for outreach services (regardless of whether a consumer ultimately becomes an NDIS participant). Further, the very low prices on offer for NDIS supports mean

17 BEING, *Submission 48,* p. 12.

18 See for example, VICSERV, *Submission 65,* p. 7; CMHA, *Submission 75,* p. 12; Wellways, *Submission 103,* p. 6.

19 Flourish Australia, *Submission 117,* p. 12.

20 Queensland Alliance for Mental Health, *Submission 23,* p. 6.

21 See for example, Mental Illness Fellowship Australia, *Submission 70,* p. 11; VCOSS, *Submission 50,* p. 6.

> that providers of psychosocial services have no scope to cross-subsidise assertive outreach activities. Without direct funding for assertive outreach, the organisations that regularly work with hard to reach people are unlikely to continue this activity.[22]

3.24 Assertive outreach services provided by the NDIS can only be delivered through the Local Area Coordination (LAC) function However; submitters noted that the current LAC approach does not have the capacity to take on functions such as outreach and advocacy services.[23] The ILC framework and LAC function are discussed in chapter 4.

3.25 According to their submission, the NDIA is currently using the learning from a number of projects to develop an approach for those participants who may be regarded as 'hard to reach'. At the time of writing, no strategy or approach has been made public by the NDIA.[24]

Advocacy services

3.26 In their submission, the Office of the Public Advocate Victoria highlighted the importance of outreach advocacy so people who are currently not in funded services get access to information and advocacy.[25]

3.27 This view is shared by many organisations[26], including the Victorian Mental Illness Awareness Council (VMIAC), which explained at the public hearing in Melbourne how it has played an active advocacy role for mental health consumers in the NDIS Barwon trial site. Their work includes the development of education resources for consumers as well as a touring musical theatre production -*NDIS: The Musical.* VMIAC recommends that resources and support be made available for advocacy services:

> It is our recommendation that the culturally appropriate independent advocacy services be resourced to safeguard vulnerable people—this includes hard-to-reach-and-engage populations including Aboriginal and Torres Strait Islanders, CALD and LGBTI communities—to ensure that the national disability standards continue to underpin and then inform all NDIS activities.[27]

3.28 Victorian Council of Social Service (VCOSS) members reported that disability advocacy services in the Barwon trial site experience substantial increase in demand that cannot be met. They identified a need for funding independent advocacy

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22 Mental Health Australia, *Submission 1,* p. 11.

23 Ballarat Community Health, *Submission 58,* p. 2.

24 NDIA, *Submission 102,* p. 8.

25 Office of the Public Advocate Victoria, *Submission 7,* p. 14–15.

26 See for example, Victorian Mental Illness Awareness Council (VMIAC), *Submission 112,* p.16; Office of the Public Guardian Queensland, *Submission 126,* pp. 4–5; Australian Red Cross, *Submission 15,* p. 8.

27 Mr Turton-Lane, *Committee Hansard,* 28 April 2017, p. 18.

to assist people to access and participate in the NDIS and to help people ineligible for NDIS services to access appropriate services.[28]

Planning process

3.29 Section 31 of the NDIS Act states that the development of a plan should so far as reasonably practicable be individualised, directed by the participant and maximise participant choice and control.

3.30 The planning process involves discussions about the participant's goals and aspirations and an assessment of function and support needs, before a support package is put together. Once a support package has been put together, the participant and planner decide how the plan will be managed and when the plan will be reviewed. Before the plan is finalised, it must be approved by the CEO of the NDIA.

3.31 The NDIS has developed a range of resources about the planning process and management of plans which are accessible from the NDIS website. This includes an access kit aimed at assisting people with a psychosocial disability entitled *Completing the access process for the NDIS-Tips for Communicating about Psychosocial Disability.*[29]

Experience, skills and training of staff

3.32 Many inquiry participants expressed concerns about the insufficient knowledge of psychosocial disabilities by NDIS staff, which can impact on access to the Scheme, planning process and quality of plans.[30]

3.33 The IAC identified major variations in the knowledge and skill base not only of the NDIS teams but more recently in regards to LACs in relation to mental health expertise.[31]

3.34 New England Partners in Recovery noted:

> In addition, early experiences in our region of New England NSW suggests that in many locations Local Area Coordinator (LAC) teams and NDIS Planners generally have a low level of understanding of mental health issues. Many of these staff appear to have backgrounds in physical or intellectual disability, and as a result their understanding of mental health, and in particular its episodic nature, is still developing.[32]

3.35 The lack of understanding of psychosocial disability by NDIS planners was also noted by Psychiatric Disability Services of Victoria (VICSERV):

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28 VCOSS, *Submission 50,* pp. 21 and 22.

29 NDIS, *Access requirements*, https://www.ndis.gov.au/people-disability/access-requirements.html (accessed 20 June 2017).

30 National Disability Services (NDS), *Submission 80,* p. 2.

31 IAC, *Submission 125*, p. 5.

32 New England Partners in Recovery, *Submission 111*, p. 3.

> Individuals don't always know what they can ask for or how to articulate their disability and it has been reported that NDIA planners do not have an adequate understanding of psychosocial disability and mental illness to support them through the planning process.[33]

3.36 Mr Greg Franklin, Administrator, Mental Health and NDIS Facebook Support Group reported:

> The experience I have had with NDIS planners is that their backgrounds are very diverse. The highest level of training I have had with any NDIS person in a planning role has been a former occupational therapist. The rest of them have come basically from ADHC, other government departments as they shift to the NDIS and that type of thing. I have been told by an ex-NDIS planner that they got two weeks intensive training, closely supervised training. That was it. As far as access people go, they have very minimal training and absolutely none in mental health.[34]

3.37 BEING reported that the planning experience is heavily dependent on the NDIA planner and that 'a recurring issue for consumers, carers and support workers was that planners did not have a good understanding of psychosocial disability'.[35]

3.38 VCOSS members working in the Barwon launch site also reported 'examples of planners lacking relevant knowledge, such as being unaware of the role of peer workers' which resulted in inappropriate plans for some participants.[36]

3.39 Ms Mary Burgess, the Public Advocate of Queensland talked about how the knowledge and skills of NDIS planners play a critical role in the planning process:

> We have also been advised by service providers that the successful transition of people with psychosocial disability into the NDIS and the development of well-constructed plans is heavily reliant on the knowledge and skill of the NDIS planners. Anecdotal reports, including recent media comments from the CEO of the national peak body for disability services, National Disability Services, suggest that capability of planners varies widely and leads in some cases to poorly constructed plans, which then have to be reviewed and altered.[37]

3.40 Ms Burgess concluded:

> In summary, I would respectfully request that the committee consider recommending (…) that key NDIA personnel receive training in the specific needs of people with psychosocial disability and recognise the centrality of the recovery framework in their treatment when interacting

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33 Psychiatric Disability Services of Victoria (VICSERV), *Submission 65*, p. 6.

34 Mr Greg Franklin, Administrator, Mental Health and NDIS Facebook Support Group, *Committee Hansard*, 17 May 2017, p. 6.

35 BEING, *Submission 48*, p. 9.

36 VCOSS, *Submission 50*, p. 12.

37 Ms Mary Burgess, the Public Advocate of Queensland, *Committee Hansard*, 12 May 2017, p. 3.

> with applicants from this cohort; and, finally, that the NDIA ensure that planners and other key staff, such as local area coordinators, are appropriately experienced and skilled in identifying and addressing issues associated with psychosocial disability.[38]

Support during the pre-planning and planning stage

3.41 Inquiry participants reported that people with psychosocial disability need and require a significant amount of support to demonstrate their eligibility and prepare for the first planning meeting. There are concerns that without this support available many people with serious mental conditions will miss out.

3.42 The Mental Health Coordinating Council (MHCC) reported that providers in the Hunter trial site, including but not limited to PIR, reported an average of 40 to 60 hours of functional assessment work to support NDIS access. MHCC noted that these activities are currently funded at only up to $750.[39]

3.43 Mr Peters, a consumer and user of Neami National services shared his personal experience and explained the importance of having support in the assessment and planning process:

> If I had any take-home messages, they would be that it was not my experience that I could do this learning process alone, or walk into a planning meeting with my goals and needs articulated in order to be funded. My firm belief is that there is a definite need for ongoing funding in the current service model to help people reach the stage where they can go into a planning meeting and talk about their needs and goals. Without that capacity building and support helping me to get where I am today I would still be isolated, alone and in bed all day every day.[40]

3.44 Providing pre-planning services is one of the functions of LACs but the Committee did not see any evidence during this inquiry of the effectiveness of LACs in this area. In its NDIS Costs position paper, the Productivity Commission pointed that because of the speed of the rollout it has not been possible for LACs to perform their pre-planning functions as envisaged.[41]

3.45 The NDIA is reportedly identifying ways to improve communications to assist people to navigate the NDIS. This includes using the ILC grant process to fund community organisations to provide information and referrals.[42]

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38 Ms Mary Burgess, the Public Advocate of Queensland, *Committee Hansard*, 12 May 2017, p. 4.

39 MHCC, *Submission 27,* p. 10.

40 Mr Peters, Consumer and user of Neami National services, *Committee Hansard*, 28 April 2017, p. 20.

41 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, June 2017.

42 NDIA, answers to questions on notice, received 30 June 2017.

Adequacy of planning meeting

3.46 A number of participants[43] expressed concerns about people being contacted by phone by an NDIA representative to undertake an official planning meeting. As discussed previously in terms of access, this often leaves people unprepared and not able to be supported by family, friends or service providers during the assessment process. This can lead to poor outcomes in terms of developing an appropriate plan that meets the needs of an individual.

3.47 Ms Elizabeth Crowther, President, Community Mental Health Australia, explained to the committee how the practice of phoning and sending mail is inadequate:

> People have been telephoned and asked over the phone to describe what their life needs are. Many of these people have major cognitive problems just at that time and are unable to engage. The problem we then have is that the person may or may not receive a letter. They do not know what to do with that letter and our experience is that they may appear at a service some nine or 10 months later not knowing what to do with it or where to proceed with that letter. That is currently a major issue. I do not know how that is going to resolve, but resolved it must be.[44]

3.48 MHCSA submitted that people with psychosocial disability are likely to require support during the assessment process:

> Phone assessments are problematic – Consumers may not understand that the phone call is actually an assessment, leading to poor outcomes - There is a high degree of social isolation in the cohort eligible due to psychosocial disability (PIR Annual Report, 2016) therefore telephone assessments without significant support is unlikely to result in an effective plan.[45]

3.49 Dr Isabella Meyer, Director Operations Support at Aftercare described to the committee why online and phone communications are not suitable for most consumers:

> One of the things that we know about our clients is that less than 24 per cent of them have access to a computer, and a similar number, 27 per cent, own a phone and are engaged in phone calls. For the rest of our clients, this process of accessing forms online and having assessments and planning done over the phone is traumatic, and it is inaccessible to them—they do not do it. If they answer the phone at all, and the request is: 'We're doing your plan now,' they will hang up. We know that. That has been our experience.[46]

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43 See for example: Queensland Alliance for Mental Health, *Submission 23,* p. 3; Neami National, *Submission 29,* p. 5; Cohealth, *Submission 43,* p. 8.

44 Ms Elizabeth Crowther, President, Community Mental Health Australia, *Committee Hansard,* 28 April 2017, p. 6.

45 MHCSA, *Submission 109,* p. 7.

46 Dr Isabella Meyer, Director Operations Support, Aftercare, *Committee Hansard,* 28 April 2017, p. 16.

3.50 VICSERV explained that 'phone calls as a means to facilitate engagement can cause significant distress for some individuals and will often result in disengagement.'[47] In its submission, VICSERV also highlighted how 'non-verbal communication is an essential part of building rapport with people with a psychosocial disability' and concluded:

> While using technology plays an important role in increasing access to services, a move away from face-to-face consultations will also mean a lack of rapport and an increase in the number of people who will disengage from services.[48]

3.51 VCOSS members reported a high number of planning meetings occurring over the phone and highlighted some key issues:

> Conducting a planning session over the phone may prevent participants with a psychosocial disability from fully understanding or participating in the planning process, and makes assessment more difficult, potentially leading to poorly informed decision making. Members report instances where phone-based planning meetings have resulted in reduced support and some cases where people were unaware the phone conversation constituted their planning meeting until they received their plan in the mail.[49]

3.52 Tandem also noted that planning meeting over the phone 'puts the participant under undue pressure, and actively excludes the family and carer from the planning discussions'.[50]

3.53 At the public hearing held on 16 June 2017 in Canberra, the NDIA reported that 65 per cent of all plans are currently developed in face-to-face conversation and that an individual has always been given the opportunity to book for face-to-face conversation rather than over the phone.[51]

The role of carers

3.54 Mental Health Carers Australia (MHCA) and others[52] are concerned with the lack of engagement by NDIS planners with carers in the planning process. MHCA reported that 'the common experience of mental health carers is that they are not included in the planning process'.[53]

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47 VICSERV, *Submission 65*, p. 5.

48 VICSERV, *Submission 65*, p. 5.

49 VCOSS, *Submission 50*, p. 12.

50 Tandem, *Submission 69*, p. 10.

51 Ms Gunn, Acting Deputy Chief Executive Officer, Participants and Planning, NDIA, *Committee Hansard*, 16 June 2017, p. 17.

52 See for example: Mind Australia, Submission 118, p. 11; Mental Health Commission of NSW, *Submission 16*, p. 5; Anglicare Australia, *Submission 62*, Attachment 2, p. 5.

53 Mental Health Carers Australia (MHCA), *Submission 116*, p. 10.

3.55 Tandem has 'heard concerning reports of participants receiving phone calls in which the carer and the family was not involved, pre-warned or consulted'.[54]

3.56 MHCA also reported that 'the majority of carers of NDIS participants consulted as part of the Carers Australia's NDIS Carer Capacity Building Project reported that NDIA staff had not made them aware of the option to have a separate conversation with the planner or of the ability to submit a Carer Statement'.[55]

3.57 Similarly, Mind Australia stated:

> Although carers can ask for a separate meeting with planners, our observations are that very few people are aware of this, with the result that carers needs are not taken into account.[56]

3.58 Additionally, as Tandem explained, it is important that carers are present during the planning conversations 'to ensure the planner is provided a holistic and true understanding of the person support needs'.[57]

3.59 VCOSS also highlighted the importance of engaging carers in the planning process as 'this can help to effectively identify the participant's needs and support required'.[58]

3.60 The lack of engagement of carers in the planning process has also resulted in carers 'experiencing reduced access to respite care and other support'.[59]

3.61 The Mental Health Commission of NSW reported that the *Carer Recognition Act 2010* makes it clear that 'Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers' and recommended:

> This needs to be fully recognised during the planning process as carers will inevitably be a key component in the implementation of any individual package.[60]

3.62 VCOSS recommended engaging carers and family members in the planning process to 'better identify the support needed for individuals and their carers'.[61]

Poor communication, delays and other issues

3.63 Submitters reported difficulty to contact NDIS staff and a lack of responsiveness of NDIS planners during the planning process.[62]

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54 Tandem, *Submission 69*, p. 10.

55 Mental Health Carers Australia (MHCA), *Submission 116*, p. 6.

56 Mind Australia, *Submission 118*, p. 11.

57 Tandem, *Submission 69*, p. 11.

58 VCOSS, *Submission 50*, p. 13.

59 VCOSS, *Submission 50*, p. 13.

60 Mental Health Commission of NSW, *Submission 16*, p. 5.

61 VCOSS, *Submission 50*, p. 5.

3.64 Mental Health Carers NSW Inc. reported that carers and support workers find it difficult to contact NDIS planners, who often do not return phone calls or meet agreed deadlines.[63]

3.65 BEING explained some of the communication issues:

> One recurring problem appears to be difficulty reaching NDIA staff. Many survey respondents commented on the long phone hold times, the long wait to find out application results, and NDIS planners not returning calls.[64]

3.66 The Commonwealth Ombudsman has received a number of complaints from people with psychosocial disability, covering a range of issues pertaining the planning process:

> The bulk of these complaints reflected similar issues as those complaints received from people with other disabilities including delays, poor communication, dissatisfaction with plans and planning staff, and difficulties with the review process.[65]

3.67 Capital Health Network reported delays of up to 12 weeks before plans have been approved.[66]

3.68 VCOSS members in the Barwon launch site report 'delays of between four and six months between when a participant is assessed as eligible and their first plan being receive' with people 'unable to access funded mental health services during this transition period'.[67]

3.69 Similarly, Collaboration in Mind (CiM) stated 'the delay, sometimes a matter of weeks, between approval of a plan and receipt of the plan is leaving participants without access to support'.[68]

Annual plan and plan reviews

3.70 Usually, a plan is established for twelve months and plan review occurs as part of the planning cycle. However, unexpected plan reviews can be triggered if the Scheme participant requests a plan review or changes their statement of goals and aspirations. Currently, any changes to a plan require a full plan review.

3.71 Given the episodic nature of conditions and symptoms, concerns have been raised by participants that the annual plan approach does not build in supports to intervene early and prevent relapse. For example, the Benevolent Society stated:

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62 See for example: Mr Chris Redmond, CEO, Woden Community Service, *Committee Hansard,* Friday 12 May, p. 34; Ms Marilyn Gale, *Submission 59,* p. 2; Mr David Lamborn, *Submission 90,* p. 1.

63 Mental Health Carers NSW Inc., *Submission 64,* p. 4.

64 BEING, *Submission 48,* p. 4.

65 Commonwealth Ombudsman, *Submission 4,* p. 4.

66 Capital Health Network, *Submission 45,* p. 2.

67 VCOSS, *Submission 50,* p. 10.

68 Collaboration in Mind (CiM), *Submission 94,* p. 6.

> We also have concerns that the NDIS planning process will be unable to accurately measure and plan annually for needs which are sporadic in nature.[69]

3.72 This view was supported by Ms Meagher of the IAC:

> There is an argument that all disabilities are also, to some extent, episodic. When we look at the issues of permanency, they have to be moderated by the understanding of episodic conditions, how extreme or not those episodes could be and whether as an agency we are responsive to those fluctuating needs. That would be amongst the work we need to do into the future to determine how flexible plans can be—not just for people with psychosocial disabilities arising from mental illness, but also for a range of disabilities.[70]

3.73 Many participants[71] found that the rigidity of the NDIS review process as well as long delays in accessing reviews, do not allow for responsive plans and support to be put in place for participants when crises occur or circumstances suddenly change.

3.74 As stated by National Disability Services (NDS) and other participants,[72] the current average three-month wait for a plan review is not appropriate for people who have a sudden increase in their need for support.[73]

3.75 The NDIA is aware of the concerns raised about current planning processes and practices. On 6 June, the NDIA announced it has undertaken a participant pathway review to deliver a significantly upgraded quality of participant and provider experience in a way that remains consistent with maintaining the Scheme's financial sustainability.[74]

3.76 Overall, the committee heard that there is need to put greater emphasis on the pre-planning and planning stage to achieve good outcomes and quality plans. Mental Health Australia and others stated that as result of poor planning process many people reported receiving NDIS plans that are not fit for purpose or tailored to their individual needs.[75]

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69 The Benevolent Society, *Submission 106,* p. 4.

70 Ms Meagher, IAC member, *Committee Hansard*, 16 June 2017, p. 2.

71 See for example: Partners in Recovery Tasmania, *Submission 97,* p. 12, Anglicare Tasmania, *Submission 98,* p. 10, RANZCP, *Submission 18,* p. 8.

72 See for example: VICSERV, *Submission 65,* p. 7; Anglicare Tasmania, *Submission 98,* p. 11.

73 NDS, *Submission 80,* p. 3.

74 David Bowen, CEO, NDIA, *Participants and providers work with the NDIS to improve processes*, 6 June 2017. https://www.ndis.gov.au/news/ceo-message-6june.html (accessed 20 June 2017).

75 Mental Health Australia, *Submission 1,* p. 3.

Committee view

Information and assertive outreach

3.77 Given the critical role that GPs and other primary health care professionals can play in identifying and referring people with psychosocial disability to NDIS services, the committee recommends the NDIA develops and proactively markets resources and training for health professionals, especially about the NDIS referral pathways, access and planning processes.

3.78 The committee acknowledges the critical role assertive outreach and advocacy services can play in identifying and engaging individuals with psychosocial disability with NDIS services. With the transition of services such as PIR and PHaMs it is important to ensure that service gaps do not emerge in the area of assertive outreach and advocacy services. Given the reported high number of people with psychosocial disability who do not want or cannot utilise phone or online services, the NDIA must consider other ways to reach and communicate, including proactively using assertive outreach services to facilitate access to the NDIS.

Skills and expertise of planners

3.79 While mental health consumers, carers and providers have on many occasions raised concerns about NDIA planners' understanding of psychosocial disability, the committee recognises the efforts of the NDIA Mental Health Team work's to address this important issue. Initiatives such as the establishment of an internal NDIA community of practice on psychosocial disability and the provision of training for staff must continue to ensure the planning process results in providing the necessary supports for people with psychosocial disability. Given that participants with psychosocial disability as their primary disability are expected to account for about 13.9 per cent of all NDIS participants by 2019–20, the NDIA should consider having a specialised team of NDIS planners for people with psychosocial disability. This would ensure better plan outcomes for participants, less need for reviews and ultimately contribute to the sustainability of the Scheme.

Planning process

3.80 Overall, the committee believes the planning process has not been operating well for people with psychosocial disability and has resulted in many cases with less than satisfactory experiences and outcomes for participants. Furthermore, the reported delays experienced by participants in getting a planning meeting, receiving their approved plan or reviewing their existing plan are a cause of great concern for the committee. Given the episodic nature of mental health conditions, an agile planning and review process is crucial to ensuring that participants have continuity of appropriate support. Notwithstanding the challenges of the rollout schedule, the committee urges the NDIA to continue reviewing its current practices to address operational issues around meetings taking place over the phone, waiting times and delays and lack of responsiveness to people's changing needs.

3.81 As discussed in the general issues report, the committee acknowledges that the NDIA is currently investigating the ways in which it can improve its participant and provider experience. The committee expects that the pathways review currently

being undertaken will be published and made accessible to all those involved in the Scheme. Those areas identified, particularly related to mental health as requiring improvement should be incorporated into the NDIA's Quarterly Reports and progress against those targets tracked over time.

Recommendation 7

3.82 The committee recommends the NDIA develops and proactively markets resources and training for primary health care professionals about the NDIS, especially in regards to access and planning processes.

Recommendation 8

3.83 The committee recommends the Department of Social Services and the NDIA collaboratively develop a plan outlining how advocacy and assertive outreach services will be delivered beyond the transition arrangements to ensure people with a psychosocial disability and those who are hard-to-reach can effectively engage with the NDIS and/or other support programs.

Recommendation 9

3.84 The committee recommends the NDIA, in conjunction with the mental health sector, creates a specialised team of NDIS planners trained and experienced in working with people who have a mental health condition as their primary disability.

Recommendation 10

3.85 The committee recommends the NDIA develops an approach to build flexibility in plans to respond to the fluctuating needs of participants with a psychosocial disability, including allowing minor adjustments to be made without the need for a full plan review.

Recommendation 11

3.86 The committee recommends the NDIA reports on the level of engagement of carers in the planning process.

Recommendation 12

3.87 The committee recommends the NDIA publishes the results of its participants and providers pathways review, particularly in the areas related to mental health, and strategies in place to achieve improved outcomes, as well as updates on progress against targets in its Quarterly Reports.