Chapter 4
Funding and services

Introduction

4.1 This chapter focuses on the transition of Commonwealth, states and territories funded services to the NDIS. It investigates the continuity of services and the risk of emerging service gaps. Finally, this chapter discusses the scope and level of funding for mental health services under the ILC framework.

4.2 It deals with terms of reference:

- (b) the transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular;
- c) the transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular; i. whether these services will continue to be provided for people deemed ineligible for the NDIS; and
- (d) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework.

4.3 For people living with a psychosocial disability, the service landscape remains complex and fragmented as services are both cross-sectoral (health and disability) and cross-jurisdictional (Commonwealth and state/territory). It is important to note that alongside the NDIS rollout, the mental health sector is undergoing significant reform with the development of the Fifth National Mental Health Plan.

4.4 A number of Commonwealth, state and territory services and funding are being transferred into the NDIS, which currently provide services for clients both in and out of scope for the NDIS. The Australian, state and territory governments have agreed to provide continuity of support for people who are not eligible for the NDIS.[1]

4.5 The NDIS is meant to work collaboratively and alongside mainstream services, not replace them. As the NDIA stated:

> The NDIS does not replace the mental health system and does not replace community based support or medical clinical care for people living with mental health conditions, but, rather, must be designed to work collaboratively with these sectors. We continue to work to do this.[2]

4.6 In practice, many inquiry participants reported confusion and uncertainty about what services and supports will continue to be funded and/or funded for

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1 Intergovernmental Agreement for the NDIS Launch, 7 December 2012, p. 11.

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

individuals with a psychosocial disability who are ineligible for the NDIS. This is partly because the roles of the Australian and state and territory governments in relation to NDIS and residual or ongoing service systems are not clear or nationally consistent. Indeed, the extent to which existing services are transitioning to the NDIS varies between jurisdictions as do the implementation timelines.[3]

Commonwealth programs

Transition to the NDIS of Commonwealth funded services

4.7 The NDIS will eventually replace a range of Commonwealth funded disability programs for people with a psychosocial disability. The funding for the following programs is gradually transitioning into the NDIS:

- Partners in recovery (PIR) funded by the Department of Health;
- Support for Day to Day Living in the Community (D2DL) funded by the Department of Health;
- Personal Helpers and Mentors (PHaMs) funded by the Department of Social Services; and
- Mental Health Respite: Carer Support (MHR:CS) funded by the Department of Social Services.

4.8 Not all of the people who had access to psychosocial services under these community based programs will become NDIS participants. Some have been or will be assessed as ineligible and some will not apply to become an NDIS participant.

4.9 A number of service providers and organisations,[4] including Mental Health Australia (MHA) estimate that about 70 per cent of PIR participants and 60 per cent of D2DL participants will be eligible for the NDIS.[5]

4.10 In the case of PHaMs, MHA submitted that the Commonwealth government indicated that while PHaMs is 100 per cent in scope for NDIS, it is hard to estimate what the actual rate of eligibility for PHaMs participants will be because PHaMS does not specify an older age limit so it is conceivable that a number of existing participants will be excluded on the basis of age.[6]

4.11 Other submitters were also concerned that not all PhaMs clients will become NDIS participants.[7] For example, Anglicare Australia reported:

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3 National Mental Health Commission, *Submission 114,* p. 3.

4 See for example: Mental Health Coordinating Council (MHCC), *Submission 27* , Attachment 1 p.35; Sunshine Coast and Gympie - Partners in Recovery, *Submission 36,* p. 4; Wide Bay Partners in Recovery Consortia, *Submission 51,* p. 7.

5 Mental Health Australia, *Submission 1 Attachment 1,* p. 23.

6 Mental Health Australia, *Submission 1 Attachment 1,* p. 22.

7 See for example: YFS, *Submission 47,* p. 2; Mental Health Council of Tasmania (MHCT), *Submission 52,* p. 4.

> It is already clear that there are major gaps between the expectation of the number of people being serviced through the Commonwealth PHaMs and PIR programs who will be able to access the NDIS, and the reality. For example, Anglicare South Australia report:
>
> …PHaMs has been classified as 100% in-scope for NDIS, however, a participant audit of our PHaMs services indicate that the clinical 'psychotic' disorders anecdotally deemed 'in-scope' for NDIS such as schizophrenia, bipolar and schizo affective disorder account for approximately 30% of participant's diagnosis.[8]

4.12 The Commonwealth government has made a commitment that no existing programme clients will be disadvantaged in the transition to the NDIS and will provide continuity of support to existing clients who are not eligible for the NDIS.[9]

4.13 The Department of Social Services made the following statement:

> The Commonwealth committed to provide continuity of support for any existing participants who do not meet the definitions of eligibility under the Act, including those aged over 65 years of age. In practice, the focus of PHaMs, Partners in Recovery and Day to Day Living providers is on providing service continuity until full scheme by supporting clients to access the NDIS, and until they have approved NDIS plans in place. Providers have funding for service continuity up until 30 June 2019, and the Departments of Social Services and Health and the National Disability Insurance Agency continue to work with providers who have clients that may require more support to engage with the NDIS. Formal continuity of support arrangements post full scheme are still to be determined, noting policy is expected to be finalised by the end of 2017.[10]

4.14 Many inquiry participants are concerned that the gap created in service provision by the transition of PIR, PHaMs, and D2DL programs into the NDIS is significant. Service providers find there is little information available as to how some people will access services once the funding transition is complete and believe funding will not be adequate or appropriately targeted to cover this emerging gap.[11]

4.15 Additionally, as discussed in chapter 2, to access continuity of support, program clients need to apply for the NDIS, regardless whether or not they are obviously ineligible for the NDIS. This may result in some existing clients losing supports and left without appropriate services.

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8 Anglicare Australia, *Submission 62*, p. 5.

9 Department of Social Services, *Transition of Commonwealth programs to the NDIS*, https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/national-disability-insurance-scheme/transition-of-commonwealth-programs-to-the-national-disability-insurance-scheme-ndis (accessed 18 July 2017).

10 Department of Social Services, answers to questions on notice, 16 June 2017 (received 30 June 2017).

11 See for example, One Door Mental Health, *Submission 74*, p.6; VICSERV, *Submission 65*, p.4.

Emerging service gaps

4.16 Inquiry participants explained that the role of PIR is much broader than individual care-coordination that may now be incorporated into an individual package under the NDIS. PIR is also about building community capacity by drawing together organisations and agencies to work innovatively together to both close gaps in traditional service delivery and referral pathways, as well as to wrap around particular individuals.[12]

4.17 As described by participants,[13] both PIR and PHaMs programs support recovery in mental illness and psychosocial disability using a wrap-around approach that facilitates coordination of care and an integrated approach to treatment and support.

4.18 According to Woden Community Services Inc., the transition of funded services to the NDIS such as PIR and PHaMs 'has left a huge hole in the service delivery continuum for people with illness. There are now fewer options for people and for service to refer to for support'.[14]

4.19 Similarly, Ms Marilyn Gale is concerned with emerging service gaps:

> PIR currently coordinates care for the most complex mental health clients, in the community. Who will support these clients in the future to ensure they have supports in place and to intervene early, to prevent relapse? Clinical services do not and will not have capacity to do this work and in fact, I believe the absence of PIR and other community mental health services will prove to a heavy burden on clinical services.[15]

4.20 As described by Mr Quinlan, the CEO of Mental Health Australia, PIR is also an active outreach program which actively engages and finds people who are hard to reach:

> Part of the great benefit of programs like Partners in Recovery,(…) was that it was actually a really active outreach program. It went to find people who might not otherwise be in contact with the system.[16]

4.21 Assertive outreach undertaken by PIR has enabled the identification of people eligible for the NDIS who were previously not engaging with service providers.[17] A major concern raised by participants is that once full transition to the NDIS occurs and PIR block funding disappears, the availability of appropriately skilled workers with

12 Mental Health Commission of NSW, *Submission 16,* p. 3.

13 See for example: Office of the Public Advocate (Queensland), *Submission 93,* p. 9; Woden Community Services Inc., *Submission 42,* p. 4; Grand Pacific Health, *Submission 55,* p. 1.

14 Woden Community Services Inc., *Submission 42,* p. 8.

15 Marilyn Gale, *Submission 59,* p. 1.

16 Mr Quinlan, CEO, Mental Health Australia, *Committee Hansard,* 28 April 2017, p. 5.

17 Mental Health Commission of NSW, *Submission 16,* p. 6.

sufficient time to undertake assertive outreach and engagement work will be virtually non-existent.[18]

4.22 Many service providers such as Aftercare are concerned that in some communities where there may not be sufficient eligible clients for the NDIS, service providers will not be in a position to continue operating. This will particularly impact regional, rural and remote communities.[19]

4.23 Cohealth argues that 'even for people eligible for the NDIS some important support services (e.g. groups) may no longer be available as agencies find that, under a market model, it is not financially viable to provide them'.[20]

Support to carers

4.24 ABS data estimates that 194 000 primary carers care for someone who with a psychosocial disability. This represents about a quarter of the primary carer population.

4.25 The MHR:CS program supports carers whose health and wellbeing, or other impediments, are negatively impacting their ability to provide care to people with mental illness. Support assists carers and their families to continue in their caring roles, improve their health and wellbeing and participate socially and economically in the community. MHR:CS has been identified as a service in scope for NDIS.[21]

4.26 Mind Australia and others are concerned that with half of the funding for MHR:CS in scope for NDIS, many people who are caring for someone outside of the NDIS will no longer be able to access the supports they need.[22]

4.27 Mental Health Australia noted that 'the NDIS does not fund respite',[23] and that 'the suite of supports for family and carers are not a direct match with the supports provided under the MHR:CS program'.[24]

4.28 There is also great uncertainty about how funding for carers under the NDIS will work. For carers of participants in the NDIS, they can be provided supports only if the participant agrees and this is determined as part of the planning process. As Ms Cresswell, the CEO of Carers Australia explains:

> We have heard different estimates of how many people will be eligible for NDIS packages, but we do know that their carers are not eligible for

18 New England Partners in Recovery, *Submission 111*, p. 7.

19 Dr Meyer, Director, Operations Support, Aftercare, *Committee Hansard*, 28 April 2017, p. 17.

20 Cohealth, *Submission 43*, p. 4.

21 Department of Social Services, *Mental Health Respite: Carer Support*, https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/mental-health-respite-carer-support (accessed 3 July 2017).

22 See for example: Mind Australia Limited, *Submission 118*, p.10; Carers Australia, *Submission 99*, p. 7.

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

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

> support. (…) There is not funding support for carers under the NDIS, so for those carers whose people have a package there will be some relief, some support, for their person. That is great, but they still need to access support in their own right. For those carers whose people are not funded under the NDIS it is a double whammy, as their people are losing their support and the carers are losing their support.[25]

4.29 In its submission, Carers Australia stated that MHR:CS funding 'will not only be lost to mental health carers of people who are eligible for NDIS packages, but also to those caring for someone who is not eligible for the NDIS'.[26]

4.30 Mental Health Australia noted that 'While work is being done by DSS on an 'Integrated Plan for Carer Support Services' and a 'Service Delivery Model',[27] carers are reporting that they are now not receiving supports that they previously had access to' and recommended:

> The Australian Government continues funding respite for carers of people with mental illness who do not enter the NDIS, and where existing supports for NDIS participants will not be funded by the NDIS.[28]

Primary Health Networks

4.31 Primary Health Networks (PHNs) were established in July 2015 with the aim to increase the efficiency and effectiveness of health services. PHNs replaced the previous Medicare Locals. One of the six key priorities for PHNS is mental health.[29]

4.32 As part of the mental health reforms, PHNs play a key role in the reform process through the planning and commissioning of primary health services at a regional level, supported by a flexible funding pool for mental health and suicide prevention services. However, PHNs do not have the ability to commission psychosocial support services.

4.33 At this stage, the role of PHNs in NDIS planning processes lacks clarity. The role of PHNs seems to be more about assessment as PHNs do not have a role in the planning process for individual NDIS plans.[30]

4.34 Inquiry participants reported that, to date, there has not been a lot of interface between PHNs and the NDIS.[31]However, with PHNs taking on a greater role in local implementation of national mental health reforms, the way in which PHNs will

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25 Ms Cresswell, CEO Carers Australia, *Committee Hansard*, 28 April 2017, p. 31.

26 Carers Australia, *Submission 99*, p. 7.

27 Mental Health Australia, *Submission 1*, p. 13.

28 Mental Health Australia, *Submission 1*, p. 4.

29 Australian Institute of Health and Welfare, *Primary Health Network (PHN) data*, http://www.aihw.gov.au/primary-health-care/phn/ (accessed 29 June 2017).

30 Mental Health Australia, *Submission 1*, p. 9.

31 MHCC, *Submission 27*, p. 9.

interface with social care providers and the NDIS will become important in addressing both individual and population wide mental health needs.[32]

4.35 Work by the NDIA and the NDIA Mental Health Sector Reference Group (NMHSRG) is underway to better understand the interface between PHNs and the NDIS.[33]

4.36 The NDIA is liaising closely with the Department of Health to develop working relationships with PHNs at a local, state/territory and national levels to understand the impact and opportunities that their planned regional commissioning of primary health and mental health services will have for access to services.[34]

4.37 Several participants suggested that PHNs could play a role in educating and supporting GPs in understanding the NDIS and how to meet the needs of patients who want to test their eligibility for, or are participants in, the Scheme.[35]

Transition to the NDIS of States and Territories funded services

4.38 Funding of the NDIS has involved bi-lateral agreements between individual state and territory governments and the Commonwealth Government. The inclusion of mental health program funding in those financing arrangements has not been uniform: in some states existing mental health funding has been added to a state's contribution to the NDIS; in others it has not.

4.39 Mental Health Australia and other organisations raised questions about how continuity of services will be guaranteed and monitored and ultimately, who will be responsible for ensuring that community support system exists for those who do not qualify for the NDIS:

> The concern is about what happens to the services transferred into the NDIS, which currently provides services for clients out of scope for the NDIS. How will the continuity of service guarantee be monitored and which jurisdiction is responsible for rectifying poor outcomes? Who is responsible for ensuring that a community support system exists for those who do not qualify for the NDIS? ILC may address these questions but it is unclear at present how the ILC will do it. There are also concerns that the ILC does not have capacity to adequately fund services within its current limited budget.[36]

32 MHCC, *Submission 27*, Attachment 3, p. 7.

33 NDIS, *NMHSRCG Communique*, October 2016, https://www.ndis.gov.au/NMHSRG-October-2016.html (accessed 29 June 2017).

34 NDIA, *Submission 102*, p. 7.

35 See for example: Mental Health community coalition ACT, *Submission 82*, p. 16. Flourish, *Submission 117*, p. 11.

36 Mental Health Australia, *Submission 1*, p. 8.

Emerging service gaps

4.40 Inquiry participants identified a risk of service gaps because of the uncertain future of state and territory programs. There is a risk that highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. For example, the Mental Health Coalition ACT reported:

> One of the consequences of the transition of ACT Government funded community managed mental health services to the NDIS has been the loss of group-based programs and drop-in style social participation supports. These services were not viable within the NDIS framework.[37]

4.41 In South Australia, Supported Residential Facilities (SRF's) provide unique, specialised accommodation, supervised care, medication prompting and administration which the NDIS care models do not cater for. SRF's are currently outside the NDIS arrangements for accommodation and support. It is likely that people in SRF's are not going to fit into the expectations and environments provided by small group homes as outlined in the NDIS. The Central Adelaide Hills Partners in Recovery reported that a loss of SRF's will potentially expose 1100 people to homelessness in the very short term.[38]

4.42 Tandem reported that state funded organisations have been unable to provide the same breadth, quantity and quality of services that they offered previously because of funding uncertainties and the pricing structures.[39]

4.43 The other risk commonly cited by participants is the closure of some services or decrease of quality of services due to the NDIS pricing framework.[40] For example, CMHA reported:

> A key tension arising relates to the financial viability of the pricing of services and supports under the NDIS. Although NDIS pricing does not officially set mental health sector workers' wages; NDIS pricing does have an extremely significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders argued that the pricing is not sufficient to purchase a suitably skilled workforce that engages in complex 'cognitive behavioural interventions' as well as direct personal care.[41]

37 Mental Health Community Coalition ACT, *Submission 82*, p. 11.

38 Central Adelaide Hills Partners in Recovery, *Submission 30*, p. 5.

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

40 See for example: Mental Health Community Coalition ACT, *Submission 82*, Attachment 3 p. 5; QAMH, *Submission 23*, p. 7.

41 CMHA, *Submission 27*, Attachment 1, p. 1.

Rural and remote challenges

4.44 The other issue often raised is the lack of services in rural and remote areas and how this may impact access to the NDIS and support services, especially given the change to a market-based system.[42]

4.45 Access to mental health services is an ongoing challenge for people living in regional, rural and remote areas due to a lack of or limited services available. This is particularly the case in remote Aboriginal and Torres Strait Islander communities.

4.46 The Benevolent Society outlined some of the issues pertaining to access to services in remote areas:

> Access to services under the NDIS for people living in remote and regional areas continues to be an issue. In these early stages of the NDIS, the market has not yet grown to meet the emerging needs of the sector, so in many isolated areas there are few if any providers of the mental health services people need. Service providers may need to travel large distances to meet the needs of all clients. Currently, the arrangements to compensate providers who need to travel large distances to consumers are inadequate.[43]

4.47 Members of the NT Mental Health Coalition reported that the NDIS is posing significant strain on small to medium services that do not have resources to redevelop organisational systems and structures to operate sustainably within a market-based service economy. There is a concern that this will result in organisation closures and lead to a market of larger, one-size-fits-all service organisations, reducing quality of services and limiting choice for consumers—especially those living in very remote communities.

4.48 The Bilateral Agreement between the Commonwealth and Northern Territory states that the NDIA is responsible for ensuring provider of last resort services are in place for all participants in the NT, where other services are not operational.[44] However, there is a lack of detailed information around what 'provider of last resort' options might look like in practice. This is causing angst throughout the NT mental health sector.[45]

4.49 The NDIA acknowledges the challenges to address the service gaps that exist for rural and remote communities as well as the emerging issues in relation to 'price caps'. The NDIA has developed a rural and remote strategy,[46] and says it is working

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42 See for example: CMHA, *Submission 75,* p. 23; National Disability Services (NDS), *Submission 80,* p. 4.

43 The Benevolent Society, *Submission 106,* p. 5.

44 *Bilateral Agreement between the Commonwealth and Northern Territory for the transition to an NDIS,* Schedule K, 5 May 2016.

45 NT Mental Health Coalition, *Submission 71,* p. 6.

46 NDIA Rural and Remote Strategy 2016–2019, February 2016, p. 3. https://www.ndis.gov.au/medias/documents/h2c/hb0/8800389824542/Rural-and-Remote-Strategy-991-KB-PDF-.pdf (accessed 18 July 2017).

with state governments to find more innovative ways to deliver services and grow the capacity for localised delivery of services.[47]

4.50 Solutions put forward include the establishment of an NDIS Community of Practice for rural areas to encourage information sharing and assist communities to learn from one another about successes in delivering NDIS in their communities.[48]

4.51 Aboriginal Community Controlled Health Services (ACCHS) could have a role in building capacity in the disability area in rural and remote locations. The RANZCP recommends appropriate funding and resourcing to be allocated to ACCHS to undertake this role.[49]

Scope and level of funding for mental health services under the Information Linkages and Capacity Building (ILC) framework

4.52 The NDIS website provides the following information about the ILC:

> The focus of ILC will be community inclusion—making sure people with disability are connected into their communities. ILC is all about making sure our community becomes more accessible and inclusive of people with disability. We want to do this in two ways:
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> 1. Personal capacity building—this is about making sure people with disability and their families have the skills, resources and confidence they need to participate in the community or access the same kind of opportunities or services as other people.
>
> 2. Community capacity building—this is about making sure mainstream services or community organisations become more inclusive of people with disability.
>
> Unlike the rest of the NDIS, ILC won't provide funding to individuals. We will provide grants to organisations to carry out activities in the community. Many of the activities that we will fund in ILC will be open to both people with disability and families. Through ILC we will also support people who have an NDIS plan as well as those who do not.[50]

4.53 The vast majority of ILC funding is allocated to Local Area Coordination.[51] As described in the ILC Commissioning framework, LACs play a central role in the delivery of ILC:

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47 Ms Gunn, Acting Deputy Chief Executive Officer, Participants and Planning, NDIA, *Committee Hansard,* 16 June 2017, p. 18.

48 Beyondblue, *Submission 34,* p. 9.

49 RANZCP, *Submission 18,* p. 6.

50 Australian Government, NDIS, https://www.ndis.gov.au/ILC-FAQ-People-with-Disability.html (accessed 4 July 2017).

51 NDIS, *Working together – Local Area Coordination and Information, Linkages and Capacity Building* p. 1. https://www.ndis.gov.au/communities/local-area-coordination.html (accessed 18 July 2017).

- they work directly with people who have an NDIS plan by connecting them to mainstream services, community activities and putting their plans into action;
- they provide some short-term assistance to non-NDIS participants and connect them to mainstream services and community activities; and
- they work with the local community to ensure it is more accessible and inclusive for people with disability.[52]

Level of funding

4.54 Most inquiry participants support the goals of ILC. However, there are widespread concerns that the allocated funding is insufficient to fill the gap for people with a mental condition and their carers who are ineligible for NDIS plans. In practice, the question is how ILC can adequately fund psychosocial services within a limited budget, which has been allocated to fund multiple types of services to be accessed by people with all disability types?[53] Overall, participants feel that the ILC is not yet filling the gaps in services created by NDIS transition, and is unlikely to do so without substantial additional investment.[54]

4.55 The short-term competitive grant mechanism being used to fund ILC activities is a cause of concerns. It provides no certainty of continuity of services and may result in some programs not being consistently offered across time and regions. For example, the Victorian Council of Social Service (VCOSS) noted that the nature of ILC grant-based funding, means coverage of programs across Victoria and Australia overall may be inconsistently offered and time-limited.[55]

4.56 Flourish Australia and other participants argue that the level of funding for the ILC program, and the short-term nature of the grants to be provided, should be revisited, given its important and ambitious aims.[56]

4.57 To ensure that provision of mental health services is adequately provided through ILC, the Office of the Public Advocate (QLD) and other organisations recommends that a proportion of ILC funding is quarantined specifically for the provision of mental health ILC services.[57]

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52 NDIS, *Information, Linkages and Capacity Building Commissioning Framework*, November 2016, p. 12.

53 $33 million in 2016–17 growing to $132 million by 2019–20, Mental Health Australia, *Submission 1,* p. 8.

54 See for example: Sunshine Coast and Gympie - Partners in Recovery, *Submission 36,* p. 5; VCOSS, *Submission 50,* p. 17; Mental Illness Fellowship of Australia, *Submission 70,* p. 12.

55 VCOSS, *Submission 50,* p. 17.

56 Flourish Australia, *Submission 117,* p. 10.

57 Office of the Public Advocate (QLD), *Submission 93,* p. 8.

Emerging gaps

4.58 Assertive outreach services are not included in the ILC Commissioning Framework or the Community Inclusion and Capacity Development Program Guidelines.

4.59 Assertive outreach services can only be delivered through the LAC function. However, with the pressure of the rollout, it appears that LACs are focusing on the transition of clients to the NDIS rather than undertaking assertive outreach activities and community development work.[58]

4.60 The issue of support for family and carers was also raised. Service providers such as Tandem argue that the ILC framework does not have the resources, scope or capacity to deliver the services required to adequately support families and carers.[59]

Committee view

Service landscape

4.61 The committee is concerned that for people living with a psychosocial disability the service landscape remains complex and fragmented as services cross both sectors and jurisdictions. Clearly there is a complex intersect between psychosocial disability services and the mental health sector. At present, consumers, their families, carers and service providers, face confusion and uncertainty about what psychosocial support programs will be available to people outside the NDIS, especially once the transition period has ended.

4.62 The committee has identified the need for a national audit and mapping of all Australian, state and territory services and associated funding available for mental health, to ensure existing and emerging service gaps are detected and addressed accordingly. Additionally, consideration should be made for the National Mental Health Commission to have an ongoing monitoring role of all Australian, state and territory mental health programs, including those delivered through primary healthcare sector.

4.63 The recent budget announcement of $80 million over four years to provide mental health services for people outside the NDIS,[60] is likely to alleviate some of the concerns around availability and access to services in the short term. Notwithstanding, the commitment of continuity of support by governments and recent budget announcements does not appear to provide a mechanism to guarantee that funding for mental health services is maintained and these services will continue to be delivered.

4.64 The committee acknowledges the particular role that carers and families have in the support of people with psychosocial disabilities. The Committee supports the view that there is a need for greater clarity around the continuity of support for carers under the NDIS. As the NDIS does not include direct provision of respite support for

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58 MHCC, *Submission 27*, p. 7.

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

60 This is contingent on states and territories contributing a similar amount.

carers, the provision of support for carers appears to only be available if it is included in the participant's plan. Whilst the Committee acknowledges that elements of the MHR:CS fall within the ILC scope, it is not yet clear how some supports, such as recreational respite activities, will be funded and supported. It is too early to assess how this is affecting carers but there is already anecdotal evidence suggesting that some carers will no longer access the level of support they require and had been provided with through the MHR:CS program.

4.65 At systems levels, there is a lack of clarity on how LACs, PHNs and LHNs will ensure people with a psychosocial disability will access NDIS and/or other services. With PHNs not able to commission psychosocial services this may also create a gap in meeting the support needs of some communities, especially in regional, rural and remote areas. The Australian, state and territory governments should urgently clarify and make public how they intend to provide services and funding for ensuring continuity of support and services for people with a psychosocial disability beyond the supports provided through the NDIS. Finally, the NDIA should provide details about the arrangements it has put in place for ensuring a provider of last resort services is available for all NDIS participants unable to find a suitable service provider.

ILC

4.66 The ILC is a key component of the NDIS, especially during the transition period when it is critical to have structures in place to ensure people with a psychosocial disability are adequately connected with the appropriate services. To some extent, the ILC has been branded as the answer to ensuring continuity of support for those who will be ineligible for NDIS services. The ILC is still in its infancy and the outcomes it will be able to achieve are still unknown and untested at this stage. However, it seems that the level of funding that has been allocated may not match the needs of the community. Additionally, with the current focus of LACs on facilitating the access process to the NDIS and supporting NDIS participants to locate supports, it is unclear to what extent LACs have the capacity to support individuals with a mental health condition who are not eligible for the NDIS. Furthermore, it is unclear how LACs will engage in active outreach to engage hard-to-reach individuals. The Committee is also concerned with widespread reports of LACs lacking skills and expertise in the area of psychosocial disability and mental health care.

Recommendation 13

4.67 The committee recommend the Australian, state and territory governments clarify and make public how they will provide services for people with a psychosocial disability who are not participants in the NDIS.

Recommendation 14

4.68 The committee recommends the Council of Australian Governments (COAG) conduct an audit of all Australian, state and territory services, programs and associated funding available for mental health.

Recommendation 15

4.69 The committee recommends the National Mental Health Commission be appointed in an oversight role to monitor and report on all Australian, state and territory mental health programs and associated funding, including those delivered through the primary healthcare sector.

Recommendation 16

4.70 The committee recommends the Department of Social Services and the NDIA develop an approach to ensure continuity of support is provided for carers of people with a psychosocial disability, both within and outside the NDIS.

Recommendation 17

4.71 The committee recommends the NDIA in collaboration with the Australian, state and territory governments develops a strategy to address the service gaps that exist for rural and remote communities.

Recommendation 18

4.72 The committee recommends the NDIA provides details how it is ensuring a provider of last resort is available for all NDIS participants unable to find a suitable service provider, regardless of their location, circumstances and types of approved supports.

Recommendation 19

4.73 The committee recommends the NDIA monitors the psychosocial disability supports, activities and services that are awarded funding through the ILC grant process to be able to identify and address any emerging service gaps as they may arise.

Recommendation 20

4.74 The committee recommends the NDIA undertakes a review of the effectiveness to date of the ILC program in improving outcomes for people with a psychosocial disability.

Recommendation 21

4.75 The committee recommends NDIA considers allocating specific funding for the provision of mental health services through the ILC.