cohealth ltd
ABN 57 167 212 302

27th January 2017

cohealth
365 Hoddle Street
Collingwood, Vic. 3066

Committee Secretary
Joint Standing Committee on the National Disability Insurance Scheme
PO Box 6100
Parliament House
Canberra ACT 2600

By email: ndis.sen@aph.gov.au

Dear Committee Secretary

cohealth welcomes the opportunity to make the following submission to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.

In addition, cohealth would welcome the opportunity to provide verbal evidence to the Inquiry, if hearings are held. We anticipate that users of cohealth mental health services will also be willing to provide their insights to the Committee.

Please do not hesitate to contact us should you require further information or assistance in your inquiry

Yours sincerely

Lyn Morgain

Chief Executive

cohealth ltd

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about cohealth

cohealth is Australia's largest not-for-profit community health service, operating across 14 local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from many mainstream health and other services. This includes people who are experiencing or at risk of homelessness, people who live with serious mental illness, vulnerable families, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs, recently released prisoners and LGBTIQ communities. Our services to people experiencing mental health issues currently include individual support, outreach services, mentoring, residential programs, homeless outreach, and complex care coordination.

cohealth also recognises that health is affected by many factors including social inclusion and participation, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community to design our services, and deliver advocacy, health promotion and education activities to improve health and connectedness.

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executive summary

cohealth welcomes the opportunity to provide a submission to the Joint Standing Committee on the National Disability Insurance Scheme inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. cohealth provides a range of services for people with these conditions, from residential accommodation to community outreach and mentoring to interagency planning coordination. Our work is based on a recovery framework and strength based approach, and as such we welcome the fundamental NDIS philosophy of client choice and control. We also acknowledge the potential opportunities for NDIS participants to identify and structure their supports in the ways that best suit them.

Nonetheless, our depth of experience working with people with mental health issues leads us to have concerns about the ability of the NDIS, as it currently stands, to provide adequate, timely support to consumers with psychosocial disability. We also have serious concerns about the loss of support to those ineligible for, or unable to access, the NDIS. Victoria is unique among the states in having transferred all funding for community mental health services to the NDIS. We therefore have serious concerns that there will be a significant loss in community based services and support for those ineligible for NDIS.

cohealth consumers in the North East Melbourne area are currently transitioning to the NDIS, and our comments in this submission reflect their experiences, along with those of workers and the service system involved.

Our **key concerns** are summarised here, and elaborated in response to each of the terms of reference, following.

- Reduced access to community mental health services and support for people experiencing mental illness.
    i. Some people currently receiving community mental health support services may no longer be eligible for supports under the NDIS. Not everyone who experiences a mental illness, and would benefit from supports, will be eligible for the NDIS. Indeed, estimates are that 400,000 such people nationally will not be eligible (compared to the estimated 60,000 eligible)[1]. In Victoria, where all current community mental health funding is being transferred to NDIS this is a particular concern.

       In addition, NDIS eligibility criteria specifically excludes those who are not permanent residents or citizens and people over the age of 65.

[1] Mental Health Australia 2016 http://www.vicserv.org.au/images/Joint_letter_regarding_PC_Review_of_the_NDIS_Mental_Health_Australia_and.pdf accessed 16/2/2017

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ii. Others, while eligible, may experience barriers to accessing support through the NDIS. Services are expected to have reduced capacity to provide outreach to consumers. Some of the most vulnerable and isolated groups in society, including refugees, people experiencing homelessness, young people, and forensic clients are likely to have reduced access to support.

In addition to the detrimental impact on their health, wellbeing and social inclusion, there is a real chance of greater pressure on other related services, including the acute health and mental health systems, alcohol and other drug services, justice, along with greater pressure on family and other informal carers.

iii. The language of permanent disability, and the requirement for a formal diagnosis, is already discouraging some consumers to identify with the NDIS and acts as a barrier to accessing services. This language is the antithesis of the recovery approach used widely in working with people with mental health issues.

- People with psychosocial disability have needs that require a different response to those with other disabilities, and we have concerns that the current NDIS pricing structure will not be sufficient for effective service responses. cohealth is already hearing of aspects of the planning process that work against effective engagement and service planning. For example, trying to contacting consumers via phone, and limiting the number of attempts; and plans not always accurately identifying the supports a consumer requires, particularly if there is no advocate or support person involved in the planning process.

- Reduction in the broad range of community mental services available in Victoria, particularly to people ineligible for the NDIS. The future of a range of 'lower level' supports that provide early intervention, assist to keep people engaged in community – a key aim of the NDIS - and keep people out of the acute system, is currently uncertain. Even for people eligible for the NDIS some important supportive services (eg groups) may no longer be available as agencies find that, under a market model, it is not financially viable to provide them.

- The NDIS pricing structure jeopardises the qualified and skilled supports currently provided to people experiencing mental illness. Most activities will be funded at a rate too low to maintain the knowledgeable workforce, or to be financially viable for services to provide. As a result therapeutic case management built on a trusting, ongoing relationship – a role very different to disability support or care coordination - will be harder to provide. Existing workers in these roles not only support consumers to access, engage in and benefit from generalist supports and inclusion activities, but also intervene to support consumers to avoid crises.

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The risks of reduced services to people with mental illness, their families and the community are real and significant. The potential unintended consequences of the change to the overall mental health support system – decline in wellbeing, greater responsibility placed on families and informal supports, and pressure on the acute mental health, health, alcohol and other drugs and justice systems - run counter to the aims of the NDIS.

key recommendations:

cohealth recommends that the NDIS, and the funding structure for community mental health services, be adapted in a number of ways to better reflect the particular needs of people with psychosocial disabilities, and provide more effective services to more people:

A. The Commonwealth and state governments commit sufficient funding to ensure that all people in need of mental health services, regardless of NDIS eligibility, will continue to be provided with high quality services and supports.

B. Ensure that community mental health services are provided to those who fall outside the eligibility criteria (refugees and asylum seekers; people from New Zealand); and those who are less likely to access services.

C. Adapt NDIS terminology for people with a mental health condition to better reflect the recovery approach, to facilitate their access to, engagement with, and use of, the NDIS.

D. Ensure the planning process meets the specific and specialised needs of people with psychosocial disability, for example by requiring planners to have knowledge of mental illness and appropriate supports; providing advocacy and support during the planning process; and ensuring that plans can respond quickly to the episodic nature of mental health conditions.

E. Adequately resource the components of the system that ensure it is responsive and takes an holistic approach, including consumer involvement; peer supports and programs; and supports for carers and families.

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The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition, with particular reference to:

a. Eligibility

NDIS eligibility criteria specifically excludes some current consumers of mental health services. Others are alienated from accessing NDIS services by the language and processes involved.

Eligibility criteria require that a person has "an impairment or condition that is likely to be permanent (lifelong) and that stops you from doing everyday things by yourself."[2] This, coupled with the scheme references to 'disability', runs counter to the language of recovery, and strength based approaches, developed over many years by consumers and providers of mental health services. As a member of our consumer advisory committee stated it's the "hope of the recovery model versus [the NDIS] permanent, enduring … there's no encouragement for hope [in NDIS]"

cohealth is aware of consumers who feel alienated by this language: some reject the 'disability' label, while others do not identify as impaired (or disabled) at the time they are contacted by the NDIS (eg due to the episodic nature of their condition). They are therefore unable to benefit from NDIS supports.

For other consumers the 'permanent impairment' criteria is a barrier. cohealth has heard of doctors unwilling to state that a consumer's condition is 'permanent', despite the consumer having a significant mental illness. Importantly, it is widely acknowledged that it is damaging to impose such a label on young people experiencing first onset of mental illness.

Current consumers of PHaMs (Personal Helpers and Mentors) programs do not have to meet the same eligibility requirements as those of MHCSS (Mental Health Community Support Service) eg a formal diagnosis is not needed. While existing consumers have been assured of continuity of services, it is unclear how this will occur. Concerns remain as to how those not already in receipt of these services will be able to obtain support in the future.

Eligibility criteria related to residence and age will also preclude other consumers of mental health services from accessing NDIS. cohealth is currently able to provide services to refugees and asylum seekers, and people from New Zealand. Once Victorian community mental health funding transfers to the NDIS these people will be unable to access services. Refugees and asylum seekers are a particularly vulnerable and disadvantaged group and reduction of supports could have a significant impact on their wellbeing. While the state Department of Health and Human Services has indicated that these consumers

[2] https://www.ndis.gov.au/ndis-access-checklist accessed 8/2/17

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will be able to have 'continuity of supports', and some of the support functions may be met with the Information, Linkages and Capacity building framework, questions remain as to the adequacy of these measures. Whether they will receive the same level of support is not clear. The support available for people who develop mental illness in the future, but fall outside NDIS guidelines, is of grave concern.

Finally, the staggered roll out of the NDIS will result in unequal treatment of people of the same age, with the same needs, but who live in different locations. Those who turn 65 prior to the date NDIS is rolled out in their area will not be eligible, even though they would have been eligible had they lived in an area where NDIS was introduced earlier.

As mentioned, these barriers are of particular concern for Victorian consumers and their supports. The transfer of community mental health funding to the NDIS will create a significant service gap for consumers ineligible for NDIS.

Recommendations:

1. Revise NDIS terminology to more closely align to the recovery approach. This should be done in close consultation with consumers, carers and existing support services.
2. The Commonwealth and state governments commit sufficient funding to ensure that all people in need of mental health services, regardless of NDIS eligibility (eg refugees, those not meeting the 'permanent disability' requirement, people from New Zealand), will continue to be provided with high quality services and supports.
3. Assess age eligibility at the time the NDIS commenced, not when the NDIS rolls out in a particular area.

b. & c. Transition of Commonwealth and state government funded services to the NDIS

The transition to the NDIS of Commonwealth and Victorian government short and long term mental health services will result in significant services gaps for people ineligible for the NDIS. For example, cohealth estimates that 40%, of current PHaMS and D2DL (Day to Day Living in the Community) clients will not be eligible for the NDIS. In Victoria, unlike other states, all state funded Mental Health Community Support Services funding will be rolled into the NDIS, along with Commonwealth Government funded services. cohealth holds grave concerns that there will be a significant loss of capacity in the Victorian community mental health sector, and supports, for people ineligible for the NDIS.

In addition, programs that provide 'lower level' support, that assist consumers remain healthy and functioning, are expected to no longer be available.

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Group programs, peer support programs and carer supports – all important contributors to recovery, and valuable to many consumers and their families - may not be financially viable or practical to run under the new funding arrangements.

At the same time, the NDIS pricing structure is likely to drive down the quality of services provided, as providers find that it is not financially viable to provide the specialised psychosocial support needed for people experiencing mental illness (see discussion on pricing structure at 'i. Any related matter', below).

Disadvantaged groups such as refugees, CALD communities, people experiencing homelessness, Aboriginal and Torres Strait Islander groups and those with complex support needs are particularly likely to be vulnerable to reductions in the amount and quality of services, and at serious risk of 'falling through the cracks'. In addition, some consumers eligible for NDIS, but unwilling or unable to join the scheme will be left without supports.

'Assertive' outreach will be required to identify, engage with and support people with complex support needs to transition to NDIS. While LACs are responsible for contacting potential participants they are currently doing this via phone calls. However, due to the nature of some psychosocial disabilities, relying on phone calls can make engagement difficult. cohealth is aware of consumers confused by the reason for these phone contacts, and so ignoring them. Others may not have credit to return calls, or have changed phone numbers. The capacity to undertake assertive outreach is essential to reach and engage with these consumers. cohealth has grave concerns that some of the groups most in need of support will be not be engaged with the NDIS without this capacity.

The National Institute of Labour Studies 2016 *Evaluation of the NDIS Intermediate Report* confirms these experiences:

> "Services considered underfunded were one-to-one community participation, mental health services, group services and services for people with complex needs. Rather than ceasing to provide particular services, providers continued to absorb financial losses but were closely monitoring their financial sustainability. Several providers anticipated their organisation would need to cease particular services when block funding ended. Funding for travel continued to be a concern at wave 2" [3]

Psychosocial support services are critical in enabling people to access and use other community and government services and supports. For people with mental illness, this can require long term, therapeutic support from a consistent and trusted worker. The loss of this support for those ineligible for NDIS will

[3] Mavromaras, K, Moskos, M, Mahuteau, S (2016) Evaluation of the NDIS Intermediate Report, National Institute of Labour Studies, Flinders University p 53

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impact on their ability to access a range of other supports, services and entitlements. Even those people eligible for the NDIS may lose the consistent support from the same worker due to the limitations of the pricing structure (see discussion on pricing structure at 'i. Any related matter', below).

The reduction of these services will clearly have an impact on individual consumers, with a real risk of a detrimental impact on their health and wellbeing, and increased pressure on acute services.

Recommendations:

4. Federal and state governments commit sufficient funding to ensure specialist community mental health service are maintained outside the NDIS to meet the mental health needs of those ineligible for, or unwilling to join, the NDIS.
5. Increase resourcing to LACs to engage in active outreach to engage harder to reach groups.

d. Information, Linkages and Capacity building framework

cohealth is concerned that insufficient funding has been allocated to the Information, Linkages and Capacity Building (ILC) program to effectively meet the aims of this framework, or to meet the support needs of consumers ineligible for funded packages. Of the $682m allocated annually to ILC (at full roll out), $550m is allocated to Local Area Coordination (LAC), leaving $132m nationally for other ILC work. The first funding round is for $13m, a limited pool for national programs. cohealth understands that the focus will be on providing modest grants to develop small scale, replicable projects to assist consumers to access services, or to build the capacity of mainstream services. While these projects are important, there will be diminished scope for services to provide effective, targeted activities for particular communities or meet the needs of consumers who require 'lower level', yet still ongoing, specialized support.

Consumers without personal supports or advocates benefit from having a support work to assist them access services. Individual advocacy (or other activities that replicate LAC work) is, however, out of scope of the ILC framework, leaving some of the most marginalised and vulnerable consumers with reduced access to supports.

Recommendations:

6. Broaden ILC grants guidelines to allow for targeted projects aimed at specific communities, particularly those most vulnerable and in need to specialised responses eg CALD, Aboriginal and Torres Strait Islanders communities and people experiencing homelessness.
7. Increase funding to the ILC framework to ensure it is able to effectively meet its functions.

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e. Planning process and the role of primary health networks

There are two key aspects of planning for people with psychosocial disability: i) the system wide processes used to identify service gaps, respond to developing areas of need and develop innovative programs; and ii) the planning process for individual consumers.

i) In relation to system wide planning, there is uncertainty as to where this role will sit, and how it will be funded. Catchment Based Planning in Victoria plays a key role in bringing a range of agencies together and identifying and responding to service gaps. Primary Health Networks have the potential to play a central role in this work, and in identifying responses for people not eligible for NDIS and/or those less likely to access NDIS, but their current role in this is unclear. How the NDIS will relate to other jurisdiction planning mechanisms (eg Catchment Based Planning, Primary Care Partnerships) is important to consider, particularly given the emphasis on accessing mainstream services. It is critical that this system wide planning, coordination and collaboration, and the ability to respond to local needs, is maintained and adequately resourced.

ii) The individual planning process is critical in ensuring that the supports a participant receives are appropriate to their circumstances and respond to their individual needs. To date, the experience of our consumers has highlighted the limitations of the current approach. cohealth shares the concerns of the National Institute of Labour Studies 2016 *Evaluation of the NDIS Intermediate Report*:

"… qualitative reports indicate that some people with disability were experiencing poorer outcomes under the NDIS and were receiving a lower level of services than previously. These were particularly people with disability who were unable to effectively advocate for services on their own behalf, including some people with psychosocial disability and/or those people who struggled to manage the new and sometimes complex NDIS processes"[4]

We have heard from cohealth consumers of a number of areas where improvements could be made:

- Support for consumers to prepare for planning would assist them to be develop the most appropriate plan – to be able to articulate the nature of their condition, their support needs, and to be informed of the types of supports they can include in their plan. Consumers have emphasised the importance of this being done face to face (rather than over the phone), and that there be capacity for multiple meetings if required.

[4] Ibid pxi

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- At planning meetings it is important that planners have a sound understanding of psychosocial disability, the types of supports and services available, and, critically, an awareness of the episodic nature of these conditions. An effective plan needs to anticipate the supports a consumer may need when they are most unwell – even if the person is not in need of such services at the time of developing the plan. In addition, if a consumer is unwell at the time of planning their insight into their needs may be constrained, along with their ability to articulate in detail the support they need. This is quite different to those with other disabilities. For example, a consumer may state they need assistance with shopping. For someone with a psychosocial disability this may mean more than physical assistance. It may involve assistance with planning meals, dealing with anxiety about leaving the house, budgeting, etc. Planners need to have the skill to ask appropriate questions, with sensitivity and utilising a strength based approach.
- Face to face planning meetings are essential to ensure proper consideration of complex consumer needs.
- cohealth has observed the importance of a consumer having a support person, or advocate, who knows them and their needs well, accompany them to planning meetings. For example, two consumers of cohealth support services, with very similar conditions and circumstances received very different plans. The main difference appeared to be that one had an advocate/support accompany them to the planning meeting. This consumer had a plan developed that was more comprehensive and provide for more effective and appropriate supports.
- Changing plans is expected to be a lengthy process due to the pressures currently on the system. However, to provide effective support if a person's condition changes plans must either be able to be altered quickly to respond to these needs; or have flexibility built into them from the outset.
- Plans need to recognise the relationship between the support worker and the person with a psychosocial disability is of critical importance[5] in recovery, and also allows for ongoing oversight of a person's condition. There is concern that the current pricing structure will prevent services from being able to provide worker consistency and skill (see discussion on pricing structure at 'i. Any related matter', below). .

Recommendations:

8. Provide greater support and advocacy for consumers for pre-planning and at planning meetings. This could be done through expansion of the LAC role, or of ensuring continued block funding to services that currently support the most vulnerable consumers.

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5 http://www.mhpod.gov.au/assets/sample_topics/combined/Building_the_Therapeutic_Relationship/index_html.html#item2 retrieved 16/2/2017

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9. Require planners to have a sound knowledge of mental illness and associated psychosocial disability and related supports. Alternatively consideration should be given to having specialised planners for people with psychosocial disability.
10. Incorporate flexibility into plans to respond to the episodic nature of mental health conditions; and/or improve the ease of adjusting plans to respond to changes in condition.
11. Extend the care coordination role to extend beyond 12 months, and ideally, not be time limited.

f. Whether spending on services is in line with projections

cohealth anticipates that, due to a number of factors, spending will not be sufficient to meet the needs of people with a psychosocial disability.

There is widespread concern that the numbers eligible for NDIS have been underestimated[6]. It is also expected that many people needing psychosocial support will not meet eligibility criteria, and so not receive services. Estimates are that approximately 60,000 people with mental illness will be eligible for the NDIS, but that over 400,000 more would benefit from access to supports[7]. This is of particular concern in Victoria, where all current community mental health funding is being transferred to the NDIS. Community based supports will be severely limited for those not eligible for the NDIS. Finally, the pricing structure is too low to provide the skilled and specialised workforce, which can provide consistent psychosocial recovery support.

We urge that ongoing monitoring of projected and actual numbers occurs, and that funding be made available to meet any shortfall. A particular concern is that funding is expended prior to NDIS being rolled out in all areas, with the risk that consumers in these locations being unable to fully benefit from its introduction.

Recommendations:

12. Guarantee that adequate funding is available for all areas, regardless of when NDIS rollout occurs.
13. Review the price structure to ensure that support for people with psychosocial disability is funded at a rate commensurate with the skills, expertise and continuity required for effective support.
14. The Commonwealth and state governments commit sufficient funding to ensure that all people in need of mental health services, regardless

[6] Williams, P & Smith, G "Can the National Disability Insurance Scheme work for mental health?" *Australian & New Zealand Journal of Psychiatry* 2014, Vol. 48(5) 391–394

[7] Mental Health Australia 2016 http://www.vicserv.org.au/images/Joint_letter_regarding_PC_Review_of_the_NDIS_Mental_Health_Australia_and.pdf accessed 16/2/2017

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of NDIS eligibility, will continue to be provided with high quality services and supports.

g. Role of outreach services to identify potential NDIS participants

cohealth experience has demonstrated the critical role of outreach support services in engaging consumers with the NDIS. Consumers without supports involved have reported being confused and concerned when contacted by the NDIS (at times, to the point of declining involvement). With a framework based on individual choice and control, consumers who don't have knowledge of the NDIS, the ability to advocate for themselves or connections with support services (eg people who are homeless or socially isolated) may miss out on the benefits of the NDIS. It is critical that existing services and supports continue to be funded to ensure supports are provided to the most vulnerable groups.

However, with funding for mental health outreach services in Victoria being rolled into the NDIS, the ability of services to continue this role is uncertain. It is also anticipated that the capacity for outreach will be significantly diminished due to the NDIS pricing structure. The most marginalised and vulnerable groups (eg homeless, CALD communities, young people, Aboriginal and Torres Strait Islanders), and those who are particularly unwell, often need assertive and active outreach to engage. This may require multiple visits to consumers, two workers for safety, the flexibility to respond to consumers outside planned appointments, and skilled, specialised workers. The additional resources required for this work are not currently available under NDIS, limiting the ability to identify and engage potential NDIS participants. We anticipate the repercussions to include pressure on the acute health and mental health systems, clinical services and the forensic system.

Recommendations:

15. Maintain block funding for community mental health services to meet the needs of the most vulnerable consumers.
16. Ensure that funding reflects the particular needs of engaging this group, for example, by allowing payment for multiple visits to a potential NDIS participant to support engagement and effective planning.
17. Extend the scope and resources of LAC to include assertive outreach to facilitate engagement.

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h. Provision and continuation of services for NDIS participants in receipt of forensic disability services

The NDIS is currently unable to fund services to continue, or commence, supporting someone during a period of incarceration. cohealth is concerned that this will have an impact on their successful transition back into the community on release, or indeed affect their ability to obtain release. For example, people in Thomas Embling Hospital (TEH) – Victoria's secure forensic mental health hospital - need to demonstrate their links to community services prior to being eligible for release, and currently receive support from these services for a period prior to their release to enable this. If not eligible for NDIS, people will potentially be unable to demonstrate the required links to community services, nor be able to develop the relationships with community based services so important on release.

Once released, it is important that NDIS plans are able to be adapted quickly if the needs are different to those prior to incarceration. In planning for release, correctional staff may also recommend that follow up visits in the community are undertaken by two workers, for safety reasons. The current pricing structure doesn't allow for this, and may result in either in risks to worker safety, or of services not accepting these clients.

The risks of reducing the services and supports available to this group of people are significant.

Recommendations:

18. Extend entitlement to continuation of support while incarcerated, to ensure that links with support services and the relationship with a worker is maintained.
19. Ensure plans can be revised quickly; or have sufficient flexibility incorporated to respond to changed needs.
20. Recognise the highly specialised nature of this work, and make provision for higher staffing ratio where needed.

i. Any related matter

i. Pricing structure

The pricing structure for supporting people with psychosocial disability is inadequate to effectively meet their needs, including:

- Providing effective support for people with psychosocial disabilities requires a highly skilled and experienced workforce that is able to work therapeutically with people. This is quite different work to the disability support work on which the pricing structure is based. The pricing structure is such that services will not be able to employ appropriately qualified

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staff to provide the necessary level of support. For example, most NDIS services are priced at $43 per hour, while cohealth estimates that effective psychosocial recovery support work for people with mental illness costs $85 per hour.

- The relationship between worker and consumer is critical to support the recovery of people with a psychosocial disability. A significant risk is posed by the new system where consumers may have different workers on each occasion (as a result of rostering of workers, rather than consumer choice), reducing continuity of care and the ongoing therapeutic relationship. Trust is a major factor in mental health recovery but will have less opportunity to develop with changing support workers.
- Worker safety is a concern. It is common for mental health support workers to visit consumers in pairs to ensure their safety, a need that is not factored in to the pricing arrangements. Sending workers out individually may place them at risk, and have potential flow on effects on consumers, the service and the public regard of the support system.
- It is not uncommon for consumers of psychosocial support to not attend, or want to meet, at scheduled times. This is not factored in to the pricing structure, preventing services offering the 'assertive' outreach and flexible response needed to maintain effective relationships and connections with supports.

Recommendation:

21. Review the pricing structure to ensure it allows sufficient resources to effectively meet the needs of people with psychosocial disability. Specifically, a separate cost line for mental health recovery support services should be included, with a higher hourly rate. Provision for payment for features essential to the work, such as active outreach work, two worker visits, 'no-shows' and extended travel provisions should be included.

ii. Consumer involvement

Consumer involvement in all areas of service provision is fundamental in ensuring that services and programs remain responsive and appropriate to the needs of the community. It is unclear how NDIS structures, with the focus on individual service delivery, will enable services to maintain this involvement.

Recommendation:

22. Establish consumer forums (supported by funding and staff and independent of NDIA or service providers) to focus on systems and outcomes.

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