SELF DIRECTED CARE, NDIS AND MENTAL HEALTH

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Good morning. I'm here to speak from a community mental health employer perspective on the implications of the NDIS for employers. I'll do this in two stages. The first will be to make comment on the relationship of the NDIS to the mental health sector. The second is to describe what RFWA is doing to prepare itself for NDIS and the general trend towards self directed care funding.

THE RELATIONSHIP OF THE NDIS TO THE MENTAL HEALTH SECTOR.

International and local context

As previous speakers have outlined, NDIS is based on the principle of person centered planning. More than this, it involves the consumer having control over how their funds and services will be provided. This concept has been gathering momentum in mental health for several years.

The US led the way in this approach through their President's New Freedom Commission on Mental Health in 2003. Many states in the US have introduced strong pilot programs with excellent results. The US also links these self directed funding

strategies to the Medicaid insurance program, but services purchased are not always tied to insurance. The UK Personalization strategy took a similar line in its mental health pilot under the National Health scheme from 2009. The November 2012 evaluation of personal budgets in the NHS revealed they were more effective with mental health consumers than in general health. The UK had already had a long standing investment in personal budgets in the Social Care sector for the learning disability area, but the mental health budgets are a very recent addition. You are familiar with the recent Australian experience nationally from Liz's presentation this morning. WA adopted the overall strategy in the Economic Audit report of 2009.

I very firmly support self direction and the various methods by which this can be achieved. RFWA as an organization sees self directed care as a central component in Recovery.

The NDIS Act

However, if we look at the application of the NDIS to mental health we would wonder whether self direction can apply to mental health clients under the NDIS because it appears almost impossible for it to be included. There is not a comfortable fit between the Act and its applicability to people with mental health problems. Recovery and rehabilitation are excluded as service streams under the COAG Agreement. The challenge is to be able to translate the concept of Recovery into the functional impairment language of NDIS. As a consumer in Geelong recently said: On the one hand you have to fight to be seen as well enough to get out of hospital, and on the other hand you have to fight to be disabled enough to be eligible to get a service under NDIS.

It is also disturbing to note that NDIS is primarily being funded by the diversion of hundreds of millions dollars of Commonwealth funded mental health programs into the NDIS. These programs will ultimately cease to exist and, if their client groups are not eligible for NDIS, many people will cease receiving the mental health services they require. Inevitably, this will push up the cost of hospital services as the revolving door grows with more people seeking crisis related services that they would not have needed if they were supported in the community. PHaMS clients are likely to be the worst affected. This is likely to be further exacerbated as state governments also relinquish mental health funds and these funds are not matched by personal budgets for people with mental health problems.

I don't believe this service reduction and impact on consumers and families is well understood. Once it does become clearer to those groups, I believe there will be a justifiable backlash from them as they realize their services have been given away with little immediate return to the mental health sector. The disability sector is very quiet on this issue of how the Commonwealth contribution to NDIS is being funded.

The Productivity Commission Inquiry into the NDIS is over 1,000 pages long, however only nine pages describe the intersection between mental health and disability. In fact the draft report did not even include mental health in the NDIS. There are no persons from mental health on the NDIS Board and only two of the twelve members of the Independent Advisory Council to the Board are from a mental health background.

Having said this, I am not suggesting mental health be excluded from NDIS but I am suggesting, along with many others, there

needs to be a better fit. This is a square peg in a round hole scenario. Looking to the future it is possible to see that we could end up with an NDIS oasis which benefits a privileged few and surrounded by thousands of other in a desert without access to supports and services, even after allowing for the usual implementation problems that are associated with new programs. For those familiar with driving a manual car, the policy and service impact of NDIS on mental health is like putting a manual gear box into reverse when you're travelling at 60kmh.

Common challenges for Disability and Mental Health Sectors

Although mental health is barely involved at this stage, even though the NDIS funding momentum is based on diverted Commonwealth mental health funds, it does share similar challenges as the disability sector in the implementation. This is most evident around matters such as pricing, the development of plans and the accessibility of services. Already there is concern around the viability of agencies to provide services at the prices being determined under NDIS.

Both sectors also share concerns around whether there will be genuine choice involved for consumers. The Act devotes 15 pages just to the issue of developing and administering Personal Plans. People will be only able to purchase services from pre registered providers. How will this promote choice given the thousands of potential services a person might choose? There is the likelihood that potential providers might be small business or individuals who are providing local services and who might not want to be engaged in bureaucratic processes such as registering with NDIS. I don't see much difference between this level of prescription and the current charge against service providers that

they are prescribing options for consumers rather than consumers making their own choices.

The key ray of hope in Western Australia lies in the My Way pilots which will be run by the Disability Services Commission in parallel with the NDIS pilots. It is hoped that the mental health component of these pilots will inform the NDIS program. It is also hoped that the My way pilot will not attempt to mirror every aspect of the NDIS, otherwise we will have yet another burgeoning bureaucracy but this time based in Perth not Canberra.

Possible solutions

As the NDIS is primarily funded initially by the diversion of Commonwealth mental health programs into NDIS, it is unlikely that the government will quarantine funds to allow for the growth in numbers of mental health participants. We can only hope that some funds might be held in reserve ear marked for the development of more tailored approaches in mental health. At the NDIS pilot sites, more scope for flexibility in the guidelines could be applied to mental health participants. Also, we would hope as mentioned previously that the learning from the My Way pilots would be applied.

RFWA EMPLOYER RESPONSE

RFWA is preparing itself for NDIS and the general trend towards person centered planning and individualized budgets by addressing the following issues:

- Advocacy
- Organizational culture

- Systems change
- Modifying approaches to self direction
- Developing new products

I have addressed **advocacy** issues today by raising the challenges of NDIS to the mental health sector. Advocacy will continue to be an ongoing strategy for RFWA, as agencies have an ethical responsibility to act in the best interests of their clients.

Organizational culture needs to be addressed when any change is being introduced. As you are aware, culture eats innovation. We have always adopted person centered planning in our services underpinned by a Recovery approach. Person Centered Planning does not automatically equate to having a Recovery focus. The difference in our work now is that there will be personal budgets involved. This requires cultural change and behavioral change as staff are generally not used to consumers being in control of their funding. Agencies tend to "Do" things to people; this approach requires agencies to work with people where the individual, not the agency, has the control over resources. In our training we take care to identify the links between what we do now and how this is similar to what is being required for the future, as well as what needs to be done differently. We are actively engaging with consumers and families and have a Consumer and Carer/Family Reference Group within RFWA. We draw on consumer and carer feedback from our sites and from stories of Recovery we hear in our services. A critical step we have taken is to dedicate one senior person on our staff to concentrate fully on the re-engineering of our services, to more actively integrate Person Centered Planning into all levels of our services.

We are reviewing all of our **systems**. This includes looking for an appropriate financial package that will accommodate personal budgets and the level of detail this entails. We are rolling out the Carelink plus system across the organization and this will bring together several data collection processes. It will capture the data contained in plans and also has an accounting module from which information can be transported into our financial reports until such a time as we identify an all round financial software package. RFWA has a number of services such as ICL, Partners in Recovery and carer respite services, which already require more individualized reporting processes and these service reports will be rolled into care link plus and other systems.

We are attending to **HR issues** that will arise from the provision of more individualized services. We already offer zero hour contracts: the relief list we hold for our accommodation services offers no guaranteed hour other than the minimum three hours industrial requirement for any casual work offered. We will be able to draw on our existing relief pool, with suitable training, to offer individualized support. We have adopted more flexible roster arrangements where possible in our accommodation services this may allow more flexibility for staff to be engaged in individual service delivery outside of our accommodation services.

We will encourage staff mobility between programs. These will assist with increasing familiarity of staff with consumers from other programs delivered by RFWA. There will be some challenges associated with the increased employment of casuals in the workforce and the training and supervision required for the support of staff that otherwise may not have easy access to these supports. These issues are being addressed as a very high

priority as personal budgets will not allow for funding of buddy orientation systems which we currently have in place on residential sites to assist with orientation and learning.

There are **variations on Self Direction** which still hold firmly to the principle of consumer control, but which achieve this through different modalities such as appointing a broker, or being engaged shared decision making, or having a provider manage the budget based on a prepared plan. RFWA is preparing to adopt all of these roles in addition to working with the individual who has complete control of their budget. We ill provide marketing which outlines our range of services and approaches to support.

RFWA has been **developing new products** in anticipation of a more market environment in which the consumers are the purchasers of services. With the potential for reduction in block funding and increase in funding of personal budgets, there will be services we currently don't provide because funding contracts don't cater for them. However, consumers may be willing to purchase these from their budgets. These include training in Recovery, Working with Voices training, individual Voices sessions and carer respite services. We are also exploring developing peer coaching and mentor services on a fee for service basis, as the current block funding arrangements are not flexible enough to support these trends and there is the demand.

RFWA is also actively exploring partnerships with other agencies that will enable the development and provision of new services which are complimentary to either RFWA or the partner agency, but which require joint collaboration to meet consumer demand. This might also include sale of services, or reciprocal

arrangements between the two agencies, but which help build agency capacity to more effectively negotiate the more individualized budget market.

Let's try to make all of this work. But that will require that we all listen to each other's concerns.

THANK YOU