The National Mental Health Commission considers the National Disability Insurance Scheme (NDIS) as an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability. There is early anecdotal evidence that for many people with severe and persistent psychosocial disability, participation in the NDIS is resulting in more effective services and supports, better tailored to the diverse and specific needs of individual consumers.

The challenge for governments as the managers and funders of the mental health system is to closely monitor and report on the impact of this far-reaching reform on people with a severe mental illness considered eligible for NDIS and their families and carers, but also the impact on the many people living with mental illness who are ineligible for or do not seek access to the NDIS. Based on this evidence, further consideration may be required to ensure that people living with mental illness, especially outside NDIS, are better supported so they can and do lead contributing lives.

For people living with mental illness, the service landscape continues to be complex and fragmented as services are both cross-sectoral (health and disability) and cross-jurisdictional (commonwealth and state/territory). There continue to significant numbers of people with mental illness who are not receiving the supports they need, severely reducing their capacity to participate in the community and the economy. In order that the needs of people with a psychosocial disability are met, coordination across these sectors and jurisdictions is required to ensure no gaps in services emerge from the implementation of NDIS. Effective coordination across the disability and mental health systems will be central to ensuring success in the reform agenda currently underway, including policy development, service coordination and program evaluation.

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, as the extent to which existing services are transitioning existing services to the NDIS varies between jurisdictions as well as the implementation timelines varying between jurisdictions.

There is much debate over the projected figure of 64,000 people projected to receive Individually Funded Packages for a primary psychosocial disability by full rollout in 2019-20. Given that this figure is based largely on participation rates in the previous system of supports – a system that was known to be falling well short of the level of need in the community – the question becomes: how accurate is this estimate of the number of people living with a severe mental illness who require access to NDIS packages? Is there capacity for the scheme to provide access if indeed the figure is higher? Anecdotal evidence indicates that some people are deterred from applying due to the process (lengthy application process) but more fundamentally, not wanting to be labelled as having a permanent disability. This raises challenging questions about the National Disability Insurance Agency's outreach and engagement with people with mental illness – a group that is often challenging for service systems to find, reach and engage.

Regardless of how accurate the 64,000 figure is, as an indication of magnitude it clearly shows that many more people with mental illness will not be eligible for package under the scheme. It is generally accepted that 2-3 per cent of the population experience a severe

mental illness each year, which equates to roughly 600,000 people. The as yet to be released National Mental Health Service Planning Framework could provide greater clarity on the issue of unmet need, once it is made available through the Australian Department of Health.

Even if the 64,000 is accepted as the best available estimate for the number of people eligible for an NDIS package for a primary psychosocial disability, many among those who are experiencing severe mental illness may, without effective early interventions and supports, eventually become eligible for the NDIS. This could place significant pressure on 'Tier 2' of the NDIS, the Information, Linkages and Capacity building (ILC) element of the NDIS and on mainstream services (clinical and non-clinical). The National Mental Health Commission is concerned that the ILC as currently envisaged will not be adequately funded to address the level of need, especially among those with psychosocial disability who do not qualify for a package under the NDIS. This will lead to increased pressure on the already stretched resources of the mainstream mental health system, especially Primary Health Networks (PHNs), which have only recently been tasked with establishing a stepped care approach for people with mental illness. Hospitals are also likely to come under increased pressure as more people reach an acute level of need in the absence of effective early interventions in the community.

Commonwealth, state and territory governments have elected to transition funding from a number of existing community mental health programs into the NDIS. This would seem to be in contrast to the Productivity Commission's (PC) 2011 report on Disability Care and Support, which implies the continued need for community mental health services concurrently with the NDIS. Chapter 5 and Appendix M of the report present evidence that there are many more people with mental illness than would be eligible for the NDIS (given the NDIS 'bar' is quite high in terms of severity of functional impairment and permanence of the disability). Chapter 5 (page 188) suggests that the NDIS would 'strengthen' community mental health services, not displace them. It is therefore likely that the PC did not envisage widespread closure of existing Commonwealth, state or territory mental health programs as part of the NDIS implementation. Rather, this is a financial decision governments have subsequently taken.

Aside from the merits or otherwise of these funding decisions, it is important to monitor the impact of transitioning of major Commonwealth, state and territory community mental health programs into the NDIS (Personal Helpers and Mentors, Day to Day Living, Partners in Recovery and Mental Health Respite: Carer Support) to ensure no overall reduction in mental health expenditure both at a macro and individual level, and that new gaps are not emerging due to the shift from block funding to individualised packages. For example, what services will be available for those who were eligible for these programs but who are ineligible for Individually Funded Packages or for those who would have been eligible had the programs continued?

Historically, the trend in Australia (and overseas) has been towards de-institutionalisation of mental illness and the provision of more services in a community context, including through various forms of supported housing and accommodation. In principal this is a laudatory policy; in practice there have been significant shortfalls in delivery, sometimes at

catastrophic cost to those experiencing severe mental illness, their careers and their familiars. The National Mental Health Commission notes that there is provision in the NDIS to include funding to help individuals with the cost of supported accommodation. Welcome though this is, the Commission is concerned that the stock of such accommodation in Australia is very low relative to community need, and it is unlikely that the funding through individual's packages of the 'user cost of capital' will be sufficient to ensure the market will respond quickly and effectively to fill the gap. The barrier to entry for potential providers that up front capital costs represent – whether equity or debt – is unlikely to be adequately addressed by the NDIS funding approach to supported accommodation.

The impact of the NDIS on families and carers needs to be closely monitored given their crucial role in the daily lives of people living with mental illness. How will continuity of support for carers be addressed? There is no direct provision of respite support for carers through the NDIS. Anecdotal evidence indicates that that some applicants are being encouraged not to include family support in order to enhance their chances of getting a package. What is the evidence that the benefits of well-designed packages are reducing the need for respite as anticipated in the design of NDIS?

As resources for disability support are being refocused, it will be particularly important to ensure that access to early intervention initiatives for people with psychosocial disability is preserved. Particularly in the context of the transition of funding from community mental health programs to the NDIS, which will provide psychosocial disability support for people with the most disabling forms of mental illness and complex interagency needs, it is important that an early intervention approach that minimises disability is also available for others with mental illness. This, in turn, will help deliver a shift in resources over time and manage the long-term cost pressures for the NDIS.

With the NDIS still in its early implementation phase, transparency and accountability are paramount. It is critical that timely and comprehensive information is available on the state-by-state (and local) impacts the reforms are having for people who gain access to the NDIS, as well as for those who do not. Reporting should encompass secondary as well as primary disability categories, as there are high numbers of people with physical or intellectual disabilities who also experience psychosocial disability arising from mental illness. More information about eligibility assessment tools and processes would also help with transparency. Tracking the experiences of people living with mental illness – and their families and carers – as they transition into NDIS needs to be in the broader context of the mental health system as all the reforms in primary health care, health and mental health impact on one another. In this context, it will be critical that the specific investments, services, impacts and outcomes for people with serious mental illness are monitored and evaluated.

The National Mental Health Commission looks forward to working with governments and key stakeholders as the learnings from the current inquiries inform governments on the future design and implementation of NDIS. The Commission will have an ongoing role in monitoring and reporting on the mental health system and its interface with NDIS, to ensure that an unintended consequence does not emerge due to the impact of social support programs transitioning to NDIS of a growing gap between the lives of those eligible and not

eligible for NDIS. The NDIS is a potentially very important element in addressing the long standing unmet needs of people with mental illness for effective community and disability supports. Addressing the capacity of mainstream (non-NDIS) service systems to support and complement the NDIS will be an important part of ensuring the success of the NDIS.