Psychiatric Disability Services
of Victoria (VICSERV)

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Submission

COAG Consultation NDIS Regulation Impact Statement

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Psychiatric Disability Services of Victoria's (VICSERV) role

VICSERV is a membership-based organisation and the peak body representing community managed mental health services (or as some continue to reference as Psychiatric Disability and Rehabilitation services) in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self-help, respite care and Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs.

VICSERV welcomes the opportunity to provide feedback on the Regulation Impact Statement (RIS) for the National Disability Insurance Scheme (NDIS). In particular, VICSERV recognises that the NDIS will affect how our member services as providers of community managed mental health services will evolve and be funded into the future.

The community managed mental health service system whilst made up of various program types, comes together in its common goals and underpinning values which is actively supporting the recovery of those with a severe mental illness. The majority of clients who access these services are those who would be classified as having a disability due to psychosocial impairment.

Funding

The RIS makes quite a few assumptions about the state of funding for disability services in Victoria particularly that many services are already well down the path of individualised funding. VICSERV is concerned that this assumption does not take into account community managed mental health services whose main state based funding stream is Psychiatric Disability and Support Services (PDRSS) funding administered by the Victorian Department of Health rather than Department of Human Services. It is also unclear whether the figures contained in the RIS regarding costs for, number of people accessing services and workforce are also inclusive of data pertaining to community managed mental health services.

The Victorian government funds approximately $93.5million per annum[1] towards what are known as the Psychiatric Disability Rehabilitation and Support Services (PDRSS) funding streams. These funds come out of the Department of Health budget and are not considered to be part of broader disability funding coming out of the Department of Human Services budget. As a result the RIS does not consider the regulatory impact and costs of funding coming out of the health budget being transferred into the disability space.

[1] *Psychiatric Disability Rehabilitation and Support Services Reform Framework: Consultation Paper* State of Victoria, Department of Health, Melbourne, April 2012, p8 accessed 1 February 2013 at www.health.vic.gov.au/mentalhealth/reformstrategy/index.htm

The RIS outlines funding arrangements by state and territory and indicates that disability services are well down the path of individualised support packages in Victoria.[2] Whilst this is certainly true in the disability space, the same cannot be said for community managed mental health services where only a few providers having some experience of this type of funding, individual funding facilitators and associated administrative mechanisms. This is a concern as the RIS analysis does not take into account the costs in shifting community managed mental health services into an NDIS system. The reality is that the community managed mental health services are predominantly block funded which poses a significant challenge ahead.

Disability support services workforce

VICSERV notes with interest some of the data contained in the RIS regarding the estimated disability workforce. In particular, it notes that these estimations are based on a report conducted by PricewaterhouseCoopers for the Department of Families, and Housing, Community Services and Indigenous Affairs titled *Final Report: Planning for a sustainable disability workforce* (publication date unspecified) which has relied on 2006 Census data. It is doubtful whether these estimations and data included those employed in community managed mental health services as there is yet to be conducted a discreet piece of work on this particular workforce that has produced reliable data on the make-up, qualifications, and number of people employed. Though the little data that is available would suggest that there are approximately 1600 people in the community managed mental health workforce with an estimated 70% holding a tertiary qualification relevant to their task based on figures obtained back in the year 2000 though this will have increased since.[3]

Victoria via the Department of Health are currently completing an analysis of the *2012 Victorian PDRSS Agency and Worker Census* the results of which it is hoped will provide up to date information around the community managed mental health workforce. VICSERV played a significant role in engaging agencies to undertake the Census so as to achieve statistically meaningful results.

Quality Assurance and Standards

VICSERV is concerned that the RIS does not consider the standards covering community managed mental health services as part of the regulation assessment around quality assurance.[4] The "One DHS" model where Department of Human Services providers are required to comply with one set of integrated quality standards do not actually include the mental health standards pertaining to PDRSS funded agencies.

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[2] The RIS states on page 19 that "Since 1996, Victoria has been progressively transitioning block funding to individual funding. Currently 30 per cent of the total disability budget is individualised funding."

[3] *Community Managed Mental Health: An agenda for the future*, Psychiatric Disability Services of Victoria (VICSERV), May 2012, Melbourne, p13

[4] The RIS at page 23 identifies the "One DHS" standards model as the only quality standards to apply in Victoria incorporating current disability standards.

Until relevantly recently, community managed mental health services were required to be accredited against the PDRSS Standards which were developed in 2004. Since 2010, these standards have been replaced by the National Standards for Mental Health Services and the associated guidelines for non-government organisations. To date however there has been no clear mandated accreditation process by the Department of Health for these national standards at the Victorian state level though some accreditation bodies are now developing products for accreditation. This is of some concern as the RIS does not outline the whole picture when it comes to quality assurance and the standards which apply to organisations other than strict disability providers.

Nominees Scheme

It is unclear how the nominee scheme will interact with established state and territory substitute and/or supported decision making schemes. There is a risk of complicating already complex systems by adding further bureaucratic processes to the mix. The RIS does not consider some of the regulation impacts of adding another substitute decision making scheme for participants, government and providers. Some issues that come to the fore include:

- Systems for ensuring accuracy and currency of appointments
- Education and training in the use of nominees
- Administrative systems to be built for appointment, discharging and challenging nominees
- Intersections with state-based legislation particularly guardianship and administration legislation

It is also noted that Victoria is anticipating the new Mental Health Act to be enacted later this year where it is proposed that a supported decision making model will be adopted including the recognition of advanced statements. This is a particularly significant step towards a human rights based model where the wishes of the person are at the forefront and upheld. The RIS has not considered how the NDIS will interact with established systems of supported as well as substituted decision making and the associated regulatory impacts.

Option 1

The first option considers the continuation of block funding as the predominant funding model under an NDIS. VICSERV agrees with the analysis as contained in the RIS and the potential costs and benefits of the continuation of the status quo. Though not a preferred option, there is some merit for the continuation of block funding in some areas where:

- the market is unable or unwilling to provide - for example in rural, remote and regional areas where it may not be attractive to the market
- a particular program or offering for reasons of efficiencies cannot be provided effectively by the market yet is vital for participants.

Options 2 and 3

It is evident that in shifting to an individualised service delivery approach, there will be an opening for new providers to begin delivering services which had previously been within the purview of PDRSS funded agencies. VICSERV agrees that competition can be good for driving innovation and creating opportunities that is why community managed mental health agencies exist today; they saw a need and developed a service to cater to that need.

The options 2 and 3 proposed by the RIS have varying degrees of restrictions as well as freedoms and choice which makes them attractive for both providers and participants in the scheme. What is clear, the option that is best able to balance considerations of individual risk, ensuring quality services, choice and innovation, is most favourable in terms of net benefit.

Restrictions on participants deemed to be high risk really needs to be weighed against the degree of risk in choice. It would have been thought that provision for a nomination scheme would go some way in supporting such participants in making decisions thought to be high risk. There is also the issue of allowing for the dignity of risk. That is not to say that there should be no restrictions or regulation of providers. VICSERV is of the view that regulation is important in ensuring the quality of services and ensuring the right motivations of providers of particular services. Whilst VICSERV agrees that with some services, it would be unreasonable to require registration and even regulation i.e. gardening and cleaning services, care services or higher risk services if you will, need to continue to be regulated. The reasons are twofold: to ensure quality service delivery at an acceptable standard and to uphold the recovery orientation underpinning community managed mental health services.

One may ask what exactly is meant by the final point. Recovery as understood in the community managed mental health space is supporting participants to lead a fulsome life and a truly contributory life. It is not about curing the illness as perhaps understood by medical professionals. But rather it is leading a full life in all domains. Further work needs to occur with respect to how organisations will be allowed to operate as well as regulated in the new service system structure to ensure that the recovery orientation is carried through to the reformed services system. Additionally, any registration processes must include specifications covering off the principles of recovery. Adherence to those specifications must be part of the process and tied into the continued authorisation to operate as a provider.

Whilst options 2 and 3 consider elements of regulation for providers and quality standards, it does not consider recovery orientation, which for VICSERV and its members is an important part of the equation.

Option 4

The fourth option considers a NDIS where all providers are unregulated and it strictly market based. VICSERV does not support this option, particularly as the market has not proved to be a reliable determiner of quality services. For reasons mentioned above, some form of regulation needs to be in place for particular services under an NDIS to ensure quality, the upholding of particular philosophies of practice and that the correct knowledge is applied in service delivery.

Impact on peak body

VICSERV notes some of the potential short to medium term actions proposed in the RIS in which peak bodies can take to assist in the transition to an NDIS. VICSERV fully supports these actions and is in fact working with key partners to establish a program of works including regular meetings and bulletins to assist member agencies. It is also noted that VICSERV is part of the national body, Community Mental Health Australia, consisting of state and territory community managed mental health peaks. This would be an ideal forum for progressing some of works as suggested by the RIS.

It is also interesting to note some of the regulation impacts of the NDIS on state-based peak bodies such as VICSERV. Whilst some of the benefits could include the growing of the traditional member base and new product offerings, a potential cost could also be with the move to a market based system a re-orientation of a state-based peak's role in a national based system.

Overall, VICSERV agrees with the cost benefit analysis of the RIS however highlights some key concerns around the exclusion of community managed mental health services in its considerations. Ultimately, a scheme which has as its guiding principle the offering of good, high quality services which maximises the benefits to participants and has at its heart the recovery of those participants, is a scheme which is wholly supported by VICSERV.