

RESPONSES FROM THE QAMH BRISBANE ILC CONSULTATION

Date:	22 October 2015	
Number of attendees:	24	
Organisations represented:	Aftercare	Metro South HHS
	APM	My Life Support Services
	Brisbane South PHN	NEAMI
	Carers Queensland	Open Minds
	Centacare	PA hospital
	Department of Veterans Affairs	Qld Health
	Grow	Richmond Fellowship Qld
	Kyabra Community Association	Stepping Stone Clubhouse

The draft ILC funding areas

- A. Specialist or Expert Delivery
- B. Cohort focused delivery
- C. Multi-regional supports
- D. Remote/ rural solutions
- E. Delivery by people with disability for people with disability

Participants identified services (existing or future) that are worthy of funding but don't seem to fit into any funding category

- Pre-planning service that is independent of the NDIS so that people can have a choice over who to use.
- Advocacy services do not seem to fit in the ILC, but are essential for people to exercise choice and control.
- Supports for family and carers are vital supports to ensure they continue in their role to support people have good lives. We understand this is an individual scheme, but there should still be consideration for carers. Where does this fit.
- Where does 'respite' and housing services fit?

No need for additional funding priorities

- The funding priorities are broad enough. There are no pressing priorities that cannot be captured in the existing priorities.

Participants concerns about these funding areas, including overlaps and risks

- A and B overlap
- Spending money in funding area C is less of a priority as it is difficult to measure effectiveness in the short term and could do more good spent on frontline services.
- The NDIA needs to be mindful of how to get information to people who don't use technology or have low literacy skills. Providing information at generic community services where this cohort may attend such as community centres or GPs would be useful in addition to the LAC role as they can't be everywhere.
- Participants emphasised the need to use language that resonated with a particular cohort. For example using the individualistic language of disability with Aboriginal and Torres Strait Islander people or people from CALD backgrounds wouldn't be appropriate and may result in lack of engagement.
- There needs to be a repository for information gaps as they are identified, particularly as existing services are no longer funded. Additionally depending on the length of the new ILC funded services, this repository would be just as necessary.

What advice did participants have for the NDIA in moving forward with the draft funding areas

- Participants suggested the need for a mapping exercise of state and commonwealth funded services to be clear about what is currently available to avoid gaps or duplication. This is particularly important as the NDIS launch gets closer and the services available change.
- It would be useful to have a realistic contract length to ensure 1) expected outcomes could be achieved, and b) service delivery staff would have time to be trained.

The priority given to the funding areas by participants is as follows:

- A. Specialist or export delivery 19%
- B. Cohort focused delivery 24%
- C. Multi-regional supports 13%
- D. Remote/ rural delivery 22%
- E. Delivery by people with disability for people with disability 22%

Reasons why participants prioritised/de-prioritised each funding area during voting

- Participants agreed that all funding areas were priorities. However participants noted the finite funding attached to the ILC and raised concerns about the example in funding area C of the

awareness campaign taking money away from direct service provision to individuals. Participants said it is difficult to judge the effectiveness of awareness campaigns especially in the short term.

- It was also noted that effective awareness campaigns can be expensive requiring lots of support.

Individual-level outcomes and/ or indicators participants identified for the ILC

- Participants said outcomes and indicators would vary depending on the nature of the service provided and the client characteristics.
- # hospital admissions decreased
- # hours social activity accessed locally
- # screening tools used to access eligibility
- Improvement in presenting issues
- Increased level of independence
- Negative/ positive feedback from client about a service
- Increased social and community participation

Community-level outcomes and/or indicators participants identified for the ILC

- No waiting list (there were some who disagreed with this, as it could encourage services not to keep waiting lists thus masking level of unmet need)
- # people accessing emergency services
- Reduction in # suicides
- # hits on a website
- #complaints
- Supports escalated as required (demonstrates parts of the system is working together)
- Inclusive partnerships between community and clinical services
- Permanent housing
- Outcomes of complaints are acted on resulting in continuous system level improvements

Participants thinking on how the ILC measure changes and outcomes

- Use a tool to measure change in needs from first entering the service to how well these needs were met when exiting the service.
- Measure progress specifically on the extent goals identified in people's plans have been achieved.
- Participants had strong feelings regarding whether the NDIA should provide a national online portal for entering outcome data similar to that provided by the DSS for PHaMS. About half of

the participants were highly supportive and half highly against this idea due to perceptions regarding whether or not this was an effective and efficient process.

Risks identified by participants in relation to measuring outcomes

- There will be different outcomes depending on the funding. Activities must be fully funded to cover the cost of inputs such as enough qualified staff or they are will be unlikely to achieve the desired outcomes.
- Outcomes and outputs must match with the timeframe provided to deliver an activity or service.
- Outcomes can be difficult to measure in the mental health space in part due to the length of time to establish a trusting relationship with the person.
- Depending on the outcome tool used e.g. Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) where a reduction in outcomes may appear to have occurred as a result of the provision of a service. This can actually reflect a person's increased awareness of the depth or breadth of needs of their needs which is reflected by the outcome tool.
- There needs to be clarity about what documentation is needed. Concerns were raised regarding Section 55 of the NDIS Act requiring service providers to disclose personal contact details of existing clients without them having provided consent to do so.

Participant advice for the NDIA relating to measuring outcomes

- The needs of people experiencing a psychosocial disability fluctuate and therefore impact on outcomes that can be achieved. An outcome may have been achieved at one point in time, however the person may need this service again later. Additionally the service may have done a good job, however the person may become unwell and depending on how outcomes are measured may reflect poorly on the service.
- The NDIA needs to be aware of the principles of the NDIS across all funding.
- The NDIA needs to be mindful of the need for ongoing funding for things like websites which need updating to maintain their usefulness.
- Some participants thought outputs and outcomes shouldn't be the focus of ILC service. Concerns were raised regarding the possibility of a requirement to record outcomes that 'look good in a report' but are not truly reflective of smaller, more realistic outcomes that could be achieved in a short time period.

Other feedback for the NDIA

- The role of the LAC's seems enormous and very unclear, in that they have a planning focus, pre and post eligibility, as well as community capacity building. It seems there are two different roles here, requiring quite different skills. The pre-planning and support for ineligible participants seems to double up/ overlap with the role of NDIA planners. Are those roles realistic? Would their role entail working with NGOs to develop up funding proposals based on need identified through their engagement with participants / non-participants? And would this raise any market competition? Would LACs actually run capacity building programs themselves or link their clients to them?
- Are there likely to be any requirements in the funding rules that program/project proposals must have no recurrent implications (ie require on-going, rather than just one-off funding)? For example, running "Peer support" or "Self-care for carers" skills development programs, that would be available in different locations on an on-going basis, recognising that such programs would always be needed for as long as there are people with disability and carers. These programs would not obviously replicate any current programs funding by other jurisdictions.
- The policy area of 'capacity building of mainstream services' doesn't seem to fit neatly with the funding area, when considering the examples given. Where would funding for capacity building of registered NDIS providers be sourced, in which to provide skills development programs to mainstream orgs, especially given that block funding will no longer be available from which NGOs would have previously been able to use some of their operating cost etc to build their workforce capability.
- Will the available funding be based around the concept of an efficient price like some of the NDIA services, therefore making it very difficult for MH providers whose staff are more highly trained (and remunerated) to work with clients with Mental Illness to compete for business? Or will funding proposals developed by providers be assessed on their own merit, similar to how submissions are currently made to funding bodies, where orgs can calculate actual costs?
- What support or transition arrangements will be in place for services that clients currently use that may no longer receive funding under the NDIS?