



Psychiatric Disability Services
of Victoria (VICSERV)

Submission on

Productivity Commission

Review of National Disability Insurance Scheme (NDIS) Costs

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Introduction

VICSERV is a membership-based organisation and the peak body representing community managed mental health services in Victoria.

The services provided by VICSERV members include programs funded through the Victorian Government's Mental Health Community Support Services (MHCSS), and many also receive funding through Commonwealth mental health programs.

The National Disability Insurance Scheme (NDIS) will have a significant role to play for many people living with serious mental illness, their families and carers.

VICSERV remains committed to the NDIS and the benefits it can bring to the lives of people living with a mental illness, and subsequently to their families and carers.

However, as implementation of the NDIS is rolled out across our State, we are becoming increasingly concerned that the design and functionality of the NDIS does not appropriately align with the needs and requirements of people living with a mental illness.

Throughout the trial process and now, during implementation of the scheme in Victoria, it is apparent that the needs and requirements of people living with a mental illness have been a secondary consideration in scheme's design.

We are concerned that, if the needs are not adequately considered and addressed prior to full roll out of the NDIS, benefits of the scheme for people living with psychiatric disability will be reduced.

In developing our submission we have drawn on the experience and expertise of community mental health organisations and stakeholders, some of which have experience implementing the scheme at different phases of its roll-out.

Our submission provides detailed discussion of the key issues raised by community mental health organisations during the consultations, including practical examples and views shared by community mental health organisations experiencing first-hand the realities of the NDIS.

We also endorse the submission of our national peak body, Community Mental Health Australia (CMHA), although in this submission we have focused on Victorian specific issues and experiences. CMHA is a coalition of the eight state and territory peak community mental health organisations which, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level across Australia.

Scheme costs

The cost drivers identified in the Commission's Issues Paper are mostly associated with the costs incurred after an individual has been engaged in the scheme. Whilst this is the boundary of the scheme, there are costs outside of it that will impact on the scheme's cost forecasts in the longer term. These include costs associated with supporting individuals before they are formally engaged through the scheme, and also costs for providing services to those not eligible for the NDIS.

Costs arising from the Victorian Context

The Victorian Government, through the bilateral agreement with the Commonwealth Government, has committed the majority of its mental health services funds to the NDIS (redirected from the Mental Health Community Support Services funds). This leaves the NDIS as the only option for most people with mental health issues who require psychosocial support in Victoria.

VICSERV estimates that as many as 10,000 Victorians living with serious mental illness will be ineligible for the NDIS, and are at risk of not receiving appropriate psychosocial rehabilitation services.

It is imperative that those people living with a mental illness who fall outside the scope of the NDIS still receive community-based mental health support, ensuring that their rehabilitation and support needs are met whether eligible or not. VICSERV is concerned that the lack of prevention and early intervention – due to a loss of state government funded mental health support services – could lead to an escalation of serious mental illness, which will ultimately impact on the overall costs. Ensuring that individuals with a mental illness have access to a high standard care, whether inside or outside of the NDIS, will reduce demand within the system and improve financial sustainability for the Scheme in the longer-term.

The planning and engagement process for people with a psychosocial disability

Through engagement with our members and other mental health organisations we have heard that consumers receive better outcomes when a support worker, advocate or peer worker have assisted them prior to attending their planning meetings, or plan review meetings.

For example, MHCSS programs in Barwon were provided with extended State funding to assist those consumers to transition into the NDIS. Many consumers credited their MHCSS support worker with getting them into the scheme, saying that without their worker organising the

paperwork and giving them a stronger voice during the planning stage, they doubt they could have secured eligibility or a funding package on their own.

However, when State funding ceases after full transition to the NDIS, under the NDIS Pricing organisations will not be funded to support individuals until they have been formally engaged through the approval of a plan by the NDIA.

VICSERV has noted a direct relationship between how much time and resources is dedicated to preparing a client (including sourcing and compiling paperwork and reports) and how likely that client is to be deemed eligible for a funding package. One service provider reported that this pre-engagement support was attributable to 20 hours of work per client, in addition to trying to meet their day-to-day needs.

An allocation of funds from the NDIA to facilitate entry into the NDIS and to support a participant through the initial planning phase would inevitably increase the engagement of individuals under the NDIS and the overall outcome for consumers.

The planning process needs to be more appropriate and sensitive to people with psychosocial disability

The feedback that VICSERV has received from the community mental health organisations and other stakeholders has been that plan implementation can prove difficult, due to some clients having limited understanding what has been written into their plan. Individuals don't always know what supports they can ask for, and may struggle to identify what would assist them in meeting their goals, or how to articulate their disability, to a planner.

Further, it has been reported that some NDIA planners do not have an adequate understanding of psychosocial disability and mental illness to support them through the planning process. If a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended, thereby reducing administrative burden on the NDIA and builds confidence in the process for the consumer.

Additionally, the current arrangements put in place for contacting mental health consumers to commence the planning process has been found to be inadequate and can be highly stressful for consumers. Service providers from Barwon, as well as those who have begun transitioning clients in NEMA, reported that conducting engagement and planning via the phone limits the assessor's

ability to get a true understanding of an individual and their situation, particularly given a large proportion of communication is non-verbal.

Non-verbal communication can be an essential part of building rapport with people with a psychosocial disability. This is especially true for people who experience symptoms such as depressive thoughts or paranoia. While using technology can play an important role in increasing access to services, a move away from face-to-face consultations will also mean a lack of rapport and an increase in the number of people who will disengage from services.

Outreach services to identify potential NDIS participants with a psychosocial disability

Participants who are not currently engaged with mental health services may need even greater support to engage with the Scheme, and may not engage at all if the process itself is a barrier.

This is a significant concern for community mental health organisations who are concerned about how consumers – who may be eligible for an NDIS support package – will be engaged and supported to access the NDIS; this is particularly true of vulnerable and dis-engaged people, including indigenous, CALD and homeless groups. These cohorts can sometimes be difficult to reach and connect with; pressure is being placed on community mental health organisations to do this outreach work, but it remains unfunded. People living in rural and remote areas are also likely to have less access to services. Identifying people within these communities requires a significant investment of – currently unfunded – time and resources.

Further, the mechanics of the NDIS provide no incentive for community mental health organisations to persist with hard-to-reach clients because work is not funded until they are engaged; in order to stay financially viable in the NDIS Market, community mental health organisations will have to take this into consideration.

Impacts of the NDIS pricing structure on the mental health workforce

Another major issue for the community mental health sector in managing service provision has been the scheme's pricing structure, and its relationship to skilled and qualified mental health staffing.

The current mental health workforce is highly qualified, with a recent base-line survey of the MHCSS workforce by VICSERV revealing that nearly two-thirds hold a graduate or postgraduate qualification, with almost ninety percent indicating they have a diploma or higher. Although it is anticipated that demand for disability workers will increase under in the new NDIS environment, feedback from current community mental health providers indicates they will be unable to afford to keep all their

existing staff, and certainly not on their current wages. The hourly rates included in the NDIS pricing structure demonstrate a lack of acknowledgement and understanding about the level of skills and expertise that are required to provide disability support to individuals with serious mental illness.

In addition, providers have commented that this workforce are finding the transition to be difficult, as the new job roles are expected to be significantly different in classification conditions and model of work; many in the current workforce see this as too removed from their training in providing recovery-oriented psychosocial rehabilitation. This has led to a concern about the potential loss of an identified mental health workforce, and the body of knowledge that would be lost as a result.

The inadequacy of the pricing structure also results in an inability to retrain the already highly skilled and experienced workforce they currently employ into a different (potentially lower level) role, and many service providers have expressed concerns about the difficulty they face in providing supervision, ongoing training and upskilling of both the existing and new workforce through professional development, with implications for ongoing quality.

Further, the likely shift towards mobile delivery has resulted in service providers expressing concerns on workplace health and safety for staff working in isolation and in uncontrolled environments such as people's homes. There is also an inability to provide a supportive and nurturing team structure and culture when staff may be working off-site and on irregular shifts

While the NDIS recognises complexity of support and differentiation in cost of service provision due to penalty rates in some of its pricing, VICSERV is aware this does not occur across the board. For example, for short term accommodation in a centre or group resident, the maximum payment is set "at a single rate per person per 24-hour period. This is an inclusive, all expenses price for a 24-hour period with no additional loading permitted. While this amount may be adequate for a range of lower needs participants, it is often not sufficient for those requiring higher support or levels of supervision to stay safe, particularly during higher wage periods."¹

Scheme boundaries

The process for assessing the eligibility of individuals with psychosocial disability should be streamlined and adjusted so that it is more appropriate for individuals with a serious mental illness.

¹ Marymead, The Disability Trust, Hartley Lifecare, Duo, and Carers ACT, Challenges of converting the NDIS category of 'short term accommodation' to meet need, ACTCOSS Update Journal, Issue 77, Spring 2016, p. 11, <https://actcoss.org.au/publications/quarterly-journal-update/update-issue-77-spring-2016-ndis-transition-where-have-we>

The experience in NEMA has raised concerns about the process of using phone contact to establish the 'first plan'. Although a recent decision by the NDIA has meant that individuals with psychiatric disability will now be provided with a face to face approach, and will likely receive support coordination in their plan, a focus on meeting targets and quickly moving people into the scheme is likely to impact on the appropriateness, and the ultimate success, of the process.

As mentioned earlier, it has also been recognised that consumers need significant support and advocacy from support workers, carers and/or peer workers in order to complete the eligibility forms. This results in substantial unbillable hours for mental health organisations and stress for consumers and their carers.

In addition, the language used by the NDIA in its processes and materials for testing NDIS eligibility, and in particular the language of 'permanency' that underpins the scheme, has been identified as a barrier that has impacted on the access and participation for people with mental illness. In particular consumers have expressed that the language of permanency:

- Is contrary to current evidence-based recovery practice and the episodic nature of mental illness which makes it very difficult for psychiatrists and GPs to formally state that a consumer has a permanent diagnosis/disability and functional impairment
- Is contrary to the recovery orientation of service delivery and support which aims to directly reduce the likelihood of a disability developing
- Is known to create high levels of stigma, distress and a loss of hope for consumers to say they have a permanent disability/impairment
- Creates a particular barrier to younger people (under 30 years of age) and those with moderate mental health needs, who are likely to recover but may not be eligible for support under the NDIS.

These issues continue to distress individuals and families, and may impact on the level of participation in the scheme, as individuals disengage from the process. At present, many community mental health organisations – and consumer and carer peak bodies – are spending time working with such individuals to 'translate' the language used by the NDIA into simple to understand information for their clients; however, as state funding is withdrawn, this approach will become unsustainable.

The intersection with mainstream services and the wider mental health system

A key requirement of a responsive and effective continuum of treatment and support for people living with a serious mental illness, is that it must be able to deliver treatment, community-based

rehabilitation and disability support especially for people more severely impacted by mental illness. Some people who are seriously impacted by mental illness will need access to all three service types. Currently however, it is uncertain how the reforms being implemented across both State and Federal levels can respond to both community-based rehabilitation and psycho-social disability support needs.

At the Federal level, mental health funding is being transferred to the NDIS, including Partners in Recovery (PIR) and Day to Day Living (D2DL) – both sitting with the Department of Health – and Personal Helpers and Mentors (PHaMs) – sitting with the Department of Social Services. Respite programs for carers are also impacted by this transfer of funding.

Along with the NDIS, a number of Department of Health programs are transitioning to the responsibility of the Primary Health Networks (PHNs) – program funding will go into a flexible mental health funding pool from which PHNs will commission services for their PHN area based on regional planning and needs assessments, including joint planning with state, territory or local area health services. The guidance documents developed to assist the PHNs on the implementation of the reforms, and which outline the expectations of them, have included the directive that PHNs cannot commission psychosocial services. It states they can promote links to broader services, recognising these services are vital, but they are not within their scope.

The Federal Government's Fifth National Mental Health Plan also focusses on the role of PHNs and the direction of the NDIS, leading to increasing the emphasis on the clinical and acute treatment of mental health and a move away from recovery focussed community-based mental health services. Further, at the State level, through the bilateral agreement with the Commonwealth Government, the Victorian Government has committed the majority of its mental health services funds to the NDIS (redirected from the Mental Health Community Support Services funds), leaving the NDIS as the only option for most people with mental health issues who require psychosocial support in Victoria.

At full implementation of NDIS, people with significant disability associated with their illness who qualify should be able to get their disability support needs met. However, with the defunding of successful rehabilitation-focused mental health programs, a growing number of people will not get their community-based rehabilitation needs met. This appears to be contrary to the intent of the Federal Government's reform - to provide a mental health system with person-centred care across the continuum when people need it.

How the reforms respond to both community-based rehabilitation and psycho-social disability support needs as well as provide a workforce that is qualified to deliver the services people need is an important issue, particularly within the NDIS structure. Ensuring continuity of care inside and outside of the NDIS will reduce demand within the system and improve financial sustainability for the Scheme in the longer-term.

Individuals in receipt of forensic disability services

In addition, there are currently concerns in community health sector about how the scheme interfaces with individuals in receipt of forensic disability services where NDIS supports cannot be provided.

It is not uncommon for an individual with psychosocial disability to move between systems.

Previously, mental health organisations would have ensured in-reach, relationship-building activities for people who have been incarcerated or held in 24-hour facilities as this would allow for a case to be built for community transition when the individual was ready to be released.

However, as the NDIS now sits outside of forensic services, the types of services community mental health organisations would have previously offered will not occur and providing continuity of care for individuals that move between systems will be challenging.

To ensure better outcomes for individuals living with mental illness, a greater focus needs to be placed on designing an effective systematic process that spans the wider mental health system.

Mental health and the Information, Linkages and Capacity (ILC) building framework

Under the current framework, there is no real benefit to mental health services from the ILC because the funding provided through the framework is so minimal; the ILC simply does not have the capacity to provide for the scope of what existing services deliver, whilst also responding to the needs of people who won't be eligible for the NDIS.

This issue reconfirms our concerns that mental health continues to be a secondary consideration in the design and functionality of disability supports provided through the NDIS.

Throughout the trial process and now, during implementation of the NDIS in Victoria, the premise of the ILC is not being achieved. For example, Local Area Coordination (LAC) is funded under the ILC framework to connect people who are outside of the NDIS to informal supports, whilst also providing assistance with the planning process for those that are eligible.

However, currently the efforts of the LAC's in Victoria are focused almost entirely on moving in scope and new participants into the scheme to meet targets, creating a gap in meeting the needs of those ineligible for the NDIS.

Planning processes

Community mental health organisations have reported to VICSERV how they - and the clients and carers they have worked with - have experienced the current planning and engagement process. This process can be divided into three parts: preplanning and initial engagement, planning, and review.

I. Preplanning and engagement

As noted earlier, through our consultations, mental health organisations have reported that consumers receive better outcomes when a support worker, advocate or peer worker have assisted them prior to attending their planning meetings, or plan review meetings. For example, MHCSS programs in Barwon were provided with extended State funding to assist those consumers to transition into the NDIS. Many consumers credited their MHCSS support worker with getting them into the scheme, saying that without their worker organising the paperwork and giving them a stronger voice during the planning stage, they doubt they could have secured eligibility or a funding package on their own.

Quotes from Mental Health Service Providers

“Many people with a psychosocial disability benefit from a lengthy engagement period as they often struggle with anxiety, trust, low self-confidence, past history of trauma, paranoia etc. It is easier for them to reject engagement with services if staff are not funded to be able to persist”

“I don't believe that many clients will understand what services to ask for. Many have difficulty planning their day, let alone their life and what supports and services, and who should provide them”

“For many it all looks TOO HARD, and they opt out”

Service providers have reported a direct relationship between how much time and resources is dedicated to preparing a client (including sourcing and compiling paperwork and reports) and how likely they are to be deemed eligible for a funding package. One service provider reported that this pre-engagement support was attributable to 20 hours of work per client, in addition to trying to meet their day-to-day needs.

An allocation of funds from the NDIA to facilitate entry into the NDIS and to support a participant through the initial planning phase would inevitably increase the engagement of individuals under the NDIS and the overall outcome for consumers.

2. Planning

Appropriate planning process for individuals with a psychosocial disability

VICSERV strongly believes that the planning process needs to be appropriate and sensitive to people with psychosocial disability. The current system put in place to connect with consumers to commence the planning process has been found to be inadequate and stressful for consumers.

Individuals don't always know what they can ask for or how to articulate their disability and it has been reported that NDIA planners do not have an adequate understanding of psychosocial disability

Quotes from Mental Health Service Providers

"I don't understand how the client's needs can be assessed accurately without a face to face meeting with them; how can a person's needs be assessed without knowing that person? As workers, the rapport that we build with the client determines the level of trust they have in us, and how much they will disclose to us about their personal circumstances and the struggles that they are facing – which determines what supports we put in place for them"

"Some people with psychosocial disabilities may not engage in the assessment or planning process if there is no face to face consultations available"

and mental illness to support them through the planning process. By contrast, if a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended, thereby reducing administrative burden on the NDIA and build confidence in the process for the consumer.

Under current processes, the NDIA attempts to engage with consumers via a maximum of three phone calls and a follow-up letter; however, service

providers have reported that some of the people they work with are not comfortable speaking on telephones or answering calls from numbers they do not know. Some do not even own mobile phones or landlines. Phone calls as a means to facilitate engagement can cause significant distress for some individuals and will often result in disengagement.

In addition, some service providers have reported that conducting engagement and planning via the phone limits the assessor's ability to get a true understanding of an individual and their situation particularly given a large proportion of communication is non-verbal. This non-verbal communication is an essential part of building rapport with people with a psychosocial disability. This is especially true for people who experience symptoms such as depressive thoughts or paranoia. While using technology plays an important role in increasing access to services, a move away from face-to-face consultations will also mean a lack of rapport and an increase in the number of people who will disengage from services.

Further, participants who are not currently engaged with mental health services may need even greater support to engage with the service; and although some service providers can still provide PHaMs, MHCSS or other staff, to assist with supporting disengaged individuals whilst in transition, when this funding ceases it is uncertain what will happen to those individuals.

VICSERV also believes that the NDIS could enable more consideration to the support of carers and peer workers by better involving them in the planning process. A lack of insight is often a factor to consider for people with psychosocial disability and often a peer worker or carer's involvement in the assessment and planning phases is beneficial to all parties.

Inclusion of a risk assessment framework

VICSERV supports the development of a risk assessment process as set out under the recently released NDIS Quality and Safeguarding Framework.

As outlined in the framework, “a holistic assessment of the risks a participant faces, which takes into account their family circumstances, informal supports and individual capabilities, is critical to enabling informed choice. It is also critical to identifying those who may be most at risk of abuse, violence, neglect and exploitation or who may be vulnerable to other risks, such as service provider failure”.

Quote from Mental Health Service Provider

“Many people with long-term psychosocial disability have become so institutionalised by the Mental Health System (even if they have never been in a psychiatric institution) that they are not familiar exercising choice, and have difficulty conceptualising what is possible. Unless planners are skilled and experienced in working with people with psychosocial disability it will be difficult for them to understand this and to adapt their processes accordingly. Socially isolated consumers are likely to be highly anxious about meeting with planners, and may have difficulty conceptualising the planner as being a person who is ‘on their side’ – they are far more used to dealing with agencies and officials who want to narrow their options, rather than expand them”

The recognition that families and carers and peer workers, in particular, can play an important role supporting individuals to make choices about their supports is also important.

3. Review

There needs to be an adaptive and flexible approach to the planning process, providing consumers with the opportunity to review plans prior to them being finalised by the NDIA. There have been reports of incidents where consumers are unaware of what they will be getting until the plan is submitted – and there is currently no opportunity to take time to consider the plan before it is finalised. Then, if it turns out that the plan is not working for them they need to go through a lengthy appeal process.

Quote from Mental Health Service Provider

“20 – 30 % of plans needed to be reviewed as supports outline in the plans were inadequate. There are delays of up to four months in getting a plan reviewed by the NDIA”

Plan errors and inconsistencies not only create confusion and frustration for consumers, their families and carers, they also place a heavy administrative burden on community mental health organisations and the NDIA.

Assessment tools

The lack of a functional assessment tool for people living with a mental illness seeking NDIS eligibility is a concern that has been raised by a number of community mental health providers. In many instances, diagnosis for mental illness will not provide an understanding of a person’s functional capability, and in situations where assessors and planners do not have specific mental health training, this lack of understanding will have an impact.

VICSERV understands that the NDIA is examining the potential use of a mental health functional assessment tool and we support the recommendation of CMHA that this work to be completed as a matter of importance. Although the NDIA undertaking this work is a welcome development, it remains a concern that this work was not undertaken prior to implementation, and of the potential impact this is having on people’s eligibility and level of support they receive through the NDIS.

Market readiness

Community Mental health Sector

As noted earlier, a central concern is that appropriate mental health supports for those with complex needs may not be available under the pricing structures of the NDIS. The issues that were raised in the section on ‘scheme costs’ are relevant in not only ensuring the ‘readiness’ of the community mental health sector, but to actually being supported in making the transition. Retaining a highly

qualified mental health workforce is likely to present a challenge, as the skills and knowledge required are not viable under the NDIS pricing structure for disability support.

The current pricing is based on the general disability sector at SCHADS level two, effectively the lowest common denominator. Many service providers have expressed a concern that this will create a market where clients are 'cherry picked' based on higher priced line items. VICSERV echoes the recommendation by CMHA that a new pricing catalogue - based on the service costs of providing complex psychiatric disability supports, rather than low level 'attendant care' supports - is needed.

Service providers have also expressed concern about the high risk of seeing significant market failure across the sector. CMHA warn of a perfect storm where - through the potential loss of existing skilled and qualified staff, and de-skilling of the mental health workforce, a removal in funding for community based rehabilitation services, and an 'exponentially growing level of disability' faced by the NDIA - organisations are unable to provide services commensurate with need, both to consumers with NDIS plans, and those without².

Carers

VICSERV strongly supports the CMHA's submission section on carers within the NDIS. Mental health cannot be simply made to fit a system which is focused on disability support, when psychosocial rehabilitation is a very different concept. A failure to recognise the complexities and issues particular to mental health may result in people who would have received psychosocial services not receiving them, and placing additional pressure on the health and social services system.

VICSERV supports CMHA in contending that support for carers should be separate to the NDIS; carers should not have their access to services – such as respite – tied to the assessment of the person they care for. This is problematic in general, but particularly in mental health where a person may be unwell and not recognise the need for a carer, or recognise that they have a carer.

The Commission's Issues paper identifies this as a workforce challenge - reducing the burden on informal carers will affect the need for formal carers. Yet the ideal that the load of informal carers caring for someone living with a mental illness will be reduced by the NDIS is somewhat of a false ideal. The reality of mental health carers is that they are typically – without the NDIS or not – going to be the first person that is called on by the person they call for, and VICSERV notes the recent release of a report by MIND Australia, which revealed that to replace informal mental health care with formal support services would cost \$13.2 billion.

² CMHA Submission (INSERT FULL DETAILS)

Regardless of supports for consumers being provided in a different way, or via a different mechanism, the informal network of supports that a consumer needs - and often relies on - will continue to be a factor.

Governance and administration of the NDIS

Quality assurance processes specifically developed for psychosocial services are a vital part to ensuring the current quality of service continues through the transition to the NDIS. VICSERV is encouraged by the announcement of the Quality and Safeguarding Framework for the NDIS, and believes that these processes can be accommodated within the ongoing development of this Framework. However, the quality of service that can be offered is likely to be affected by the impact of NDIS Pricing on the ability to provide ongoing training, supervision, and ongoing development to the workforce. As noted in earlier sections, the current unit pricing will not cover these costs, with the potential for this to lead to a decline in the quality and safety for both consumers and the workforce.

In terms of performance measurement, VICSERV believes there must be indicators other than simply the number of people receiving NDIS plans; these indicators might include the number of reviews and appeals that are requested, as well as overall consumer satisfaction with their plans. VICSERV supports CMHA's recommendation that as part of genuine engagement with consumers, people with a disability should be seen as a central part of the overall governance structures, including through representation on the NDIS Board.

Paying for the NDIS

VICSERV has concerns about a culture of 'cost shifting' occurring between state and territory, and federal governments. This includes the withdrawal of funding for state and territory funded mental health programs under the guise of this gap being addressed by the NDIS

We support CMHA's concern that having a stated guarantee of 'continuity of service' provides only assurances in word, but not in actuality. This concern extends to the lack of transparency in the bilateral agreements, which provide no information on funding contributions or commitments by governments to both the NDIS or state and territory mental health programs and services.

Finally, VICSERV stands with CMHA in supporting the submission by the Australian Council of Social Service (ACOSS) to the inquiry on the NDIS Savings Fund Special Account Bill 2016, which refers to other areas of essential human services not being targeted to fund another area of human services such as the NDIS