TITLE
The National Disability Insurance Scheme (NDIS) and mental health: A policy analysis

by
Ms Ruth Langmead
November 2018

Masters of Arts in Community Development
ART 610 12 Point Dissertation
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Ruth M Langmead
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ABSTRACT

The National Disability Insurance Scheme (NDIS) is a landmark policy commitment made by the Australian Government in 2013. The NDIS has established market mechanisms to support the delivery of services that, according to the National Disability Insurance Agency, offer participants both choice and control. The NDIS is also remarkable as being the first disability policy that has included mental health (referred to as psychosocial disability). There is a large financial commitment to delivering the NDIS, with a projected $22 billion investment by 2020 when full national roll-out is achieved; it is therefore necessary to analyse if the policy is effective in delivering the outcomes it promises. The aetiology of impairment in mental health conditions is largely positioned within the social, economic, systemic and political environments, the primary impact of which can be observed as stigma. This aetiology of impairment necessitates that policy promising to offer a better life to people living with mental health conditions, must have ecological frameworks central to policy mechanisms. It is imperative to understand what the NDIS policy foundations are to analyse if it is a viable alternative to current service delivery for people living with mental health conditions. A policy analysis is presented in two parts; firstly, a discourse analysis is undertaken that provides an historical context to the problem and further identifies the theoretical assumptions embedded in the policy foundations. Secondly, an analysis of the effectiveness of the NDIS in achieving its desired outcomes for psychosocial disability is measured against economic and social criteria. It is identified that the NDIS is a policy founded on strong neoliberal ideologies and whilst an ecological perspective is occasionally cited within policy material it is not supported within a market driven service delivery model. Due to the NDIS rollout being in its infancy there is a dearth of research around its effectiveness, this policy analysis identifies that there is a critical need for such research. Future research must specifically focus on outcomes for people with mental health conditions to advise on the need for ecological frameworks as an economically efficient and socially inclusive alternative.
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<td>ILC</td>
<td>Information Linkages and Capacity Building</td>
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<td>International Classification of Function</td>
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Chapter 1. Introduction

Public policy is a powerful tool that has the capacity to shape and be shaped by the understandings and expectations of a society in its given area of concern. Mental illness has consistently been misunderstood by society and consequently has had a global history of practices and policies that have demonised people experiencing mental health distress, depriving them of their rights, and dictating what treatment they could have access to, when and where. Our social evolution to the current day has resulted in policy and practice that is thankfully more humane, dignified and rights based, however as a society we still wrestle to understand and therefore accept, mental illness within our communities. Fear of mental illness is still prevalent in our society. It is projected onto individuals as stigma and drives government to make policy decisions constrained by our collective ignorance and prejudice. When fear and ignorance in society become institutionalised in systems and services, it ironically creates an environment with the capacity to increase both the prevalence and impact of mental illness.

There is no recent history in any modern nation-state, of mental health public policy embracing an ecological perspective of mental illness and associated disability. Understanding how the social, political, economic and institutional environments can impact on mental health is pivotal to understanding how best to respond to the needs of those living with a mental health condition. Australia has most recently introduced the National Disability Insurance Scheme - an individualised funding model for disability services that is inclusive of psychosocial disability associated with mental health conditions. This model establishes a market for support services as a means of offering people choice and control. This dissertation is primarily interested in asking two questions: What are the policy foundations of the National Disability Insurance Scheme and what do market-driven disability solutions deliver for people living with a mental health condition? In order to answer these questions this dissertation will conduct a policy analysis of the National Disability Insurance Scheme.

1.1 Background to the research

The National Disability Insurance Scheme (NDIS) was introduced to Australian public policy in 2013 when legislation was passed supporting disability reform. In response to calls from disability advocates seeking improved services, the Australian Government developed the scheme modelled on concepts of individualised funding, such as those utilised in the United Kingdom. The NDIS Act 2013 paved the way for the scheme to be progressively rolled out in 2016 via the established National Disability Insurance Agency (NDIA). The concept of individualised funding is intended to ensure that people are provided with tailored supports suited to their specific needs, instead of being at the mercy of generic and standardised systems that offer little flexibility. The NDIS “will support a better life for hundreds of thousands of Australians with a significant and permanent disability and their families and carers” (National Disability Insurance Agency, 2018a, p. 1). The NDIS is inclusive of people living with persistent mental health conditions who experience permanent functional impairment (termed as psychosocial disability by the scheme). This dissertation will provide a discourse analysis of the NDIS policy to identify the theoretical foundations and mentalities of government (or governmentalities) on which it stands, and seek to understand not only the opportunities, but also the limitations, of these foundations specific to mental health and psychosocial disability.
Within the NDIS the marketisation of disability support services aims to offer people greater choice and control in how they pursue life goals. Marketisation is a mechanism of neoliberalism, whereby the free market is expected to result in better services due to the nature of competition. It allows individuals to choose what services they want and who they want to provide them. Whilst a neoliberal market strategy responds to the demand for individual choice and control, this dissertation argues that it narrows the national disability policy discourse to a focus on the individual’s impairments, neglecting the wealth of research that supports disability as a construct embedded in the ecological model. The ecological model supports a policy paradigm that directs intervention not just at the individual level but also at the social, economic, systemic and political environments that the person lives within. Market-based approaches are effective in delivering tailored services, but they also place the onus of responsibility on the individual living with the impairment (Christiansen, 2017; Esposito & Perez, 2014; Sakellariou & Rotarou, 2017). This allows broader society to defer all responsibility to the individual for functional impairments that are constructed by the external environment. It is therefore important to understand how market-driven disability solutions work and what they deliver. To what extent can the NDIS deliver better lives? What limitations are there to the promise of a better life within market-driven solutions? It is the intention of this dissertation to explore not just what NDIS will deliver to the individual but also what it will deliver to the wider community. When individualisation is at the centre of disability policy what impact does this have on our broader society? Can individualised funding models sustainably deliver a more inclusive, cohesive and accessible society?

Analysing the NDIS in relation to the ecological model of health and disability is important because some diagnostic cohorts are more readily affected by social, economic, systemic and political factors. Mental health conditions have long been misunderstood by the broader society, and of all disability cohorts, have had the most enduring history of institutionalisation, marginalisation and stigma (Patel et al., 2018). Mental health literature clearly and consistently identifies the community within which people live as a primary resource for promotion, prevention and treatment (Min, Lee, & Lee, 2013). The most current iteration of best practice within mental health treatment is the recovery model, which draws attention to how mental illness interacts with the broader environment (Commonwealth of Australia, 2013). The concept of recovery in mental health is distinctly different from the typical understanding of the term and its application in general health settings pertaining to the absence of illness, symptoms or a return to ‘normal’ function. First defined by Anthony (1993, p. 15) mental health recovery is “a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness…it involves the development of new meaning and purpose for consumers and the ability to pursue personal goals”. This model focuses on gaining and retaining hope, understanding one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self (Commonwealth of Australia, 2010). The interpersonal nature of recovery is emphasised by Price-Robertson, Obradovic, and Morgan (2017), who further assert the need for future mental health service delivery to have greater emphasis on the environmental context beyond the individual. This dissertation proposes, that an individualised funding model that assesses functional impairments decontextualized from the ecological environment, will be inadequate for mental health recovery. It has been consistently acknowledged that people living with mental health conditions have been the least represented in the design, development, and implementation of the NDIS (Mental Health Australia, 2017); this highlights the need for closer analysis of the impact the policy is having on the lives of those it purports to help.
1.2 Literature review

1.2.1 Aetiology of impairment: the importance of the environment

Understanding the cause of ill health and disability is essential to developing adequate policy responses that meet the needs of those experiencing ill health and disability. The ecological model of health assumes that there are multiple levels of the environment external to an individual’s physiology that influence health, and furthermore that these levels interact with each other to impact upon health (Grzywacz & Fuqua, 2000). These environmental levels are most commonly categorised as intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy (McLeroy, Steckler, & Bibeau, 1998). As Dustin, Bricker, and Schwab (2009, p. 1) stated the ecological model “considers a broader conception of health that moves beyond human physical and mental health to include familial, communal, national, international, and global ecology”. Golden and Earp (2012) argue that sustainable health improvements are most likely to occur when all ecological factors are targeted simultaneously. Therefore, an individual cannot be well independent of the broader community at micro, meso and macro levels (Dustin et al., 2009). Specific to understanding disability Howe-Murphy and Charboneau (as cited by Wise, 2016, p. 6), state that the ecological model “portrays the source of disability as interactions between individuals and their environments”. Wise (2016) goes on to say that disability cannot be understood if any of the following three variables are excluded- the impairment, the environment and a person’s subjective experience of how the former two interact.

The International Classification of Functioning, Disability and Health (ICF) is an internationally recognised tool, developed by the World Health Organisation (WHO) that provides a scientific structure for describing, understanding and organising information on functioning and disability (World Health Organisation, 2001). It responded to criticisms of both the medical and social model of disability and integrated an ecological perspective within the aetiology of impairment (Guscia, Ekberg, Harries, & Kirby, 2006). The ICF uses three main categories to describe disability:

- Impairments: problems in body function and / or structure.
- Activity limitations: difficulties an individual may have in executing activities.
- Participation restrictions: problems an individual may experience in involvement in life situations.

The ICF clearly acknowledges that whilst personal factors can contribute to one’s experience of disability, so do environmental factors. Consequently, activity limitations and participation restrictions are never understood from assessment of the impairment alone but in the context of environmental factors—“the physical, social and attitudinal environment in which people live and conduct their lives” (World Health Organisation, 2002, p. 10). How these variables interact is depicted in Diagram 1.
Environmental factors can either act as an enabler or barrier to function. The ICF describes the environmental factors as - products and technology; natural environment and human-made changes to the environment; support and relationships; attitudes; services, systems and policies. The ICF provides excellent definition of these environmental factors to ensure the breadth and depth of impact they can have on function is comprehensively considered (further defined in Table 1). Barriers and enablers to function are understood to be embedded in the physical surrounds as much as in the attitudes of people delivering services and the values of society embedded within policy language.

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<th>ICF Environmental Factors</th>
<th>Description</th>
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<tr>
<td><strong>Products and technology</strong></td>
<td>Any product instrument, equipment or technology adapted or specifically designed for improving the function of a disabled person.</td>
</tr>
<tr>
<td><strong>Natural environment &amp; human made changes</strong></td>
<td>Animate and inanimate elements of the physical environment; components that have been modified; characteristics of human population</td>
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<tr>
<td><strong>Support and relationships</strong></td>
<td>People or animals that provide practical, physical or emotional support; nurturing protection; assistance</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td>Observable consequences of customs, practices, ideologies, values, norms, factual beliefs and religious beliefs.</td>
</tr>
<tr>
<td><strong>Services, systems and policies</strong></td>
<td>Services providing benefits, structured programs and operations in sectors of society to meet needs; administrative controls and organisational mechanisms, rules and regulations, conventions and standards used by micro, meso and macro communities.</td>
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Table 1: ICF Environmental factors (World Health Organisation, 2001)

Disturbingly, Guscia et al. (2006) note that few disability assessment tools and instruments give attention to the environmental factors aside from the ICF, with the broader factors of services, systems and policies ignored by all other instruments researched. Guscia et al. (2006) go on to argue in support of the ICF environmental assessment being used to guide intervention at a policy as evidence suggests that this will result in improved outcomes of participation for people living with a disability (Kuipers, Foster, & Bellamy, 2003; Min et al., 2013).
The **Social Determinants of Health** is an additional framework that supports the ecological perspective of health. The WHO established the **Social Determinants of Health** to formally validate that the environment, not human genetics, is the greatest cause of ill health in populations (World Health Organisation, 2003). These determinants are inclusive of social gradient, early life, stress, social exclusion and social supports, work conditions and unemployment; recognising that poor social and economic standards effect health throughout the lifespan. The World Health Organisation (2008) implores governments to write public policy through the lens of social determinants, in order to affect change on the root causes of ill-health and impairment. The World Health Organisation (2003) further urges governments to consider the role that political institutions play in influencing these determinants in that the distribution of money, wealth and power at local, national and international levels shape determinants.

It is apparent that health and disability policy in Australia focuses on individual behaviour change and medical treatment, to the neglect of the environmental factors that determine health (Fisher, Baum, Macdougall, Newman, & McDermott, 2016). In an Australian health policy analysis conducted by Fisher et al. (2016), it was identified that even where social determinants were acknowledged in policy it was limited to an identified need for education. This was restricted to providing health literacy to change individual behaviour choices rather than redirecting policy to address the broader environmental factors affecting socio-economic inequities that result in ill health and disability. Knowledge has not translated into action. Whilst the Australian Government recognises environmental factors and social determinants as a source of ill health and disability, Fisher et al. (2016, p. 17) identify that it has “not (been) combined with the political support, institutional partnerships and policy tools required to achieve systemic change”. Policy and intervention devoid of any understanding of the interactive nature of disability, the environment and situational experience, only serves to decontextualise and adversely individualise the problems (Kuipers et al., 2003). It can be argued that unless functional impairment is comprehensively understood within the context of environmental factors, not just the body structure or function, it will result in inadequate support to the individual. Carey, Malbon, Reeders, Kavanagh, and Llewellyn (2017) express similar concerns, focusing on the propensity for the NDIS to exacerbate health inequality through failure to recognise the variability of peoples’ ecological context. Analysing the problem in a compensable structure, Kuipers et al. (2003, p. 4) believes that failure to assess the environment results in unrealistic and unfair settlements stating “decisions made on the basis of individual impairment and assessment of functional outcomes alone do not account for the capacity of the individual in his or her environment, or his or her interaction with features of that unique context”. We can conclude from the literature that understanding the aetiology of impairment is pivotal to ensuring policy benefits those living with a disability. Whilst it is the individual who experiences the impairment in body structures and function, it is the micro, meso and macro level social, economic, systemic and political environments that construct barriers which interact with the impairments to either minimise or exacerbate the experience of disablement. Dustin et al. (2009, p. 7) state that “the larger community cannot be healthy independent of the condition of the individuals constituting it”, which suggests that an ecological perspective of disability has the potential to benefit not just the individual, but society as a whole.
1.2.2 Neoliberalism and disability policy

Neoliberalism is a broad political and economic movement that promotes the free market as the most efficient and effective way to organise and regulate all aspects of society (Esposito & Perez, 2014). The main perceived benefit of neoliberal market strategy is the promotion of individual responsibility, which is believed to offer individual liberty and freedom (Harvey, 2005). The role of the state in a neoliberal society is to create and sustain an institutional foundation that suitably cultivates free-market transactions, thereafter the market controls the state and becomes the sole regulatory force for government, economics and society at large (Esposito & Perez, 2014; Harvey, 2005; Liboro, 2015).

In addition, Liboro (2015) notes that where no markets exist, the role of the state is to create them (as seen within the NDIS). Specific to health and disability, neoliberal markets are viewed as an opportunity to offer people better service provision where government services are deemed expensive and inefficient (Christiansen, 2017; Haislmaier, 2008). This belief is demonstrated by the rise in neoliberal healthcare policy across the world, which correlated with a demand for austerity measures post-global financial crisis (Sakellariou & Rotarou, 2017). Competition embedded within markets effectively produces motivation for providers to deliver efficient and effective services at a lower cost. Individual responsibility is activated when people become ‘consumers’ purchasing goods and services, essentially turning disability services and healthcare into a commodity rather than a right (Henderson, 2005).

Christiansen (2017, p. 17) critiques market driven healthcare that focuses on strengthening an individual’s perceived deficits as targeting the individuals themselves to “remedy the impact of larger socio-economic systems that produce highly unequal outcomes in health”. When focusing on individuals, Esposito and Perez (2014, p. 421) state that neoliberal markets reduce society down to “a heap of individuals” and those individuals are considered normal and functional when they take responsibility for their own problems (Henderson, 2005). Disregarding the ecological model of health and disability, the individualising of disability care fails to acknowledge the negative impact on wellbeing that government policies can have (Christiansen, 2017; Shogren, 2013; Teghtsoonian, 2009). In health services “rather than emphasizing the web of institutional forces and social relations that shape individual behaviours and decisions, human agency is understood as simply a matter of individualised choices and private pursuits” (Esposito & Perez, 2014, p. 421). It is for these reasons that Liboro (2015 p. 213) calls for greater civic scrutiny of neoliberal policy and its effect on society, especially within psychological practice, stating that “as more people begin to recognize that health and economic problems are largely due to inequalities and inequities present in society, they can also start to understand the role that neoliberalism plays in promoting extreme consumerism”. Sakellariou and Rotarou (2017) analysed neoliberal healthcare reforms across many developed and developing nations and consistently identified the resultant increase in socio-economic disparity and health inequality for people living with a disability. This is evident in Australia as the rise of neoliberal politics in the 1980’s has resulted in an increase in socioeconomic, and therefore health inequity, in the past decade (Fisher et al., 2016).

Analysing the role of neoliberalism in mental health policy is crucial. When written into public policy, the apparent natural synergies between neoliberal ideology and the recovery framework, provide a false sense of security that mask significant problems, that warrant closer critique. With deinstitutionalisation and the anti-psychiatry movement of the late 90’s, the voice of advocate groups
resulted in the development of the Recovery Framework which became prevalent in policy discourse and remains today. Recovery principles seek greater autonomy and self-direction over treatment of mental health conditions in order to build a meaningful life as hope is associated with having personal agency (Commonwealth of Australia, 2013). Those supporting the free-market presuppose that it is complementary to these principles, delivering on individualisation and responsibilisation. In contrast to this seemingly natural fit of neoliberal theory embedded in mental health policy, Esposito and Perez (2014) consider prevailing neoliberal logic to be the driving force that sustains the viewpoint of mental illness being a problem with the individual, pathologising thoughts and behaviours that deviate from the norm as dysfunctional, unproductive and undesirable. Several authors have gone so far as to conclude that neoliberal policy in disability is a form of structural violence (Esposito & Perez, 2014; Sakellariou & Rotarou, 2017). Esposito and Perez (2014) challenge the neoliberal policy construct in accordance with the ecological model, stating that mental health impairments should not be divorced from social, economic and political aetiologies. Christiansen (2017) discusses the need for healthy macro policies, those that consider the ecological context of health and disability, as being diametrically opposed to global monopoly capitalism (Liboro, 2015).

1.2.3. Citizenship and justice

Citizenship is concerned with what it means to be a member of society, it encompasses identities, loyalties, rights, obligations and duties (Germov, 2014; Kenny & Connors, 2017). Germov (2014) explores citizenship in health from a sociological perspective, asserting that there are social institutions of citizenship that articulate the formal rights and obligations of individuals i.e. legislation, policies and parliamentary structures. These citizenship mechanisms control access to scarce resources by determining membership and eligibility. Germov (2014) goes on to say that morbidity and mortality rates become an index of citizenship. Citizenship in disability studies often centres around the role, opportunities and actualisation of citizenry for people with a disability. People with disabilities are more likely to be limited to passive citizenship, where, according to social expectations, opportunities for actualising citizen rights are bestowed upon them by systems and society at large (Kenny, 2011). It is often the case that in wanting to increase a marginalised group’s active citizenship, the marginalised themselves become the target of policy interventions aimed at building their capacity for civic engagement. Sakellariou and Rotarou (2017) recognise that neoliberal citizenship is seen as the responsibilities and obligations of people with disabilities to help themselves. As Teghtsoonian (2009, p. 29) describes it, neoliberal policy pushes people to be “enterprising selves” where issues of poverty and social exclusion become matters of self-care and self-management. This raises the question of whether it is just to expect the marginalised and oppressed to be the catalyst for change and the source of the solutions. Is it the individual’s responsibility to mitigate, compensate or remediate the impact of external environmental variables on their ability to be full participating citizens? Esposito and Perez (2014) believe that the rise of consumerism in disability policy has resulted in a decline of active citizenship within our communities where people hold civic obligations to a wider society beyond themselves. Tesoriero (2010) concurs that the term citizen, is often viewed through the individualistic lens of neoliberalism, and promotes the use of social-citizenship as a preferred alternative. Consistent with this sentiment, DeGuzman (2010) describes citizenship as a civic responsibility to serve others. Reduced citizenship participation of people living with a disability, should not be viewed as a problem belonging to people with disabilities, it is essential to focus attention on the environment within which the person lives which restricts citizenship. Phillips and Berman (2001, p. 24) describe the interaction between the environmental factors and citizenship rights as “the granting and maintenance of community citizenship rights is conditional upon the
community’s social quality, particularly with respect to the interaction of community social inclusion, social cohesion and empowerment”. What would it mean for the dominant majority to hold social-citizenship responsibilities to remove barriers to participation in civic life for people with a disability? In this dissertation, citizenship will be discussed not from the perspective of the person living with a disability, but from the perspective of community members more broadly. This dissertation seeks to explore the role of the dominant majority who construct the ecological environment within which people with a disability live, and the role of policy as a citizenship mechanism in the redistribution of scarce resources, power and responsibilities.

1.3 Methodology
1.3.1 Policy analysis

Public policy in modern Western democracy guides and governs most aspects of civic life—education, health, welfare, transport, justice, law, commerce and environmental management. As Althaus, Bridgman, and Davis (2018, p. 6) state “public policy is how politicians make a difference”. Policy is an instrument of governance that determines which objectives and substantive measures should be chosen in order to deal with a particular problem or issue (Althaus et al., 2018; Bessant, 2006; Fink-Hafner, 2011; Geva-May, 1997; Howlett, 2009; Munger, 2000). In relation to social problems such as health and disability, policy is the tool that government uses to determine the distribution of resources in response to unmet and competing needs—who gets what, when and how (Lasswell, 1951). This is done in an endeavour to improve people’s quality of life, wellbeing and dignity (Bessant, 2006; Fink-Hafner, 2011). Policy is a powerful tool that has the capacity to shape and be shaped by the understandings and expectations of a nation-state’s citizens in its given area of concern. Policy analysis is focused on understanding the problem and assisting policy actors (politicians, private stakeholders, consumers, community, trade unions and the third sector) to appreciate the costs and benefits of various approaches to a policy problem (Althaus et al., 2018). Policy analysis is an iterative process where the context and history of the problem is examined, and all possible alternative solutions identified and explored in terms of practicability, fiscal viability and effectiveness (Althaus et al., 2018; Bessant, 2006).

Policy analysis has been criticised for lacking rigour and impartiality, accused of becoming a bureaucratic exercise that is abused by political and ideological interests (Althaus et al., 2018; Bessant, 2006; Fink-Hafner, 2011). For policy analysis to be an independent process, Fink-Hafner (2011) proposes two essential aspects to guide the analyst-contextualisation and participatory orientation. Contextualisation is required for understanding both what is in the policy (content) and understanding how the policy came about (the policy process itself) (Fink-Hafner, 2011). Contextualisation requires that the problem and the policy is understood in its entirety, ensuring total configuration of all the interconnecting aspects with respect to both the history of the problem and the temporary nature of the current condition, whilst acknowledging that the policy environment is fluid (Fink-Hafner, 2011). Participatory orientation seeks to ensure policy stakeholders are involved in the analytical process and research of the problem, and that the analysis is not divorced from the real-world policy process, nor the coalface where policy is put into practice (Fink-Hafner, 2011). Participation of stakeholders ensures that recommendations are founded in public interest and consensus, and forces transparency of various stakeholder ideologies that can then be recognised and translated into a pragmatic struggle
for competing interests (Fink-Hafner, 2011). Good policy analysis should facilitate meaningful discussion of policy issues in a way that maintains political efficacy (Hajer, 2003).

The process of policy analysis is commonly simplified into five steps: problem identification/formulation; selection criteria (against which analysis occurs), comparison and selection of alternatives; consideration of constraints; and implementation and evaluation (indicating a ‘policy cycle’) (Althaus et al., 2018; Munger, 2000). Problem identification requires the analyst to identify and understand the context and actors—the sites/settings where the problem and policy decisions exist, and the individuals or groups currently concerned or likely to be involved in the problem (Geva-May, 1997). The analysis can draw from several frameworks, including economic, social, environmental, legal and political. Selection criteria are then applied to a range of possible policy alternatives (including historical policies) to determine their impact and feasibility, this component of policy analysis is known as modelling (Geva-May, 1997). Modelling contributes to the objective comparison of alternatives and selection of new solutions to the problem. It is unlikely that any public policy will be without constraints (Althaus et al., 2018). Constraints require careful consideration to negotiate and mediate the influence they may have on the policy goals, thereafter the selected policy option can be implemented and evaluated.

1.3.2 Analysing the NDIS

A policy analysis will be conducted specific to the NDIS and psychosocial disability. This analysis will centre on the identified problem of higher rates of disablement associated with environmental factors, experienced by people living with a mental health condition compared to people of other diagnostic cohorts. This policy analysis will pursue three areas of inquiry:

- What are the policy foundations of the NDIS and how might it be different?
- What, and how, do market-driven solutions deliver specific to the NDIS and mental health?
- Are, market driven-solutions proving to be effective within mental health/psychosocial disability thus far?

A policy analysis of the NDIS and its application to psychosocial disability will be contextualised and juxtaposed with an exploration of Australian mental health policy and practice. A discourse analysis will identify the policy foundations specific to individualisation associated with neoliberal ideologies, and conversely social citizenship associated with ecological frameworks. Information Linkages and Capacity Building policy components will be included in the discourse analysis. This dissertation will utilise economic and social selection criteria frameworks (as defined in Table 2) to analyse the practicability, fiscal viability and effectiveness of market-driven solutions in improving the lives of people living with mental illness. Evidence of outcomes and impact of the NDIS for this cohort will be identified. Participatory orientation is upheld within the analysis by drawing on primary literature from consumer and carer advocacy groups, mental health non-government sector peak bodies, and government statistical data and evaluations of participant engagement and satisfaction with NDIS. Policy solutions are proposed as recommendations that apply, not just to the NDIS, but to mental health and disability policy more broadly.
<table>
<thead>
<tr>
<th>Analytical frameworks</th>
<th>Criteria options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic</td>
<td>Cost effectiveness: which policy option will achieve its goals most efficiently?</td>
</tr>
<tr>
<td></td>
<td>Cost benefit analysis: what policy option will produce the greatest economic benefit to society?</td>
</tr>
<tr>
<td></td>
<td>Opportunity cost: what is not being funded in the decision to choose one policy direction above another?</td>
</tr>
<tr>
<td>Social</td>
<td>Rights: which policy option protects or advances people’s rights and educates on social obligations?</td>
</tr>
<tr>
<td></td>
<td>Equity: which policy option identifies and empowers community groups in the process? How does the policy affect them?</td>
</tr>
<tr>
<td></td>
<td>Participation &amp; access: how does the policy impact on people’s ability to participate in society and access resources they need?</td>
</tr>
</tbody>
</table>

Table 2: NDIS policy analysis criteria, modified from Althaus et al. (2018)
Chapter 2. Policy outline: NDIS and psychosocial disability

2.1 Policy content: Eligibility, access and service delivery in mental health

In 2011, the National Productivity Commission released an inquiry report examining disability services in Australia. The report identified that the disability system was “underfunded, unfair, fragmented and inefficient and gave people with disability, their families and carers little choice and no certainty of access to appropriate supports” (Commonwealth of Australia, 2011a, p. 2). The National Disability Insurance Scheme Act 2013 marked the nation-wide implementation of a policy providing individualised support for people with disabilities, their carer’s and families (National Disability Insurance Agency, 2018b). It is intended that full roll-out of the scheme will occur by July 2019, with an estimated 460,000 participants (National Disability Insurance Agency, 2018b). People 65 years and under, who have a permanent and significant disability, are eligible to access an individualised plan funding services and supports considered reasonable and necessary (Office of Parliamentary Counsel, 2014). A ‘permanent and significant disability’ is that which impacts on everyday activity and is unable to be resolved through treatment (also referred to as functional impairment). In alignment with this definition, the NDIS will not fund ongoing medical/psychiatric costs, clinical treatment including inpatient services and ongoing rehabilitation or medication interventions. Importantly, the NDIA specifies that the NDIS is a social insurance scheme not welfare, and as such it takes a lifetime approach seeking to minimise support costs over a participants lifespan “by investing in people early to build their capacity to help them pursue their goals and aspirations resulting in greater outcomes later in life” (National Disability Insurance Agency, 2018b, p. 4.3).

People living with a mental health condition, and meeting the aforementioned eligibility criteria, can access the scheme under the rules for psychosocial disability;

“Psychosocial disability is the term used to describe disabilities that may arise from mental health issues. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage” (National Disability Insurance Agency, 2016b, p. 1)

NDIS purports to provide eligible people living with a mental health condition certainty of funding to support opportunities in the community, offering the participant flexible choice and control on how funding is utilised in order to be responsive to changing needs. Participants establish goals that address functional impairments and will result in the participant living a better life; thereafter “a participant’s individualised plan documents their goals and how much funded support they need to achieve those goals” (National Disability Insurance Agency, 2016b, p. 2).

The NDIS aims to:

- support the independence, social and economic participation of people with disability;
- enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;
- promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community;
raise community awareness of the issues that affect the social and economic participation of people with disability and facilitate greater community inclusion of people with disability.

(National Disability Insurance Agency, 2018b, p. 4.4.1)

Information Linkages and Capacity Building (ILC) is a component of NDIS (previously known as tier 2 of the NDIS) that seeks to:

- provide information, linkages and referrals to efficiently and effectively connect people with disability, their families and carers, with appropriate disability, community and mainstream supports;
- ensure the NDIS establishes and facilitates capacity building supports for people with disability, their families, and carers that are not directly tied to a person through an individually funded package;
- promote collaboration and partnership with local communities and mainstream and universal services to create greater inclusivity and accessibility of people with disability.

(National Disability Insurance Agency, 2015, p1)

The NDIS is a mechanism through which the Australian Government can implement the National Disability Strategy 2010-2020, which is described as a shared vision for “an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens” (Commonwealth of Australia, 2011b, p. 8). Furthermore, the NDIS fulﬁls international obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which Australia ratified in 2008. In summary the NDIS is considered by government to be an instrument for upholding the basic human rights of people living with a disability, embodying the whole-of-life approach outlined in the National Disability Strategy 2010-2020 that sought to prioritise comprehensive and coordinated planning at local, state and national levels of government.

2.2 Policy context: an historical perspective of mental health policy

Mental health policy typically outlines a government’s official intent in terms of actions, strategies, timeframes, budgets, targets and indicators for improving the mental wellbeing of the population (Shen, 2013). According to Shen (2013), mental health policy should clearly articulate what a government (and arguably a society) values and believes in relation to mental health and illness. The NDIS is the first national policy applied to mental health that focuses on providing targeted individualised support for long term, permanent functional impairments in community settings. It is the first policy that has separated active mental health treatment, rehabilitation and recovery, from permanent mental health impairment and disability. The NDIS does offer some benefit to people living with mental illness, but there are a growing number of opponents who believe it to be ill-fitting and misplaced (Antcliffe, 2017; Choahan, 2018; Morton, 2017; Tisdell, 2018). An exploration of Australia’s mental health policy history can provide clarity on why a targeted psychosocial disability policy has not existed in the past, and why concerns might exist for this future approach to mental health.

In nineteenth-century Australia, mental health policy was typified by the use of asylums. Asylums enabled “emerging colonial aspirations of ordered space and moral rectitude” (Day, as cited by
Gooding, 2016, p35) but were also misused to support detection and surveillance of gender and ethnicity subgroups and those people believed to be degenerate and immoral (Coleburne, 2003; Finnane, 2003; Hunter, 1997; Rosen, 2006 as cited by Gooding, 2016). Such use of asylums was embedded in eugenics, which is a belief and practice aimed at improving the genetic quality of a population (Collins Dictionaries, 1994). Hence with the rise and fall of Nazi Germany in the minds of post-war Australia (and globally), such practices lost popularity and public confidence (Gooding, 2016). The implementation of the Dangerous Lunatics Act 1943 represents an understanding of the need to distinguish mental illness from criminality, but still uphold a requirement for incarceration (Gooding, 2016), therefore asylums continued to be heavily utilised as post-war mental distress and disability was medicalised. Medicalisation and institutionalisation were strengthened in law with the advent of the first Mental Health Act 1959 in Victoria which, as Gooding (2016, p. 3) describes “expanded the scope and importance of the term ‘health’ in justifying detention and involuntary treatment”. Locally and globally however, policy conversations began to broach de-institutionalisation, the conceptual emergence of which is attributed to a number of variables inclusive of: the development of psychopharmacotherapy, changing patterns of welfare provisions, the emergence of the anti-psychiatry/survivor movement and the rapidly decreasing popularity of large asylums and institutions. The anti-psychiatry movement, led by ex-patients of asylums who had ‘survived the system’, demanded policy change that embraced human rights, dignity, integration and social inclusion. In the 1980’s, Australia underwent a rapid process of de-institutionalisation to community-based service delivery (Gooding, 2016). In addition to the aforementioned variables, the momentum of de-institutionalisation was aided by the emergence of neoliberal politics. Policy supporting de-institutionalisation was largely driven by economic factors as government sought to privatise and deregulate expensive human services (Gooding, 2016; Grace et al., 2015; Ramon, Healy, & Renouf, 2007). The end result was the closure of psychiatric institutions, acute psychiatric services were integrated into general hospitals and health care; and the development community mental health clinics took place (Gooding, 2016; Grace et al., 2015).

By the following decade it was internationally agreed that a rights-based approach to mental health policy needed to be mandated, resulting in the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991. The Australian National Mental Health Policy (NMHP) 1992 reflected the need for legal protection against violations of human rights and civil liberties for people in mental distress (Commonwealth of Australia, 1992). Australia still maintains a practice of medically authorised detainment and involuntary treatment for acute mental distress and crisis, supported by law and policy, but the NMHP 1992 mandated that such practices would be held to high standards of account by Mental Health Review Boards and statutory bodies. In addition, it promoted the creation of professional roles for service users more commonly referred to as ‘people with a lived experience of mental health’. Establishing these roles was an action in keeping with the need to transfer power away from service providers towards service users, and a commitment to showing respect to service users and their carers (Gooding, 2016; Grace et al., 2015). The NMHP 1992 was the first national plan that began centralising mental health policy reform and was followed by four consecutive 5 yearly plans (Grace et al., 2015). The ongoing appetite of the national Liberal Party government for neoliberal economic and social policy resulted in privatisation of mental health services and the growth of the non-government sector who were funded with unprecedented budget to deliver community-based mental health support (Gooding, 2016; Grace et al., 2015; Ramon et al., 2007; Shen, 2013). The NMHP 1992 also referred to service users as consumers, consolidating the marketisation of mental health service provision and concurrently reflecting the
demand from advocacy groups for people living with mental illness to be recognised as self-actualising and be empowered to have more control (Grace et al., 2015; Ramon et al., 2007). This synergy between neoliberal governance and the mental health advocacy movement is, as Gooding (2016, p. 11) suggests, “an uneasy alliance”. This alliance was consolidated with the rise of the recovery movement in the late 1990's and beyond.

The Second NMHP was released in 1998 and focused on mild to moderate mental illness and associated promotion and prevention (Grace et al., 2015), thereby moving attention away from the needs of people living with severe mental illness. As consumer advocacy in Australia grew, the recovery paradigm was further conceptualised but not yet embedded in policy practice (Commonwealth of Australia, 2013). Consistent in all recovery writing is approaching people as individuals with unique experiences and strengths that enables a move away from the biomedical model alone and a shift towards personal recovery rather than clinical recovery (Price-Robertson et al., 2017; Ramon et al., 2007). The Third NMHP 2003-2008 was the first policy to overtly centre around recovery principles, specifically defining them in accordance with Anthony (1993), stating that “mental health service providers should operate within a framework that supports recovery” (Commonwealth of Australia, 2003, p. 5). This was consistent with global mental health reform where recovery was the rally-cry for 21st century policy (Hunt & Resnick, 2015). Concerns exist that whilst shifting greater responsibility to consumers offers autonomy and agency, the policy adoption of recovery relieves society, service systems, structural factors and government of responsibility for issues of social justice intertwined with the experience of mental illness (Price-Robertson et al., 2017; Ramon et al., 2007). This is in addition to concerns that the promotion of self-determination within a recovery framework has been co-opted by market-based individualism. In response to these criticisms Price-Robertson et al. (2017, p. 2) put forward the concept of “relational recovery” to acknowledge that “people’s lives and experiences cannot be separated from the social contexts in which they are embedded”. These criticisms, together with the proposed relational recovery, merit further discussion in an NDIS policy analysis and will be expanded upon in understanding the problem as policy.

In 2009 the Fourth NMHP 2009-2014 was released. It focused on minority groups (Aboriginal and Torres Strait Islanders) and further accreditation and reporting standards. This did not garner so much attention, as the National Action Plan on Mental Health 2006 superseded the Fourth NMHP. The National Action Plan on Mental Health promised $1.8 billion of funding to support mental health reform that again focused on prevention and early intervention, especially in the youth sector, and the 2011 budget contributed a further $2.2 billion. The Fifth National Mental Health and Suicide Prevention Plan 2017 is the most current iteration of national mental health policy. It centres all reform around the active role of consumers, carers and advocates in service delivery and development, and prioritises the need for integrated services across sectors. It again endeavours to target resources in Aboriginal and Torres Strait Islander communities, but most importantly, includes suicide prevention within its core policy statement. Recovery is still front and centre in Australian mental health policy. The National Mental Health Standards 2010 direct that service delivery focuses on recovery, requiring that consumer strengths be acknowledged and integrated into all aspects of care, service delivery and development (Commonwealth of Australia, 2010). The Fifth NMHP 2017 acknowledges the importance of the NDIS as a parallel policy for psychosocial disability (Commonwealth of Australia, 2017). The NDIS marks the emergence of the term ‘psychosocial disability’ and a focus on permanent impairments, a discourse not utilised since the asylum era and overtly contrary to the ethos of hope, strength and autonomy embedded in recovery frameworks. The NDIS policy language of disability and deficit is one that has been both foreign and foe to the mental
health sectors’ recent history and is one of several indicators that the NDIS may not be an adequate policy approach.

Diagram 2: Australian mental health policy history

<table>
<thead>
<tr>
<th>1900s</th>
<th>Post WWII</th>
<th>1980s</th>
<th>Late 90s - 2000</th>
<th>Late 2000s</th>
<th>2010 onwards</th>
</tr>
</thead>
</table>

Master of Arts in Community Development
ART610 Dissertation

R. Langmead 3132 6375
November 2018
Chapter 3. A policy analysis: NDIS effectiveness in mental health & possible alternatives

3.1 Identification of the problem:

Typical to most areas of health and disability, government understanding of mental health is characterised by three primary problems: the impact of mental health conditions on a person’s life; the costs associated with treatment and/or non-treatment; and the prevalence of mental health conditions. The National Mental Health Plan 2017 in conjunction with the NDIS, is focused on reducing the impact, cost and incidence of mental health related disabilities in the Australian population. Specifically, NDIS policy focuses on impact and offers an individualised funding model to those people whose mental health condition has a substantial impact on their life due to a permanent and significant functional impairment. Herein lies the problem, the cause of impairment does not lie within the individual alone.

3.1.1 Disability and mental illness - the aetiology of impairment

“The experience of profound mental distress is embedded in a series of relationships to social structures and institutions, which can simultaneously care, cure, confine, control, alienate, support and stigmatise” (Gooding, 2016. p. 4)

It is a commonplace assumption that a person’s experience of disability is determined by their symptomology (their body structures and function) alone. Sadly, however, this is not the case, yet it is a persistent misunderstanding faced by people living with a mental health condition. As suggested by Drake, Bond, Thornicroft, Knapp, and Goldman (2012, p. 7) “psychiatric illness outcomes minimally correlate with functional outcomes”. Extending upon this, Marfeo (2012) reveals that people with similar diagnostic features measured against the strict criteria of a mental health condition can have substantial variations in role functioning and disability. Drawing upon the understanding that disability is not quantified by the symptoms and impairments alone, but by the dynamic interaction of the mental health symptoms, the person and their environment (Marfeo, 2012). Environmental factors construct a large part of peoples’ lived experience of mental ill-health when the social, attitudinal, systemic and policy environments create barriers to participation in normal activities. There is a wealth of evidence validating the fact that people with mental health conditions regularly experience stigma, prejudice and discrimination (Drake et al., 2012; Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). Stigma leads people to judge another as illegitimate, followed by actions that exclude others from social participation (Brohan, Slade, Clement, & Thornicroft, 2010). This participation exclusion is extended to education, employment and even access to healthcare services (Cummings, Lucas, & Druss, 2013; Evans-Lacko et al., 2012) when society at large adopts stereotypes of people with mental health conditions as being incompetent or prone to violent, unpredictable and criminal behaviour (Brohan et al., 2010; Cummings et al., 2013). Stigma can be pervasive and subtle. People living a mental health condition often report health practitioners’ attitudes being disempowering and stigmatising (Grace et al., 2015). Stigma constructs an environment that exacerbates the functional impact of psychiatric symptoms. Intersectionality (the interconnected nature of social categorisations (Collins Dictionaries, 1994)) is a matter of significance when discussing stigma and mental health. The experience of mental health stigma is amplified for those people who are Aboriginal, LGBTQI or culturally and linguistically diverse (CALD), and mental health conditions are of higher prevalence in
Aboriginal, LGBTQI and CALD communities (Commonwealth of Australia, 2017; Livingston, 2013). These populations are not only marginalised but also minority groups and therefore socially and structurally underrepresented, and so the presence and impact of stigma is greater (Livingston, 2013).

<table>
<thead>
<tr>
<th>Concept of stigma</th>
<th>Scope of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social stigma</td>
<td>individual and collective stigmatising attitudes and beliefs about mental illness</td>
</tr>
<tr>
<td>Self-stigma</td>
<td>the stigmatising views that people living with mental illness hold about themselves, adopted from social stigma</td>
</tr>
<tr>
<td>Structural stigma</td>
<td>the policies and practices of social institutions that restrict opportunities for people living with mental illness</td>
</tr>
</tbody>
</table>

Table 3 Defining stigma (Livingston, 2013)

Stigma and discrimination associated with mental illness creates a vicious cycle of exclusion as people with a mental health condition do not seek to engage with various roles as they believe they are not deserving of certain rights and opportunities. This is defined as self-stigma in table 3. For example, when an individual living with schizophrenia chooses not pursue employment because they assume, they will be discriminated against or assume that despite qualifications they are not deserving of the job (Brohan et al., 2010; Cummings et al., 2013; Evans-Lacko et al., 2012; Livingston, 2013; Naanyu, 2009; Tang & Wu, 2012). Livingston (2013, p. 6) summarises that “the subjects of stigma are redirected on a path where their identities are engulfed, their relationships transformed, and the direction of their lives shifted because they have been marked by a stereotyped attribute”. Consequently, people living with mental health conditions are twice as likely to remain unemployed and live in poverty; that is, 30–50% less likely to be employed compared to other disabilities and health conditions (Drake et al., 2012). When one lives in poverty the experience of economic exclusion increases. According to Drake et al. (2012) schizophrenia and bipolar are diagnoses that are often more difficult to treat, longer lasting and of greater severity. Stigma compounds this prognosis, as schizophrenia attracts more stigmatising attitudes than depression and anxiety (Evans-Lacko et al., 2012). Furthermore, the effects of stigma are understood by Schulze and Angermeyer (2003) to be more debilitating than the effects of the illness itself, so much so it can result in secondary illness (Naanyu, 2009). Unsurprisingly, the societal costs associated with mental health include the cost of supporting income and housing and these costs that are likely to persist for many years due to the chronicity of more severe conditions (Drake et al., 2012). Naanyu (2009) makes some insightful remarks on how stigma functions to decrease expectations society has of people with mental illness and leads to a belief that people with mental illness are less entitled to have access to civic resources which has the overall impact of decreasing one’s quality of life. Consequently, if we understand that in democratic nations it is collective societal values that dictate distribution of resources through government policy, we can extrapolate that stigma results in less advocacy and public demand for increased mental health funding, which translates into smaller budgetary allocations and siloed policy. When social stigma dictates public policy, the policy environment itself contributes to the experience of disability. This is defined as structural stigma in table 3. Shen (2013) urges the structural context of inequities experienced by people living with mental health conditions be addressed by policymakers which would require a shift away from the current focus on biological, medical and pharmacological investment. Policy that contributes to reducing stigma, prejudice and discrimination in the general
public would result in improved quality of life for people living with mental health conditions (Evans-Lacko et al., 2012) and it is argued that this would be a sustainable and cost-effective approach to disability policy in mental health.

3.1.2 A discourse analysis: understanding the NDIS policy foundations

“How a policy problem is discovered, understood or represented has much to do with the way that certain ideas or discourses helped to invent or constitute that problem.”

(Bessant, 2006, p. 268)

Understanding the aetiology of impairment in mental health conditions indicates that psychosocial disability needs policy which directs attention to ecological models of health. As previously discussed, neoliberal healthcare policies typically seek to individualise and marketise problems resulting in responsibility of the problem being attributed to the individual (responsibilisation). To evaluate the effectiveness of NDIS as a policy approach to psychosocial disability, we must understand the origins of its discourse pertaining to both ecological and neoliberal approaches to the problem. Table 4 NDIS discourse analysis identifies policy aspects that indicate foundations within either neoliberal or ecological ideologies.

The policy architects behind the NDIS, believe independence, economic participation and social inclusion is achievable by providing supports and services to individuals to compensate for impairments. As an individualised funding model, the NDIS is inherently aligned with neoliberal discourse, where it is the responsibility of the individual experiencing disablement to exercise choice and control over supports and services deemed reasonable and necessary for, what NDIA has described as both a “better life” and a “normal life” (National Disability Insurance Agency, 2018a, p. 1; 2018b, p. 4.1). This implies that if participants do not experience increased social and economic participation, it is associated with failings in the execution of their own ‘choice and control’ and consequently it is their responsibility to rectify within the structures provided by the NDIS i.e. planning and review processes. The impact of individualisation within NDIS is particularly concerning for psychosocial disability participants, especially when funding allocation requires that support needs be articulated within participant goals. Drawing on the impact of self-stigma, it should not be assumed that NDIS participants with a mental health condition will readily aspire to ‘normal life’ achievement. This is not because they are not aspirational by virtue of character but rather their aspirations are oppressed by stigma. Evidence suggests that self-stigma results in decreased expectations of what one is both capable of and deserving of regarding quality of life (Livingston, 2013). Individualisation of the problem is counterproductive to the policy goal of supporting a ‘normal life’ for psychosocial disability participants, as effective outcomes can only be achieved once environmental barriers have been rectified, thereby reducing the impact of stigma.

The NDIS claims to adopt recovery principles, stating that recovery in relation to NDIS “is about maximising the potential of individuals with a psychosocial disability to participate in the community” (National Disability Insurance Agency, 2016a, p. 1). As has been previously suggested, recovery paradigms and neoliberal ideology have an immediate synergy that masks how the philosophical foundations are diametrically opposed. The appeal of this immediate synergy has not evaded NDIS
Considering the aetiology of impairment, it is concerning that recovery has been translated into neoliberal language ‘maximising potential of individuals’ and not ‘creating opportunities for individuals’ to participate in community. Maximising potential of the individual infers a focus on changing the behaviours, attitudes, skills and beliefs of the individual, placing direct responsibility for the problem onto the participant. Further to this, the policy aligns itself with the strength-based focus of a recovery journey, stating that NDIS planning identifies and harnesses strengths (National Disability Insurance Agency, 2016a). Strength-based policy paradigms continue to perpetuate dominant understandings of mental health conditions – that individuals have the responsibility to improve their lives and should they fail to do so, it is because they are somehow morally deficient or flawed human beings and therefore not deserving of full citizenship and social inclusion. Choice and control for participants is also purported to uphold recovery principles, since “the road to recovery is best judged by the participant...support includes capacity building for self-management, including choosing supports and who provides supports” (National Disability Insurance Agency, 2016b, p. 1). Self-management and provision of supports to the individual extends the discourse of responsibilisation rather than promoting a form of client-centred practice that would relieve participants of ill-directed responsibilisation and redirect attention toward changing the social, economic and political environments participants function within. Recovery, when saddled by neoliberalism as it is in the NDIS, results in what Harper and Speed (2012, p. 1) describe as an “individualistic experiential narrative accompaniment to medical understandings where the structural causes of distress are obscured”. Individualisation of psychosocial disability within NDIS policy limits the scope of recovery practice to consider only the individual as a catalyst for change towards the goal of a better life. Recovery as a philosophical concept was an extension of the survivor movement, a celebration of having survived an oppressive system and a consequent reclaiming of human rights. The origins of the recovery movement were deeply rooted in a collective struggle for dignity and recognition that would have the secondary gain of socio-economic inclusion. Harper and Speed (2012) and Price-Robertson et al. (2017) both note the failure of modern recovery language to include aspects of redistributive justice that would target the underlying causes of distress embedded in the environment. Individualisation of the recovery model as written into the NDIS, serves only to continue to perpetuate an expectation of responsibility for impairments onto participants. In light of understanding the aetiology of impairment, this is misplaced responsibility and serves to further reinforce societies negative views of mental health conditions that produce stigma. Redistributive justice would seek to shift responsibility away from NDIS participants and otherwise expect and equip society to engage with those responsibilities embedded in ‘social citizenship’.

Included in the NDIS is the Information, Linkages and Capacity Building policy component (ILC). ILC is an aspect of the policy that clearly has origins within an ecological context however the ecological intent becomes skewed by individualised discourse that subtly appears throughout the ILC policy components. In describing ILC, the National Disability Insurance Agency (2015, p. 12) states it “has a key role in supporting and strengthening effective local initiatives by community groups and businesses to address disability issues in the community”. Whilst acknowledging that the aetiology of impairment is embedded in a broad range of environmental factors (National Disability Insurance Agency, 2015), ILC problematically relies on the community to take the initiative to redress barriers which the NDIS can then align with to support. Community awareness and capacity building for mainstream services is enacted by providing information and training on how services, businesses and groups can increase accessibility. This assumes that society at large is aware of its contribution to the lived experience of disability and in the mental health context, assumes there is interest and incentive
within communities to rise above stigma associated with aligning one’s business or group with mental health initiatives and inclusion. There is a wealth of evidence in the employment and housing sectors alone of how stigma has resulted in businesses rejecting the opportunity to adopt initiatives for people with mental health conditions, concerned with impact on business image, profitability and safety (Marfeo, 2012; Morrow, Wasik, Cohen, & Perry, 2009; Shim, Kho, & Murray-García, 2018; Tang & Wu, 2012). Whilst ILC does draw on the notion of social-citizenship (responsibilities held by society to remove barriers to participation in civic life, for people with a disabilities) it is undermined by society having no basic insight into how it constructs barriers to participation and inclusion for people with mental health conditions. Furthermore, society has no awareness of their responsibility to contribute to removal of barriers, namely stigma. Psychosocial disability aspects of the policy rely on this dangerous assumption stating that;

“A participant’s individualised plan will also document their informal supports (such as friends, family, colleagues) along with supports they access from their local community and other government systems. That way, we can work with you and community organisations to see that these are continuing to meet your needs over time.” (National Disability Insurance Agency, 2016b, p. 2)

The policy has made no accommodation for the significantly depleted social resources that people living with chronic and persistent mental health conditions experience because of stigma. With no policy commitment to raising society’s consciousness of the roles and responsibilities they have in relation to stigma there is no foundation upon which social citizenship can be expected as is the case in the ILC components of the NDIS policy. Perhaps almost by default the ILC reverts to language of individualisation, assuming it is the individual’s responsibility to bring their own ecological resources or otherwise focusing on building the participants knowledge and capacity to engage with mainstream services and supports.
Table 4: NDIS discourse analysis

<table>
<thead>
<tr>
<th>Policy reference</th>
<th>Discourse indicators</th>
<th>Identification of neoliberal and/or ecological assumptions</th>
</tr>
</thead>
</table>
| NDIS Act, Chapter 1 Section 3: Basic description & outline | States that NDIS will  
▪ support the independence and social and economic participation of people with disability (section 3(1)(c));  
▪ provide reasonable and necessary supports, including early intervention supports, for participants in the NDIS (section 3(1)(d));  
▪ enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports (section 3(1)(e))  
▪ promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community (section 3(1)(g)); | Supporting social and economic participation is embedded in an understanding that inability to do so is due to a lack of support provided to the individual and their impairments. Full inclusion is associated with maximum independence that will be achieved when the individual has supports provided to them, rather than full inclusion being a result of removal of environmental barriers to participation i.e. stigma. |
| NDIS Act, Chapter 1 Section 4: General principles that guide the Act | Principles guiding the Act are based in appropriation of human rights-the right to access and control services and supports, and the right to full citizenship and community inclusion/participation. These rights will be actualised primarily through the provision of ‘reasonable and necessary supports’ for people with disability that should:  
i. support people with disability to pursue their goals and maximise their independence (section 4(11)(a));  
ii. support people with disability to live independently and to be included in the community as fully participating citizens (section 4(11)(b)); and  
iii. develop and support the capacity of people with disability to undertake activities that enable them to participate in the community and in employment (section 4(11)(c)); | The securing of rights for people with a disability is achieved via intervening at the individual level-compensating an individual’s inability to secure one’s rights independently through provision of personalised support services (an individualised approach) rather than removing the environmental factors that result in abuses of rights. Focusing on the individual appears benevolent and paternalistic. Focusing on the environment rather than the individual, would be a truly rights-based approach that removes the source of the oppression rather than expecting further initiative and investment from the oppressed. |
### NDIS Act, Chapter 3, Section 33: Participants and their plans

“The goals, objectives and aspirations of the participant A participant’s statement of goals and aspirations must identify the personal goals, objectives and aspirations a participant wishes to pursue (section 33(1)(a)).”

“The NDIA will adopt a strengths-based approach in supporting a participant to identify their goals, objectives and aspirations. Strengths based approaches focus on untapped gifts, positive attributes and underdeveloped capabilities which can direct a participant’s potential for positive functioning. The decision on how far to pursue these ideals remains with the participant.”

(National Disability Insurance Scheme, 2018, p. 7.5)

Support is ‘goal’ oriented, relying on the individual to identify goals, in so doing it neglects the impact that stigma can have on reducing people’s expectations of self. The outcome of self-stigma results is a reduced sense of entitlement to equal rights and quality of life, therefore self-identified goals may never truly result in a realisation of one’s full rights to equal participation.

### Role of the NDIA

Describes the role of the NDIA in building community awareness of disabilities and the social contributors to disabilities. This will be achieved though provision of ‘general supports’ primarily within the policy category of Information, Linkages and Capacity Building (ILC) (section 13(2)).

<table>
<thead>
<tr>
<th>ILC Streams</th>
<th>Description</th>
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<tbody>
<tr>
<td>Information linkages and referrals</td>
<td>Connects people with disability, their families and carers with appropriate disability, community and mainstream supports via provision of information.</td>
</tr>
<tr>
<td>Capacity building for mainstream services</td>
<td>Ensures people with disability are connected to and can access mainstream supports.</td>
</tr>
<tr>
<td>Community awareness</td>
<td>Invests in building long-term community capacity to support people with disability, their families and carers to ultimately reduce the need for formal disability supports e.g. providing basic training to businesses or volunteers</td>
</tr>
</tbody>
</table>

A focus on social contributors to disability is embedded in an ecological framework however this is achieved via passive ‘awareness raising’. Careful attention to the language continues to reveal an individualised approach i.e. connects people with disabilities to mainstream supports rather than the expectation that mainstream services actively seek inclusion. Capacity building for mainstream services takes the form of information provision but there is no significant funding attached to activities that improve accessibility (further analysed in section 3.2). Community awareness is for ‘basic training’ only. i.e. there is no funding offered for implementing mandatory complex training on identifying and understanding the impact of stigma and demystifying signs and symptoms of mental illness in all government services and systems. The attempt to address environmental barriers to participation within ILC is further undermined by the inclusion of individual capacity building and coordination, perpetuating the expectation that the individual needs to compensate for
| Individual capacity building | Invests in building capacity of individuals to improve outcomes for people with disability, their families and carers. Helps people to plan and access supports in the community, with an emphasis on connecting people with mainstream supports and services. e.g. helping people sign up to local clubs. |
| Local area coordination | barriers embedded in the environment by utilising their own resources and investment. |

NDIS publications: Psychosocial disability definitions

| “Psychosocial disability is the term used to describe disabilities that may arise from mental health issues. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage.” (National Disability Insurance Agency, 2015) |
| The NDIS description of psychosocial disability presents the belief that mental health conditions (understood as symptoms internal to the individual that result in functional impairments) are the cause of social disadvantage. It does not acknowledge that social disadvantage is embedded in environmental barriers to participation in social and economic activities, this establishes the premise that the cause and solution to social disadvantage lies within the individual. |

NDIS publications: Psychosocial disability and recovery

| A focus on integrating the recovery model into NDIS policy: “Recovery is about achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental health condition. |

- Choice and control for participants: The road to recovery is best judged by the participant. Support includes capacity building for self-management, including choosing supports and who provides supports.
- A lifetime commitment to supports and funding as required: Recovery is possible. The journey is personal and support when you need it is a key component of recovery.
- Increased independence and social and economic participation: Engaging with the community through social participation, education and employment helps build resilience and purpose. |
| Recovery language is narrowed to embrace only individual and personal recovery. Choice, control, self-management and strengths approach are deemed to support recovery resulting in continued focus on individualisation and responsibilisation of the problem. e.g. It is implied that the participant needs to engage with the community to develop their resilience and purpose, inferring the individual currently lacks purpose and resilience. This continues the discourse of the problem being individual deficits and a change in the person’s behaviour/skills will result in improved socio-economic wellbeing. |
The NDIS is committed to funding supports that help participants increase their independence and social and economic participation.

- Support for a partnership approach: Support provided under the NDIS is disability focused but recovery oriented. It is connected to diverse supports as required.”
  (National Disability Insurance Agency, 2016b, p. 1-2)

“It is important that within the process of assessment, recovery planning or planning with the NDIS, that strengths are identified and harnessed. This further supports a recovery-oriented approach.”
  (National Disability Insurance Agency, 2016a, p. 3)
3.2. Exploring the problem as policy

The identified problem required to be addressed by policy is the cause of functional impairment for psychosocial disability being significantly attributed to participation barriers that lie within environmental factors—the social, economic, systemic and political environments. It is imperative to question the effectiveness of the NDIS policy in positively contributing to mitigating the impact of, and ideally, constructing viable solutions towards resolution of, this problem. A discourse analysis has identified that the NDIS is a policy written through the lens of neoliberal ideology that serves to individualise, marketise and therefore responsibilise psychosocial disability; with some cursory recognition of ecological frameworks. Using existing research and current NDIS evaluation reports, an economic and social analysis of the effectiveness of NDIS in psychosocial disability will proceed; neoliberal and ecological constructs identified within the NDIS will be analysed against specific social and economic criteria proposed in methodology.

3.2.1 Towards the goal of a better life: an economic analysis

The total proposed budget allocated for the NDIS is $22 billion per annum, and psychosocial disability is projected to account for 13% of this figure at full scheme roll-out in 2020.

Current spending on psychosocial disability accounts for 7% of total costs to date. The Australian Government Department for Social Services, Housing and Disability report that psychosocial disability participants are receiving annual funding between $12-20,000 within NDIS, where previously they would have received an average of $6000 of support services (Henderson, 2018). At full scheme rollout 2020 ILC expenditure will be $131 million and will continue within this budgetary allocation per annum thereafter. This investment must be analysed in accordance with cost-effectiveness, cost-benefit and opportunity cost.
3.2.1.1 Cost effectiveness: which policy option will achieve its goals most efficiently?

The goal of the NDIS is to provide psychosocial disability participants with a better life by offering both choice and control over support services. This is the goal of the scheme itself, in addition it is pertinent to consider the overarching goals of any health/disability government policy as previously identified; to reduce impact, costs and therefore prevalence of illness (in this instance specifically focusing on mental health conditions). In the COAG Disability Reform Council (2018) second quarterly report, 71% of participants indicated that the NDIS had helped them with their daily living activities. There is no specific data available for the psychosocial disability subset, however to date there have been several studies that have researched precursory Australian individualised funding models in mental health. These studies have concluded that individualised funding is effective in meeting some needs, notably the opportunity to execute autonomy throughout the process of service planning, previously dictated by professionals (Carey et al., 2017; Peterson, Buchanan, & Falkmer, 2014). In all studies, this aspect was considered beneficial to people’s sense of self and skill development. Such benefits, however, are often mitigated by self-stigma, isolation and symptomatic impairment, limiting people’s willingness and capacity to exercise choice and control. International research has identified that success of individualised funding models in mental health is dependent on the availability of good advocacy and brokerage support (Carey et al., 2017; Needham, 2013; Peterson et al., 2014; Riddell et al., 2005; Williams & Dickinson, 2016). We know that people living with permanent and significant mental health conditions are more likely to be socially excluded and isolated and therefore poorly resourced for self-advocacy, advocacy and brokerage. This inequity impacts greatly on cost-effectiveness of the NDIS, as someone who can self-manage their plan can purchase daily living support for $30 per hour whereas those who require an agency-managed plan are faced with a rate of $70 per hour. This is an expensive failing of the scheme with an average of only 21% of total participants choosing to self-manage (COAG Disability Reform Council, 2018; Hughes, 2017). Not only is the NDIS at risk of being ineffective for psychosocial disability participants but also at risk of further perpetuating health inequity.

The NDIS utilises market mechanisms to deliver on its policy goal of choice and control, it is therefore troubling that early analysis of the NDIS marketplace has revealed inefficiencies which significantly compromise the policy’s effectiveness in achieving this goal. Most recently, only 67% of participants indicated that the NDIS had helped them with choice and control (COAG Disability Reform Council, 2018), whilst for psychosocial disability participants high levels of dissatisfaction with the planning process have been reported by participants and their families and carers, in addition to complaints of inappropriate and inflexible plans (Australian Government, 2017; Smith-Merry, Hancock, Gilroy, Llewellyn, & Yen, 2018). These issues collectively denote an absence of choice and control, and it could also be argued that reporting on participants’ satisfaction with choice and control is misrepresented. The NDIS purports to offer choice and control over how participants live their lives and achieve goals, however it is evident in the preliminary reports and analyses of the NDIS that choice and control is limited to who delivered support services within the available options. It is observed that the NDIS market limits available options through poorly managed pricing structures and competition between providers, resulting in smaller organisations being squeezed out of the market altogether, regardless of the quality of service they are providing (Smith-Merry et al., 2018). A competitive market further reduces choice of services in rural, remote and isolated regions where; costs associated with delivery are much higher than in metropolitan areas; demand for services is lower due to population spread; and therefore, profit margins will be smaller, failing to attract any growth in registered NDIS service providers (Barton, Robinson, Llewellyn, Thorncraft, & Smidt, 2015). Such supply and demand economics are resulting in thin markets. Whilst there has been consistent increases in the number of
providers (17% growth in the last quarter (COAG Disability Reform Council, 2018)) it is not yet clear if this growth is simply in response to expansion of the rollout into new geographical areas, such as metropolitan Western Australia where the rollout has only recently begun beyond trial sites, in 2018. It is, however, apparent that it is not the participant that controls choice of services but the market itself which dictates which services are available to choose from.

The intention of this analysis is not to suggest that individualised funding in mental health is of no benefit. The NDIS participants are offered lifelong security of supports and services that are tailored to their specific needs which is a worthy outcome. As mentioned previously, 71% of participants report the NDIS has assisted them with their daily living activities (COAG Disability Reform Council, 2018). Ensuring participants have access to necessary supports contributes to prevention of secondary impairments and in some cases results in improved social and economic participation. Currently there are no research studies available specific to psychosocial disability and the NDIS that enable us to conclusively understand the impact of individualised funding in improving socio-economic outcomes for people with a mental health condition. Drawing on individualised funding models in the United States it was identified that people with severe and persistent mental health conditions purchased goods and services related to unmet need and poverty (not impairments) associated with socio-economic disadvantage directly linked to their disability (Dickinson & Carey, 2017). This finding was replicated in Australian studies where mental health participants of an individualised funding program were utilising funds to access education and resources they otherwise couldn’t afford (Peterson et al., 2014). We know that some psychosocial disability participants may experience improved social and economic participation via provision of support workers and access to education, but understanding the role of stigma causes us to critically consider that these participants are not necessarily going to experience social and economic inclusion as a result. Distinguishing between participation and inclusion is perhaps the point at which we can delineate policy options that are ‘most efficient’ in reducing the impact and cost associated with psychosocial disability. Therefore, whilst there is some evidence that NDIS can deliver a better life for psychosocial disability participants, it cannot do so efficiently without addressing how stigma and self-stigma result in the consistent absence of advocacy and brokerage resources to support participants (effectively voiding the scheme’s goal of participant control); and fundamental barriers to economic and social inclusion. In addition, market mechanisms are negatively impacting on choice resulting in a more costly service delivery model and arguably impinging on the goal of ‘better lives’. Further to this, the NDIS is proving ineffective in reaching people with psychosocial disability with only 6.4% participant representation, half of that which was projected at 13% (COAG Disability Reform Council, 2018). It is identified within the sector that barriers to engagement include lack of funded outreach into hard-to-reach communities (homeless) and highly stressful eligibility processes causing people to disengage (Smith-Merry et al., 2018), on both accounts people most in need of support are unable to access it. This indicates that even if the scheme was able to optimise social and economic inclusion it’s cost-benefit impact would be minimal.

3.2.1.2 Cost benefit analysis: what policy option will produce the greatest economic benefit to society?

The greatest economic benefit to society will be achieved when mental health policy results in the full social and economic inclusion of people living with a mental health condition. This is because economic security is essential for mental health recovery, which in turn reduces the burden of
healthcare and disability costs in the long term (Morrow et al., 2009). Social and economic inclusion offers exposure to positive environments, supportive social relationships and opportunities, and further reduction in symptoms as self-concept and life satisfaction increases (Markowitz, 2001; Trainor et al., 2004; Onken et al., 2007 as cited by Morrow et al., 2009). The NDIS will not be able to deliver sustainable change if environmental barriers to social and economic inclusion are not concurrently and systematically addressed. Barriers to inclusion do not lie within the individual but within the broader environment -social, economic, systemic and political. This draws analytical attention the Information Linkages and Capacity Building policy aspects of the scheme. To date 24% of total psychosocial disability spending is within the ILC policy, this figure is consistent with the projected 25% of total NDIS expenditure being attributed to ILC (NB. these reported figures do not however correlate with the budgetary figures projected at 2020 see figure 3). The most recent NDIS quarterly report identified that NDIA’s greatest difficulty to date has been achieving outcomes in social, cultural and economic inclusion. This same report noted that of participants 25yrs and over (the most relevant category to analyse for psychosocial disability):

- Only 59% considered the NDIS had helped them with social, community and civic participation;
- Only 36% had been actively involved in a community, cultural or religious group in the last 12 months;
- Only 25% report having a paid job.

(COAG Disability Reform Council, 2018, p. 11)

The NDIA looks to ILC policy aspects to redeem these outcomes, however it continues to disproportionately invest in building individual participant capacity over and above community capacity. It is important to note that ILC costs are primarily attributed to local coordination which helps people to manage their plan; it is not building the capacity of the broader community. The misappropriation of ILC funds is revealed in the Joint Standing Committee report on psychosocial disability service provision which recently recommended that “NDIA considers allocating specific funding for the provision of mental health services through the ILC” (Australian Government, 2017, p. xv). This disproportionate directing of funds to individual capacity is further evident in the June 30th quarterly report as follows:

<table>
<thead>
<tr>
<th>ILC policy components</th>
<th>Budgetary allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal capacity building: Making sure people with disability have the skills, confidence and resources to participate in their community and access the same opportunities and services as other people.</td>
<td>$28 million Allocated in June 2018 to 44 National Readiness grants with a focus on Information, Linkages and Referral activities across Australia</td>
</tr>
<tr>
<td>Community capacity building: Building the capacity of the community to include people with disability, including mainstream services and community organisations</td>
<td>$14 million Allocated to 39 National Readiness grants in 2016-17, with a focus on mainstream services and community awareness</td>
</tr>
</tbody>
</table>

Table 5 (COAG Disability Reform Council, 2018)

Whilst the NDIA reported that 24% of expenditure is associated with ILC policy, a more accurate representation is given by the Australian Government Productivity Commission (2017, p10) which
state that 90% of expenditure is on core individualised supports with the remaining 10% being spent within ILC and operating costs. Budgetary allocations for ILC began in July 2017 with $33 million, a full 18 months after official roll-out began; this delay in ILC funding was reportedly due to awaiting monies to be transitioned from state to federal budgets. Despite NDIA recognising that ILC will contribute to sustainability of the scheme (National Disability Insurance Agency, 2015), the delay in actioning ILC policy aspects in conjunction with minimal budgetary allocation (less than 10% actual expenditure as per the Productivity Commission) indicates that no more than a perfunctory value has been placed on addressing ecological drivers. The Australian Government Productivity Commission (2017) has recognised the importance of ILC funding to contribute to sustainability of the NDIS and improve outcomes for non-eligible persons. Their recommendation is for a rapid increase in the ILC funding allocations prior to 2020 with a focus on national ILC activities inclusive of outcome evaluations. They further recommend that $131 million per annum be the fixed minimum allocated to ILC, however this calculates to be a mere 0.6% of total scheme expenditure. It is pertinent to note that ILC funding is not for psychosocial disability alone but for all disabilities, making the expenditure impact in psychosocial disability negligible. Not only would greater emphasis on environmental barriers to social and economic inclusion result in greater impact and sustainability of outcomes for eligible psychosocial disability participants, but it would result in greater economic benefit for society as a whole (discussed below).

3.2.1.3 Opportunity cost: what is not being funded in the decision to choose one policy direction above another?

The decision to have such minimal expenditure on environmental barriers to social and economic participation within NDIS comes at the loss of a large economic opportunity. The opportunity costs encompass negative effects on housing, family breakdown, physical health problems, addiction, poverty and crime related to social and economic marginalisation for people living with a mental health condition. This often results in long term dependency on not just mental health but other social services as well (Drake et al., 2012; Patel et al., 2018). The Commonwealth of Australia (2017) estimates that the total health and non-health related cost of supporting people living with mental illness is $28.6 billion, equating to 2.2% of GDP. The ILC policy purports to create a more accessible and inclusive community, not just for eligible participants but also those ineligible (National Disability Insurance Agency, 2015). In the case of psychosocial disability, 3.7 million Australians experience a mental health condition, 690,000 of these people are living with severe illness (Australian Government, 2015). Australian Government estimates suggest one third of these people (230,000) will need ongoing supports whilst at full rollout the NDIS projects it will provide services for 64,000 psychosocial disability participants (see figure 1) (Australian Government, 2015; National Disability Insurance Agency, 2017). In the absence of any clear funding commitment from state and federal governments for community based mental health non-clinical support in addition to the NDIS, this means that at full scheme rollout 72% of people living with a mental health condition in need of ongoing support will not be funded. It is important to understand that the NDIS does not stand alone; it is referred to within the Fifth National Mental Health & Suicide Prevention Plan as a complimentary policy measure. This current NMHP clearly identifies the need to reduce stigma and discrimination however the government has invested $338.1 million across four years into policy that supports funding of individual services and supports, primarily frontline clinical services, with a focus on eating disorders and suicide prevention (Australian Government, 2018b; Commonwealth of Australia, 2017). Within the plan there are no clearly identified actions associated with the aim of reducing stigma and discrimination in the broader community, with direct action items limited to the promotion of peer
workforce and reducing stigma and discrimination within the health workplace (Commonwealth of Australia, 2017). Consequently, there is no significant financial commitment within the NDIS, or independent of the NDIS, to support social and economic inclusion via an ecological policy framework. This will potentially result in 91% of Australians living with a mental health condition continuing to be affected by the influence of stigma, self-stigma and discrimination. If greater funding was directed towards community capacity building within ILC, and greater emphasis on ecological drivers of impairment within psychosocial disability, the NDIS investment would benefit not just those eligible but also those ineligible, resulting in greater net economic impact across health, employment, housing and justice sectors.

3.2.2 Towards the goal of a better life: a social analysis

Social outcomes for people living with a persistent and severe mental health condition are globally poor, and there is a wealth of evidence supporting a bidirectional causal relationship (Patel et al., 2018). In Australia, this cohort is found to be accessing multiple sector services ranging from housing, drug and alcohol, hospital, welfare and justice supports indicating poverty, social exclusion and isolation and health inequity (Commonwealth of Australia, 2017; Mental Health Australia, 2018a). A policy that utilises an individualised funding model seeking to offer participants a better life must withstand a social analysis independent of economic gains. Any expenditure is redundant if positive social impact is not evident. As such the NDIS needs to be measured against robust criteria addressing participation and access; equity and rights for psychosocial disability participants.

3.2.2.1 Participation & access: How does the policy impact on people’s ability to participate in society and access resources they need?

The NDIS has not been highly successful at improving people’s participation in society, with just 36% of participants reporting they have been actively involved in a community, cultural or religious group in the last 12 months and only 25% successfully acquiring employment. Whilst 59% reported improved social, community and civic participation, the fact that participation is differentiated from ‘active engagement’ would suggest that there continues to be significant barriers to full inclusion not being addressed by the NDIS. This failure of the NDIS to increase participation is a double-edged sword for psychosocial disability whilst employment and community engagement remain low societal negative attitudes remain unchallenged. For as long as people living with mental health conditions are absent from our communities, there is no opportunity to create new norms and expectations hence false beliefs that people with mental illness are dangerous, unpredictable, violent, incompetent, weak in character and of less worth and value remain (Commonwealth of Australia, 2017). If NDIS continues to fail in improving social participation and inclusion it continues to perpetuate social stigma and reinforces structural stigma.

It is proposed that structural stigma is responsible for fewer people with psychosocial disability having access to resources via NDIS. Currently 81.4% of people applying for psychosocial disability eligibility are being approved, which is lower than the 97% approval rate for all other cohorts (Smith-Merry et al., 2018). Social stigma, self-stigma and structural stigma are potentially all contributing factors to the proportion of psychosocial disability participants being just half of that which was expected, representing 7% rather than the anticipated 14% of participants (Australian Government, 2018a;
COAG Disability Reform Council, 2018; Smith-Merry et al., 2018). Whilst the NDIS may increase participants’ access to resources, we know from the aforementioned statistics that the scheme itself is proving inaccessible to people living with mental health conditions. Mental Health Australia (2018b) have reported on multiple barriers to accessing the scheme including: stressful eligibility processes that increase peoples’ vulnerability to illness relapse and often result in application withdrawal; the lack of public knowledge about the NDIS and its relevance to mental health conditions; and a lack of assertive outreach to those disengaged from service providers and socially isolated due to illness. Mental Health Australia (2018b) consequently recommends that structures be modified to respond to the needs of potential psychosocial disability participants through provision of a specific pathway that employs trained and skilled personnel. It can be concluded from the evidence available that the NDIS policy does not consistently impact positively on access to resources for people with mental health conditions and where resources are allocated to eligible participants, outcome evaluations demonstrate that it is equally ineffectual at improving people’s participation in society.

3.2.2.2 Equity: which policy option identifies and empowers community groups in the process? How does the policy affect them?

Empowerment is the ability to control one’s own life choices (Tengland, 2008). The NDIS purports to afford participants choice and control but in reality, this is limited in scope to only entail choice and control over which service provider will deliver support. Within this limited scope, there are clear shortfalls in the scheme with only 67% of participants reporting positively against choice and control outcomes and just 21% of participants accepting self-management responsibilities. If NDIS is not effectively empowering psychosocial participants, is it then actively disempowering? Disempowerment is a product of oppression (Allen, 2008; Starkey, 2003; Tengland, 2008). Oppression refers to “the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms” (Allen, 2008, p. 160). In the case of mental illness, oppression is best identified by the presence of stigma (social, self and structural), therefore stigma impinges on the empowerment of people living with a mental health condition. Understanding that mental health impairment is attributed to stigma entrenched in social, economic, systemic and political environments, it is reasonable to conclude that a policy with neoliberal foundations that seeks to individualise the problem will be inadequate in reducing oppression. This proposition is supported by Harper and Speed (2012, p. 8), who have adopted the concept of relational recovery stating that “it is only when the collective, structural experiences of inequality and injustice are explicitly linked to processes of emotional distress that recovery (*a reduction in the experience of disability*) will be possible”. Dillon (2011) also outlines a political and collective approach to recovery, that requires society to collectively address oppressive political structures. The NDIS may offer psychosocial disability participants a better life through provision of services but individual wellbeing is not to be confused with individual empowerment. The NDIS policy is unable to deliver against equity criteria, and for mental health this failure is two-fold—not only do the internal processes of NDIS inconsistently support participant choice and control, but the policy globally fails to address stigma and therefore does little to reduce oppression and empower individuals.
3.2.2.3 Rights: which policy option protects or advances people’s rights and educates on social obligations.

Australia has signed and ratified both the United Nations Convention on the Rights of People with a Disability (UN-CRPD) and agreed to the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 (UN-MI Principles). As such these are the primary documents that guide analysis of the NDIS policy against rights-based criteria. The UN-CRPD is, as understood by the Australian Government, a series of principles that collectively “aims to enhance opportunities for people with disability to participate in all aspects of social and political life including access to employment, education, health care, information, justice, public transport and the built environment” (The Australian Department of Social Services, 2018, p. 1). The primary principles of relevance to the NDIS include:

- Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity;
- Accessibility;

(United Nations, 2006)

The UN-MI Principles has two values of significant relevance to the NDIS:

- Principle 1 Fundamental freedoms and basic rights - freedom from discrimination to ensure people living with mental illness have the right to exercise all civil, political, economic, social and cultural rights fundamentally
- Principle 3 Life in the community - the right of persons with mental illness to live and work, as far as possible, in the community.

(United Nations, 1991)

Human rights are a shared set of rights and responsibilities, meaning there are rights-holders and duty-bearers. In this instance, the NDIS psychosocial disability participants are the rights-holders and the role of duty-bearers extends to include NDIA, local organisations, private companies and community individuals.

Rights-holder: the individuals or social groups that have particular entitlements in relation to specific duty-bearers.

Duty-bearer: those actors who have a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations. The term is most commonly used to refer to State actors, but non-State actors can also be considered duty bearers.

(United Nations, 2004)

It is acknowledged that the NDIS has achieved some success in improving social participation, but minimal success at achieving sustained inclusion (COAG Disability Reform Council, 2018). When
analysing the policy’s ability to educate on social obligations, the focus is on the social obligations of
the broader community as discussed within the context of social-citizenship, whereby the dominant
majority hold social-citizenship responsibilities to remove barriers to participation in civic life for
people with a disability. The NDIS has not yet released any evaluation outcomes that measure the
scope and impact of capacity building activities within the broader community as funded by ILC. It
may, realistically, be too premature given the eighteen-month delay in release of ILC funding rollout,
however as previously identified ILC funded activities are focused as much on individual capacity
building as they are on community capacity. The NDIS is incapable of educating people on social
obligations as a means of upholding the rights of psychosocial disability participants, as it simply was
not written into the scope of ILC policy aspects. As previously identified, ILC is constrained to providing
the community with information and basic training on disability inclusion with no targeted funding for
psychosocial disability and stigma reduction initiatives. In addition, the NDIS has not explicitly stated
long term outcome indicators that will measure social and structural stigma reduction as a vital policy
impact associated with the rights of persons living a mental illness. The over-reliance on compensating
the individual participant through both resource allocation and capacity building effectively renders
the NDIS impotent in its ability to prevent discrimination and advance people’s rights to full social,
economic, cultural and political inclusion for psychosocial disability participants. A policy can
compensate an individual though provision of resources, supports and capacity building but they
continue to be rights-holders and should not be expected to be duty-bearers.
Chapter 4. Recommendations and conclusion

The NDIS is delivering better lives to psychosocial disability participants; there is quantitative evidence for this identified within both NDIA internal and external reports and qualitative evidence presented in NDIA case studies and snapshots (COAG Disability Reform Council, 2018; National Disability Insurance Agency, 2018c). An analysis of public policy against economic criteria must identify serves to identify outcomes most efficiently delivered that have the greatest cost-benefit. Analysis against social criteria tests the policy’s ability to deliver outcomes that uphold the Australian Government’s commitment to internationally agreed upon human rights and principles of equity. Whilst the NDIS can deliver a better life to psychosocial disability participants, the perceived impact is limited to improvements in participants daily living activities (most commonly associated with self-care). There is no guarantee on the scope or consistency of improvements to include more holistic aspects of wellbeing, including social and economic participation. There is mounting evidence to suggest that the NDIS is unable to deliver sustainable outcomes associated with stigma reduction, individual empowerment and social citizenship.

4.1 Policy recommendations: ecologically targeted policy expenditure

Instead of trying to fix people, we should fix the spaces between people.

Mental health policy needs to address disability and recovery within an ecological framework if it is to achieve economically sustainable improvements (Patel et al., 2018). Addressing social, economic, systemic and political environments (the spaces between people) will result in improvements, not only to individual wellbeing, but also to individual rights and empowerment. In this study of the NDIS, a discourse analysis has identified that neoliberal foundations undermine any attempt to address ecological barriers to participation because a free-market continuously places responsibility on the individual to mitigate the impact of their impairments. To achieve a better life for people living with a severe and persistent mental health condition, psychosocial disability could be withdrawn from the NDIS, allowing the opportunity to develop a free-standing mental health disability policy that targets both provision of individualised supports/services, and capacity building within the broader environment, to effectively achieve social and economic inclusion. It is also apparent that society’s understanding of what inclusion looks like needs to be transformed before their capacity to support people with mental illness can be established. Public policy development in mental health, is, perhaps, best guided by the principles of social-citizenship, and should seek to advance society’s consciousness as duty-bearers in relation to the UN-CRPD and UN-MI Principles. The conversation on inclusion within the current National Mental Health Plan and National Disability Strategy, is reduced to government rhetoric when it remains completely unsubstantiated by policy goals and funding.

The NDIS was a response to consumer and carer voices demanding disability reform. It has received bipartisan support as well as bilateral state and federal financial agreement. It may therefore, seem foolish to some, to recommend that it be abandoned within the mental health sector. Beneficially, the NDIS provides individualised services and supports for psychosocial disability participants with significantly larger funding than they would have access to outside of the scheme, and the eligibility
criteria seeks to provide support to individuals who experience the greatest level psychosocial disability and disease burden. A second, less desirable, option for consideration, is to modify the existing policy so that the scheme itself places greater (if not equal) emphasis on ecological frameworks. This would require ILC components of the policy to remove the focus on individual capacity building and address only environmental barriers to inclusion, while directing greater expenditure to programs that specifically target stigma within local communities. NDIA would not only need to commit more funding to ILC-related activities, it would need to allocate a fixed percentage to psychosocial disability, in recognition of the environmental barriers to participation (namely stigma) that contribute to the aetiology of impairment. ILC funding would need to support activities that educate the broader community on their social-citizenship responsibilities, before attempting to build community capacity. In so doing, this would cultivate a level of responsiveness to community capacity building that is, therefore, more likely result in social and economic inclusion of people living with a permanent and significant mental illness. If stigma reduction is included in the policy outcome indicators, then it will be able to measure positively against the goals of delivering people a better life and affording them genuine choice and control. Retro-fitting an ecological framework to a market-based strategy seems fraught with potential inefficiencies and compromises and requires caution. The policy culture of individualisation and responsibilisation is likely to be embedded within the agency itself, and a significant shift in focus would probably result in ecological driven initiatives being the poor-relation, in both principle and practice.

Two consistent limitations of this policy analysis have been the lack of psychosocial disability specific data and the absence of outcome measures associated with the ILC policy. Having relevant and specific statistical data available, is essential to aide any future policy analysis and therefore guide policy directions. To date, data being released by NDIA relates to eligibility requests, approved participants, number and type of plans funded and general participant satisfaction (primarily related to NDIS processes and minimal outcome measures specific to functional impact). Much of this data is not distilled to provide psychosocial disability specific statistics, hence policy analysts are required to extrapolate the data against international literature and empirical norms, which has resulted in limitations within this policy analysis. Mental health was a late inclusion to the scheme, with psychosocial disability components designed after the legislation was written. This has attracted greater consumer, carer and sector-based criticism compared to any other NDIS diagnostic cohort, it therefore warrants closer evaluation. There is also an absence of evaluation associated with ILC policy aspects and expenditure, specifically relating to outcome measurements of community capacity building. Evaluation should not just consider process and short-term outcome indicators, it also needs to specifically report against social and economic inclusion and participant experience of stigma. This would allow for more accurate analysis of the NDIS goal of supporting a better life, and the health/disability policy goals of reducing the impact and cost of mental illness. Future research should seek to uphold a participatory orientation that is both consumer-led or co-designed and ascertains both quantitative and qualitative outcomes of the NDIS policy for psychosocial disability participants.

4.2 Conclusion

The NDIS policy is firmly founded on neoliberal assumptions with cursory recognition of ecological frameworks. Identifying how and where the policy upholds neoliberal assumptions to the neglect of ecological frameworks exposes a momentous disregard for the aetiology of impairment in mental
illness. The NDIS relies on the establishment of a market for delivering disability supports and services that offer participants choice and control in the pursuit of a better life. Emphasis on the marketisation of supports and services not only places the burden of responsibility for a ‘better life’ on the participant, but it denies people living with a mental health condition (NDIS eligible and ineligible) the opportunity to actualise their right to social and economic inclusion. Irrespective of this opportunity cost, the NDIS market-place is proving to be inconsistent at best and ineffective at worst. Environmental barriers to social and economic inclusion are central to the aetiology of impairment in psychosocial disability, therefore the disregard for ecological frameworks within the policy results in a scheme that is incapable of sustaining desired outcomes for this cohort. This policy analysis validates the concerns and frustrations voiced by mental health consumers, carers, and sector stakeholders, and warns that advocating for adjustments and modifications to the existing policy and processes alone will not be enough to create sustainable positive impact. This analysis recommends that the NDIA and sector stakeholders pay close attention to evaluations of NDIS outcomes for psychosocial disability participants and specifically measure the long-term impact of the policy on social and economic inclusion.

Stigma embedded in social, economic, systemic and political environments excludes people living with a mental health condition and contributes to the large and costly burden of disease. Neoliberal and ecological frameworks are not necessarily incompatible. If environmental barriers to social and economic participation are addressed, it is plausible that a market strategy could realistically deliver on individual choice and control for people with a psychosocial disability. However, individualisation and responsibilisation are seemingly inseparable within modern policy discourse and responsibilisation is overtly counterproductive to engendering the social-citizenship required to achieve stigma reduction. When considering future policy developments for psychosocial disability, be it within the existing NDIS structure or another, the Australian Government must ask the question - how far have we progressed from the era of institutionalisation if our mental health policy serves to institutionalise people living with mental illness within the community, by maintaining the walls of fear and isolation in society’s mind?
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