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Submission to the Joint Standing Committee on the NDIS:

Transitional arrangements for the NDIS

Patron : His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd)
President: Mick Reid

Mental Illness Fellowship of Australia (MIFA) is a federation of long-standing member organisations, established in 1986. Our members deliver specialist services for individuals living with mental illness and their carers, friends and families, out of nearly 60 'front doors' in metropolitan and regional areas, to over 20,000 people each year. Our membership has a strong focus on building community, valuing peer support and lived experience, and supporting recovery. We have substantial experience delivering specialist, place-based, community-building programs to those experiencing mental illness, and over 50% of our workforce has a lived experience as a consumer or carer; as such, we feel we are well placed to assist the Joint Standing Committee on the NDIS in its inquiry into the transition to the NDIS, and we welcome the opportunity to provide our input.

Boundaries: who is in and who is out?

Population modelling indicates that around 3.8 million[1] Australians of all ages experience mental illness in Australia each year. Of these, 690,000 have a severe mental health issue.[2,3,4]

There is uncertainty around the number of people with severe mental illness who have an associated psychosocial disability and require psychosocial community support and rehabilitation (or 'disability support'). Different modelling suggests between 280,000[5] to 290,000[6] people with severe mental illness require some level of disability support for a primary psychosocial disability each year. It is likely the entire cohort of people with severe mental illness (up to 690,000 people) will require some level of disability support at some point.[7,8]

There is further uncertainty about how many of those people will be eligible for the NDIS. The original Productivity Commission (PC) numbers, based on Australian Government modelling, indicated 57,000 people were in scope (that is, 0.4% of the adult population or around 12% of those with a severe mental illness).[9] This number has now updated by the NDIA to 64,000.[10]

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[1] Based on National Mental Health Services Planning Framework (unpublished), adjusted to 2015 Australian population, in McGrath, D. (2016). *The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches.* Available at: http://www.pc.gov.au/__data/assets/pdf_file/0008/215864/sub0155-ndis-costs-attachment.pdf

[2] p46, National Mental Health Commission (NMHC) (2014). *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services.*

[3] p26, *Fifth National Mental Health Plan*, Advanced Reading. Available at: http://www.coaghealthcouncil.gov.au/Portals/0/Reports/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan%20%20-%20Advanced%20reading%20copy%20-%207%20August%202017.pdf

[4] NDIA (2017). Additional document to JSC on NDIS Inquiry into NDIS and Psychosocial disability. Available at: http://www.aph.gov.au/DocumentStore.ashx?id=e381f4e0-5784-422a-9397-a2c244da509d

[5] People aged 0-64. Department of Health (2017). Submission 175 to PC Review of NDIS Costs Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf

[6] People aged 12-64, McGrath, D. (2016). *Op. cit.*

[7] p46, NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*

[8] p14, Australian Government Actuary (2012). *NDIS Costings – Review by the Australian Government Actuary.* Available at: http://www.treasury.gov.au/~/media/Treasury/Access%20to%20Information/Disclosure%20Log/2012/National%20Disability%20Insurance%20Scheme%20Costings%20Review%20by%20the%20Australian%20Government%20Actuary/Downloads/PDF/doc1.ashx

[9] Detail of Australian Government modelling reported on p14, Australian Government Actuary (AGA) (2012). *Ibid.*

However, recent modelling by the Department of Health based on the (unpublished) National Mental Health Services Planning Framework (NMHSPF) suggests 91,916 people with "severe and complex disorders"[11] would be eligible.

The National Disability Insurance Agency (NDIA) has done significant work on communicating the meaning of psychosocial disability to participants,[12] but there are still definitional issues and greater clarity is required in order to properly delineate the population in scope for the NDIS from the broader population of those with severe mental illness requiring disability support. This was a key recommendation of the 2014 National Review of Mental Health Services[13].

The NDIA has stated that when determining eligibility it considers the "*likely permanence of impairment and substantially reduced psychosocial functioning in undertaking activities".*[14] However, the need to provide evidence of permanency is problematic, and MIFA advocates removing this criterion in the context of psychosocial disability. Permanency is not a good tool to delineate the target population, and is antithetical to recovery-oriented practice. These issues are covered in further commentary available if required in Appendix I, and in MIFA, Community Mental Health Australia (CMHA) and Mental Health Australia (MHA)'s joint submission to the Joint Standing Committee on the NDIS – Psychosocial disability inquiry available if required in Appendix II.

System planning

Mental health is currently extremely siloed and fragmented, and the transition of one sub-cohort of people into yet another service system (the NDIS) has exacerbated this issue. MIFA strongly supports the integrated approach adopted in the recently endorsed Fifth Mental Health Plan[15], and advocates strengthening the role of the Primary Health Networks in system planning for mental health, including mapping services, and assessing needs, gaps and accessibility rates across their region, and commissioning or making recommendations for commissioning from other bodies. PHN guidelines[16] should be changed to allow PHNs to commission psychosocial supports. PHNs must be positioned to work closely with the NDIA, Local Hospital Networks (LHNs), State/Territory Departments, Commonwealth Departments, private hospital and general practice and allied health private practitioners. Local data available from the NDIA on plan inclusions, service provider and rejected NDIS access requests

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[10] p26, *NDIA Annual report 2015-16*

[11] Department of Health (2017) Submission 175 to PC Costs Issues Paper, *op cit.*

[12] Including the pending Best Practice Guide for Access to the NDIS, public factsheet "Psychosocial disability, recovery and the NDIS", guide "Completing the access process for the NDIS: Tips for Communicating about Psychosocial Disability", and reimagine.today website.

[13] Recommendation 3 in NMHC (2014). *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services.*

[14] NDIA (2017). Additional document to JSC on NDIS Inquiry into psychosocial disability. *Op. cit.*

[15] p19, *Fifth National Mental Health Plan*, Advanced Reading. *Op.cit.*

[16] p6, Department of Health (2016). *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care.* Available at: http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF

provide essential data on met and un-met expressed need for disability and broader psychosocial supports.

There is some concern that PHNs are operating in an inconsistent manner across Australia and that some PHNs may not have the internal capacity to undertake the comprehensive public health planning and commissioning approach required of them. Although responsibilities are devolved to a regional level, it is essential that appropriate governance, accountability mechanisms and guidelines are in place to ensure PHN activity is consistent and coordinated across Australia. The Primary Health Network Advisory Panel on Mental Health is tasked with reviewing PHN activity in mental health across Australia[17] and some form of oversight of this nature should be ongoing.

The cohort of people with psychosocial disability, and the even smaller cohort of people with psychosocial disability resulting in significant functional impairment, are the most in need and therefore should have the highest levels of support. Nevertheless, it should be noted when discussing system planning and the intersection with other service systems, that the broader cohort of people with mental illness (whether mild, moderate or severe) also require ongoing psychosocial supports from the community mental health sector. These include programs with flexible eligibility requirements and no lag-time in support, that provide: information, referral and service navigation; peer support; skills development, capacity building and community participation programs; general counselling and psycho-education; outreach support; low-intensity clinical services; housing and employment services; support with legal, guardianship or criminal justice issues; primary prevention initiatives; stigma reduction activities; and systemic advocacy.

Continuity of support and ongoing services for psychosocial disability

MIFA welcomes the announcement of the $80m ($160m in matched funding), however we remain concerned the funded amounts are inadequate to meet Continuity of Support needs for transitioning mental health clients. They also will not meet the needs of the 225,000 people with severe mental illness and psychosocial disability who are not considered in scope for the NDIS, nor will they ensure the types of support unavailable under NDIS plans remain in place. Failing to provide alternative programs for those outside the NDIS would result in the significant worsening of functionality for the cohort as a whole and create greater dependence on high level support in the future.

[17] Terms of Reference for the Primary Health Network Advisory Panel on Mental Health. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel

In Senate estimates, Department of Health representatives advised the funding would be applied as follows[18]:

2017-18	planning and getting infrastructure in place	$7.8m
2018-19	Investment into expanding services	$23.7m
2019-20	Maximum investment deployment at full Scheme transition	$24.1m
2020-21		$24.4m

Even if matched by States and Territories, the amount at final implementation would be $48.8m.

MIFA strongly advocates maintaining beyond full scheme the existing Commonwealth programs that support people with severe mental illness; namely, Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), and Day to Day Living (D2DL). MIFA further advocates maintaining independent programs for carers, such as Mental Health Respite: Carer Support (MHR-CS). Rather than dismantling the infrastructure, workforce capacity and institutional memory in these existing programs, these services should remain to provide continuity of support to current ineligible clients, to provide services to new ineligible clients, and to continue to provide other types of services that cannot be easily provided under the NDIS. Programs rolled into the NDIS had much more accessible criteria, more assertive outreach capacity, and much greater flexibility of service than is possible under the NDIS. Further investment from States and Territories is also necessary to ensure the needs of the 225,000 people outside the NDIS are supported.

Transition of existing Commonwealth programs

MIFA is concerned there has been an overestimation of the number of current Commonwealth clients eligible for the NDIS.

The Department of Health has indicated that the three Commonwealth Community Mental Health programs currently support up to 41,509 people across PIR, D2DL and PHaMs[19]. Given they have previously indicated that approximating numbers in PIR is difficult[20], it is unclear how this number was estimated.

The Department of Social Services (DSS) indicated that there were 20,409 people in PHaMs and 29,141 in MHC-RS in 2015-16[21].

DSS has indicated they are expecting 8,700 will require Continuity of Support[22]. It is unclear how this was modelled. It is also unclear whether this includes Department of Health or only Department of Social Services programs.

When responding to questions around transitions, departmental representatives often quote eligibility rates of 83% of people who have made access requests[23], however, this includes all

[18] p20 Senate Estimates 30 May 2017, Community Affairs Legislation Committee.
[19] Department of Health (2017). Submission 175 to PC Review of NDIS Costs Issues Paper. *Op. cit.*
[20] p9, Senate Estimates 30 May 2017, Community Affairs Legislation Committee.
[21] p12-13, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.
[22] p15 *ibid.*

psychosocial clients (new and existing) applying, and the NDIS has indicated that 56% of applicants are not currently State/Territory of Commonwealth clients[24].

This eligibility rate also does not acknowledge the significant number of people who are choosing not to apply. PIR consortia in NSW are reporting a "lost consumer rate" of between 17% and 37% of participants in PIR programs[25], meaning the true eligibility rate for people in Partners in Recovery (PIR) may be closer to 60%.

These reports from the sector suggest up to 40% of PIR clients are not transitioning, around 60% of PHaMs clients, and up to 50% of D2DL clients. Based on these estimates, 12,245 people will require Continuity of Support in PHaMs alone, and a potential $193.8m in Continuity of Support funding for existing programs may be required. The $24.4m currently dedicated to Commonwealth Department of Health Continuity of Support arrangements will therefore fall short.

	Partners in Recovery	Day to Day Living	PHaMs	MHR-CS	Total
2016-17[26]	$143.9m	$15m	$113.3m	$60.7m	$332.9m
Estimated % of non-transitioning clients	40%	50%	60%	100%	60%
Possible level of Continuity of Support funding required	$57.6	$7.5	$68m	$60.7m	$193.8m

Note that 2015-16 funded amounts already represent a reduction on previous years.

This estimation is based on anecdotal evidence from the sector, whereas accurate real-time data is required. The NDIA should investigate and publish the current eligibility rates from existing programs, disaggregated by existing program (State/Territory and Commonwealth). Rates of clients who are choosing not to apply to the NDIS should also be monitored, and the reasons these clients are choosing not to apply should be thoroughly investigated[27].

Commonwealth Continuity of Support arrangements are not the only cause for concern. States and Territories currently provide over 70% of Community mental health funding[28], and 62.1% of overall mental health funding.[29] State and Territory governments' Continuity of Support arrangements are mostly unclear, as are their forward commitments to adequately fund psychosocial disability services for new clients ineligible for the NDIS, and broader community mental health services for people with all levels of mental illness.

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[23] p16 *ibid.*
[24] NDIA (2017). Additional document to JSC on NDIS Inquiry into NDIS and Psychosocial disability. *Op. cit.*
[25] p4, One Door Mental Health (2017). Post- Paper Submission 266 to the PC Review of NDIS Costs Position Paper, Available at: http://www.pc.gov.au/__data/assets/pdf_file/0018/219321/subpp0266-ndis-costs.pdf
[26] p9, Senate Estimates 30 May 2017, Community Affairs Legislation Committee, and p12-13, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.
[27] MIFA members report that clients are choosing not to apply in part due to issues with the need for permanency, as well as concerns and reservations about the invasiveness and overwhelming nature of applying.
[28] p7, Senate Estimates 30 May 2017, Community Affairs Legislation Committee.
[29] p3, PC (2017) *Report on Government Services: 13. Mental Health Management.* Available at: http://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/mental-health-management/rogs-2017-volumee-chapter13.pdf

As recommended in the PC Position Paper for the Review of NDIS Costs, Draft Recommendation 5.2, Commonwealth, State and Territory governments must make public their continuity of support approaches; and should report to the COAG Disability Reform Council any boundary issues, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability. The PC further recommends in Draft Recommendation 5.3 that each COAG Council area that interfaces with the NDIS should have agenda items to address interfaces, including monitoring service gaps, duplications, and other boundary issues.

Loss of service in transitioning programs

It should also be noted that when stakeholders describe the gap emerging as programs are rolled into the NDIS, we are referring not only to the gap in disability services for those ineligible, but to other features of programs rolled in to the NDIS that that we believe need to be retained. These services are difficult or impossible to provide under the individual fee-for-service model. These include:

a) Assertive outreach or assertive engagement;
b) Ability to be flexible in kinds and length of support provided;
c) Individual systems navigation and multiagency care co-ordination; and
d) Cross-sector collaboration and systemic advocacy

These needs were further outlined in responses to questions on notice from two PIR regions[30,31]. This gap goes beyond Continuity of Support, as people eligible for individual packages also require these supports. These supports are best provided by services that have visibility, diagnostic-specific expertise, and pre-existing community connections. This could occur via maintaining funding for Partners in Recovery or PHaMs-style programs under the Commonwealth Department of Health Psychosocial Support Program, or under the Information, Linkages, and Capacity Building (ILC) Program.

Many participants require ongoing, coordinated support with the interface between clinical support, housing providers, welfare, and other systems. The need for case management was identified as an important part of the Partners In Recovery (PIR) model[32], and often lacking for people with psychosocial disability. Systemic advocacy and multiagency coordination was also a core feature of the Support Facilitator role in PIR. There are mixed views about the role of NDIS Support Coordination in providing systems navigation, and one step further, systemic advocacy. There is increasing recognition that complex care coordination is essential to overcoming multiagency communication issues, delays and/or duplication in service delivery, reducing safety risks[33]. Given the NDIS is targeted at people with psychosocial disability whose "complex

[30] Response to Question On Notice, Wide Bay PIR, Available at: http://www.aph.gov.au/DocumentStore.ashx?id=e1a87e9d-ef8e-4573-ac9d-edeb1f15b79f
[31] Response to Question On Notice, Sunshine Coast and Gympie PIR, available at: http://www.aph.gov.au/DocumentStore.ashx?id=44b8c19e-21cb-4aac-b35d-7a02f06124cb
[32] Urbis (2015). *Partners in Recovery Annual Report 2014-15.* Available at http://www.health.gov.au/internet/main/publishing.nsf/content/FA19DF60B8CA6904CA25802800127C1D/$File/annual15.pdf
[33] Department of Health (Cth) (2016). *Health Care Homes: for health professionals – Why is this a priority?* Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-professional

needs requiring coordinated services from multiple agencies"[34], it follows that care coordination is a necessary and essential part of their ongoing support.

Carer support programs

MIFA further advocates maintaining programs for carers of people with a mental illness, independent of a participant's plan. Carers need a range of supports, including information, referral, peer support groups, counselling and one-on-one support. This is particularly important as often carers are the first to reach out, and can be instrumental in encouraging consumers to access services (noting that around 54% of people with mental ill-health do not seek help)[35]. There is emerging evidence that NDIS planners are failing to properly consider the needs of carers when formulating plans, and participants, planners and support coordinators may not always recognise or value the needs of carers.

Independent carer support programs should be provided in a consistent way across jurisdictions via additional investment under Information, Linkages and Capacity Building (ILC). MIFA is also advocating maintaining the MHR-CS program outside the NDIS to enable continuity of support for carers where the participant is ineligible for a plan, or does not want to apply, as well as providing flexible entry for carers without the stringent NDIS access process.

Intersection issues with mainstream services

There are a range of reported issues resulting from ambiguities in program responsibility in the interface between the NDIS and other service systems. These include denial of service for people with comorbid health issues - see for example, Community Mental Health Australia's submission to this inquiry and their submission to the Community Affairs Legislative Committee inquiry into the National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017. There have also been issues for clients exiting forensic facilities. For example, MIFA member One Door Mental Health reports that forensic consumer overnight leave services initially covered by the NDIS have been de-funded, with no resolution as to the relevant jurisdiction who holds responsibility[36]. A number of participants have also report they are have been denied access to the NDIS due to not being considered "adequately treated," which in the context of mental health is ambiguous. Such examples of unclear boundaries and potential cost-shifting need to be addressed.

Consistency in planning

In the experience of MIFA's members, the definition of reasonable and necessary has been too ambiguous to provide operational clarity for planners and for those seeking to obtain packages. There is significant evidence of inconsistent packages across Australia, with some participants with similar conditions and similar support needs receiving vastly different plans. The NDIA

[34] p14. AGA (2012). *Op. cit.*
[35] Whiteford, H., Buckingham W., Harris, M. et al. (2014). 'Estimating treatment rates for mental disorders in Australia.' *Australian Health Review* 38(1): 80-5.
[36] See One Door's submission to JSC on NDIS Inquiry into psychosocial disability. Available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Submissions

must continue to clarify through public resources that give practical examples to participants and their supporters (for example, by continuing to add to the reimagine website[37] with case examples and sample plans). The review of 300 plans and creation of reference packages for people with psychosocial disability may also support a better understanding of what supports are consistently required for people with psychosocial disability, and what is considered not only reasonable and necessary, but best practice in terms of supporting people to move to higher levels of functioning. In the context of psychosocial disability, MIFA members have noted that support coordination is critical, should be a fundamental part of someone's plan, and ongoing (even if at a lower level) for the life of a plan. Support coordination is an integral part of enabling people to navigate their plans and services. This investment is likely to ensure that participants implement their plans with the greatest potential for success. Support coordinators also play a significant role in empowering participants to report on the success of their plan, and set goals for plan reviews.

Information, Linkages and Capacity Building program

There is strong potential for specialist, bulk-funded programs under the Information, Linkages and Capacity Building (ILC) component of the NDIS to address some of the gaps for those with psychosocial disability who are ineligible for an individual plan. Indeed, with the variability and inadequacy of other federal portfolio or State/Territory government taking responsibility for the psychosocial needs of the 225,000 people who will not be eligible the NDIS, there must be programs that fill this vacuum. This is consistent with NHMC recommendations in the 2014 Review of Services report:

> "*The logic of Tier 2*[38] *should be that it is of sufficient capacity to support people whose psychosocial disabilities are not sufficiently "permanent" or profound[,] to live productive lives in the community and reduce their risk of entering Tier 3 due to worsening disability."*[39]

The ILC is designed to support all people with psychosocial disability, whether or not they are eligible for the NDIS. Many of the outcomes for mental health recovery and the ILC are aligned, and in particular the Individual Capacity Building Activity in the ILC suggests individual psychosocial supports for those without a package may be in scope. Without permanency or high, complex needs eligibility criteria for the wider ILC program, there is potential for it to support a wide range of people. However, MIFA has strong reservations about the ability the ILC program in its current formulation to adequately support such programs. Immediate action is required to quarantine funding for psychosocial services specifically, increase funding, clarify the funding criteria, and plan for integration between ILC programs, individual plans and other mental health systems, including PHNs, public and community health.

The current level of funding under the ILC is inadequate. Even with the PC's Draft Recommendation 5.1 to roll-out the funding to the full amount early, with the full range of

[37] Reimagine website (2017). http://reimagine.today/
[38] Former term for ILC
[39] p62, NHMC (2014). Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.

other disabilities requiring services under the ILC, psychosocial disability stands to only receive a very small part of the $131m in funding. Indeed, in the latest round of the National Readiness Grants for ILC, only one mental health organisation received funding[40]. Programs funded under the ILC need to have national coverage to provide individual information, referral and connection to mainstream supports, individual capacity building, as well as community education, mainstream capacity building, and stigma reduction, in order to meet the wide ranges of outcomes expected of the ILC.[41]

The ILC must also provide greater clarity around the funding criteria. There are many ambiguities in ILC Policy that make it difficult for organisations providing psychosocial support to know how resources will be allocated. These include:

- Crossovers between outcomes for individual plans and the Individual Capacity Building activity of the ILC;
- Ambiguity between Local Area Coordinator (LAC) functions and the potential work of other ILC programs, particularly as LACs are not yet fully operational in regions;
- Contradictions between the ILC Commissioning Framework, which indicates commissioning will focus on diagnostic specific expertise and/or cohort-focused delivery[42] (among other focus areas), while ILC documents elsewhere indicate that programs must benefit a wide range of people[43]
- General ambiguity about the intent and focus of the funding, in particular the kinds of projects that are in scope

This lack of clarity has made it difficult for service providers to prepare funding bids or plan for future service delivery to clients. The short funding period and small amounts available dis-incentivise tendering. The focus in the ILC and LACs around mainstream service and broader community inclusion suggests a shift away from diagnostic specific expertise; there is concern about the ability of mainstream services to support those with psychosocial disability without strong partnerships or guidance from organisations with the experience, and consumer/carer connections to understand the needs of those with mental ill-health.

The roles and responsibilities of NDIS individually funded packages, programs funded under the Information Linkages and Capacity (ILC) program, LACs, PHNs, public and community health should be clearly delineated, with adequate resources to ensure that integration across services is possible.

Rural and remote issues

There are many issues facing rural and remote service provision. In brief, MIFA would like to note that current price loading does not currently adequately incentivise providing services in

[40] http://www.disabilityservicesconsulting.com.au/resources/ilc-national-grants
[41] NDIA (2016). *Information, Linkages and Capacity Building (ILC) – Outcomes Framework Discussion Starter.* Available at: https://ndis.gov.au/medias/zip/documents/h0c/h0c/8799178719262/ILC-Outcomes-Framework-Web-Version-17.11.2016.docx
[42] ILC Commissioning Framework, p. 18
[43] "We expect the activities we fund in ILC to benefit a wide range of people." From https://www.ndis.gov.au/ILC-FAQ-Organisations

most rural and remote areas, particularly for psychosocial supports. This is especially the case given transport needs are so much higher in these areas. Loading should be extended to include Modified Monash Model areas 4 and 5, or alternatively, a more locally responsive approach to assigning rural and remote pricing and loading should be adopted.

MIFA thanks the Joint Parliamentary Committee for the opportunity to provide input into the inquiry.

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Disclaimer

This submission represents the position of MIFA. The views of MIFA members may vary.

Appendix I: Permanency and psychosocial disability in the NDIS

The disability requirements for National Disability Insurance Scheme (NDIS) stipulate that a person's impairment (condition) must be permanent, or likely to be permanent[44]:

> **Section 24 Disability requirements**
> (a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and
> **(b) the impairment or impairments are, or are likely to be, permanent**; and
> (c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:
> (i) communication;
> (ii) social interaction;
> (iii) learning;
> (iv) mobility;
> (v) self-care;
> (vi) self-management; and
> (d) the impairment or impairments affect the person's capacity for social or economic participation; and
> (e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.

Mental Illness Fellowship of Australia (MIFA) maintains that the criteria for permanency in the context of psychosocial disability is inappropriate, as it is not based in prognostic evidence, is incongruent with recovery-oriented practice, and is unnecessary for ensuring the NDIS supports those most in need. We advocate adopting a working definition that operationalises the intent of the scheme and maintains important boundaries, without requiring a condition be permanent. This would be supported by the adoption of a psychosocial specific assessment tool, with publicly understood standards of what constitutes a substantially reduced level of functioning for the purposes of NDIS eligibility.

MIFA notes that in its review of NDIS Costs Position Paper, the PC advised against 'relaxing' the eligibility criteria for psychosocial disability[45], on the grounds that this would impact on the financial viability of the scheme. There is no desire from the sector to make the criteria less stringent for people with psychosocial disability; indeed, MIFA has repeatedly advocated that the NDIS must target those *most* in need, and adopt strategies to ensure the costs of the NDIS

[44] s24(1)(b) and s25(1)(a)(ii), *NDIS Act 2013*
[45] p144, Productivity Commission Position Paper – NDIS Costs Review

do not blow out by inadvertently including a larger cohort of people than those for whom the scheme was designed.[46]

We recommend the criteria for permanency is removed in the context of psychosocial disability in order to overcome the significant definitional barriers for people with psychosocial disability; while maintaining the other elements of the criteria and placing a greater emphasis on current and historical functional impact.

Is permanency a barrier?

The PC notes that there are currently 5000 people with psychosocial disability in the NDIS, citing this as evidence that the permanency requirement does not present barrier for people accessing the scheme[47]. They further note that 81% of people who have made access requests have been found eligible[48]. These two statistics have also been cited by the Department of Social Services as evidence that people with psychosocial disabilities are able to "participate in the same way as people with other significant and permanent disabilities."[49]

However, these statistics do not provide convincing evidence that the eligibility criteria are not a barrier. These numbers do not acknowledge the significant number of people who are choosing not to apply (MIFA members report between 17% and 37% of participants in PIR programs[50]), in part, due to the requirement for permanency, based on issues providing evidence to that effect and to philosophical issues with the criteria.

These statistics also do not acknowledge that significant barriers have been overcome through the support of community mental health providers to gain access to the NDIS, including advocacy to health professionals to understand how the NDIS expects "permanency".

Participants in MIFA member programs report being rejected from the NDIS on the grounds that the person's health professional mentioned the possibility of recovery in their supporting evidence; or on the grounds that their diagnosis is not a permanent condition – in particular, people with bipolar and other mood disorders. Psychosocial disability has the lowest rate of successful access requests[51], and trial site evaluations showed that those with PTSD, depression and mood disorders are more likely to be declined a package.[52] This is particularly concerning as

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[46] p6, MIFA Submission 122 to the PC NDIS Cost Review Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0008/215747/sub0122-ndis-costs.pdf

[47] p143, Productivity Commission Position Paper – NDIS Costs

[48] *ibid*

[49] Evidence given by John Riley, Acting Group Manager, NDIS Market Reform Group, Department of Social Services, to JSC on NDIS Inquiry into psychosocial disability, Public Hearing 16 Jun 2017. Available at: http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F49e1b918-497e-47c9-94ed-ba49a52f05a3%2F0000%22

[50] p4, One Door Mental Health (2017). Post- Paper Submission 266 to the PC Review of NDIS Costs Position Paper, Available at: http://www.pc.gov.au/__data/assets/pdf_file/0018/219321/subpp0266-ndis-costs.pdf

[51] 71.3% in Q2, Oct-Dec 2016. p56. National Disability Insurance Agency (NDIA) (2017). *COAG Disability Reform Council Quarterly Report Q2 2016-17*. Available at: https://www.ndis.gov.au/medias/documents/hda/h8d/8800076922910/CDRC-Report-2016-17-Q2.pdf

[52] 15% of people with mood disorders had their application declined, see p10 in Hunter Primary Care and 360 Health and Community (2015). *Partners in Recovery and NDIS Interface: A Data Report from the Hunter and Perth Hills Trial Sites*, https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf

people with mood disorders often make up the largest percentage of those in programs set for transition into the NDIS.[53] Research shows that while these disorders are commonly considered 'less severe', they are significantly disabling for a large percentage of people[54], providing evidence that diagnosis-driven access decisions must be avoided.

Other reported barriers can occur once a person has gained access. In one case example, a participant received access to the NDIS, and attended his planning meeting, during which he refused to characterise his illness as permanent as he found that discouraging and offensive. His access to the NDIS was consequently reviewed.

The issue of definitional alignment is so widespread that the new *reimagine* website, designed to support people with mental health issues to access the NDIS, includes a section advising participants they must shift their recovery beliefs in order to fit with the National Disability Insurance Agency (NDIA)'s definitions[55].

There is certainly disagreement in the sector around whether permanency is a barrier for people with psychosocial disability, as noted by the PC[56]. There are some participants who like the stability and finality that a "permanent" diagnosis brings them[57]. Some advocates are comfortable with the inclusion of permanency because they are reading the early intervention requirements as moderating the need for permanency[58] – however, the early intervention requirements are clear that the impairment itself must still be, or be likely to be, permanent. A person can access early intervention if their *need for support* is not permanent (or lifelong); they still need to have a permanent impairment. Furthermore, anecdotal reports suggest that few people with psychosocial disability are entering the scheme under early intervention requirements.

In order to better understand these barriers, the NDIA should undertake, as a matter of priority, a comprehensive analysis of access decisions (both accepted and rejected) in the context of psychosocial disability, including a finer level of analysis to disaggregate the factors supporting the decision, such as presence and type of diagnosis, functional impact and domains of impact, evidence for past and present treatment, previous program if transitioning, and any other factors relevant to understanding the cohort of people accessing the NDIS.

MIFA maintains that permanency presents a significant barrier because it is not evidence-based, is inconsistent with recovery principles, and is unnecessary in the context of psychosocial disability. The reasons for our position will be outlined below.

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[53] 27.8% of NSW PIR clients had mood disorders: p20, Amos, P. (2015). Persistent Mental Illness And Complex Needs A Project Of New South Wales Partners In Recovery Organisations

[54] Sanderson, K. and Andrews, G. (2002). 'Prevalence and Severity of Mental Health–Related Disability and Relationship to Diagnosis.' *Psychiatric Services* 53(1). Available at: http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.1.80

[55] Reimagine website (2017). Mental health recovery, psychosocial disability and the NDIS. http://reimagine.today/step-1/mental-health-recovery-psychosocial-disability-and-the-ndis/

[56] p143, Productivity Commission Position Paper – NDIS Costs

[57] See for example, https://waamh.org.au/news/permanency-requirement-draws-mixed-reactions.aspx

[58] See for example, p4, Submission 63, available at: http://www.pc.gov.au/__data/assets/pdf_file/0016/215413/sub0063-ndis-costs.pdf

Can permanency be predicted?

There are no clear diagnostic or other factors that can reliably predict whether a person will be permanently impaired by a mental health condition, or require permanent support. The Mind Literature review commissioned by the Independent Advisory Council (IAC) to the NDIA[59] presented research that a subset of people with schizophrenia will never completely "recover" (in a psychiatric sense of no symptoms), and that there are researched indicators that may enable prediction of whether a person will have ongoing impairments.

While it may be true that a subset of people never recover, the evidence for rates of recovery in mental health conditions is highly inconsistent. For example, one review showed at least 1 in 7 people with schizophrenia fully recover, but results varied with some studies reporting as high as 1 in 3 or 1 in 2 people fully recovering from schizophrenia[60].

Furthermore, while some factors, such as age of onset or baseline functioning, may be predictors of poor prognosis over a lifetime, there are few that have high predictive power. This means that although factors may be associated with better outcomes, they are not able to actually predict with a high reliability who will and who will not be permanently impaired. For example, in Austin et. al. (2013), even a multifactorial model including a range of predictors (such as baseline functioning and negative symptoms) found 78% of full recovery in psychotic illness is explained by other, unknown factors[61].

It is not uncommon for predictive factors in psychology to have low effect sizes, given the complexity of human behaviour; these predictors may be significant in a statistical sense, and considered adequate from a research perspective. However, from a clinical perspective, the research evidence is too heterogenous and the effect sizes too small to accurately predict the course and outcome of someone's mental illness[62,63]. It is difficult, if not clinically inaccurate, therefore, for health professionals to give evidence to that effect.

Recovery-oriented practice

Health professionals can be unwilling to provide evidence that an impairment is or is likely to be permanent, both because this may be clinically impossible to predict, but also because it is at odds with a recovery framework. This is particularly true for health professionals who do not subscribe to an organic or medical model of mental illness. In the context of psychosocial disability, research shows that motivation and self-belief have an independent and significant

[59] Nicholas, A., Reifels, L., King, K., and Pollock, S. (2014). *Mental Health and the NDIS: A Literature Review.* Available at: https://www.ndis.gov.au/html/sites/default/files/files/Mental-health-and-the-NDIS-Literature-Review.pdf

[60] Jaaskelainen et al. (2012). 'A systemic review and meta-analysis of recovery in schizophrenia.' *Schizophrenia Bulletin.* 39(6), pp1296-1306. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3796077/

[61] Austin, et. al. (2013). 'Predictors of recovery in first episode psychosis: The OPUS cohort at 10 year follow-up.' Schizophrenia Research, 1(150), pp163-168. Available at: http://schizophrenia.elsevierresource.com/articles/predictors-recovery-first-episode-psychosis-opus-cohort-10-year-follow/fulltext#back-bb0240

[62] Chen,H., Cohen, P., and Chen, S. (2009). 'How Big is a Big Odds Ratio? Interpreting the Magnitudes of Odds Ratios in Epidemiological Studies.' *Journal of Communication in Statistics – Simulation and Computation*, 39 (4), available at: http://www.tandfonline.com/doi/abs/10.1080/03610911003650383

[63] Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences*. Routledge.

role in generating better outcomes for participants[64]. Stating that someone has a permanent impairment may not only be clinically inaccurate, but may be harmful.

Many stakeholders, including MIFA, believe that permanency is incongruent with a recovery-oriented model. The recovery oriented model is well articulated in the principles *National Framework for Recovery-Oriented Mental Health Services*, endorsed by the Australian Health Ministers' Advisory Council in 2013[65]. The recovery model is founded in the principles that *recovery is possible*, that hope and empowerment are essential, and that mental health is a deeply personal journey in which one's own perspective and experience is central. The language used with and about people with mental health issues is an integral part of recovery; as stated in the Framework Policy and Theory, "Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma."[66] Adherence to Domain 1 of the Practice Framework requires that practitioners and services to promote a service culture and language that "communicates positive expectations and promotes hope and optimism."[67] It is difficult to promote positive expectations for someone when the eligibility criteria require practitioners to provide evidence that the person will be 'permanently impaired'.

Some have argued that there is significant alignment between the NDIS principles of rights, choice and control, and recovery principles of person-centred practice, as has been explored elsewhere[68]. MIFA also acknowledges the internal and external work that the NDIA has done to attempt to reconcile these differences and support access processes[69]. However, we still maintain that requiring participants and health professionals to characterise mental health conditions as permanent is fundamentally antithetical to recovery principles.

Many participants in MIFA member programs say that the label "permanently impaired" is demoralising, and even insulting and denigrating. Many workers who operate from a recovery framework are similarly highly critical of its use, because it denies participants hope and may make them less motivated, and therefore less likely to recover.

Janet Meagher, expert advisor to the IAC and key advocate in the lived experience and recovery movement, gave the following evidence to the Joint Standing Committee on the NDIS:

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[64] Horan, W. et. al. (2010). 'Further Support For the Role of Dysfunctional Attitudes in Models of Real-World Functioning in Schizophrenia.' *Journal of Psychiatric Research*, 44(8), pp.499-505. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3414437/#!po=9.28571

[65] Department of Health (2014). *National framework for recovery-oriented mental health services*. Available at: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-recovfra

[66] p5, Department of Health (2014). *National framework for recovery-oriented mental health services: Policy & theory*. Available at: http://www.coaghealthcouncil.gov.au/Portals/0/National%20Mental%20Health%20Recovery%20Framework%202013-Policy%26theory.pdf

[67] p28, Department of Health (2014). *National framework for recovery-oriented mental health services: Policy & theory*. Available at: http://www.coaghealthcouncil.gov.au/Portals/0/National%20Mental%20Health%20Recovery%20Framework%202013-Guide-practitioners%26providers.PDF

[68] O'Halloran, P. About Psychosocial Disability and the NDIS, Introduction to the Concept of Holistic Psychosocial Disability Support. https://www.ndis.gov.au/html/sites/default/files/O'Halloran%20paper.pdf

[69] Including the pending Best Practice Guide for Access to the NDIS, public factsheet "Psychosocial disability, recovery and the NDIS", guide "Completing the access process for the NDIS: Tips for Communicating about Psychosocial Disability", and reimagine website.

> *"Ideologically, I cannot see how recovery is aligned to permanency … permanency has very little to do with recovery; it has everything to do with hope."*[70]

Professor Pat McGorrie, Professor of Youth Mental Health at The University of Melbourne, Executive Director of Orygen (the National Centre for Excellence in Youth Mental Health), and expert in early psychosis and youth mental health, gave evidence to the same inquiry which explained the difficulty and potential unhelpfulness of attributing permanency:

> *"The way mental illness causes disability, as Frank [Quinlan, CEO of Mental Health Australia] was alluding to, is somewhat different. There are some people where it does have a permanent and long-term effect. Certainly, the way we work with youth mental health and early intervention is that we do not want to assume that is going to be the case, even though it does end up being the case for a substantial minority of the young people that do develop these serious illnesses. Our aim is to achieve recovery. A very important thing in psychiatry is early intervention and recovery … and changing the pessimism that used to be associated with these illnesses. To have a model that assumes and requires permanent and fixed disability does not really work for us; certainly not in youth mental health. This is what young people have told us.* [71]

The idea that the impairments experienced because of mental ill-health are intrinsic, physically founded and un-changeable is not supported by clinical research and is in direct contradiction to recovery principles, which hold that impairments are changeable and fluctuating; and that through external supports and internal resources, individuals can achieve wellness and even completely recover.

Other misalignments with permanency

The issue of whether permanency can apply to psychosocial disability is further complicated by the effect of psychosocial support on mental health impairment. Indeed, with the right supports, it is arguable that impairments may diminish to the extent that the impairment no longer exists. This does not negate that a person may have been significantly and severely impaired for many years prior. The effective management of symptoms through capacity building and an ongoing, although hopefully lower, level of supports is the goal of recovery, even in cases where someone has severe and enduring mental illness. This contrasts with physical impairments, where the impairment itself will patently exist for life, while only the *functional impact* of the impairment will vary dependent on the supports the person receives and the level of internal capacity.

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[70] Evidence given by Janet Meagher, IAC expert, to the JSC on NDIS Inquiry into psychosocial disability, Public Hearing 28 April 2017. Available at: http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F24d13a89-fe9a-4292-ad38-971691d03471%2F0000%22

[71] Evidence given by Professor Pat McGorrie, to the Joint Standing Committee on the NDIS – Mental Health inquiry, Public Hearing 28 April 2017. Available at: http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommjnt%2F24d13a89-fe9a-4292-ad38-971691d03471%2F0000%22

Psychosocial disability also operates differently insofar as medical and clinical supports are likely to be required ongoingly, which can cause confusion with regards to the *NDIS (Becoming a Participant) Rules 2016*, Rule 5.4, which states that there must be "no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment"[72]. In the context of psychosocial disability, this condition can be met by providing evidence that a person has received adequate treatment and that their condition is stable, but how this is best evidenced remains to be clarified by the NDIA. There are also overlaps between what is considered psychosocial support and what is considered clinical treatment (for example, behavioural interventions).

Is permanency necessary?

MIFA acknowledges the PC's concerns around "relaxing" the eligibility criteria for people with psychosocial disability. As noted by the PC, boundaries are important[73] and the financial sustainability of the scheme must be protected. However, these arguments do not support maintaining false boundaries that do not reflect the clinical evidence, or the lived experience of the people who the NDIS aims to support.

MIFA maintains it is possible to delineate the cohort of people requiring support under the NDIS – that is, those with severe and enduring mental illness, significant impairments in functioning, and requiring extensive supports to maintain their life outside institutional care[74] - without reference to permanency. This can be achieved through a strong focus on the level of functioning, and the need for support. The cohort of people requiring support under the NDIS are able to provide evidence of severe functional impacts, and evidence of the need for ongoing, high level supports. It is also possible for them or their treating health professional to describe previous attempts at treatment and the current treatment. These factors combined are adequate to identify the cohort of people with severe mental illness and complex support needs, without requiring that someone's condition be permanent.

Other systems have overcome the limitation of permanency by providing clear, working definitions around the meaning of permanent; for example, the *Social Security Act 1991*, which uses the definition of "likely to persist for more than two years" and "not likely to improve in the next two years"[75]. This standard of evidence may be too low for the NDIS, which provides lifetime entitlements. McGrath (2016) suggested that in the context of psychosocial disability, a change in the eligibility criteria may require a change in the presumption of lifetime support[76].

In terms of managing boundaries, there are no additional risks from including someone who has a severe and enduring mental health condition, versus someone who has a permanent

[72] *NDIS (Becoming a Participant) Rules 2016* (Cth). Available at: https://www.legislation.gov.au/Details/F2017C00121
[73] p143, Productivity Commission Position Paper – NDIS Costs
[74] p754-p755 , PC (2011). *Disability Care and Support: Productivity Commission Inquiry Report*, 54(2), Canberra
[75] Section 6(4), 6(5), and 6(6). *Social Security (Tables for the Assessment of Work-related Impariment for Disability Support Pension) Determination 2011* (Cth). Available at: https://www.legislation.gov.au/Details/F2011L02716
[76] McGrath, D. (2016). The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches, available at: http://www.aph.gov.au/DocumentStore.ashx?id=2102830b-fade-440f-b4e1-c498d1a70490&subId=461257

mental health condition. Where the need for support diminishes, plan reviews will reduce packages accordingly, enabling a reduction in costs. Operationally, targeting the right group of people with severe and enduring psychosocial disability might require identifying a recommended length of time that functional impacts have been experienced in the past, and/or a length of time they are likely to be experienced into the future. Alternatively, evidence of previous long-term need for support and likelihood of need for support into the foreseeable future might be satisfactory.

MIFA, Mental Health Australia, and Community Mental Health Australia put forward an options paper to the Joint Standing Committee on the NDIS for addressing the permanency criteria for people with psychosocial disability (Appendix II). This included a recommendation to replace the word *permanency* with *ongoing*, *enduring*, or *chronic*. It further notes that the *NDIS Act* is due for review[77].

[77] p3, Ernst and Young. (2015) *Independent Review of the NDIS Act.* Available at: https://www.dss.gov.au/sites/default/files/documents/04_2016/independent_review_of_the_ndis_act.pdf

Appendix II: Options for achieving recovery oriented psychosocial support in the NDIS

Options for achieving recovery oriented psychosocial support in the NDIS

Supplementary submission to the Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

This supplementary submission has been prepared for the Joint Committee on the National Disability Insurance Scheme in response to its question on what needs to change for the Scheme to have a recovery focus for people with psychosocial disability. We believe the issue, which is the subject of widespread stakeholder concern, has arisen in part because the Scheme was initially designed for people with physical disability, with psychosocial disability a late addition.

Our recommendations are informed by the principles in the *National Framework for Recovery-Oriented Mental Health Services*, endorsed by the Australian Health Ministers' Advisory Council in 2013. A recovery-oriented approach aligns with the objective of the NDIS to maximise independence and social and economic participation at the individual level. A recovery orientation is also consistent with the Scheme's emphasis on choice and control.

The options presented are intended to clarify the original intended cohort for the Scheme – i.e. people with the greatest need for disability support – not to expand the Scheme's reach. We do not recommend a relaxation in access criteria or their application, but instead to make improvements in order to assist the right people to access the NDIS as easily as possible.

Legislation

We recommend the following amendments to section 24 of the *National Disability Insurance Scheme Act 2013*:

- Remove references to *psychiatric condition* and replace with *psychosocial disability.* Using a validated assessment tool, a full assessment of a person's functional capacity to undertake activities of daily living can preclude the current requirement that a *psychiatric condition* be demonstrated by medical certification.
- Replace the word *permanent* with *ongoing, enduring,* or *chronic*
- Consider incorporating into 24.1 (b): *the impairment or impairments are ongoing, or likely to be ongoing without the person receiving supports intended to build their capacity.*

While a change to the legislation is necessary, we believe the urgent priority is to ensure the operation of the Scheme is recovery-oriented for people with psychosocial disability.

Regulation

Amendments to NDIS Rules will give the NDIA greater flexibility to implement the Scheme for people with psychosocial disability based on recovery principles. We recommend the following amendments to the Rules:

Amend the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* to:

- Include the principle of recovery-oriented practice for psychosocial disability.
- Remove the requirement that psychosocial disability must be, or likely to be, permanent. (Subrule 5.1.(e) requires that a person is likely to require support under the NDIS for their lifetime, which adequately covers the longevity of the impairment.)
- Clarify that Rule 5.4 does not apply to psychosocial disability, to reflect that people with mental illness will receive ongoing clinical, medical and other treatments and psychosocial services to aid their recovery.

> Rule 5.4 An impairment is, or is likely to be, permanent (see paragraph 5.1(b)) only if there are no known, available and appropriate evidence-based clinical, medical or other treatments that would be likely to remedy the impairment.

- Recognise that medical evidence obtained for the purposes of gaining the Disability Support Pension is sufficient in confirming both the medical fact of and the enduring nature of a psychosocial disability.

Amend the *National Disability Insurance Scheme (Supports for Participants) Rules 2013* to:

- Recognise that a recovery-oriented approach will be taken by the NDIA in determining support needs for people with psychosocial disability.
- Require that a validated assessment tool is used for assessing reasonable and necessary supports for people with psychosocial disability, which would ensure equity for these NDIS participants while enabling the NDIS to operate according to insurance principles with timely investment to minimise lifetime costs.

Operational processes

The universal model of the NDIS is admirable. However, unique needs can and should have tailored approaches, such as that which has already occurred with early childhood. Recovery-oriented practice can be applied to the operational aspects of the Scheme for psychosocial disability.

Given the philosophical differences between the recovery-oriented assessment of and planning processes for people with psychosocial disability and those with other disabilities, the organisational structure of the NDIA should accommodate a specific psychosocial disability stream and NDIA staff (including staff involved in assessment and planning) should have expertise in psychosocial disability.

Other options for recovery-oriented practice in NDIS processes are set out below.

Assessment process

- Remove the requirement for people with psychosocial disability to produce medical evidence of the psychiatric condition and a medical testament to its permanence. This administrative practice to truncate individualised assessment of functional capacity is not a recovery-oriented approach to providing psychosocial supports services for people with mental illness.
- Adopt a validated assessment tool that is fit for purpose to assess the eligibility of people with psychosocial disability that focusses on their impairment and functional capacity to undertake activities of daily living.
- Assessment of people with psychosocial disability should be undertaken by a person with the right professional expertise. This can be done within the NDIA or outsourced, noting that the professional expertise largely exists in community based mental health service provider organisations and mental health professionals working with people with psychosocial disability.

Planning process

- Participants' plans should be oriented to capacity building supports to aid recovery, wherever possible.
- The planning process should be based on evidence of what constitutes effective and recovery-oriented packages of support for psychosocial disability.

Pricing

- Prices for psychosocial supports services should reflect the costs of a recovery-oriented services, i.e. not simply assistance with activities of daily living.

Since rollout commenced, mental health providers have repeatedly highlighted that the price of supports is set well below the hourly rate for psychosocial support work currently delivered by suitably qualified people. There is no hourly price for psychosocial support services in the NDIS Price Guide, and mental health providers have had no involvement in the process to set prices for different support types.

Background

The *National Framework for Recovery-Oriented Mental Health Services* was developed by the Australian Health Ministers'' Advisory Council in 2013 and is formal government policy. The Framework acknowledges that "Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma". This is why the use of the term "permanent" in the NDIS legislation presents such a big barrier to the cohort for whom the Scheme is intended to support. It is why so many stakeholders have made this point in their submissions to Parliamentary inquiries, review of the NDIS legislation and to the Productivity Commission.

In 2015, reporting on its review of the *National Disability Insurance Scheme Act 2013*, Ernst and Young recommended that the government conduct another review of the Act in two to three years given that the "legislative framework will be exposed to more participants, more

locations and more sources of stress".[1] Ernst and Young noted that the [second] review will "help government ensure that the legislative framework is 'fit for purpose' for full Scheme".

Eligibility assessment tool

In its advice for implementing the NDIS for people with mental health issues[2], the NDIS Independent Advisory Council found there was "no commonly accepted and used instruments for assessing functional impairments and indicating support needs related to disability due to a psychiatric condition". The Council highlighted the risk of inconsistent approaches in both eligibility and support needs being determined by the NDIA.

The issue remains unresolved and the Council has recommended, in its submission to the Parliamentary Joint Standing Committee on the NDIS, that the NDIA "invest in the development of a validated instrument for identifying an evidence-based approach to the determination of functional impairments and support needs for people with an impairment related to a psychiatric condition". It is unclear what has prevented the NDIA from: a) developing an NDIS specific tool; b) modifying the existing assessment tool for physical disability to assess psychosocial disability; or c) purchasing the licence for an existing psychosocial assessment tool.

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[1] Ernst and Young. *Independent review of the NDIS Act*. December 2015. Page 3.
[2] Independent Advisory Council for the National Disability Insurance Scheme, *IAC advice on implementing the NDIS for people with mental health* issues, 2014