Attn. Legislative Affairs Committee- National Disability Insurance Scheme (NDIS) Amendment Bill 2024 (*hereafter called 'the Bill')

Occupational Therapy Community of Practice Supplementary Submission – RISK OF HARM

14 May 2024

INTRODUCTION

The NDIS Occupational Therapy Community of Practice (NDIS OT CoP) is comprised of over 10,000 occupational therapist and was created to establish best practice and optimal outcomes for, and with, NDIS participants. We welcome the Inquiry by the Senate Standing Committee on Social Affairs, Legislative Committee into the Bill. This supplementary submission follows our original submission, dated April 26th 2024.

Here, we share our concerns **regarding current and potential risks of harm** to participants and applicants, that require consideration alongside the Bill, and broader reform processes. Currently we are very concerned that reforms processes may already pose significant risk of harm, as there is strong evidence that NDIS reforms are already rolling out, and there has not been any publicly available strategy to mitigate and prevent these risks. As current implementation of reform processes has not been clearly communicated, there is growing concern regarding the extent to which further reforms will be genuinely co-designed in future. While our concerns are broad, we draw on two examples to illustrate our concerns. These are: NDIS assessment; and pathways for people with psychosocial disability.

1. ASSESSMENT

1.1. Risk of harm due to reform processes – arising from the Bill

- The NDIS Bill introduces mandatory assessment processes to the NDIS, that will inform the supports participants with have funded through their plans. Disability support re-assessments carry a documented risk of harm [1][2]. The introduction of mandated assessment processes would require close surveillance at the population level, and monitoring at an individual participant level, to ensure risk of harm is understood and minimised. This risk must be explored, estimated and mitigated in advance of policy change. Assessment processes require piloting and evaluation.
- The Bill centralises the support needs assessment to the participant experience and in informing plan budgets. This creates the risk that the assessment process will become adversarial, stressful and traumatic. The absence of routes to appeal the assessment results, further increase this risk.
- There is no minimum standard of assessment or assessor identified through the Bill, elevating the risk of an inappropriate tool or process e.g. a tick and flick by an unqualified assessor. The separation of functional assessment from support needs assessment increases the likelihood of functional capacity is not broadly understood or explored through support needs assessment.
- The new definition of supports in Section 10 may mean that a narrower range of support needs can be met through the NDIS and identified through assessment. Agreements with States and Territories around responsibilities for comprehensive provision of disability support must be in place before changing eligibility thresholds or funding responsibilities. Without this, there is a risk of unacceptable service gaps.
- There is an absence of conceptual clarity within the Bill. We recommend conceptual align with the ICF, and that be reflected in the Bill and underpin assessment processes, as per the NDIS Review recommendations.

1.2. Risk of harm due to NDIS reform processes - current

- Currently the NDIS Participant Service Guarantee is on hold. This is causing unprecedented delays in plan reassessment and in disability support needs being met. NDIA delegates explain that this is due to significant change in internal process. Have the risks associated with these changes and the pause on PSG, been identified, and what strategies are in place to mitigate these risks?
- Participants describe the fear that they won't have assessments and allied health reports in time for plan re-assessments; then fear they will not be considered or read by planners; and currently, due to delays in re-assessments, planners are telling participants the assessment must be re-done if they are more than 3months old. This causes absolute chaos for participants and OT's aiming to provide quality evidence on the assumption it will be considered by planners.
- The OT CoP has received reports that LACs are completing 'functional' assessments, in Queensland. These assessors are not trained allied health professionals, raising concern regarding quality of assessment and breach of practice scope.
- The OT CoP has been inundated with reports that planners are completing 'gotcha calls' , cold calls that were unscheduled and it is unclear that the phone-call is actually a plan re-assessment. They then receive a new plan shortly afterwards, often with plan funding cut without explanation. One participant stated "I'm too afraid to answer my phone now, in case it is a planner calling to cut my plan".

1.3. How the Bill may exacerbate existing issues

- In the NDIS OT CoP submission to the NDIS Review, we referenced the ANAO report [3] that describes the variance in plan funding due to planner-delivered WHODAS informing Typical Support Packages- resulting in plans not tailored to individual support need and extreme variances in plan funding, for no difference in actual support need. Allied health generated assessment reports appear to have significantly decreased Agency expenditure on core support [4] - Please refer to Appendix 1 for further details. The ANAO report described the risks posed for Scheme sustainability when relaying on assessment scores to generate participant budgets. The changes introduced by this Bill may replicate and exacerbate these issues, unless proven fit-for-purpose assessments can be implemented by suitably qualified allied health assessors, alongside a transparent and co-designed 'method' for calculating budgets.

1.4. Alternative solutions

- To mitigate the potential traumatising effects of the assessment process, it's essential for the NDIS to prioritise trauma-informed approaches to service delivery and ensure that assessments are conducted with sensitivity, empathy, and respect for individuals' autonomy and self-determination. This includes providing opportunities for informed consent, offering choice and control over the assessment process, therapists, assessors and using trauma informed, experienced health professionals with an understanding and expertise in function.

- An alternative model to achieve this goal was explored and costed by the NDIS Joint Standing Committee on Independent Assessments, and we recommend this model is revisited for comparison and through a risk of harm and trauma lens. This model includes combining functional and support needs assessment; retaining choice of provider for participants; ensuring skilled and qualified assessors; and could be utilised to deliver a co-designed assessment tool. "*the committee considers that the Government should consider providing people with disability access to bulk-billed consultations with specialists and allied health professionals for the purposes of NDIS access and plan requests. The committee proposes that these consultations be funded under a new Medicare Benefits Schedule item*." See also Appendix 3 and 4 of this report p.134 and Recommendation 5, 9.47 [5]

2. PATHWAYS FOR PEOPLE WITH PSYCHOSOCIAL DISABILITY

2.1 Risk of harm due to reform processes – arising from the Bill

- The Bill may narrow the range of supports to people living with psychosocial disability and set up a mechanism by which to divert to early intervention pathways that have a more limited and prescribed range of supports. This may have implications for access to supports and impact outcomes across the lifespan, and exacerbate existing disability, health, and mortality trends [6].
- There is a severe lack of foundational supports for this cohort, this would need to be in place prior to changing the NDIS legislation. Foundational supports are likely to be low-intensity and not including access to capacity building supports delivered by mental health occupational therapists.
- This cohort are at very high risk of harm due to traumatic assessment processes; unpredictable access to support; or reduced access to essential disability support.
- The risks associated with NDIS plan revocation, where there are no alternative supports confirmed, are high and documented for this group [7]

2.2 Risk of harm due to change processes- current

- Many participants with psychosocial disability are describing experiences with cold-calls from planners who complete an undisclosed plan review, as described in 1.2 above.
- Current reports indicate that people with psychosocial disability are already being placed on an early intervention pathway with a limited range of supports. The rationale and evidence-base for this placement and principles underpinning this diversion have not been made public. Media reports has indicated the government intention to divert 27,000 people with psychosocial disability from NDIS [8], who would currently be eligible.
- Despite evidence-based capacity building as core business, exceptionally high-reach across NDIS participants with psychosocial disability, and models supported by allied health assistants as a sustainable practice model, the occupational therapy profession has not been included in NDIA co-design groups for psychosocial early intervention, and other aspects of the psychosocial participant pathway.

2.3 Alternative solutions

- The NDIS Community of Practice has articulated key concerns and solutions for people living with psychosocial disability, from the NDIS Review final report. This was submitted to the NDIS Joint Standing Committee (General Issues). This document is included in Appendix 2 below.

CONCLUSION

The final report od the *Royal Commission into violence, abuse, neglect and exploitation of people with disabilities* provide a set of recommendations that will enhance safe care and active participation for people living with disabilities. Principles of safe, participant led, trauma-informed care are pivotal to ensuring safe NDIS reform. Occupational therapists, as AHPRA registered health professionals, hold a key role in ensuring high standards of care for NDIS participants, and in identifying support needs and developing tailored capacity building interventions. The profession of occupational therapy is committed to building a strong and sustainable NDIS for the future.

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8. People with psychosocial disability may be diverted from NDIS in future, as government forecasts 27,000 reduction in participant growth - ABC News Retrieved 10/05/2024

APPENDIX 1: EXTRACT FROM THE NDIS OT COP SUBMISSION TO THE NDIS REVIEW 27 AUGUST 2023

Issue: The absence of a fit-for-purpose functional and support needs assessment to underpin individualised NDIS plans.

The steps required to co-design a fit-for-purpose functional and support needs assessment are detailed in our previous submission to the NDIS Review [1]. We underscore the importance of establishing this assessment process as fundamental to the development of tailored, individualised support plans.

Further, we re-iterate a call to the NDIS Review to consider the findings of the Parliamentary Inquiry to Independent Assessments [3], as this is the outcome of a national discourse on NDIS assessment processes, grounded in democratic principles.

As previously described, our NDIS Occupational Therapy Community of Practice, stands alongside peak body Occupational Therapy Australia [4: Sub 20, p.4] , and other allied health groups [5: Sub 28] in highlighting the limitations of both the use of planner-delivered functional screening tools, and the reduction of occupational therapy (OT) assessments to single scores as 'inputs' to generate functional levels informing Typical Support Packages (TSP) for NDIS participants.

The occupational therapy profession supports the provision of NDIS plans tailored to individualised disability support needs, based on fit-for-purpose functional and support needs assessment. NDIS systems that use input-scores to generate standard TSPs are an unreliable proxy; these result in significantly under and over-funded plans [7: p.39].

The process of mapping assessment scores to functional levels to generate TSPs, was initially made public through the JSC Inquiry to NDIS Independent Assessments [6]. The current process of using, or misusing, functional assessments to produce single scores, or sets of scores, to determine functional 'levels' to inform TSPs, may continue to pose risks to the financial sustainability of the NDIS [7], and may compromise the accuracy of support-needs based planning [4; 5; 7].

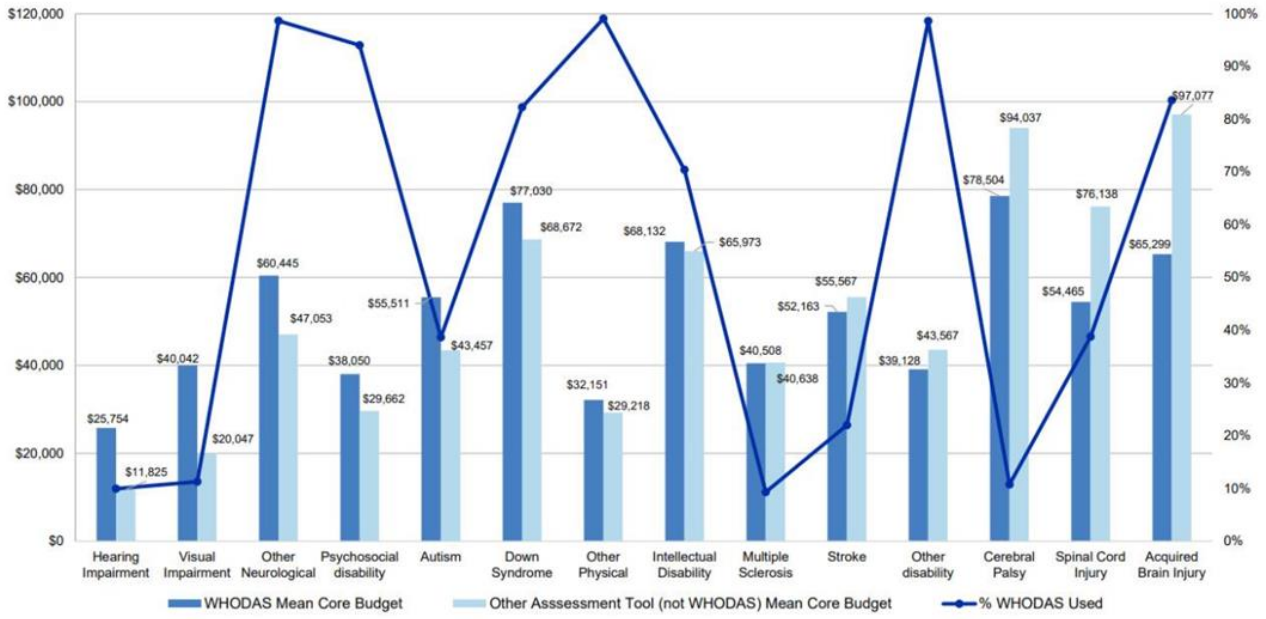
Evidence that the use of (largely NDIS planner delivered) World Health Organisation Disability Assessment Scale 2 (WHODAS) assessments pose risks to the financial sustainability of the NDIS, has been identified by the recent ANAO

audit-report to the Australian Auditor General on *Effectiveness of the NDIA's management of assistance with daily life supports report* (June 2023) [7].

The ANAO report evidences the funding variances between using (largely planner delivered) WHODAS, and occupational therapy functional capacity assessments (OT FCA)/health professional reports*, respectively. The variances appear attributable to the manner in which the assessment tools scores are utilised by the NDIS [7], and do not represent an actual variance in participant support need. [See ANAO analysis of NDIA data, June 2023 Fig 2.1, p. 39 & copied below in Fig 1].

Fig 1: ANAO analysis of NDIA data, June 2023 Fig 2.1, p. 39 [7]

Figure 2.1: Assistance with Daily Life (ADL): WHODAS assessment tool usage and average core supports budget 2021–22, relative to other assessment tool, by disability



Note: ADL is included in core supports budget (see paragraph 1.7). Analysis includes plans for participants aged 17 years or older approved in 2020–21 and 2021–22, and expenditure greater than zero. Excludes plans less than one month duration and groups with less than 1000 plans: Development Delay, Global Development Delay and Other Sensory/Speech. High usage of WHODAS is expected as the preferred tool for Other Neurological, Other Physical and Other Disability (see Appendix 3).

Source: ANAO analysis of NDIA data.

For the first time, the ANAO audit-report revealed the budgetary impact of funding variance attributable to the use of assessment tools by NDIS planners. This variance represents a high-risk potential budgetary inaccuracy that threatens the sustainability of the NDIS, and risks individual participant access to NDIS support tailored to their needs.

Using the average core support budgets identified by ANAO (Fig 1) and applying these to current Scheme numbers and assuming every participant had a plan re-assessment within the financial year, a 100% use of WHODAS would lead to an estimated total core-support cost of $28 billion and 100% 'other' assessment tool (OT FCA/health professional) would lead to an estimated total core-support cost of $25 billion, for the financial year 2022-2023. This is an estimated cost-variance of approximately $3 billion for the FY [Fig 2) attributable to assessment score method**, **with no actual difference in participant support-need**. This figure represents an 11% variance within the overall NDIS support budget of $35.1 billion, and is an average variance of $6111 per participant (Fig 2). Note this is for core-support budget alone, not total support budget, as the ANAO focused only on core-support funding within their 'assistance with daily life supports' scope.

The ANAO report [7] cites the following examples (p.38):

- *"for adult participants with autism as a primary diagnosis, WHODAS was used for 39 per cent of plans, resulting in 28 per cent higher average funding for core supports of $55,511, compared to $43,457 where another tool was used."*
- *"Conversely, for participants with an acquired brain injury, WHODAS was used 84 per cent of the time, but resulted in average core supports funding of two thirds of that based on another tool, in most instances being the Care and Needs Scale (CANS)."*

A further example, for psychosocial disability, the ANAO report highlights an average variance of $8388 for core-support per participant plan, depending on which input is used – (largely planner delivered) WHODAS or OT FCA/health professional report (Fig 1). This potential absolute variance could amount to $520,056,000 p.a., over half a billion dollars, when estimated for the 62,000 participants living with psychosocial disability - **with no actual difference in participant support-need**. For autism, the average variance per plan is $12,504. For spinal cord injury, the average variance for core-support is a whopping $21,673, per participant plan (Fig 1).

Further attempts to extrapolate data from the ANAO graph (fig 2.1 p.39) (See Fig 2), examining net variance, reveals that OT FCA/health professional reports offering assessments other than WHODAS, were utilised in approx 45% of total plan re-assessments during FY21-22. Applying the variances identified in the ANAO audit to current Scheme participant numbers & FY22-23, the average core support plan value when (largely planner delivered) WHODAS was utilised as an input to TSP, by comparison to OT FCA/health-professional assessment, would be $53,879 compared to $47,768, an average difference of $6,111 per participant plan for core-support across all disability types.

In other words, the provision of OT FCA/health professional reports for plan-reassessment, preventing the need for reliance on WHODAS for 45% of participants, likely led to an estimated NDIS core-support cost-'saving' of $1,446,022,708, a figure close to $1.5 billion, for the financial year 22-23. While this is a budgetary 'cost-saving', it is not a true 'saving' as in some cases, it may represent an inappropriate reduction of needed daily living supports for some participants. It is unknown whether there was an overall plan-reduction for these participants, as the impact on other budget categories, such as capacity building, was not analysed by ANAO.

**OT FCA is the main source of functional assessment submitted by NDIS participants at plan re-assessments, while other allied health and medical reports may comprise a small proportion also. ** The estimates does not include additional factors used to generate TSP's as this information is not in the public domain e.g. variables, such as age and geographical location, which may contribute to the differences. Also, the estimate does not consider variables introduced by use of Paediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT) for children up to age 16, as this was not published within the ANAO report.*

Fig 2: Core Support net variance, assuming current scheme numbers and variance as per ANAO calculation FY21-22 - WHODAS compared 'other' i.e. OT FCA/health professional

		Budget		Total Budget		% WHODAS Used		Budget
Disability	Number of Participants	WHODAS	Other Tool (not WHODAS)	WHODAS	Other Tool (not WHODAS)	WHODAS	Other Tool (not WHODAS)	WHODAS by % Used
Hearing Impairment	26,507	$ 25,754	$ 11,825	$ 682,661,278	$ 313,445,275	15%	85%	$ 368,827,675
Visual Impairment	10,158	$ 40,042	$ 20,047	$ 406,746,636	$ 203,637,426	15%	85%	$ 234,103,808
Other Neurological	22,442	$ 60,445	$ 47,053	$ 1,356,506,690	$ 1,055,963,426	98%	2%	$ 1,350,495,825
Psychosocial disability	62,011	$ 38,050	$ 29,662	$ 2,359,518,550	$ 1,839,370,282	94%	6%	$ 2,328,309,654
Autism	214,800	$ 55,511	$ 43,457	$ 11,923,762,800	$ 9,334,563,600	39%	61%	$ 10,344,351,288
Down Syndrome	no data	$ 77,030	$ 68,672	$ -	$ -	82%	18%	$ -
Other Physical	19,961	$ 32,151	$ 29,218	$ 641,766,111	$ 583,220,498	99%	1%	$ 641,180,655
Intellectual Disability	100,692	$ 68,132	$ 65,973	$ 6,860,347,344	$ 6,642,953,316	70%	30%	$ 6,795,129,136
Multiple Sclerosis	10,337	$ 40,508	$ 40,638	$ 418,731,196	$ 420,075,006	10%	90%	$ 419,940,625
Stroke	8,967	$ 52,163	$ 55,567	$ 467,745,621	$ 498,269,289	22%	78%	$ 491,554,082
Other disability	8,341	$ 39,128	$ 43,567	$ 326,366,648	$ 363,392,347	97%	3%	$ 327,477,419
Cerebral Palsy	17,680	$ 78,504	$ 94,037	$ 1,387,950,720	$ 1,662,574,160	10%	90%	$ 1,635,111,816
Spinal Cord Injury	5,895	$ 54,465	$ 76,138	$ 321,071,175	$ 448,833,510	38%	62%	$ 400,283,823
Acquired Brain Injury	18,045	$ 65,299	$ 97,077	$ 1,178,320,455	$ 1,751,754,465	84%	16%	$ 1,270,069,897
	525,836			**$ 28,331,495,224**	**$ 25,118,052,600**	Av 55%	Av 45%	**$ 26,606,835,701**
		Variance			-11.3%			-6.1%
excludes:		Per person		$ 53,879	$ 47,768			$ 50,599
Global developmental	14,926	**Avg per person var**			**$ 6,111**			
Other sensory/speech	2,072							
Developmental delay	67,558							
Total	610,392							
Variance	110							1,446,022,708

While the cost-'saving' attributable to OT FCA/health professional assessment is no doubt viewed favourably from an NDIS budget perspective, the practice of minimizing comprehensive health-professional reports by extrapolating a single assessment score from a particular tool as an input to a TSP system to inform plan-budget, is highly inappropriate and represents a misuse of health and allied health reports, including occupational therapy functional capacity assessments (OT FCA).

OT FCA's are designed to assess functional capacity to provide evidence for comprehensive, individualised, tailored participant support need – and the practice of extrapolating single assessment scores from these reports to feed a TSP-system leads to further inaccuracies and inconsistencies in plan funding. Assessment tool scores have limited value unless reviewed in the context of overall OT FCA report which includes clinical reasoning and contextualizing assessment scores in the context of a broad range of assessment methods including participant self-report, therapist observation, environment, participant goals and life stage, and history of disability support need and support utilization. The NDIA has never issued guidance on OT FCA/health professional report requirements, and the OT profession has independently developed practice in this area to align with assessing functional capacity across functional domains defined in the NDIS legislation, to make recommendations on reasonable and necessary support needs.

The ANAO audit report states that the NDIA has not assessed the impact of its over-reliance on WHODAS, including whether it may be distorting plan funding outcomes for participants overall, or for certain participant cohorts [7] The ANAO audit report recommended:

Recommendation no. 2 2.57 The National Disability Insurance Agency (NDIA) review: (a) the use of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS) tool by planners in developing participant plans, including analysis of plan outcomes, to assess the impact the use of this assessment tool has on participant plan outcomes and scheme sustainability; and (b) guidelines, procedures and web content to ensure it transparently conveys NDIA policy about the use of assessment tools consistent with legislative requirements. National Disability Insurance Agency response: Agreed. (p.40)

The ANAO audit report further recommended: "*…[The NDIA] transparently inform participants about the NDIA's use of WHODAS consideration of evidence in planning"* (p.40).

This submission focuses on the absolute variance in plan values revealed in the ANAO audit report, because neither of the two current processes – (largely planner delivered) WHODAS scores nor scores inappropriately derived from OT FCA/health assessments – are likely to adequately inform core support needs, and are a poor proxy for individualised assessment of disability support need.

What this means is that, 10 years since the NDIS began, the Scheme does not yet have an accurate and consistent approach to determining and funding individualised participant support needs. This absence has likely led to wild variances in plan funding at an individual level, and massively contributed to the current challenges of financial sustainability within the Scheme. To add another NDIS metaphor to the plethora, the absence of a fit-for-purpose functional and support needs assessment is akin to the 'horse-shoe nail' of the NDIS i.e. a seemingly minor omission that has led to grave and unforeseen consequences.

We express our concern that past failures to ensure a NDIS fit-for-purpose functional and support needs assessment, has now led to a position where the core NDIS principle of provision of tailored, individualised support, is at risk of compromise, including through future legislative reform.

Solution: Prioritise the development of a co-designed fit-for-purpose functional and support needs assessment to underpin individualised NDIS plans, enabling transparency in funding allocation.

Our previous submission details the steps required to co-design a fit for purpose assessment process [1], alongside a call for the NDIS Review to consider the findings of the Joint Standing Committee Inquiry to independent assessments [2]. Here we propose the International Classification of Functioning (ICF) as a potential framework to build the assessment process. The potential benefits of the ICF framework to the NDIS, including in the development of person-centred assessment, have been previously articulated in detail [8].

The introduction of a combined functional assessment (focused on understanding and measuring impairment) and support needs assessment (focused on identifying tailored supports to reduce participation restriction) framework based on the ICF could lead to more accurate, evidence-based and internationally-recognised understanding of disability, including psychosocial disability, alongside identification of support needs.

Re-conceptualising disability within the NDIS, in terms of ICF concepts to replace the widely-criticised primary disability/diagnostic focus, has the potential to bring real change to the entire NDIS experience for people with disability, alongside enhanced capacity to measure outcomes and build data to continuously improve the NDIS [9].

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APPENDIX 2: NDIS MHOT SUBMISSION TO THE NDIS JOINT STANDING COMMITTEE [GENERAL ISSUES], MARCH 7TH, 2024

Attn. NDIS Joint Standing Committee- General Issues Inquiry

March 7th, 2024

1. PURPOSE

This paper has been prepared for the NDIS Joint Standing Committee by the NDIS mental health occupational therapy community of practice, and responds to the NDIS Review Final report with a focus on psychosocial disability. This paper is intended to inform policy makers and decision-makers regarding potential risks, gaps and solutions pertaining to the NDIS Review Final Report, for people living with psychosocial disability.

Occupational Therapy Australia, the professional association and peak representative body for occupational therapists in Australia, supports this submission.

2. INTRODUCTION

The NDIS Review Final report is a landmark report sign-posting the road ahead for the NDIS and the broader disability ecosystem. We welcome the report and acknowledge the effort that has led to it. In particular, we commend the recommendations to build an Australia-wide ecosystem for psychosocial disability, including the commitment to building foundational supports. We welcome a strong focus on the reduction and elimination of restrictive practice for all groups, including psychosocial disability. We welcome the introduction of the *International Classification of Functioning (ICF)* as a best practice, internationally recognised, framework with high compatibility with the NDIS.

While the Review report brings some recommendations that have potential to improve both NDIS outcomes for participants alongside Scheme sustainability, we highlight that Recommendation 7, without careful and deliberate design aligned to disability insurance principles, is at high risk of manifesting and exacerbating existing issues, for both people living with psychosocial disability, and for Scheme sustainability. We are also concerned that the expected cost savings, and participant outcomes, anticipated in the proposed new operating model for psychosocial disability through Actions 7.1 and 7.2, will not in fact eventuate as anticipated.

We appreciate the reinvigorated NDIS must reduce the rate of cost growth (targeting 8% p.a) and understand the importance of the outcomes of this Review to save money, improve outcomes for people with psychosocial disability and ensure Scheme sustainability over the long term. We are contributing this paper to help ensure the recommendations from this Review have the best chance to deliver on these aims. This response paper focuses on NDIS Review Supporting Analysis Chapter 2, Part 6, p.507- 536. Specifically, Recommendation 7, Actions 7.1 and 7.2 (p.508).

Recommendation 7: Introduce a new approach to NDIS supports for psychosocial disability, focused on personal recovery, and develop mental health reforms to better support people with severe mental illness

Legislative change required

- Action 7.1: The National Disability Insurance Agency should introduce a new approach to psychosocial disability in the NDIS based on personal recovery and optimising independence.
- Action 7.2: The National Disability Insurance Agency should establish an early intervention pathway for the majority of new participants with psychosocial disability under section 25 of the *National Disability Insurance Scheme Act 2013*.

3. PSYCHOSOCIAL DISABILITY

We highlight the need for the NDIS Review implementation to recognise the profound impact psychosocial disability has on daily lives. The profound impact persists between acute episodes and is not adequately addressed by systems outside the NDIS. We call for ongoing commitment to choice and control and the right to an 'ordinary' life for this group.

Further, potential risks due to the development of the ecosystem and introduction of the NDIS early intervention pathway, must be explored to mitigate the risk of creating further barriers to accessing disability support. These risks include: The step-up step down approach creating a revolving door for the NDIS; the limited and prescribed nature of early intervention supports and the proposed frequency of assessment creating barriers to effective support; and the potential complexity and gate-keeping a multi-tiered system with multiple funding streams across Federal and State funding systems, will bring.

4. Response to Action 7.1: The NDIA should introduce a new approach to psychosocial disability based on personal recovery and optimising independence.

The risks and benefits of introducing this new approach, which departs from existing NDIS concepts and constructs, require further examination, particularly from the perspectives of conceptual clarity, expanding Scheme scope, and the creation of new, separate constructs and pathways for the psychosocial disability cohort. We highlight that the National Mental Health Consumer and Carer Forum has published a position statement focused on the NDIS Review, highlighting that the Review report has misunderstood the concept of personal recovery [13], and we concur with this position.

4.1. CONCEPTUAL CLARITY & SCHEME SCOPE

The core construct utilised within the NDIS Act is functional capacity, and eligibility for the NDIS is determined by evidence demonstrating substantially reduced functional capacity. The focus on functional capacity as core construct is a key point of difference that demonstrates the role of the NDIS, beyond other service systems. The Review report introduces the construct of 'personal recovery' and 'independence' and recommends a legislation change to formally incorporate these concepts to the NDIS (Action 7.1).

The issues with this direction, are evidenced throughout Chapter 2, Section 6, where there is blurring, overlap and inappropriate interchange of each of these constructs, and also between recovery from symptoms, and the recovery of function. Each of these constructs are discrete, with specific theories of change, intervention targets, and role in the lives of people with disability. 'Personal recovery', the highly personal and internal recovery of hope and self-identity, is an entirely separate construct to both clinical, and functional, recovery, and these appear conflated in the Review report, which goes so far as to suggest a personal recovery approach can remediate impairment or reduce disability [1].

An understanding of personal recovery as a basic principle, holds significant value in the same way that underpinning principles such as a trauma-informed approach, or culturally safe practice, hold value within the NDIS. The psychosocial recovery-oriented framework may retain value as an *accommodation* within the NDIS, as per the original design of this framework. Beyond these, formalising the introduction of a personal recovery approach risks expanding Scheme scope at a time when greater focus is required to achieve outcomes for people with the most significant disability; and further entrenching conceptual confusion.

Conceptual clarity is paramount, and it is recommended the NDIS maintain construct integrity with the focus on functional capacity, and construct validity in the design of both functional and support needs assessment processes, and intervention. The focus on functional capacity is compatible with the broader introduction of the ICF to the NDIS, and psychosocial disability policy should progress in alignment, for example, by drawing upon the international best practice such as the World Health Organisation core sets to frame functional impairment and address restriction in participation [2].

4.2. EQUITY ACROSS DISABILITY GROUPS

The proposed introduction of a 'personal recovery and independence' approach, alongside a recommended early intervention pathway, initiates a new psychosocial-disability specific construct and pathway. This raises potential questions around fair and equal access to support for all groups, and, is this segregation by policy targeting a particular group of disabled people? While the Review broadly recommends moving away from a diagnostic to a functional capacity focus for people with disabilities, the psychosocial disability cohort are not afforded that right. They are in fact defined by and segregated according to the diagnostic origins of the disability. The early intervention pathway proposed within the Review report for the majority of this group, including detailed and prescribed intervention plans, clearly singles out this adult group only.

5. *Response to Action 7.2: The NDIA should establish an early intervention pathway for the majority of new participants under Section 25 of the NDIS Act 2013*

We recognise an early intervention approach may be effective for some people with psychosocial disability if the service delivery model is well designed and includes models that encompass evidence-based capacity building by trained mental health professionals. A robust *Theory of Change* would need to be developed and the pathway piloted, prior to changing the legislation. Streamlined access to the NDIS under Section 24 of the NDIS must be upheld, for those who meet the criteria for inclusion. We express concern that the proposed pathway as it is described in the Review departs from disability insurance principles, and the evidence base and case for the select early interventions proposed is not sound and will not deliver on the outcomes expected from it.

5.1. PROPOSED EARLY INTERVENTION PATHWAY & DISABILITY INSURANCE PRINCIPLES

Currently, the NDIS lacks tailored assessment processes to determine when remedial approaches (capacity building) are required, and when accommodations (compensatory/core) approaches are required. It has largely lacked the capacity to fund and implement interventions in tune with these principles. This has resulted in the much-highlighted over-reliance on core support, essentially an accommodation, when allocating resources to the psychosocial disability cohort. This has had significant and ongoing cost-implications, in both the short and longer term. Concerningly, this issue has not been addressed through the NDIS Review, despite being fundamental to the success of an early (in-scheme) intervention pathway which aims to 'front-load' capacity building to reduce future need for compensatory strategies. In fact, the proposed early intervention pathway under Section 25 of the NDIS Act, for psychosocial disability, appears to depart from these disability insurance principles.

5.1 PROPOSED EARLY INTERVENTION PATHWAY & DISABILITY INSURANCE PRINCIPLES (cont)

This glaring gap is highlighted in Case Study 17 provided in the NDIS Review, 'Brett', (p. 508, NDIS Review Supporting Analysis) Brett is allocated to the early intervention pathway, apparently without consideration or assessment by a professional of his functioning. The navigator offers him a limited range of options devoid of *Theory of Change*, apparently not tailored to need, capacity or consideration of remediation or potential accommodation factors, or goals. When these interventions are proven to be ineffective - 2 years later -the navigator supports him to access the NDIS under Section 24 of the Act.

An early intervention pathway that does not focus on disability insurance principles to allocate resources, funding and support, risks perpetuating and worsening the already problematic issue of inappropriate supports being delivered to people with psychosocial disability. The trend of poor outcomes and high cost, at both human and fiscal levels will only continue to worsen under the proposed early intervention model described in the Review.

We recommend the re-establishment of disability insurance principles to determine remediation and accommodation requirements in both NDIS early intervention (Section 25) and the NDIS (Section 24), as an urgent priority, before progressing policy and model design and legislation change. This nuance is critical to achieving both improved participant outcomes and cost savings. The workforce would then need to be structured to meet these Scheme requirements, so that these principals can be implemented with competence through targeted, personalised approaches.

The recent Australia National Audit Office audit-report to the Australian Auditor General Effectiveness of the *NDIA's management of assistance with daily life supports (June 2023) [3],* indicates the completion of a (non-WHODAS) functional capacity and assessment, generally completed by mental health occupational therapists, led to a core-support budget reduction of an average of $8000 per psychosocial participant during 2021-2022. If we assumed each of the 63,000 participants with psychosocial disability undertook a plan review that year utilising this assessment approach, this would create a core-support cost-reduction of $540,000,000, based on this assessment approach alone, for the year – possibly significantly more, if personalised capacity building intervention were implemented based on tailored assessment recommendations. The existing NDIS policy and system of allocating core budgets based on Typical Support Packages, and the absence of a comprehensive assessment of support needs for people who do not access occupational therapy, have been primary drivers of over-reliance on high core-budget allocation and compensatory funding for people with psychosocial disability.

This NDIS Review provides the opportunity to rebalance the provision of individualised supports and save money through an increased focus on remediation (capacity building funding) and a consequent reduction in the accommodative/compensation approach (core support funding). This rebalancing will save costs overall, improve outcomes for the participant, reduce workforce risk for the Scheme, and increase the likelihood of an early intervention pathway delivering on its aims.

5.2. A CONTEMPORARY EVIDENCE-BASE FOR EARLY INTERVENTION?

The Review report recommends a timeframe of 3 years for the early intervention pathway, with assessments to occur frequently. Following this, the Review report indicates that some people will no longer need the NDIS can be exited back to foundational supports, as part of a step-up, step-down approach. There is no rationale or justification provided in the Review report for the specific 3-year timeframe or the frequency of assessment.

Such a significant policy recommendation requires broad and deep justification, including evidence of effectiveness for this group. We have significant concerns from our decades of experience working with this cohort experiencing substantial psychosocial disability, that there is a high likelihood that the limited range of early intervention supports proposed in the NDIS Review report, will not lead to substantial functional outcomes for the cohort, and may result in delays to accessing effective support and intervention. We recommend early intervention supports are tailored to individual need.

Tailored functional and support needs assessment built on the ICF core sets could assist with identification of the vast and unrecognised range of factors that persist between acute episodes and lead to poor social and economic participation outcomes for people living with psychosocial disability. Use of evidence-based assessments, identifying impairment-related participation restrictions, would result in identification of supports that could then be structured in accordance to actual need.

There are very significant and under-recognised complexities experienced by those who live with substantial psychosocial disability, that contribute to reduced lifespan of 20 years compared to the average Australian [4]. For example, current research highlights the high rates of persistent disability experienced by the cohort identifying with an impairment of schizophrenia, which includes two-thirds with a cognitive impairment [5]; 24% experience hearing impairment [6]; 26-70% of people experiencing vision, or visual processing, difficulties with functional impact, impacting literacy and social engagement[7]; motor skills and gait difficulties [8] [9]; and a 2.5 fold increase in lifetime risk of developing early-onset dementia [10]. An individual experiencing one or a combination of these issues will be inappropriately placed within a social skills group, or a recovery college, for example, without prior recognition and accommodation of functional capacity; and addressing a range of disability support needs. It is critical to note a skilled professional workforce is required to make these support needs assessments.

Early intervention approaches that do no not recognise and address complex layers of disability faced by individuals, will not fulfil the aims of early intervention for the disabled person or for the NDIS. Nor will it save the NDIS money.

The proposed interventions do not reflect practice learnings or the factors associated with positive experience and outcomes, from the NDIS over the past 10 years. They do not substantially reflect developments in international research and practice during that period. For example, social skills training for people with psychosocial disability is currently not an intervention commonly used in practice due to the inconclusive evidence supporting efficacy [11]. Further, while the Review report recommends cognitive remediation as an intervention, a 2023 NDIA evidence snapshot reviewed 16 cognitive remediation studies and stated “results were mixed and not statistically significant, meaning we still do not know whether we should expect meaningful improvements on functional capacity and recovery. Finally, compensatory cognitive training…may be effective as well” [12]. A practicing occupational therapist has shared some of her concerns with the evidence-base for the listed early interventions, in Appendix 1 below.

We recommend that early interventions delivered under Section 25 undergo detailed literature review and review of fitness for purpose, particularly if they are intended to be prescribed in a blanket manner. Consultation with the sector and the pursuit of co-designed models and market interventions may yield more effective and innovative approaches.

A potential systemic bias towards historical, and dated interventions, must be acknowledged. We must ensure any new models being proposed are reflective of current consumer, carer and community expectations, and contemporary research. This bias may be understandable if there is a prevailing perception of administrative ease through reverting to historical models, though these remain unproven in terms of government return on investment. While there may be cost-drivers and administrative convenience in reverting to previous models, or a temptation to conflate the development of NDIS models with concurrent model development through the Department of Health psychosocial support programs, solid process, genuine co-design, and rigor in model development is imperative to ensure fitness for purpose and for the NDIS to meet its stated aims. Conceptual considerations cannot be short-cut in the development of contemporary models. We do not want the NDIS Review to take the Scheme backwards for people with psychosocial disability.

5.3. WORKFORCE CONSIDERATIONS

The Review report indicates a particular 'non-clinical' workforce providing the prescribed early interventions proposed. This would not only restrict participant choice and control, but also restrict access to available skilled and effective interventions and practitioners. It will also introduce new layers of risk into the scheme, which clearly add their own significant cost to the Scheme.

The conceptual separation of "clinical" and "non-clinical" elements of the workforce is a false dichotomy and has no place in a contemporary disability system focused on optimising outcomes. This false dichotomy hails back to a bygone era where service options were either: a heavily biomedical and patriarchal public mental health system ('clinical') OR community-based assistance, welfare and help ('non-clinical'). The separation of 'clinical' and 'non-clinical' supports appears to be applied by the NDIS Review to psychosocial disability only (See NDIS Factsheet on Psychosocial Disability), and there is no evidence that this is based on the perspectives of lived-experience or evidence-informed practice. Instead, the workforce planning and design must focus on fit-for-purpose, regulated and professional skillsets, and cost-effective practice governance for the NDIS, as the primary system addressing functional and support needs for people with substantial psychosocial disability

An integrated system recognising the whole-of-workforce will be needed to ensure the broader ecosystem can realise the vision of a safe step-up, step-down approach. This will be required if people are shifting between support levels, including foundational supports, targeted foundational supports, early intervention, and the NDIS (See Fig 76, p. 508).

We refer you to Attachment 1, the document titled Discussion Paper: *Towards active citizenship for people living with psychosocial disability (October 2023)* written by the NDIS Mental Health Community of Practice and supported by peak body Occupational Therapy Australia, where we explore contemporary models and interventions for a psychosocial disability ecosystem; governance and safeguarding considerations; evidence-based occupational therapy-led interventions aligned to the NDIS functional domains and a participation-focused social model of disability; and a detailed

description of psychosocial disability workforce elements and their role in achieving functional-domain focused interventions and outcomes.

We highlight that the Allied Health Assistance role is an underutilised and cost-effective resource, that could be developed to ensure the implementation of evidence-based interventions while maximising the reach of the allied health workforce. The role of an Allied Health Assistant is a growing, but at present significantly underutilised, skilled resource. We believe that the increased use of allied health assistants presents a significant opportunity for the NDIS that can be developed to ensure the implementation of evidence-based interventions while maximising the reach of the allied health workforce. The Allied Health Assistant workforce represent an opportunity due to their sharp focus on capacity building and the in-built clinical governance and delegation framework provided by the supervising Allied health professional. Important to note here the extensive benefits to individualised capacity building, risk reduction and access to workforce supply – this all for a similar hourly rate to support workers. It makes sense that AHAs should be used extensively across the Scheme.

6. CONCLUSION

We call for ongoing commitment to equitable access to the NDIS, and individualised supports, for people with substantial psychosocial disability. We propose that the NDIS early intervention pathway requires further conceptual clarity, explicit theory of change, access to a skilled workforce, and evidence-based interventions grounded in disability insurance principles, prior to implementation. We believe there has been insufficient consultation and co-design of the early intervention pathway for psychosocial disability, and recommend detailed review of the evidence-base and a clear consultation and co-design strategy be implemented.

ABOUT THE NDIS OCCUPATIONAL THERAPY COMMUNITY OF PRACTICE

The NDIS OT community of practice is an NDIS -tailored workforce capacity building platform with national reach. It enables 10,000 OT's, including approximately 2000 OT's who work with people with psychosocial disability, rapid connection and response to a full spectrum of practice queries as they arise. It provides immediate connection to specialists and practice leaders; extensive supervision options; and NDIS tailored training and professional development. It enables and supports the OT community to rapidly build resources to respond to newly emerging trends or a need to adapt practice, for example during covid-19 pandemic responses. It is free to join, and enables small practices and OT sole traders across Australia to access benefits typically associated with large organisations, while preserving their unique contribution to the lives of people with disabilities.

This submission does not intend to represent individual members of the NDIS Mental Health Occupational Therapy Community of Practice, but rather represents the views of this collective group.

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