Psychosocial Disability and the NDIS

The NDIS Access Process

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Workshop Objectives

- Increased understanding of how to provide evidence to support an NDIS access request.
- Increased understanding of how the NDIS legislation works and is applied. Specifically ‘likely to be permanent’ and ‘substantially reduced functional capacity’.
- Understanding of how access decisions are made.
- Increased confidence in talking about/explaining the NDIS access requirements amongst your networks in a consistent and accurate way.

Data on the NDIS and Psychosocial Disability - National

All figures as at 31 March 2018

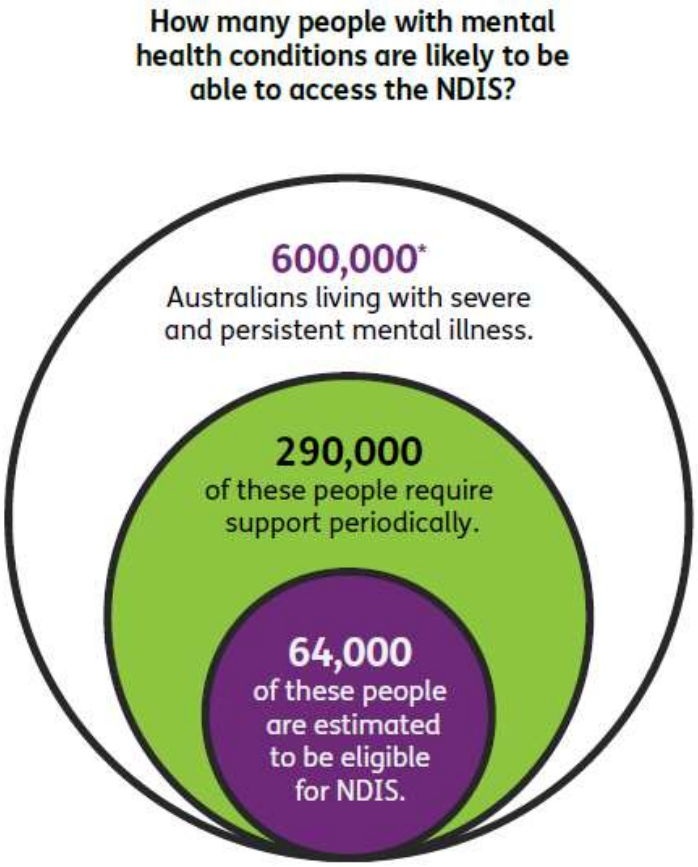
- Across all States/Territories **28,433 (15.0%)** of all scheme participants who have had their access met have a psychosocial disability.

- **14,545** participants **(7.7%)** have psychosocial disability recorded as their primary disability (an increase from 11,926 participants (7.3%) with a primary psychosocial disability at 31 December 2017).

- **27,899** people are active participants with a psychosocial disability (15.0%) and of this, **14,189** are active participants with a primary psychosocial disability (7.6%).

- In some trial site locations, the proportion of participants with psychosocial disability are closer to the **13.8%** projected by the Productivity Commission with Hunter region having **12.6%** and Barwon **13.5%.**

Psychosocial Disability Data



Access Requirements

Age

- The *NDIS Act* requires
  - Under 65 years of age; and

Residency

- The *NDIS Act* Section 23 requires
  - that the potential participant resides in Australia and is either an Australian citizen, is the holder of a permanent visa, or is a special category visa holder who is a protected SCV holder; and

Disability

- The Potential Participant meets all legislative Requirements under Section 24- subsections a, b, c, d, and e; or

Early Intervention

- There are limited circumstances that potential participants with disability attributable to a mental heath condition will meet the legislative requirements under Section 25 MA2

Slide 5

MA2 Will we explain this as we get a lot of questions?
Matthews, Amy, 12/01/2018

Early Intervention and Mental Health

- *(3) Despite subsections (1) and (2), the person does not* ***meet the early intervention requirements*** *if the CEO is satisfied that early intervention support for the person is not most appropriately funded or provided through the National Disability Insurance Scheme, and is more appropriately funded or provided through other general systems of service delivery….* *Section* 25 NDIS Act 2013

- *"The health system will be responsible for…. Treatment of mental illness, including acute inpatient, ambulatory, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs"* COAG Principles 27 November 2015.

Disability Requirements

Section 24

(1) A person meets the disability requirements if:

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.

(2) For the purposes of subsection (1), an impairment or impairments that vary in intensity may be permanent, and the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime, despite the variation.

Applying the Disability Requirements- S24(1)(a)

Section 24 (1)(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"

- **Disability** – a reduction or loss of an ability to perform an activity
- **Impairment** - loss of or damage to mental function resulting from the condition / diagnosis of symptoms.

- S24(1)(a) does not require diagnosis of specific psychiatric condition (although extremely helpful if available). Instead evidence must be provided to confirm the presence of a psychiatric condition.

Disability/Impairment

Mythbusters

If a person has been diagnosed with Schizophrenia, which they have lived with for a number of years, they will automatically meet the NDIS access criteria?

False. No specific mental health diagnosis will automatically meet or not meet the NDIS access criteria.

Likely Permanence of Impairment

- *NDIS Act 2013* section 24(b)
- A likely permanent impairment is an impairment caused by the mental health condition that is likely to remain across the person's lifetime (i.e. be permanent).
- Confirming that the person's impairment is likely to remain across their lifetime has no reflection on whether the person has met their optimal state of personal and emotional wellbeing.
- People with episodic conditions are able to access the NDIS.

Recovery and the NDIS

The NDIS defines recovery as *"achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with, or recovering from, a mental health condition"*

Q. Doesn't the 'likely to be permanent requirement' contradict the concept of mental health personal recovery?

No, the NDIA needs evidence that the impairment caused by the mental health condition is likely to remain across the person's lifetime. Confirming that the person's impairment is likely to remain across their lifetime has no reflection on whether the person has achieved their best possible version of personal and emotional wellbeing.

Likely permanency of impairment

Q. What factors may a delegate consider regarding permanency of impairment?

- When the person was diagnosed and how long has the impairment been evident?
- How old is the person and is it reasonable to anticipate the impairment may alleviate with age appropriate development?
- To what extent have treatment options been explored?
- Is further review required to determine permanence of impairment?

Evidence of permanent impairment

Who can provide evidence?

- Primary Treating Clinicians
  - A primary treating clinicians would generally be a psychiatrist or a general practitioner.
  - In extremely rare circumstances, i.e. rural and remote areas, a psychologist may be considered as a primary treating clinician.

What evidence should be provided?

- Evidence relating to the likely permanence of the impairment and reasoning why the impairment is not likely to remedy.
- Summaries of treatments received and reasoning why ongoing treatment is unlikely to remedy impairment.

Example

Gaylene is 45 years old, she was diagnosed with schizophrenia and depression in 1989 by a Doctor of an Adult Mental Health Service after a series of admissions to a psychiatric unit.

Currently Gaylene is seeing her treating psychologist and psychiatrist. Both confirm the diagnosis, the permanence of impairment and compliance with medication. A treatment history of multiple psychological interventions, psychotherapy and medication is provided.

The psychiatrist indicated that although the treatment Gaylene is receiving is helping, it is unlikely that the impairments she experiences will remedy and treatment is largely focused on Gaylene's recovery journey.

Questions?

Are there any questions?

Applying the Disability Requirements- S 24(1)(c)

Section 24(1)(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:

- ***Communication;***
- ***Social interaction;***
- ***Learning;***
- ***Mobility;***
- ***Self-care;***
- ***Self-management.***

Substantially Reduced Functional Capacity

- *NDIS Act 2013* section 24(c)

- A substantial reduction in capacity is an inability to effectively participate in or complete a task (much more than a person experiencing difficulty with task completion or taking longer than most people to complete the task).

- For a reduction to be considered substantial within at least one of the six areas of functioning: *communication, social interaction, learning, mobility, self-care, or self-management*, there must be an inability to effectively function within the whole or majority of the area not just a singular activity.

Applying Substantially Reduced Capacity

- A substantial reduction in capacity is an inability to effectively participate in or complete a task (much more than a person experiencing difficulty with task completion).
- NDIA considers the impact of the psychiatric impairment on to day-to-day functioning between acute episodes not at any given point in time.
- It is irrelevant whether a potential participant is acutely unwell or having a particularly good day at the time of access request.

Who can provide evidence of substantially reduced functional capacity?

Primary Evidence

- Primary Treating Clinician (depending on nature of patient/clinician relationship);
- Allied Health Professional (including Mental Health Professionals); and
- Support Workers (AMHOCN qualified).

Secondary Evidence

- Support Workers and Peer Workers;
- Carers, family, and friends; and
- The potential participant
  - May be able/prepared to provide evidence of how their impairment affects their day-to-day living.

Substantially reduced functional capacity

Example:

Gary has been attending a chess club, however he has been asked to leave the club as he can't comply with the rules and social norms accepted by the group. Gary often has issues with social structure and can be verbally aggressive.

Gary attends a walking group where the environment is less rigid and he can walk with others or walk on his own as he chooses. Gary goes shopping independently (albeit at quieter times of the day) and on occasion he has dinner with a friend.

Applying the Disability Requirements- S24(1)(d)

Section 24(1)(d)

"the impairment or impairments affect the person's capacity for social or economic participation."

- Access Assessors are required to consider whether a person's permanent impairment/s affect their capacity for social or economic participation

Applying the Disability Requirements- S24(1)(e)

Section 24(1)(e)

"The person is likely to require support under the National Disability Insurance Scheme for the person's lifetime."

- Access Assessors need to consider the nature and purpose of the NDIS generally.

Mainstream Interface

The health or mental health system is responsible for:

- Treatment* of mental illness, including acute inpatient, ambulatory, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs;
- Residential care where the primary purpose is for time limited follow-up linked to treatment or diversion from acute hospital treatment; and
- The operation of mental health facilities.

The NDIA is responsible for:

- The NDIS is responsible for ongoing functional support for psychosocial disability' (targeted at reducing the impact on a persons functional capacity of impairments/s attributable to a psychiatric condition).

Continuity of Supports

- Continuity of Support means that people who do not meet the NDIA access requirements, but were accessing a disability service before being NDIA assessed, **will continue to receive support consistent with their current arrangements.**

- The commitment to the continuity of support for current service participants who are not eligible for the NDIA has been **agreed to by all** Commonwealth, State and Territory governments as part of bilateral agreements.

- Each government is responsible for providing continuity of support within the programs they fund.

Tips to make access assessment easier

Access Delegates find it harder to determine whether the person meets the requirements when:

- Exploration of treatment options is not demonstrated :
  - Need to have GP/Psychiatrist advise formally (NDIA can't make assumptions based on diagnosis).
  - Evidence of interventions that have been explored not provided.
- The evidence does not demonstrate that the mental health condition has resulted in the substantially reduced functional capacity.

Note: It is not necessary to disclose an applicant's private and personal traumas, stating a history of trauma is sufficient.

Tips for preparing EOD

It is important to keep in mind when supporting an access request that:

- A diagnosis does not provide evidence of functional impairment.
- A general statement of substantial impairment in a letter or as a ‘tick box’ is not sufficient evidence of a substantial reduction in functional capacity.
- Financial Administration and guardianship orders are very helpful.
- The functional domain of Learning is not about educational supports, it relates to capacity to learn or ‘re-learn’ everyday tasks.
- Information describing an applicant’s functioning without supports in place, is helpful.

Evidence Requirements Revisited

- It is a misconception that an individual is required to provide a large volume of evidence.
- The NDIA considers all evidence on its individual merit and circumstances. Factors including the qualification of the person providing the evidence and the nature and length of the practitioner patient relationship impact on the reliance placed on the evidence.

Likely Permanence of impairment:

- What is required is evidence from a treating clinician (usually a GP or psychiatrist) that all available treatment/intervention options appropriate to the person have been explored and the impairment is likely to remain regardless of ongoing recovery-focused treatment/interventions.

Substantially Reduced Functional Capacity:

- The NDIS considers the impact of the impairment on to day-to-day functioning between acute episodes not at any given point in time.

Tips for the Access Process

It is important to keep in mind when supporting an access request that:

- The NDIS does not fund clinical therapy and evidence needs to support a need for NDIS support around functional impairment.
- If the applicant is currently supported by services (such as PiR or PHaMs), it is important to include this information in the access request.
- Access delegates do not make clinical judgments and are reliant on the evidence provided to determine access.

Tips for the Access Process continued

- **KEEP IT SIMPLE**

- Evidence needs to relate to the impairment causing the disability.

- Unhelpful language:
  - "When unwell"
  - "Would benefit from"
  - "Guidance and prompting"

- **Support Applicants**
  - Accessors are part of a national team, and we ask for your support to help the applicants with their interactions with the NDIA.

- Decisions are made based on the individual circumstances/evidence of the person requesting access.
- If you receive an access not met decision, ask the assessor to explain the reasons for the decision.
- If you believe a review is appropriate, there is a formal process in place to ensure that a review decision is made independently of the original decision.

Resources for the sector

Resources

reimagine
MENTAL HEALTH, MY RECOVERY AND THE NDIS

- *reimagine.today* helps adults under 65 years of age living with a mental health condition to better understand the National Disability Insurance Scheme (NDIS) and what supports and services it can offer: www.reimagine.today
  - Sector Partner: MHCC NSW

- NDIA communication and resources on psychosocial disability and the NDIS: www.ndis.gov.au/psychosocial/products.html

Thank you for attending

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