
**Submission to the Review of the
National Disability Insurance Scheme Legislative
Framework**



WAAMH

**Western Australian Association
for Mental Health**

Peak body representing the community-managed
mental health sector in Western Australia

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1. Background

The Western Australian Association for Mental Health (WAAMH) was incorporated in 1966 and is the peak body representing the community-managed mental health sector in WA. With around 150 organisational and individual members, our vision is to lead the way in supporting and promoting the human rights of people with mental illness and their families and carers, through the provision of inclusive, well-governed community-based services focused on recovery. WAAMH advocates for effective public policy on mental health issues, delivers workforce training and development and promotes positive attitudes to mental health and recovery. Further information on WAAMH can be found at <http://www.waamh.org.au>

The NDIS is an important reform, and WAAMH welcomes the inclusion of psychosocial disability in the scheme. However, the mental health sector has some critical differences to disability, which will affect how people with psychosocial disability and the community managed mental health sector engage in the scheme.

WAAMH welcomes the opportunity to contribute to the Review of the National Disability Insurance Scheme (NDIS) Legislative Framework (the review). Our submission focuses on the extent to which the legislative framework requires change to enable it to equitably meet the support and advocacy needs of people with psychosocial disability.

2. Objects and Principles

2.1 Do the Objects and Principles of the NDIS Act provide a sufficient basis for giving effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities?

WAAMH welcomes the significant progress the NDIS makes towards furthering the rights of people with disability. We appreciate the need to balance scheme sustainability with the rights of people with disability and their requirement for supports, and acknowledge this is a complex and challenging matter.

We note that the human rights analysis contained in the 'Explanatory Statement, NDIS (Facilitating the Preparation of Participants Plans – Western Australia) Rules 2014' states:

“To the extent that the Rules limit human rights in some circumstances, those limitations are reasonable, necessary and proportionate to ensure the long-term integrity and sustainability of the scheme.”¹

WAAMH strongly supports proper accountability and value for money in government expenditure. However, WAAMH is concerned that the interpretation of what is reasonable and necessary may be frequently undertaken by planners without in depth understanding of mental illness and psychosocial disability, and that this may skew the balance away from

¹ Explanatory Statement, *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—Western Australia) Rules 2014*, p. 7

human rights towards scheme sustainability with a disproportionate effect on people with mental illness. We make recommendations to improve this in section 4.1 of this submission.

Sections 3.1 and 4.1 of this submission outline areas where we identify problems with equitable access to the scheme for people with psychosocial disability compared to other people with disability, and resultant concerns about how the scheme will meet human rights obligations. The requirement for permanency or likely permanency to access individual funding under the scheme is an issue that particularly disadvantages people with psychosocial disability.

3. Accessing the NDIS for People with Mental Health Issues

3.1 How well do the access criteria enable government to further the objects and principles of the NDIS Act? With particular reference to the following principles:

People with disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development

People with disability should be supported to participate in and contribute to social and economic life to the extent of their ability

People with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime.

People with lived experience of mental health issues, carers and family members, advocates and mental health organisations have long raised serious concerns about the requirement for permanency of disability to access funded supports under the NDIS.²

International best practice and national policy in mental health is driven by the recovery approach:

"... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning"³

² Including Consumers of Mental Health WA, 'Making Inroads: Addressing the needs of consumers and those with psychosocial disability within NDIS/My Way' www.comhwa.org.au/wp-content/uploads/2013/02/Att-1_CoMhWA-Making-Inroads-NDIS-Report-Autosaved.pdf; 2015, Hunter Partners in Recovery 'Hunter PIR and the NDIS: Building a Stronger Partnership'

³ *A national framework for recovery-oriented mental health services: Policy and theory*, 2013, Commonwealth of Australia, www.ahmac.gov.au

There are some unique elements of the recovery approach, such as the centrality of hope and the redefining of self, that are critical to the engagement of and the provision of support to people with psychosocial disability in the NDIS.

The NDIS Act requires that “the impairment or impairments are, or are likely to be, permanent”. While permanency is often intrinsic to definitions of other disabilities, most people with psychosocial disability have support needs that fluctuate over weeks, months or their lifetime, often related to the episodic nature of their illness. Further, many people with mental illness recover, although it is difficult to predict which people will require long-term support and which will recover sufficiently to no longer require it.⁴ The recovery rates identified in research vary widely, in part due to the nature of the research, the illness and the definition of recovery used. Nevertheless, it is clear that people with severe and persistent mental illness can recover.

The importance of language is well articulated by the Mental Illness Fellowship:

“... the language of permanent impairment [is] stigmatising and disempowering. It takes away hope and undermines personal recovery. We have been told by consumers that engaging with a program where evidence of permanent impairment is required presents major barriers to engagement.”⁵

There is an assumption within the scheme’s Objects and Principles that all people with disability are equal to each other. Yet the requirement for a permanent disability and the ways in which the NDIA interprets and applies it, disadvantages potential scheme participants with mental health issues compared to those with other disability types. This is further compounded by the roll-in of mental health programs because this causes loss of service access for people who do not meet NDIS access criteria, and combined they lead to significant disadvantage to people with mental health issues. These effects limit the scheme’s ability to further its objectives.

In summary, the problems with the requirement for permanency or likely permanency can be described within the following areas:

- Lack of fit with contemporary understandings and evidence about mental health problems and recovery
- Refuting hope
- Emphasising (a difficult to predict) expected length of disability over the actual, lived, needs and experiences of the person
- Lack of fit with contemporary good practice
- Likelihood of further stigma and discrimination if the person is labelled as having a permanent illness
- Creating barriers to engaging with the scheme

⁴ 2014, Centre for Mental Health, University of Melbourne, ‘Mental health and the NDIS: A literature review’

⁵ Ibid , p. 3

- Influencing the types of supports funded which may result in inappropriate packages with little or no recovery focus and which limit the opportunity for individual capacity building
- Disadvantaging people with psychosocial disability compared to people with disabilities that are generally considered permanent.

It is clear that access criteria would benefit from a more nuanced approach to enable people with psychosocial disability to access the scheme and enable the scheme to operate in keeping with mental health recovery principles, whilst ensuring access is available to those with greatest need.

Recommendation 1: That amendments are made to the access criteria for people with mental health conditions. These should not require permanency or likely permanency of impairment but instead consider the impact of the impairment on person’s lived need and functioning in keeping with the core activities identified in the Act: communication, social interaction, learning, mobility, self-care, and self-management.

3.1.1 Early intervention access requirements

Similarly, it is particularly difficult for a person with mental illness to access the early intervention supports under the Scheme because the early intervention requirements set out in Section 25 of the Act, require ‘one or more identified impairments that are attributable to a psychiatric condition and are, or are likely to be, permanent’.

Intervening early in psychosocial disability caused by mental illness is likely to meet the requirements of the Act in sections 25 (b), likely to reduce the person’s future support needs; and 25 (c), likely to benefit the person by mitigating or alleviating the impact of the person’s impairment on their functional capacity and thus have a financial benefit in terms of reducing the likely cost of the care and support they may need over their lifetime. However, the challenges of meeting the permanency criteria when needing to access early intervention supports proves especially difficult with mental health conditions, as it is difficult to predict when a person’s condition and therefore disability will be permanent.

The effect of these combined factors is to effectively exclude, or at best limit, access to early intervention supports for people with psychosocial disability through the scheme. This restricts the ability of the scheme to give effect to the Objects and Principles of the Act, in particular its principle that ‘people with disability should be supported to participate in and contribute to social and economic life to the extent of their ability’. As previously noted, the scheme’s principles should apply equally to all people with disability. It also limits the effectiveness of the scheme with regard to section 2(2)(b) of the Act which states that the objects of the Act are to be achieved by ‘adopting an insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability’.

Recommendation 2: Amend the Act and clarify the Rules to remove the permanency requirements and to increase access to early intervention supports for people with mental illness.

3.2 How clearly defined are the access criteria?

The access criteria are not clearly defined for people with psychosocial disability. In sections 3.3 and 3.4 outline we outline what amendments could be made to address this.

3.3 What amendments could be made to the legislative framework (if any) to:

a. Enhance the clarity of the access criteria?

In addition to the recommendations about permanency raised earlier in this submission, other language issues are also important. Early in the scheme's life people with lived experience of mental health issues and mental health service providers identified problems with the scheme's language and its relevance to people experiencing mental health difficulties. Many people do not identify with having a disability, with the term 'psychosocial disability' being not well understood, or identified with, by many people with mental health support needs. As noted by one of our members "words can be barriers". As mental health is the language used nationally by the National Mental Health Commission, we propose this as the preferred language.

Recommendation 3: Replace references to 'psychosocial' with 'mental health' in the Act.

3.4 What amendments could be made to the legislative framework (if any) to:

b. Improve the effectiveness and/or efficiency of the access request process?

Consumers, carers, advocates and mental health organisations have told WAAMH about some of the barriers to scheme access that exist within the community. These include limited understandings of the scheme and how to access it within primary care providers. WAAMH received input that practitioners, GPs, psychologists and psychiatrists may not even entertain the idea that the person will be eligible for the scheme and therefore complete the required forms. The access request form is the operationalising of the Act and Rules and as such contains the same prescriptive language as the legislative framework about permanency, recovery and siloes health systems, and as such, the form constitutes a significant barrier for people with psychosocial disability. In addition, the access request form is lengthy and this also proving to be a barrier.

Other access barriers include the provision of inaccurate information by practitioners and health professions, the challenges for securing the required access evidence for people who are not linked with a psychiatrist or do not have a diagnosis, and a reliance on skilled, knowledgeable and proactive local area coordinators to support scheme access when challenges in doing so are experienced.

We have also received input about the significant number of people with mental illness who have been historically disenfranchised and excluded from services and the community, and the proactive approaches that are needed to engage these individuals, build trust and support their access. With assessment processes taking up to four months it is likely that people who are episodically and chronically unwell will disengage.

There are major challenges for people with psychosocial disability attempting to access the scheme, particularly to the lack of fit of the scheme with the health services systems and with contemporary mental health understanding and practice.

These barriers could be alleviated by appropriate of supports that can engage mental health consumers and carers and support them to understand and access the scheme. Targeted work also needs to occur with professionals and services that support people with mental health issues including primary care services.

It is anticipated that the services and supports commissioned through Information, Linkages and Capacity Building (ILC) will assist in overcoming these barriers specifically for people with psychosocial disability. However, we remain concerned about the limitations of the Act with regard to ILC. The Act merely enables the provision of coordination, strategic and referral services at Section 13, rather than making any commitments about what these supports will entail, who will be able to access them and how they will engage with providers in other service systems. We are concerned that without further clarification of the scheme's commitments in this area people with psychosocial disability will fall through these substantial gaps.

In order to enable the principle that people with disability have the same right as others to realise their potential for physical, social, emotional and intellectual development, we propose that the scheme needs to actively facilitate the inclusion of people with psychosocial disability. We recommend that this be acknowledged within the legislative framework. This could occur, for example, as recommended by one of our members, through the inclusion of a mental health consumer check list/ guidelines and principles, as well as those for carers and family members. One way to achieve this could be through the inclusion of a new Rule about accessing the scheme for people with mental illness and associated psychosocial disability.

Recommendation 4: Establish guidelines within the Rules (or as a new Rule) that provide practical guidance to overcome these access barriers and facilitate access to the scheme for people with mental health issues and associated psychosocial disability.

Recommendation 5: Amend the Rules to provide further detail about how the scheme will further its objects and principles through ILC, including how it will enable and facilitate access, enable people to exercise choice, and support carers and other key supporters.

Recommendation 6: Amend the Rules to clarify how the operationalisation of the NDIS will provide assertive outreach and other supports that facilitate engagement of people with psychosocial disability through Information, Linkages and Capacity Building.

A further option to better enable scheme access would be to allow registered NDIS service provider that have established a supportive relationship with prospective participants to submit, on behalf of and in partnership with the individual, an access request. The development of participant plans together with the service provider/s with whom the participant has an existing relationship would strengthen the ability of plans to enable an

individual to achieve good outcomes. Safeguards to address conflict of interest would need to be developed.

4. Participant Plans, Reasonable and Necessary Supports

4.1 How well does the legislative framework's definition of what constitutes 'reasonable and necessary supports' support the independence and social and economic participation of people with disability?

4.1.1 Reasonable and necessary supports

WAAMH has received feedback from participants, their families and mental health organisations in the Western Australian trial sites that the NDIS is facilitating access to supports that are furthering independence and community living for some people with psychosocial disability.

Challenges are also being experienced with regard to reasonable and necessary supports. We note that these are defined in neither the Act nor Rules, but that the Rules provide guidance to enable assessors and planners to determine what constitutes these supports. Neither document defines or lists specific supports that are considered reasonable and necessary.

The Supports for Participants Rule notes that in mental health the NDIS will be responsible for supports that are not clinical in nature and that focus on a person's functional ability, including supports that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life. It also states that the NDIS will not be responsible for:

- (a) supports related to mental health that are clinical in nature, including acute, ambulatory and continuing care, rehabilitation/recovery; or
- (b) early intervention supports related to mental health that are clinical in nature, including supports that are clinical in nature and that are for child and adolescent developmental needs.

There are several problems with this part of the legislative framework. Firstly, the framework relies on the professional judgement of planners and the CEO to interpret reasonable and necessary. However, at the moment we do not consistently have planners that have the in depth knowledge and understanding of mental illness and associated psychosocial disability that is required to best enable appropriate interpretation.

Secondly, the Rule misunderstands the nature of recovery supports, and implies that recovery supports are clinical supports. In reality, all mental health supports that are contemporary good practice are recovery supports, whether provided by a clinician through a government health service, or provided by a registered disability provider under the NDIS. The MI Fellowship recently summarised the differences between clinical recovery and personal recovery, with the former focused on absence of symptoms, and the latter

emphasising the centrality of hope, identify, meaning and personal responsibility.⁶ Another definition is that ‘recovery involves living as well as possible’⁷; this is entirely within the NDIS framework of what supports may be needed to live a good life.

Thirdly, the legislative framework creates an artificial separation between the reasonable and necessary supports that the NDIS funds, and the supports and services that should be provided by health systems, thus reinforcing unhelpful siloed approaches. ‘Clinical’ is not defined which may lead to problems and inconsistency in interpretation and application undesirable for a national scheme. In reality, recovery supports may be provided by clinicians or non clinicians and focus on the person’s functional capacity to participate in the community, noting that recovery is defined as “a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness”⁸. WAAMH notes that this definition of recovery fits very well with the principles and objects of the NDIS Act, and that excluding recovery from NDIS supports appears contradictory to both the scheme’s objects and the National Recovery Framework.

The types of supports that the Rules stipulate as the role of the health system for people with mental health issues may be funded by the scheme for people with other disabilities. Under the NDIS, ‘clinical’ mental health supports are the responsibility of other service systems, whereas the ‘clinical’ supports for other disabilities are within NDIS and considered part of what is required for the person to live a good life in the community. For example, Occupational Therapy or Clinical psychology, which is ‘clinical’ in nature, are likely to be funded for a person with an intellectual disability displaying challenging behaviour. In contrast, a mental health recovery service that enables people to avoid escalation of their mental health problem with associated reduction in functional capacity to access the community, and which may include supports provided by psychologists, may not be funded.

The artificial separation set out in the NDIS Rules appears to be based not on the nature of the supports or their intended purpose, but on how they have been historically provided. The assumption that people with mental illness can access these supports in the health system is problematic. The National Mental Health Commission’s Review of Mental Health Programmes and Services⁹ recently identified increased access to services as an urgent need; service gaps in rural and remote areas can be particularly dire.

The effect of this approach is that allied health supports are being funded by the NDIS for some disabilities but not others¹⁰. WAAMH is concerned that this inequitable provision of supports through the scheme will result in inequity of outcomes for people with psychosocial disability.

In this way, the siloing the support needs of mental health scheme participants undermines the scheme’s ability to meet its international obligations and its own principle that ‘people

⁶ *ibid*

⁷ South London and Maudsley NHS Foundation Trust. *Social Inclusion and Recovery Strategy 2010-2015*. London: SLAM; 2010

⁸ *A national framework for recovery-oriented mental health services: Policy and theory*, 2013, Commonwealth of Australia, www.ahmac.gov.au

⁹ National Review of Mental Health Programmes and Services

¹⁰ Notwithstanding one or two occasions WAAMH is aware of where people with mental illness have been funded to access clinical psychology

with disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development'. We submit that the scheme's principles should apply equally to all people with disability, but in this aspect do not.

Recommendation 7: That the Supports for Participants Rule remove the reference to recovery within clinical supports.

Recommendation 8: That the NDIA to consult with mental health consumers, carers, advocates and organisations on the nature of reasonable and necessary supports for people with psychosocial disability in order to develop contemporary guidance that details the specific supports that are appropriately funded for this group, that will maximise wellbeing and recovery, and explain how they interface with other services systems.

4.1.2 Plans for people with psychosocial disability

WAAMH also heard feedback that the plans and supports funded for people with psychosocial disability developed in Western Australia can have little or no recovery orientation. WAAMH is concerned that limited knowledge of mental health and its differences to other disability types amongst NDIA and DSC staff may limit the types of supports that are funded, leading to a focus on 'maintenance' supports rather than recovery oriented supports. This could halt or delay people's recovery and development of individual capacity. It may also result in inequity between participants.

We heard input that the language around permanency or likely permanency within the access requirements significantly affects not only access to the scheme but the types of supports developed during the planning process. If funded supports are based on the premise of a permanent disability, it is difficult to see how they could best support recovery. The Mental Illness Fellowship notes there are

“major risks in building a scheme on the concept of permanent impairment that results in compensatory supports rather than capacity building. This is the same as building a ramp for a person, where we could build their skills to walk. We must use better language and make sure everybody knows that change – and recovery – is possible.”¹¹

Further, psychosocial supports that are not based on recovery could not be considered contemporary supports, and should therefore not be considered as such within the Rules reasonable and necessary criteria. Here we return to the issue of who decides what should be funded and what experience or knowledge those staff have, rather than having clear and accepted guidance which would enable the scheme to achieve national consistency across varied contexts and disabilities. We provide some recommendations about how to support access and contemporary recovery oriented plans later in this section of our submission. A recommendation about resolving the permanency language is made in section 3.1 of this submission.

¹¹ 2015, MI Fellowship, 'The empirical evidence about mental health and recovery: how likely, how long, what helps?' http://mifellowship.org/sites/default/files/MI_Fellowship_Slade_Longden_Empirical%20evidence%20about%20mental%20illness_WEB_5_8_2015.pdf, p. 3

4.2 What amendments could be made to the legislative framework (if any) to:

a. Improve the effectiveness and/or efficiency of the participant planning and assessment process (including review)?

4.2.1 Recovery principles

WAAMH notes that the Act includes principles relating to plans including that the preparation, review and replacement of a plan and the management of funding should:

- advance inclusion and participation in the community with the aim of achieving the person's aspirations,
- maximise the choice and independence of the participant,
- facilitate tailored and flexible responses to the individual goals and needs of the participant, and
- coordinate the delivery of disability services where there is more than one provider.

Whilst these are all in keeping with recovery, we also recommend adding a principle specific to recovery to ensure that planners and the scheme itself operate in keeping with contemporary good practice approaches with people with psychosocial disability.

Recommendation 9: Add a principle to section 31 of the Act, that the preparation, review and replacement of a participant's plan, and the management of the funding for supports under a participant's plan, should support the recovery of people with psychosocial disability in keeping with their goals and aspirations.

4.2.2 Episodic nature of mental illness – access, planning and review

The episodic nature of some mental illness creates challenges for determining both access to the scheme, and what are considered reasonable and necessary supports, because the impact of the illness on a person's functional capacity can fluctuate. We are concerned that times of higher support need may not be adequately identified during access, planning or review processes, which would limit the ability of the scheme to fulfil the principle that 'people with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime'.

Specific review timeframes, particularly when combined with limited knowledge of psychosocial disability by reviewers, could result in a shortfall of supports at times of higher need, and conversely a surfeit at times of lower need with resultant impacts on scheme costs and financial sustainability. In the Lower South West NDIS My Way trial site greater flexibility and responsiveness is being observed. It is essential that the scheme's Rules include principles that enable and encourage greater flexibility and responsiveness in reviewing plans and responding flexibility to changing support requirements for people with psychosocial disability rather than this being a matter for policy.

4.2.3 Rural and remote areas

We also received input about the need for decisions about funded supports to occur within the context of what is locally available within rural, regional and remote areas. In the Lower South West trial site people have been funded to access local services, however there may not be an appropriate service within the district. In such cases, travel and staffing costs can be a stumbling block. What should be deemed reasonable and necessary may be different within regional areas where support and transport costs are higher and the population is lower. We hope that the commissioned ILC services will consider and address such service gaps.

4.2.4 Access to advocacy

Advocacy for people with a psychosocial disability is a major issue in the pre-planning and planning phase. Access to independent advocates is an enabler of choice and control however is not properly exercised in the Act or pricing. WAAMH received input from consumers and carers that the supports that are funded are dependent on the quality of advocacy they receive and the expertise of the planner in understanding psychosocial disability or responding to changing needs. One contributor to this submission noted:

“What is deemed reasonable and necessary for a person to be supported along to see their psychiatrist, psychologist etc . is determined on an individual basis. There may be funding, but when people do not have the correct information, or don't give the right information whilst writing their plan, or do not know what questions to ask at any time during the process, they may not get the support they require. Inconsistency within plans can arise because of this. “

It follows that such inconsistency could impact on to what extent the scheme furthers the objects of the Act in supporting people's independence and social and economic participation, and in facilitating a nationally consistent approach to funded supports.

In order to enable access comparable to other people with disability, as well as facilitate the principle of choice and control, independent mental health advocates with knowledge and information about the NDIS process should be made available to everyone, but particularly to those people with psychosocial disability who do not have any family supports to walk by their side during the process.

The 'Proposed National Disability Insurance Scheme Human Rights Analysis' notes independent representation and advocacy as essential in order to give full effect to the obligations in Article 19 of the Convention on the Rights of Persons with Disabilities to equal choice, full inclusion and participation, and recommends advocacy should be a core part of the NDIS.¹² To ensure this occur WAAMH proposes advocacy be included in the legislative framework, not only in policy.

Recommendation 10: That the role of mental health advocacy in enabling the development of plans appropriate to the individual and consistent with recovery

¹² 2011, Dr. D. Wadiwel, 'Proposed National Disability Insurance Scheme Human Rights Analysis'

approaches, and in furthering the objects and principles of the Act, be made explicit in a new Rule about ILC.

4.2.5 Capacity building

The ILC Framework should also commission supports that build capacity. International evidence clearly identifies that capacity building for services, consumers, families and carers is a key determinant of success for person directed service reform¹³.

Often in reform, capacity building supports sector organisations without recognition of the need to also empower consumers and families. Consumers of Mental Health WA (CoMHWA) identifies the “ability to empower people with psychosocial disabilities ... to identify their needs and develop capabilities for self-direction and recover” as a key issue affecting consumer access to, and benefit from, the NDIS.¹⁴ Consistent with best practice in mental health and psychosocial disability support, NDIS My Way should consider the value of peer support in achieving access, choice and control for scheme participants and in moving toward self-management.

Recommendation 11: That the role of ILC in building the capacity of people with psychosocial disability be made explicit in a new Rule about ILC.

4.2.6 Pre-planning

We have also received input about the pre-planning stage for a disenfranchised population. Many people living in psychiatric hostels lack trust in new systems based on past experiences of attempting to engage but not receiving the supports they needed. The scheme arrangements are established in such a way that the onus is on them to walk through the NDIS door. However, a more relational approach is required to engage many people with psychosocial disability in planning, assessment and review processes.

WAAMH is encouraged by noting that the ILC Framework specifically identifies people with mental illness as a target group requiring proactive outreach and engagement.

Recommendations about services that may assist in engaging this group are made earlier in this submission.

It would be beneficial if the Rules enabled organisations working with people that have been historically disengaged or disenfranchised to be remunerated for the pre-planning work that could enable their access.

Recommendation 12: Establish guidelines within the Rules (or as a new Rule) that provide practical guidance to address these participant planning and review issues and facilitate quality processes and plans for people with mental health issues.

¹³ Report by Theresa Williams *To Investigate the Policy & Practice of Mental Health Self Directed Support for People with Mental Illness*, 2011, Winston Churchill Memorial Trust, http://waamh.org.au/assets/documents/reports/self-directed-support_t-williams-2012.pdf

¹⁴ Consumers of Mental Health WA, 2014, ‘Disability Insurance Initiatives Consumer Participation: Advocacy Brief’ <http://www.comhwa.org.au/wp-content/uploads/2013/02/CoMHWA-NDIS-Advocacy-Brief-07072014.pdf>

5. What amendments could be made to the legislative framework (if any) to:

b. Ensure the NDIA has the required capacity to control costs in relation to participant plans?

The NDIS should facilitate through its legislative framework the recovery of people with psychosocial disability. As mental health issues are often episodic and support needs may wax and wane over time, building in more flexible support, funding and review systems that are responsive to changing needs rather than fixed plans with six monthly review would assist the scheme to reduce and manage scheme costs for this population. The resolution of the permanency and recovery issue also has the ability to enable the scheme to better support people's recovery, which can lead to gradual reduction in funded supports.

6. Registered Providers of Supports

6.1 How well does the legislative framework (including, but not limited to, the provider registration requirements) enable government to promote innovation, quality, continuous improvement, contemporary best practice and effectiveness in the provision of supports to people with disability?

There are potential incentives within the scheme and pricing structure for providers not to support and encourage people towards self-management and not to 'manage' challenging behaviour well. In this way, the scheme does not engender innovation and contemporary practice. With the pricing structure as an activity based or transactional system, rather than an incentivised outcomes system, there is the potential for a perverse incentive for providers to advocate for increased funded supports or to discourage people with disability to take reasonable risks and exercise choice and control.

We see the absence of an outcomes focus as an essential element of contemporary good practice that is very limited within the scheme including its legislative framework.

Recommendation 13: The development of an outcomes focus, along with incentives that reward the achievement of positive outcomes for people with disability with less emphasis on the transactional nature of the existing scheme arrangements.

We received input¹⁵ that a limiting factor in quality and achievement of outcomes is likely to be the lack of depth of relationship between the NDIA/My Way coordinator and the new participant. This is particularly so with psychosocial participants who are a new sub-group of participants and who don't have an historical relationship/familiarity with NDIA/DSC, and who have a form of disability (e.g. anxiety, depression or schizophrenia) that can be quite a barrier to access and fulsome articulation of individual needs and aspirations. Effective

¹⁵ This paragraph is an edited version of that provided by Tendercare, personal communication 29 September 2015

advocates or the involvement of workers with whom the individual has an existing relationship can mitigate this:

“In our experience, our recovery support workers have been able to somewhat mediate this new relationship for existing clients. Our workers have had input into planning meetings which has been helpful both to the new participant and the My Way coordinator. However, the quality and timeliness of the participant plans would improve if our existing client could devise their participant plan with their familiar recovery support worker.”¹⁶

Safeguards to mitigate conflict of interest would need to be developed.

6.2 Do the registration requirements strike the right balance between supporting principles of choice and control, including in relation to taking reasonable risks and the rights of people with a disability to freedom from abuse, neglect and exploitation?

People with psychosocial disability may need additional support or capacity building to enable self-management. This is addressed in section 4.2.5 of this submission.

A local advocacy service told WAAMH of instances in which a registered provider agreed to only support people with disability if they agreed to sign up with that organisation to provide all of their funded supports. This directly removes choice and control and safeguards to prevent this should be developed.

Recommendation 14: That the Act and Rules are reviewed with a view to identifying appropriate safeguards in such circumstances, including the provision of independent advocacy through ILC.

7. Other Matters

7.1 Are there any other aspects of the NDIS Legislative framework that you believe are impacting on:

Government’s ability to further the objects and principles of the NDIS Act?

General principles guiding actions of people who may do acts or things on behalf of others are set out in section 5 of the Act. These are currently too limited to facilitate access and quality outcomes for people with psychosocial disability, and to be responsive to the diverse regions and locally relevant factors across Australia.

Recommendation 15: That the following is added to Section 5 of the Act

- ‘other personal circumstances’ should be added to d. ‘the cultural and linguistic circumstances, and the gender, or people with disability should be taken into account.’

¹⁶ ibid

- ‘the impact of the specific disability should be taken into account’
- ‘a relational approach to engaging people with disability will likely achieve the best outcomes’
- ‘locally relevant circumstances to where the person lives should be taken into account, particularly if the person lives in a rural, regional or remote location’

7.2 Part 4 Review of the Act

Part 4 sets out the requirements regarding review of the Act. While WAAMH acknowledges the benefits of having tight review timeframes, they also affect the extent to which all stakeholder groups can provide effective and considered input to reviews. The timeframe for submissions to the Review of the Act was too tight to enable a thorough consultation with our members and stakeholders on such a complex matter.

Recommendation 16: That amendments are made to this section of the Act to enable stakeholders to effectively involve and consult with people with disability to enable their input to the Act’s review.

8. Summary of Recommendations

Recommendation 1: That amendments are made to the access criteria for people with mental health conditions. These should not require permanency or likely permanency of impairment but instead consider the impact of the impairment on person’s lived need and functioning in keeping with the core activities identified in the Act: communication, social interaction, learning, mobility, self-care, and self-management.

Recommendation 2: Amend the Act and clarify the Rules to remove the permanency requirements and to increase access to early intervention supports for people with mental illness.

Recommendation 3: Replace references to ‘psychosocial’ with ‘mental health’ in the Act.

Recommendation 4: Establish guidelines within the Rules (or as a new Rule) that provide practical guidance to overcome these access barriers and facilitate access to the scheme for people with mental health issues and associated psychosocial disability.

Recommendation 5: Amend the Rules to provide further detail about how the scheme will further its objects and principles through ILC, including how it will enable and facilitate access, enable people to exercise choice, and support carers and other key supporters.

Recommendation 6: Amend the Rules to clarify how the operationalisation of the NDIS will provide assertive outreach and other supports that facilitate engagement of people with psychosocial disability through Information, Linkages and Capacity Building.

Recommendation 7: That the Supports for Participants Rule remove the reference to recovery within clinical supports.

Recommendation 8: That the NDIA to consult with mental health consumers, carers, advocates and organisations on the nature of reasonable and necessary supports for people with psychosocial disability in order to develop contemporary guidance that details the specific supports that are appropriately funded for this group, that will maximise wellbeing and recovery, and explain how they interface with other services systems.

Recommendation 9: Add a principle to section 31 of the Act, that the preparation, review and replacement of a participant's plan, and the management of the funding for supports under a participant's plan, should support the recovery of people with psychosocial disability in keeping with their goals and aspirations.

Recommendation 10: That the role of mental health advocacy in enabling the development of plans appropriate to the individual and consistent with recovery approaches, and in furthering the objects and principles of the Act, be made explicit in a new Rule about ILC.

Recommendation 11: That the role of ILC in building the capacity of people with psychosocial disability be made explicit in a new Rule about ILC.

Recommendation 12: Establish guidelines within the Rules (or as a new Rule) that provide practical guidance to address these participant planning and review issues and facilitate quality processes and plans for people with mental health issues.

Recommendation 13: The development of an outcomes focus, along with incentives that reward the achievement of positive outcomes for people with disability with less emphasis on the transactional nature of the existing scheme arrangements.

Recommendation 14: That the Act and Rules are reviewed with a view to identifying appropriate safeguards in such circumstances, including the provision of independent advocacy through ILC.

Recommendation 15: That the following is added to Section 5 of the Act

- 'other personal circumstances' should be added to d. 'the cultural and linguistic circumstances, and the gender, or people with disability should be taken into account.'
- 'the impact of the specific disability should be taken into account'
- 'a relational approach to engaging people with disability will likely achieve the best outcomes'
- 'locally relevant circumstances to where the person lives should be taken into account, particularly if the person lives in a rural, regional or remote location'

Recommendation 16: That amendments are made to this section of the Act to enable stakeholders to effectively involve and consult with people with disability to enable their input to the Act's review.

Authorised by:

Rod Astbury



CEO

Western Australian Association for Mental Health

15 October 2015