Office of the Public Advocate

Joint Standing Committee on the NDIS – Mental Health: Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

The role of the Public Advocate (Queensland)

The Public Advocate was established under the *Guardianship and Administration Act 2000* (Qld) to undertake systems advocacy on behalf of adults with impaired decision-making capacity who live in Queensland.

The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity in all aspects of community life. More specifically, the Public Advocate has the following functions:

- promoting and protecting the rights of adults with impaired capacity for a matter;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach the greatest practicable degree of autonomy;
- promoting the provision of services and facilities for the adults; and
- monitoring and reviewing the delivery of services and facilities to the adults.[1]

Response to the Terms of Reference

Some people with psychosocial disability may, at some point in their lives, if not on a regular and ongoing basis, experience impaired decision-making capacity. On this basis, it is considered appropriate for the Public Advocate to comment on factors impacting upon people with psychosocial disability as they seek access to the NDIS.

This submission addresses the Terms of Reference for the inquiry as they relate to the functions of the Public Advocate.

Eligibility criteria for the NDIS for people with psychosocial disability

NDIS access and eligibility criteria for people with psychosocial disability are, broadly, the same as those for people with other disabilities. The criteria require that potential participants meet the age, residence, disability and, if appropriate, early intervention requirements outlined in the *National Disability Insurance Scheme Act 2013* (Cth) (the Act).[2] Disability criteria[3] are similarly applicable across all disability types.[4] The Act also provides for variation in the intensity of the disability[5] which

[1] *Guardianship and Administration Act 2000* (Qld) s 209.
[2] ss 22-25.
[3] People are considered to have a disability if they have a permanent impairment or psychiatric condition that results in reduced functional capacity and reduced capacity for social and economic participation, and may require support for their lifetime.
[4] s 24.
[5] s 24(2).

has important implications for people with psychosocial disability whose functionality may vary periodically across their lifetime.

While these criteria are broad enough to allow entry into the NDIS for people with long-term mental health conditions, determining the nature of 'disability' for this group may not be as straightforward as it is for people whose disability is physically evident (e.g. someone who uses a wheelchair) or whose disability can be readily established by recognised evidence-based or expert sources (e.g. MRI scans). In contrast, it may be difficult for people with a long-term mental health condition to prove that they have a disability and require on-going support, particularly if the illness fluctuates. They may, for example, need to source evidence about their condition, treatment and life experiences from a range of authorities to support their claims of functional limitation.

Some reports,[6] along with a number of Queensland agencies that are engaged in the NDIS mental health sector,[7] have identified that problems with proving eligibility may be preventing many people with psychosocial disability from accessing the NDIS. National Disability Insurance Agency (NDIA) quarterly reports confirm the relatively low eligibility rates for people with psychosocial disability. The first quarterly report for 2016-2017 highlights that the eligibility rates for people with psychosocial disability are the lowest of all disability groups (apart from those included in the category of 'other') at 69.5 per cent.[8] People with psychosocial disability are, as such, generally less likely than all other identified groups of people with disability to secure NDIS funding and support.

The low NDIS participation rate of people with psychosocial disability is supported by evidence collected in the NDIS trial sites. The Mental Health Coordinating Council (the MHCC), for example, reports that in NDIS trial sites in the Hunter, New South Wales, a significant number of people with psychosocial disability receiving support through Partners in Recovery (PIR)[9] were assessed as ineligible for NDIS supports, with only 22 per cent of PIR applicants successful in securing packages.[10] Given the highly complex needs of many PIR service users, it was expected that most, if not all, would successfully transition into the NDIS.[11] It appears that this trend of people with psychosocial disability failing to qualify for the NDIS on the basis of disability may be continuing in Queensland with the Queensland Alliance for Mental Health reporting that more than half of participants in the Day to Day Living program who are currently receiving support from a service provider in a Queensland launch site were assessed as ineligible for the NDIS.[12]

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[6] See, for example, Mental Health Coordinating Council, *Further Unravelling Psychosocial Disability: Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis* (August 2015); Hunter Primary Care Ltd and 360 Health and Community, *Partners in Recovery and NDIS Interface* (2015) <https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf>; Queensland Alliance for Mental Health, *Queensland Transition to NDIS for Mental Health (QTN Forum) Communique* (October 2016) <http://qldalliance.org.au/queensland-transition-to-ndis-for-mental-health-strategic-forum/>.

[7] This office invited a number of service providers and agencies working in the area of mental health and psychosocial disability in the NDIS in Queensland to provide us with their feedback on the Terms of Reference for the inquiry and/or share their knowledge about psychosocial disability in the NDIS.

[8] National Disability Insurance Agency, *National Disability Insurance Scheme: COAG Disability Reform Council Quarterly Actuarial Report Ver 1* (October 2016) 45 <https://www.ndis.gov.au/about-us/information-publications-and-reports/quarterly-reports>.

[9] PIR clients have severe and persistent mental illness and complex needs. See Australian Government Department of Health, *Partners in Recovery: Coordinated Support and Flexible Funding for People with Severe and Persistent Mental Illness with Complex Needs* (August 2015) <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pir>.

[10] Mental Health Coordinating Council, *Further Unravelling Psychosocial Disability: Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis* (August 2015) 38.

[11] Ibid.

[12] Queensland Alliance for Mental Health, *Queensland Transition to NDIS for Mental Health (QTN Forum) Communique* (October 2016) 2 <http://qldalliance.org.au/queensland-transition-to-ndis-for-mental-health-strategic-forum/>.

There is also evidence to suggest, however, that where people with psychosocial disability have intensive support to access the NDIS and meet eligibility criteria, they are generally more likely to meet the evidence benchmark for disability. For example, some PIR services in the Hunter and Perth Hills found that when people with psychosocial disability received approximately 22-25 hours of support to become NDIS participants, their applications were often successful.[13] Support included informing the person about the NDIS, completing NDIS documentation, working closely with allied health staff and doctors to obtain the relevant documentation (which often required multiple visits), participation in planning meetings, and pursuing a review if the application was unsuccessful.[14] Another Queensland mental health agency has confirmed that intensive support may help achieve a positive determination of eligibility for the NDIS. These findings and comments suggest that the eligibility criteria are not unreasonable, only that a proportion of people with psychosocial disability need intensive support to establish their eligibility.

Unfortunately not all people with psychosocial disability will have access to this level of support. People who are not part of the existing system of community mental health services and who do not have access to professional supports facilitators may struggle to prove their eligibility. This group would include those who have varying levels of engagement with general practitioner (GP) doctors and other health or social systems (such as homelessness services, domestic violence services, carer organisations, community hubs, and the criminal justice system). It is unlikely that these services would have the resources, such as a sufficiently skilled workforce or capacity, to provide applicants with psychosocial disability with the intensive supports required to meet NDIS eligibility criteria.

The United Nations *Convention on the Rights of People with Disabilities* (UNCRPD) requires that people with disability receive the supports necessary to access services and systems in line with the principle of reasonable adjustment.[15] The Australian government is obligated to ensure that all people with disabilities, including people with psychosocial disability, who are seeking entry into the NDIS, have the supports necessary to assist them with accessing the NDIS.

The Public Advocate strongly urges the Committee to recommend the Australian Government establish and fund a network of appropriate supports to assist people with psychosocial disability to apply for entry to the NDIS or to seek review of decisions denying them access.

Additionally, anecdotal evidence from Queensland NDIS launch sites suggests that eligibility determinations made by NDIA staff in this state have been heavily reliant on diagnosis rather than functionality and the need for support. Some Queensland service providers have, for instance, commented that individuals with psychosocial disability who have a diagnosis of schizophrenia or depression are more likely to receive NDIS funding than those with diagnoses of post-traumatic

[13] Success rates were generally upwards of 80 per cent for applicants with psychosocial disability. See, for example, Hunter Primary Care Ltd and 360 Health and Community, *Partners in Recovery and NDIS Interface* (2015) <https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf>.

[14] Hunter Primary Care Ltd and 360 Health and Community, *Partners in Recovery and NDIS Interface* (2015) <https://hunterpir.com.au/wp-content/uploads/2015/12/PIR-NDIS-Interface.pdf>.

[15] United Nations, *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) preamble <http://www.un.org/disabilities/convention/conventionfull.shtml>.

stress disorder (PTSD), personality disorders, and other, less acknowledged conditions. This preference of diagnosis over the person's functionality undermines the original intent of the NDIS as proposed by the Australian Government Productivity Commission:

> *A comprehensive component would consider the supports that would allow a person to fulfil a range of functions, such as participate in their community. This component would be supports driven, and so would not solely focus on an individual's diagnosis or what they cannot do.*[16]

This emphasis on function is also better aligned with the recovery model, the underpinning framework for the mental health service system in Australia.[17] Some people with psychosocial disability resist being assigned a formal diagnosis and the label of 'disability', preferring to focus on their resources, strengths and capabilities. Individuals who prefer a strengths-based recovery approach may present themselves as recovering and functioning members of their communities rather than as medically unwell and consequently fail to demonstrate eligibility for the NDIS. There is, as such, a fundamental tension between the 'wellness' promoted within the recovery framework and the disability orientation of the NDIS. It will take a well-trained workforce to be able to manage this tension effectively and avoid excluding potentially eligible individuals from receiving the supports they need to participate socially and economically in Australian society.

The Public Advocate recommends that resources such as training, policy and procedure for key personnel in the NDIA (including assessors, planners and Local Area Coordinators (LACs)) recognise the centrality of the recovery framework when interacting with applicants and participants with psychosocial disability. These resources must provide NDIA staff with sufficient guidance regarding how to determine eligibility, develop robust plans, and provide support to people with psychosocial disability (who perceive their treatment and supports in terms of promoting recovery and 'wellness') to seek NDIS support.

We also recommend that the NDIA develops policy that clarifies the criteria for eligibility, aligns these criteria with the concept of functionality, and clarifies the degree to which diagnosis may influence eligibility decisions.

The transition to the NDIS of all current long- and short-term mental health Commonwealth Government funded services

As discussed above, early reports about the NDIS suggest that a significant proportion of people with psychosocial disability who are currently receiving supports through the Personal Helpers and Mentors Services (PHaMs) and PIR programs may not be successful in securing NDIS funding. If this trend continues, and PHaMs and PIR are phased out, many people with psychosocial disability could find themselves without essential supports and resources to live functionally in, and contribute to, their communities. It is therefore critical that individuals who require these (and similar) services

[16] Australian Government Productivity Commission, *Disability Care and Support: Productivity Commission Inquiry Report* Vol 1 No 54 (2011) 312 <http://www.pc.gov.au/inquiries/completed/disability-support/report>.
[17] Australian Health Ministers' Advisory Council, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (2013) 1 <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>.

have on-going access to these services post-rollout of the NDIS, irrespective of their eligibility for NDIS funding.

The widespread removal of crucial supports without replacing them with adequate service alternatives could result in the types of outcomes experienced by people with long-term mental health conditions during the deinstitutionalisation movement of the 1980s and 90s. Deinstitutionalisation resulted in substantially increased rates of homelessness,[18] criminalisation[19] and social rejection[20] among those living with serious mental illness. In their discussion on the negative impact of deinstitutionalisation on this group, Lamb and Bachrach (2001) warn against simply changing the form of service delivery without incorporating a range of other safeguards that include ensuring continuity of care.[21] It should not be assumed that simply transitioning to a new system of care and support for people with psychosocial disability will result in improved outcomes for either the people themselves or the communities in which they live. People's individual systems of recovery (including treatment, paid and unpaid supports, resources and networks) must be transitioned with them.

The Public Advocate recommends that Commonwealth Government-funded long- and short-term mental health services must continue for those people with psychosocial disability who are not initially considered eligible for the NDIS. These people should have access to support so that they can gather sufficient evidence of disability and seek reviews of NDIA decisions. Their regular supports should be continued as a safeguard against falling into crisis and also to minimise the possibility that some may experience chronic, lifelong engagement with the human service and criminal justice systems.

The transition to the NDIS of all current long- and short-term mental health state and territory government-funded services

In Queensland, most community-based support services for people with psychosocial disability are funded through the Department of Communities, Child Safety and Disability Services (DCCSDS). DCCSDS, for example, currently funds the Housing and Support Program (HASP) which supports people with psychiatric disability to live in the community in stable social housing.[22] The program involves collaboration between the Department of Housing and Public Works, Queensland Health, and community-based mental health service providers.[23] It is expected that HASP will gradually be phased out as clients transfer to the NDIS. As HASP participants generally meet the NDIS eligibility, it

[18] H R Lamb and L L Bachrach, 'Some Perspectives on Deinstitutionalization' (2001) 52(8) *Psychiatric Services* 1039-45.
[19] Ibid.
[20] Eric R Wright, William P Gronfein and Timothy J Owens, 'Deinstitutionalization, Social Rejection, and the Self-Esteem of Former Mental Patients' (2000) 41(March) *Journal of Health and Social Behavior* 68-90.
[21] Above n 18.
[22] Queensland Health, *Housing and Support Program (HASP)* <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/resources/housing-support>.
[23] Ibid.

is reasonable to expect that most, if not all participants in these existing programs should transition to the NDIS.

The situation is not as straightforward for potential NDIS participants with psychosocial disability who are currently receiving treatment or supports funded through other Queensland Government agencies. For example, people with mental health conditions who are receiving inpatient treatment in mental health facilities (under involuntary treatment orders (ITOs) or forensic orders) are considered to be receiving mainstream health services. Consequently, while they are receiving treatment and services as inpatients of the health system, they have limited, if any, access to NDIS funding.[24]

Key objectives of treatment for individuals under ITOs or forensic orders include strengthening their ability to live ordinary lives, participate socially and economically in society, and achieve the greatest autonomy possible. Some people with long-term mental health conditions will, however, require on-going access to inpatient mental health treatment. As a consequence, some people with serious, chronic mental health conditions will cycle in and out of inpatient treatment facilities for much of their lives even as they strive to live functionally and meaningfully in their communities.

There is, as such, urgent need for the development of a robust interface between the various systems that will facilitate the seamless, periodic transitioning of people from community living to inpatient treatment and then to community living again. This interface must be in place for the duration of people's lives. At present, we have been unable to determine whether any formalised arrangements or protocols have been established between the NDIA, Queensland Health, and the Queensland Department of Housing that will enable people with serious, long-term mental health conditions to move seamlessly between systems of support (NDIS) and treatment (Queensland Health) without compromising other vital facets of their lives (e.g. their housing and community supports).

Clearly, there needs to be a formal recognition of the needs of this group and arrangements established that facilitate seamless transitions between mainstream Queensland Health services and NDIS funded supports and services whenever required. HASP provides a practical example of the type of commitment and cooperation required to support people to transition out of inpatient services into the community. If cooperation between the NDIS and state health authorities fails, there is the risk that people who enter inpatient mental health services may experience barriers to moving back into the community. People should not be disadvantaged because government agencies at federal and state levels cannot coordinate the essential services that support their recovery.

As part of this coordinated approach, there is also a need for state and territory governments to establish internal processes for identifying inpatients who are eligible for, and may benefit from, NDIS services and supports. We are aware, for example, that Queensland Health has established an NDIS transition team to progress the transition of existing Health and Hospital Services (HHS) users to the NDIS. However, we expect that many of these potential NDIS participants will require significant support to compile the evidence necessary to meet the eligibility threshold and to ensure

[24] The Council of Australian Governments' *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* (2013) outline what each department is able to deliver so that overlap of services is avoided, and people do not receive the same, or similar, supports and services across multiple systems.

that the many aspects of their lives are coordinated. Such an approach does, therefore, need to be appropriately resourced.

The Public Advocate recommends that the NDIA and state and territory governments establish protocols for responding to people with lifelong psychosocial conditions who cycle in and out of inpatient mental health services, to ensure seamless transition from the inpatient, state-based services to community-based, NDIS services and supports. These protocols need to be developed with a commitment to the NDIS values of choice and control and the goal of supporting people to participate socially and economically in the community with the greatest possible degree of autonomy.

State and territory governments should also invest in time-limited projects that facilitate the transition of people with psychosocial disability into the NDIS, providing them with adequate supports to access the system and demonstrate eligibility. In the event that some are still deemed ineligible for NDIS supports, we recommend that governments continue to provide services and support to this group in addition to clinical treatment.

Funding for mental health services under the Information, Linkages and Capacity building framework

It should not be assumed that Information, Linkages and Capacity Building (ILC) services can adequately fill the gap left by the phasing out of state, territory and Commonwealth mental health services. While the ILC will offer a range of information and mentoring services to people, this program cannot provide the direct supports that will be lost under the closure of state, territory and Commonwealth mental health programs. Information supports are important to the wellbeing of people with psychosocial disability, however they are not sufficient to address people's very practical, functional and sometimes urgent day-to-day service and support needs.

Some agencies in Queensland have also suggested to our office that not all ILC programs will be sufficiently equipped to provide the necessary services to people with psychosocial disability. One provider argued that generalist disability responses may not be appropriate in all instances for this group and that ILC services for people with psychosocial disability will need to have specialist knowledge of services and mainstream supports that are specifically relevant to people with mental health issues. We understand that this type of specialist knowledge is not consistently being demonstrated by ILC services.

The Public Advocate recommends that the Committee recommends that a proportion of ILC funding is quarantined specifically for the provision of mental health ILC services.

We also caution government and the NDIA against viewing the ILC as an adequate alternative to direct support services for people with psychosocial disability who are unsuccessful in securing NDIS funding.

The planning process for people with psychosocial disability, and the role of primary health networks

Service providers and agencies have advised this office that the successful transition of people with psychosocial disability into the NDIS, along with the development of well-constructed NDIS plans, is heavily reliant on the knowledge and skills of NDIS planners. Anecdotal reports indicate, however, that the capabilities and knowledge of planners vary widely, and planners' knowledge about psychosocial disability, the recovery model, and mainstream and specialist resources and services is frequently inadequate. Some providers have suggested that the NDIA should employ planners with a background in psychosocial disability and/or establish a specialist group of planners with expertise in psychosocial disability to undertake planning specifically with this group.

The Public Advocate recommends that the NDIA ensures that planners and other key NDIA staff, such as LACs, are sufficiently knowledgeable about, and skilled in, identifying and addressing issues associated with psychosocial disability.

Our office has also been informed that planners are undertaking the NDIS planning process via telephone rather than by engaging face-to-face with people. They often do so without the participant having a support person or advocate present. Providers suggest that this method of engagement is not always suitable for people with psychosocial disability and is therefore likely to result in poorer quality, less appropriate plans leading to early re-negotiation of plans, thus adding significantly to the cost of planning for the NDIA.

The Public Advocate recommends that the NDIA review its current protocols regarding planning to ensure that participants are offered the opportunity to undertake planning in person, and to have a support person, advocate or other person who is knowledgeable about their goals, aspirations, and needs present during planning discussions.

We are aware that there is controversy about the engagement of primary health networks (PHNs) in the planning process.[25] There is some acknowledgement that a multi-disciplinary and evidence-based approach to planning may assist with developing robust NDIS plans. Both the PIR and PHaMs initiatives, for example, support recovery in mental illness and psychosocial disability using a wrap-around approach that facilitates the coordination of systems and an integrated approach to treatment and support. From this perspective, a robust approach to planning that includes relevant stakeholders and key professionals and practitioners within people's primary health networks and multi-disciplinary teams is more likely to result in a more comprehensive plan and approach to services and support. We are aware, however, that some people with psychosocial disability have a different philosophical approach to their condition and consider that a recovery approach should not be dominated by the medicalisation of mental illness and disability. Individuals who take this approach may resist the involvement of PHNs in the planning process. While we acknowledge that PHNs are well placed to understand the local community health context, identify gaps in health

[25] PHNs have been established to improve health practitioners' efficiency and effectiveness by coordinating patient treatment. See Australian Government Department of Health, *PHN Background* <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background>.

service needs, and contribute to a coordinated approach to meeting people's needs, the underpinning principles of the NDIS – choice and control – must be honoured.

We expect that the need to balance the robustness of planning and supports with ensuring people's autonomy will remain a central tension in the NDIS. The two approaches are not antithetical; the synthesis of these approaches does, however, require sensitive handling and sophisticated decision-making by those involved.

The Public Advocate recommends that NDIA staff, particularly planners and LACs, be provided with professional development in dealing with some of the complex elements of their roles such as managing the tensions between honouring choice and respecting differing values and philosophies while still ensuring that participants have robust plans and systems of support that sustain wellbeing and participation to the maximum possible degree.

Spending on services for people with psychosocial disability

Given the limited information available from the NDIA, the early stage of rollout, and regular upward projections regarding the costs of the NDIS,[26] it is not possible for this office to determine whether spending for people with psychosocial disability is in line with projections.

We note, however, that the proportion of people with psychosocial disability who are currently in receipt of an NDIS package is lower than expected. According to the NDIA's 4th quarterly report on the NDIS for 2015-2016, 7 per cent of people with an approved NDIS plan list psychosocial disability as their primary disability.[27] This proportion drops to 5.8 per cent for the first quarter of 2016-2017.[28] The MHCC, however, anticipates that at full roll-out, the percentage of NDIS participants with psychosocial disability as their primary disability should constitute approximately 13 per cent of the total number of NDIS participants (an estimated 57,000 of 430,000 participants).[29] While we acknowledge that the NDIS is still at an early stage of rollout, the disparity between rates of early engagement (approximately 6 per cent) and actual projections (13 per cent) is concerning: the current level of engagement by people with psychosocial disability is less than half of what was projected by the MHCC.

Additionally, figures provided by the NDIA during the final quarter of 2015-2016 indicate that approximately 5.7 per cent of NDIS funding (committed supports expected to be provided in 2015-26) is being provided to participants with psychosocial disability as their primary disability.[30] This percentage seems low given:

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[26] Andrew Baker, 'The New Leviathan: A National Disability Insurance Scheme' (2012) 131 *CIS Policy Monograph* 1.
[27] National Disability Insurance Agency, *Quarterly Report to COAG Disability Reform Council* (30 June 2016) 34 <https://www.ndis.gov.au/about-us/information-publications-and-reports/quarterly-reports>.
[28] Above n8, 49.
[29] Above n 10, 15.
[30] Above n 27, 40.

- the anticipated proportion of involvement of people with psychosocial disability in the NDIS (see previous paragraph), and
- the average annualised cost of a plan for a participant with psychosocial disability ($36,491[31]) is almost the same as that of the average annualised cost per participant irrespective of disability ($36,049[32]).

Considering that the average value of NDIS packages for participants with psychosocial disability is currently very close to that of NDIS participants generally and the expected participation levels of people with psychosocial disability are less than expected, we can reasonably assume that spending on NDIS supports for people with psychosocial disability is relatively low in comparison to some other groups of people with disability.

There is insufficient information provided in the NDIA reports to determine the reasons for this trend. The lower participation rates may be reflective of barriers experienced by people with psychosocial disability with respect to accessing the NDIS and securing packages (some of which we have already outlined in this submission). If this is the case, work needs to be done to clearly identify those factors that are acting as barriers, and develop strategies to address them and increase NDIS participation rates for people with psychosocial disability.

The Public Advocate recommends that the NDIA conducts a review into the allocation of NDIS packages for people with psychosocial disability to determine whether participation in the NDIS, and expenditure on this group, is lower than expected. If participation and/or expenditure is relatively low, we recommend that the NDIA take steps to identify the barriers to participation for this group and address them.

The role and extent of outreach services to identify potential NDIS participants with psychosocial disability

This office has not been able to locate comprehensive information about the extent of government and non-government outreach activities to people with psychosocial disability who may benefit from the NDIS. We are, however, aware that the Queensland Government has funded 11 organisations to undertake outreach to people with disability living in Queensland and assist them with preparing for the NDIS. Two of these organisations – Connections and Mental Illness Fellowship Queensland – have been undertaking outreach, in the form of participant readiness activities, to people with mental illness and their carers throughout Queensland. Queenslanders with Disability Network has also been funded to reach vulnerable populations of people with disability (including those with psychosocial disability) and provide them with information about the NDIS.

The funding for these initiatives is, however, limited and insufficient to undertake the breadth and types of activities that will be needed to reach the bulk of Queenslanders with psychosocial disability who may be eligible for NDIS funding. Of particular concern are those people external to existing social service systems and those who, as a result of previous negative experiences with formal

[31] Above n 27, 55.
[32] Ibid.

systems, are unwilling to engage with the NDIS. There are also others who may choose not to access the NDIS due to the stigma associated with mental illness. Many others may simply not know about the NDIS or may lack capacity to understand what the NDIS offers or how to access it and progress an application. These individuals will probably require considerable support to secure NDIS funding.

While the Queensland Government should be commended for funding the participant readiness outreach project, **the Public Advocate recommends** that additional commitment from Commonwealth, state and territory governments is needed to identify people in hard-to-reach groups, including those in institutional care (such as prisons, hospitals and residential aged care facilities) and assist them to access the NDIS. These initiatives will need to be far-reaching and appropriately resourced so that people are not merely identified and informed, but also are provided with the necessary supports to access the system and secure NDIS funding.

Providers and agencies working in the mental health space have also raised the importance of educating and supporting GPs to identify and facilitate access to the NDIS for people with psychosocial disability. GPs are often the 'frontline' access point to treatment for this group, and if resourced with information about the NDIS and how they can streamline people's access, they may play a critical role in identifying potential participants and providing them with essential information.

The Public Advocate recommends that the NDIA develops and proactively markets resources and training for GPs to: inform GPs about the NDIS; explain the importance of referring potential participants to the NDIS; assist GPs with identifying potential NDIS participants; provide GPs with information about agencies with resources that can assist people with psychosocial disability to access the NDIS; and explain the types of evidence required to support a patient's application for the NDIS.

The provision and continuation of services for NDIS participants in receipt of forensic disability services

In this office's 2016 submission to the Senate Community Affairs References Committee's Inquiry into the *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, we recommended that people with impaired decision-making capacity (which may include people with psychosocial disability) should, where appropriate, be transitioned from mental health facilities and forensic environments to NDIS-based supported community living arrangements at the earliest possible opportunity.[33] We continue to support this position. A key issue is how these individuals will gain access to the NDIS, be supported to apply for funding and develop a plan, and be transitioned appropriately into community based settings.

In instances where individuals are unable to immediately, safely and appropriately transition to community living, it will be necessary for the NDIA and the health and corrective services systems to

[33] Office of the Public Advocate (Qld), *Submission to the Senate Community Affairs References Committee: Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (April 2016) <http://www.justice.qld.gov.au/public-advocate/submissions> 27-28.

ensure that the treatment aspects of people's care are carefully integrated with their long-term disability supports. For example, individuals under ITOs or forensic orders may need to put their NDIS plans on hold during the period they are receiving treatment in a facility or are incarcerated. Additionally, individuals whose incarceration or inpatient treatment is ending may need support to apply for NDIS funding. This support could come from:

- forensic and mental health services staff, who could assist patients to liaise with the NDIA and/or apply for NDIS funding, or
- a team funded by the NDIA to liaise with individuals in these services directly and support them to apply for NDIS funding.

If this transition is managed well for participants, these services may ultimately help reduce rates of relapse and recidivism, and prevent highly vulnerable people from cycling through the health, criminal justice and human service systems for much of their lives.

The Public Advocate recommends that the NDIA and state and territory governments develop joint action plans to facilitate the transition of people currently in forensic disability services into the NDIS. We similarly recommend that these action plans address the assessment and transitioning of eligible people under forensic orders or ITOs into the NDIS.

Final comment

It was apparent from our discussions with agencies and providers in the development of this submission that the Terms of Reference for the inquiry are highly relevant to the Queensland mental health sector at this time. It was also evident from our investigations that significant further work needs to be undertaken by all levels of government and the NDIA to address issues affecting access to, and participation of, people with psychosocial disability in the NDIS.

The recommendations made in this submission are aimed at supporting the Committee's work in this area and are summarised below.

The Public Advocate strongly urges the Committee to recommend to the Australian Government that:

- a network of appropriate supports, sufficient for assisting people with psychosocial disability to apply for entry to the NDIS or to seek review of decisions denying them access, be established and funded.

- resources such as training, policy and procedure for key personnel in the NDIA (including assessors, planners and LACs) recognise the centrality of the recovery framework when interacting with applicants and participants with psychosocial disability. These resources must provide NDIA staff with sufficient guidance regarding how to determine eligibility, develop robust plans, and provide support to people with psychosocial disability (who perceive their treatment and supports in terms of promoting recovery and 'wellness') to

seek NDIS support. We also recommend that the NDIA develops policy that clarifies the criteria for eligibility, aligns these criteria with the concept of functionality, and clarifies the degree to which diagnosis may influence eligibility decisions.

- Commonwealth Government-funded long-and short-term mental health services must continue for those people with psychosocial disability who are not initially considered eligible for the NDIS. These people should have access to support so that they can gather sufficient evidence of disability and seek reviews of NDIA decisions. Their regular supports should be continued as a safeguard against falling into crisis and also to minimise the possibility that some may become chronic, lifelong users of human service and criminal justice systems.

- the NDIA and state and territory governments establish protocols for responding to people with lifelong psychosocial conditions who cycle in and out of inpatient mental health services, to ensure seamless transition from inpatient, state-based services to community-based, NDIS services and supports. These protocols need to be developed with a commitment to the NDIS values of choice and control, and the goal of supporting people to participate socially and economically in their communities with the greatest possible degree of autonomy. State and territory governments should also invest in time-limited projects that facilitate the transition of people with psychosocial disability into the NDIS, providing them with adequate supports to access the system and demonstrate eligibility. In the event that some are still deemed ineligible for NDIS supports, we recommend that governments continue to provide services and support to this group in addition to clinical treatment.

- a proportion of ILC funding is quarantined specifically for the provision of mental health ILC services. We also caution government and the NDIA against viewing the ILC as an adequate alternative to direct support services for people with psychosocial disability who are unsuccessful in securing NDIS funding.

- planners and other key NDIA staff, such as LACs, are sufficiently knowledgeable about, and skilled in, identifying and addressing issues associated with psychosocial disability.

- the NDIA review its current protocols regarding planning to ensure that participants are offered the opportunity to undertake planning in person, and to have a support person, advocate or other person who is knowledgeable about their goals, aspirations, and needs present during planning discussions.

- NDIA staff, particularly planners and LACs, be provided with professional development in dealing with some of the complex elements of their roles such as managing the tensions between honouring choice and respecting differing values and philosophies while still ensuring that participants have robust plans and systems of support that honour sustain wellbeing and participation to the maximum possible degree.

- the NDIA conducts a review into the allocation of NDIS packages for people with psychosocial disability to determine whether participation in the NDIS, and expenditure on this group, is lower than expected. If participation and/or expenditure is relatively low, we

recommend that the NDIA take steps to identify the barriers to participation for this group and address them.

- Commonwealth, state and territory governments undertake outreach projects to identify people in hard-to-reach groups, including those in institutional care (such as prisons, hospitals and residential aged care facilities) and assist them to access the NDIS. These initiatives will need to be far-reaching and appropriately resourced so that people are not merely identified and informed, but also are provided with the necessary supports to access the system and secure NDIS funding.

- the NDIA develops and proactively markets resources and training for GPs to: inform GPs about the NDIS; explain the importance of referring potential participants to the NDIS; assist GPs with identifying potential NDIS participants; provide GPs with information about organisations/agencies with resources that can assist people with psychosocial disability to access the NDIS; and explain the types of evidence required to support a patient's application for the NDIS.

- the NDIA and state and territory governments develop joint action plans to facilitate the transition of people currently in forensic disability services into the NDIS. We similarly recommend that these action plans address the assessment and transitioning of eligible people under forensic orders or ITOs into the NDIS.

Thank you for the opportunity to provide feedback in relation to the Joint Standing Committee's inquiry into the implementation, performance and governance of the NDIS. Should the opportunity arise, I would be pleased to be part of further consultations in relation to this inquiry or any of the matters discussed in this submission.

Yours sincerely

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